Mental Health Services Review
First Nations and Inuit Health Branch
Manitoba Region

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UNIVERSITY OF MANITOBA

CENTRE for Aboriginal Health RESEARCH

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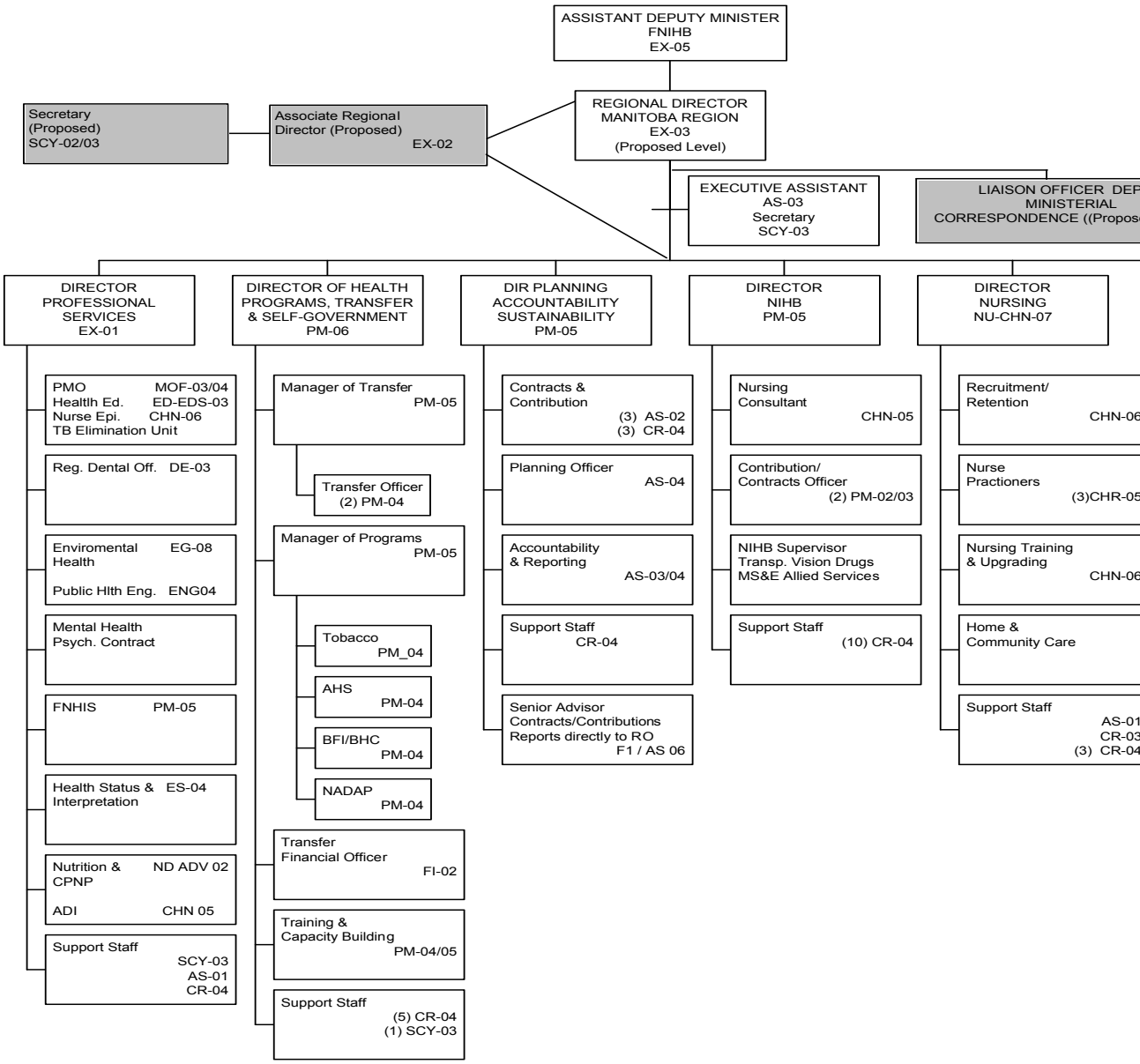

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1. Introduction

This review of the Mental Health Services of FNIHB, Manitoba Region, was conducted at the request of the regional director over a period of several months between April and July of 2003. The purpose of the review was to examine all aspects of mental health programming and services undertaken by FNIHB, Manitoba Region and to provide recommendations for change that address the following areas:

- Most effective use of available resources (funding and personnel).
- Interdisciplinary programs planning and delivery, at both management and field levels.
- Professional support system for field workers.
- Recommendations for program revision, based on best available evidence.

The report consists of five sections. After the introduction there is a brief section describing the methods of the inquiry. The third section provides a descriptive overview of FNIHB Manitoba Region's mental health services. Section four details the major themes and issues identified through the interviews and the review of the documentation, providing an account of both successes and challenges faced by the department and its various initiatives. The final section provides a list of recommendations for the department to consider as a way to improve its delivery of services.

We wish to acknowledge all those that generously gave of their time by participating in the interviews, and in some cases also providing documentation they considered relevant to the review. It is our hope that this report will be of use to further improve the valuable mental health services provided by FNIHB.

2. Methods

The main source of information for this review came from interviews with different stakeholders. The researchers met individually or in small groups with 48 individuals. Of these: nine were mental health therapists with Standing Offer Agreements (SOA) and fee-for-service contracts, 14 were community workers (BHC/BFI/NNADAP/CHR/Band Councilors/CFS)[1] from four communities, nine FNIHB management, nine Tribal Council and other First Nations organizations representatives, three were former FNIHB management personnel, two physicians, and two staff members from provincial departments.

Eighty percent of the interviews were taped and transcribed. For the other 20% notes were taken during the interview. As well, numerous documents were reviewed. Appendix A provides the document listing. Finally, observations were made during field visits while conducting interviews.

Interviews were designed to elicit information on the following topics:

- Deficiencies in the current system
- Potential changes and revisions to current programs
- Identification of new programs or services of potential benefit
- Review of surveillance mechanisms, including events and measurable outcomes.

The data were analyzed to identify themes and patterns. Triangulation methods were used to verify information. These methods were of two types, information from one source (e.g., interviewee) was validated by at least one other source (e.g., a second interviewee), or information gathered by one method (e.g., interview) was validated by another method (e.g., documentation). Because most of the information was gathered via individual interviews and small groups, the former approach to triangulation was the most frequently used. The criteria were the following: information that resulted in theme identification had to come from at least three independent sources, information resulting in identification of an issue of relevance had to come from at least two independent sources. As well, original ideas that were consistent with the overall evidence were selected for further discussion by the research team and consideration in the context of developing recommendations.

The **Centre for Aboriginal Health Research (CAHR)** is a joint initiative of the University of Manitoba and the Assembly of Manitoba Chiefs. All work involving First Nations in Manitoba is conducted in consultation with the AMC Health Information and Research Committee (HIRC)[2]. This project was presented to HIRC and the committee supported CAHR to undertake the project. Periodic progress reports were provided to HIRC and their comments and insights were taken into consideration.

[1] BHC-Building Healthy Communities; BFI-Brighter Futures Initiative; NNADAP-National Native Alcohol and Drug Abuse Program; CHR-Community Health Representatives; CFS-Child and Family Services.

[2] HIRC members include representation from AMC, MKO, SCO, all Tribal Councils in Manitoba and Independent Bands in northern and southern Manitoba.

3. Description of FNIHB Manitoba Region mental health services

FNIHB Manitoba Region provides mental health services in a number of ways through different programs. The review will briefly describe each of these programs.

3.1. FNIHB Manitoba Region

The organizational chart (see Diagram 1) of the FNIHB Manitoba Region describes two separate divisions that have responsibilities related to mental health: 1) Director of Professional Services, and 2) Director of Health Programs, Transfer and Self-Government. Departmental documentation refers to a mental health services continuum, that ranges from promotion and preventive services, to crisis intervention and institutional referrals. However, the organizational structure appears to be set in relation to funding streams and type of funding arrangements rather than to a mental health program approach that would coordinate the mental health continuum. In addition, other programs such as nursing, that is also relevant to mental health services via primary care, does not appear to have close connections to mental health portfolios. Consequently, the main problem appears to be that positions with portfolios relevant to mental health fall into separate divisions, presenting a structural obstacle to a more coordinated work within the mental health continuum.

There are seven Tribal Councils in Manitoba, and all are active in health and mental health issues. Contribution Agreements exist with Tribal Councils for mental health services. There is also a Contribution Agreement with the Assembly of Manitoba Chiefs for a Youth Secretariat. These agreements require continual working relationships between FNIHB and these organizations.

3.2. Brighter Futures Initiative (BFI)

This program is intended to support community-based activities within a community development framework that fosters the well being of First Nation children, families, and communities. It covers the areas of mental health, child development, parenting, healthy babies, and injury prevention. Its objectives are: to increase awareness and improve knowledge and skills in those areas for front line workers and community members, to provide opportunities to improve health services and develop community based model projects, to address health problems affecting children and families in a community-based, holistic and integrated manner, to improve the health of children by facilitating the prevention of and early intervention on health problems, to support community development, and to ensure integrated and coordinated care for children and families by coordinating human services sectors (health, social services, justice, education, employment). All 62 First Nations communities in Manitoba have one BFI worker, and several communities have two.

3.3. Building Healthy Communities (BHC)

This initiative is intended to support the development of specialized community-based mental health treatment services, crisis intervention services, and solvent abuse prevention programming. It is intended to cover mental health crisis management, community-based mental health training, mental health aftercare/follow-up, solvent abuse, solvent abuse early intervention, solvent abuse prevention, and solvent abuse aftercare. Its objectives are to establish a community-based mental health crisis management program, enhance community management and control and provide necessary tools to tackle problems of hopelessness and suicide in communities in crisis, address critical gaps in mental health services and programs, and provide crisis intervention, aftercare, and training for caregivers and community members. Specifically, it is intended to provide supports for intervention in crisis situations in order to reduce the number of suicide attempts and other violent crisis situations. All 62 First Nations communities in Manitoba have one BHC worker, and some communities have two. The Assembly of Manitoba Chiefs sponsors a Manitoba Community Wellness Working Group (MCWWG) consisting of representatives from the seven Tribal Councils. FNIHB provides some technical support to the MCWWG. This working group oversees the design, development, implementation, and evaluation of both the BFI and BHC programs.

3.4. National Native Alcohol and Drug Abuse Program (NNADAP)

The goal of NNADAP is to support First Nations communities in establishing and operating programs aimed at arresting and off-setting high levels of alcohol, drug, and solvent abuse. Most of NNADAP's activities are included in the following four areas of emphasis: prevention, treatment, training, research and development. All 62 First Nations communities in Manitoba have at least one NNADAP worker, and several communities have more. First Nations communities and organizations largely control the implementation of the program at the local level. These are alcohol and drug abuse community based prevention programs. The NNADAP program also includes a network of 54 treatment centres across the country, representing approximately 700 inpatient treatment beds. Community NNADAP workers refer individuals to these treatment centres.

3.5. Crisis Intervention/Mental Health Services

This is an intervention set up to fulfill the mandate of the Interim Program Directive for Mental Health Services of 1994. It is a non-insured health benefit. As such, the program provides "limited funding of last resort for professional mental health treatment for individuals and communities in at risk, crisis situations." The purpose of Directive 94 was to provide "professional mental health treatment required on an early intervention, short-term basis, to address at-risk, crisis situations when such treatment is not available elsewhere…" (Health Canada, 1994). The documentation indicates that treatment may be provided to either individuals in a private practice setting or individuals in their community. The methods of service delivery can include: a) service to individuals by

therapists in a private practice setting; b) Medical Services Branch contracts with mental health therapists; or c) Medical Services Contribution Agreement with First Nations. The first option is fee for service, whereas the second option is done via Standing Offer Agreements (SOA) with the therapists. In essence, all therapists are contractors, including the acting manager of these services at FNIHB. Directive 94 recognizes the disciplines of clinical psychology, psychiatric nursing, and social work, and requires that "the therapist(s) providing service, or supervising it, are registered/licensed with their professional College or Association in the province in which the service is provided…" There is provision to contract therapists that are not registered with one of the above licensing bodies, but are so with another professional body (eg., Canadian Counselling Association). These therapists are required to receive clinical supervision from one of the recognized supervisors. All therapists are required to carry professional liability insurance of no less than $2,000,000. Therapists are approved by the acting manager of the services, based on meeting the above criteria and through a bidding process. The rates for therapists under SOAs vary from $400 to $550 per day, to a large extent dependent on the outcome of negotiations with the program manager. Fee-for -service rates range from $65 to $85 per hour of clinical work, according to the credentials of the therapist. Therapists under SOAs provide mental health services in First Nations communities, whereas fee-for-service practice is done outside of reserves. Some fee-for-service therapists also provide suicide clearances of individuals "medivaced" into Winnipeg, authorizing those who have attempted suicide or were at high risk to return to their communities. As well, some clinical supervisors are paid fee- for-service. Tribal Councils that have signed Contribution Agreements with FNIHB are responsible for hiring and overseeing the therapists, although they must follow the same criteria and standards. As well, they are expected to send accountability information to the manager of mental health services.

Currently, there are 14 mental health therapists under contract that travel to different First Nations communities in Manitoba, on average six days a month to each community. Of the 14, six are First Nations therapists and one is of aboriginal ancestry. The emphasis of the program is on crisis intervention. The therapist's responsibilities are grouped in three areas, Clinical and Crisis Intervention, Community Development, and Administrative/Deliverables. Within the first area, therapists are required to provide the Mental Health Services manager with an initial Diagnostic Assessment/Treatment Plan and subsequent Progress Reports. Prior Approval Numbers (PAN) are provided by the Mental Health Services manager after receiving the diagnostic assessments from the therapists, and authorization for six initial sessions and then up to a maximum of 12 additional sessions if required. In exceptional circumstances, more sessions have been authorized. Among other requirements, therapists are to assist with crisis responses as needed in conjunction with the health team and community based program staff. Community development responsibilities include participating in counseling skill transfer processes with community health team members, and to provide workshops and seminars on various relevant topics. Twenty percent of the time of the therapist in the community is to be dedicated to community development initiatives.

There is also a list of therapists that provide services off-reserve on a fee for service basis. They also are required to meet the same credentialing and professional liability insurance criteria. Therapists are contracted following the approval of the Mental Health Services manager. Currently there are approximately 60 mental health therapists on the service provider list.

FNIHB has a Contribution Agreement with the Assembly of Manitoba Chiefs for a Youth Suicide Prevention initiative. The purpose of the initiative is to review protocols of FNIHB's mental health therapists in relation to crisis management, suicide attempts, seeking to make them more culturally relevant. The initiative also provides training to First Nations youth on suicide prevention.

3.6. Health Centres/Nursing Stations (Nurses and physicians)

Nursing stations and health centres in First Nations communities play an important role, albeit sometimes not clearly recognized, in providing mental health services. Nurses are frequently the entry point into the system. However, few nurses have specialized training in the area of mental health, and their primary role is referral.

Depending on the size and location of the community, physician services are provided on a contractual or fee for service basis. In several larger communities in northern Manitoba, physicians reside in the community, in others, physicians fly in for several days each week. Where communities are close to towns or cities, residents access physicians in their offices and clinics. Although these family physicians are qualified to provide mental health services, these services are generally in response to crisis or rely on referral of seriously ill patients to specialists. There is little interaction between nurse/physicians and the other mental health services and therapists as described above.

3.7. Psychiatric centres (psychiatrists)

Individuals that have attempted suicide or are at high risk, as well as individuals diagnosed with other severe psychiatric disorders are referred to psychiatric centres in urban centres of Manitoba. It is here that the major contact with psychiatrists occurs. Adolescent inpatient care is provided at Manitoba Adolescent Treatment Centre, the Centre for Adolescent Treatment in Brandon and at the Health Sciences Centre. Adult inpatient care is provided at a ten bed unit in Thompson, an eight bed unit in The Pas, a ten bed unit in Dauphin (each with one psychiatrist), the Adult Mental Health Centre in Brandon, Eden Mental Health Centre in Winkler, Selkirk Mental Health Centre and the five hospitals in Winnipeg with psychiatric beds including the Health Sciences Centre, St. Boniface Hospital, Seven Oaks Hospital, Grace Hospital and the Victoria General Hospital. The rural centres provide care primarily to individuals living in their catchments areas. Selkirk Mental Health Centre provides rehabilitation, extended treatment and long-term forensic psychiatric services to individuals throughout Manitoba and acute psychiatric services to the Interlake, South and North Eastman regions and some services to the Norman and Burntwood regions as well as Nunavut. The Winnipeg hospitals primarily provide services to residents of Winnipeg with the exception of the

Manitoba Adolescent Treatment Centre and child and adolescent services at the Health Sciences Centre. A few individuals receive out patient psychiatric care or are followed by psychiatrists in private offices (funded by Manitoba Health similar to any other medical practitioner). Itinerant psychiatric care has been provided by psychiatrists affiliated with the J. A. Hildes Northern Medical Unit in Hodgson, Norway House and Churchill. One psychiatrist travels regularly to Shamattawa. Consultant psychiatric care is available to the Crisis Stabilization Units in Selkirk and at the Salvation Army and Sarah Riel C.S.U.'s in Winnipeg where patients are admitted for brief crisis oriented care.

4. Mental Health Services: Themes and Issues

This section presents major themes and issues that emerged from the numerous interviews held with different stakeholders. It seeks to capture the issues identified by interviewees as relevant to the review.

4.1. Mental Health Issues in First Nations

There is limited epidemiological data on the mental health of First Nations in Manitoba. Efforts to increase and improve the availability of this information need to continue and would be welcomed by the stakeholders. For the purposes of the review this section outlines issues that interviewees considered important based on their work experience (the order of topics does not imply priorities). These are not diagnostic categories, but the actual terminology of the interviewees. They are distinct (albeit related) issues that they consider as part of mental health and thus within the area of responsibility of mental health services. The list suggests that issues categorized as pertaining to mental health cover a wide range.

Somatizations
Intergenerational issues
Parenting
Depression
Trauma
Post Traumatic Stress Disorders
Suicide ideations
Suicides
Accidental deaths
Solvent abuse
Families
Alcohol abuse
Prescription drug abuse
Addictions
Problems underlying the addictions
Gambling
Anger management
Well-being of individuals with chronic illnesses
Stress
Anxiety
Grief
Loss
Violence
Relationship issues.

There was some insistence that the stigma related to mental health is quite present among community members, and that it still plays a deterrent role in seeking help before a crisis occurs. As a result, crisis situations in many cases provide the opening for people to begin to talk about their issues.

4.2. BFI/BHC, NNADAP workers (local workers)

The importance of the work done by local workers was highlighted in many of the interviews. There was a general agreement that they play a very relevant role in the mental health services provided by FNIHB. The main issues that were raised can be categorized as follows: role, support, and training.

Role

Some interviewees mentioned that the roles of the BFI/BHC and NNADAP workers were at times not clear to them. The evidence suggests that their actual roles vary to some degree among the different communities in accordance with different realities. The general consensus is that they do preventive work and mental health promotion activities, and that there is a move towards more service delivery (e.g., counseling). Local workers may follow-up on individuals at risk that are seen by the therapists or that may have returned from treatment centres. Some BFI/BHC workers expressed a concern that although they felt they were supposed to provide counseling, they did not have the necessary training or qualifications. Some confusion was mentioned in relation to changes that occur from year to year about distinct responsibilities of the BFI and BHC programs (e.g., solvent abuse). An issue that came up with some insistence was the need for youth workers, given the high percentage of youth population, and because youth appear to relate better with someone closer in age. Concerns were raised that local workers might at times feel overburdened, in particular because they are required to respond to crisis any day or night of the week. It was recognized that local workers may be in difficult situations of dual relationships (e.g., being privy to personal information of close relatives) that make their task quite delicate at times. One central issue was the perception of confidentiality, which at times community members appear to be concerned about, and that may explain in certain cases the preference to talk with a therapist that does not live in the community. Local workers have the clear advantage of knowing the community well, of understanding nuances that are relevant when working in the mental health area in a particular context. On the other hand, especially in moments of crisis, they may be too close to the situation (i.e., too affected themselves) and thus have difficulty in offering effective support to other community members.

Support for local workers

The issues of high turnover, possible burnout, and difficult and stressful work, came up repeatedly from different sources. In general, there was agreement that local workers would benefit from more support in a number of areas. One area relates to training, which will be addressed in the next sub-section. The other area includes the need for self-care, provision of opportunities of working through their own issues, opportunities for debriefing, supervision, having backup assistance, more institutional support, etc. Among these aspects of support, contact with FNIHBs head office or Tribal Council's, was deemed important. In general, workers expressed that they felt relatively comfortable with asking for support, although there was some variability in this regard. Thus, more emphasis on maintaining good relations with FNIHB head office would only be of

benefit. The existence of a good working relationship with Chief and Council also played an important role in how local workers felt supported or not.

Local workers also raised the issue that to obtain funding for certain initiatives they need to write proposals, and many times they would benefit from more training in proposal writing or more assistance from FNIHB or Tribal Councils. In particular, it was mentioned that smaller communities might be losing funding opportunities because of this. As well, the Contribution Agreements require regular reports that the Band Administration may have difficulty providing and the task usually falls on BFI/BHC workers.

The requirement that mental health therapists work with local workers was generally seen as positive and needed. In some cases local workers also benefit in having counseling sessions with the therapists. However, given the fact that they may also work together, some local workers would prefer the flexibility of being able to have access to other therapists if that were their choice. The implementation of more routine debriefing sessions among local workers was proposed. The organization of workshops where local workers can discuss issues with other workers (health, CFS, etc.) that work in the community as well as from other communities, was considered highly beneficial. Several interviewees suggested that these workshops should be organized with more frequency and held in different communities. As well, many felt that some sort of self-care protocol should be established. A concern was raised in relation to possible professional liability issues for local workers.

Training of local workers

The importance of ongoing training opportunities for local workers was stated unanimously. Several training initiatives have been successfully undertaken over the years (e.g., First Nations Community Wellness Diploma, Basic Skills for Community Wellness Workers Training Series). As well, local workers wanted to partake in capacity development opportunities with the mental health therapists or other health professionals. However, this appears to occur mostly dependent on informal arrangements.

Certain issues were mentioned that would require attention for further development of training opportunities. One issue is the difficulty local workers have of leaving the community, in part due to financial reasons, in part due to the lack of a backup person that can take over their work in case of a crisis situation, and in some occasions because of lack of authorization by Chief and Council. Another concern was that despite receiving diplomas for attending training workshops, these are not necessarily part of a certification program that may end up giving workers some form of formal education degree.

Concern was raised that workers without skills were at times hired (although lack of formal education is not necessarily equivalent to lack of skills) and thus would feel insecure in their jobs while at the same time not being able to acknowledge their limitations and thus work on improving their skills. Some interviewees reflected on the lack of minimum academic standards for hiring. Finally, interviewees indicated that the

pay scale of BFI/BHC and NNADAP workers does not recognize the efforts of these workers in furthering their training, nor the years of experience on the job. Thus, there is no economic incentive for training or career development.

One suggestion was that there be a formal training program for local workers as requirement for the job. Among several suggested topics for training, the following were mentioned: intergenerational impacts on mental health, residential school syndrome, co-occurring disorders, counseling, anger management, gambling, grandparents parenting, stress, depression, anxiety, how to deal with people with AIDS, gang issues, report and proposal writing, etc. An important notion in relation to the training of local workers was that it be based on a strength approach model, where workers' prior experience and knowledge is recognized and further skill development is done by sharing and enhancing that knowledge while addressing specific information needs. As well, training should be comprehensive and include basic administrative skills (e.g., budgeting, report writing, organizational skills).

4.3 Mental health therapists

This theme focuses on issues pertaining to the mental health therapists under Standing Offer Agreements that work in First Nations communities (including communities with Contribution Agreements), and therapists that work via fee-for-service outside the communities. Issues relating to the program itself will be addressed in another section.

In general, there is agreement that management and accountability of the services provided by mental health therapists has improved over the last several years. In particular the apparent historical abuse of the system by some therapists was solved, proper credentialing of therapists was established, and clinical standards of practice were enforced. The importance of professional liability insurance was recognized and understood as a necessary requirement. Nonetheless, a series of concerns and suggestions emerged in conversation with different therapists, managers and other interviewees.

The process of bidding for contracts was raised as a concern because of a resulting differential in pay. This differential pay for the same amount of work and similar levels of expertise appeared to be more related to the contract negotiation skills of the therapist than to professionally relevant criteria. The concern is that it creates a perception of unfairness and arbitrariness that may be having an effect on work morale.

In general supervision was recognized as important and necessary. However, certain concerns were raised. In particular, in some cases supervision seemed to focus more on accountability and reporting requirements, than on actual clinical knowledge exchange. It was suggested that more solid guidance about the purposes of supervision would be beneficial, as well as input from therapists about supervision needs. Several therapists emphasized that it be complemented by a system of peer supervision to make supervision more meaningful, relevant, and useful to improve their work. A side benefit of this would be to increase the opportunities to interact with other mental health therapists. Several therapists emphasized how beneficial a meeting had been to which all therapists had been

invited that was held more than a year ago, both as knowledge exchange experience and as a way of establishing more fruitful working relationships. Interviewees regretted that only one of such meetings had taken place and suggested that this be organized on a regular basis, for example once every six months.

In terms of the hiring process (aside from the bidding process already mentioned), some specific suggestions were made. A key issue in the work of mental health therapists is the development of relationships of trust with the communities and clients. A major deterrent in building trust was the experience of high turnover of therapists. Different interviewees recalled that one of the most frequent initial questions asked by clients to the therapists was "How long are you going to stay?" Although some degree of turnover is unavoidable and expected, steps to minimize turnover are important. One such step could be taken at the hiring stage. It was suggested that before the contract is finalized, therapists should do a series of visits to the communities where they would be working in order to meet with community workers, Chief and Council, the existing mental health therapist, and health staff. This would provide the new mental health therapist with some understanding of the community's concerns and realities and would help them make an informed decision about their willingness and ability to conduct mental health work in that particular community. Consequently, the contract could require a certain time commitment that the therapist would agree to. A related issue of concern was that, although due to apparently justified situations, therapists were some times transferred to different communities without much time to adjust to the challenges and difficulties of new communities.

Opinions in regards to paperwork demands varied somewhat. In general there was agreement that assessment, treatment plan, and termination forms were adequate and useful. Nonetheless, it was sometimes felt that the paperwork was too time consuming. An issue that was commented on was that no formal presentation of reporting requirements was done, nor was there any consultation in terms of the utility and practicality of the information. In summary, the issue of most concern was not the need for this information, but the lack of consultation and clear explanation of its procedures and purposes. There were opinions that there could be ways of making this process more efficient, reducing repetition. In terms of information requested for each invoice, it was mentioned that a number of repetitive details were required that did not seem to provide useful information. Concern was raised in relation to the fact that FNIHB has access to full files of clients. Despite the fact that clients are asked to sign consent forms, the degree of information together with the identifiable nature of it (clients' names are included) provides the potential for serious confidentiality breaches. As one therapist indicated, "no insurance agency requires that degree of detail of clients."

Therapists almost unanimously questioned the length of time it takes to get reimbursed for the services provided (due to time lag in obtaining the PAN and due to time lag from date of invoice to actual cheque being mailed) as well as for the expenses incurred to provide those services (e.g., air fare, mileage). This seemed to place unnecessary financial burden on therapists. Simple mechanisms that speed the time it takes for therapists to access their payments (e.g., direct deposit) should also be considered. This

could be having a negative impact on therapists' morale, and may also be a deterrent for the recruitment of therapists.

Other issues raised were related to lack of reimbursement for travel time, lack of administrative support, lack of funding to participate in professional development initiatives related to First Nations mental heath. Also, more attention should be put into addressing possible burnout or stress issues of therapists that work in relative isolation. It was acknowledged that the therapeutic work challenges the therapists in many ways. In the community the therapists sometimes might feel alone professionally, particularly when they are dealing with highly traumatic cases and this has an effect on the emotional and professional well-being of the therapists. Interviewees tended to concur that certain mechanisms to deal with the effects of this work should be put in place. Supervision was acknowledged as an important potential mechanism for this, but other options should also be implemented. The implementation of self-care protocols for the therapists (e.g., attending psychotherapy sessions) was suggested.

4.4. Nurses

The role of nurses in the provision of mental health services came up repeatedly in the interviews. Most interviewees agreed that they play an important role, albeit not properly recognized. It was discussed that nurses often bear the brunt of mental health issues of people they see at nursing stations and health centres, but without proper mental health training. In was the opinion of several interviewees that there are many mental health demands placed on nurses. Several suggested that at least 30% to 50% of the issues for which people seek the help of nurses are mental health related. They mentioned as examples somatizations, anxiety related physical disorders, family violence, etc. Nurses appear to have an important role as gatekeepers. However, in some communities they feel they are not part of the mental health team, or somewhat isolated from it. In particular, there appears to be a lack of adequate information exchange with the mental health therapists and community mental health workers. The main point appears to be the need to be validated as part of the mental health team. The importance of having more professional support on how to deal with certain mental health situations, as well as receiving some mental health training were emphasized.

It was mentioned that nurses have been excluded from the Mental Health Act, despite the fact that they need to practice in concordance with the act. It was considered that nurses should have more authority under the mental health act.

4.5. Relations among agencies

Mental health issues to some extent also fall within the area of responsibility of other agencies and programs like Child and Family Services (CFS), Justice, and Education, and this was highlighted by interviewees. The frequent working relationship with CFS in particular raised a number of issues and suggestions. A number of difficulties in terms of confidentiality appear when dealing with foster parents and social workers that are legal

guardians. As well, there are problems in relation to reports requested by CFS or for court requirements.

Another issue that is sometimes problematic is the fact that therapists are not supposed to provide crisis counseling to CFS, NNADAP, school, and Justice clients. The separate funding streams explain the need for the program to protect its own funding, although it may create some treatment limitations and reporting distortions at the community level. As interviewees emphasized, formal arrangements among agencies should be better defined on how to deal with these situations, not leaving it to field staff to resolve. On a similar vein, interviewees suggested that matters of reporting and information sharing would require clearer guidelines.

4.6. Relations with psychiatrists

According to interviewees, working relations with psychiatrists are mostly based on individual relationship building rather than any organizational protocols. A number of therapists and local workers indicated that they have no contact with psychiatrists at the Health Sciences Centre or other hospitals. Referrals to these centres have to be made by an MD. Only one psychiatrist was identified as working in consultation with FNIHB staff or contractors. Case consultations are rare. Concern was raised about clients discharged from psychiatric centres and the lack of proper notification to local workers or therapists to enable them to establish proper follow-up. One comment was quite illustrative of certain perceptions of psychiatrists, that "they're great on assessments, but don't really do treatment" and that it's basically a revolving door.

The challenge at the macro level appears to be the provincial/federal jurisdictions. According to some interviewees, provincial psychiatric centres and regional health authorities work on the assumption is that there are many resources in First Nations communities. Thus, an education component is needed for these institutions to know what is actually in the communities and who to contact.

4.7. Programs

Many of the topics under this heading have been to some extent mentioned in previous sub-sections. Nonetheless, this section presents the issues from a programmatic point of view rather than from the perspective of the service providers' situation.

FNIHB's programs and initiatives can be understood as forming a mental health services continuum. In fact some of the documentation reviewed explicitly locates the continuum as extending from BFI, to BHC, to Non-Insured Health Benefits. However, the interviews suggested that there is still a way to go for this continuum to work in a coordinated and integrated manner.

BFI, BHC and NNADAP were recognized as community-based programs. This was emphasized as an important asset of these initiatives. However, a number of issues were raised. Some interviewees argued that the funding formula does not appear to be needs

based, and that some inequities in funding persist based on the initial funding formula. The funding formula apparently is 25% core funding, 10% for isolation, and 65% per capita. In terms of administration, some comments suggested that generally speaking, transferred communities do better than non-transferred communities. The move towards more service delivery by BFI/BHC workers was questioned by some, in particular the expectation that these workers provide counseling.

A number of suggestions were made in relation to community-based initiatives, several of which are taking place (or have taken place) in some communities, but that were emphasized as relevant to continue pursuing. Among the most mentioned were: parenting classes (with more focus on emotional health component); recreation programs for kids and adults; family activities; Mom's (parents) support group; therapy groups for children and youth.

The need for the crisis intervention/mental health services was unanimously supported, and there was a general opinion that in the last several years there has been an improvement in accountability and professional standards. The issues that were raised related to certain emphases of these services and certain practice modalities.

The initiative describes itself as being crisis intervention, and thus justifies a limited number of sessions to be provided. From a funding perspective this is understandable, but despite some degree of flexibility in allowing for an extension in number of sessions, most interviewees considered this as an issue that should be examined. Interviewees raised the question of the meaning of crisis, and consequently of what constitutes a crisis intervention. To complicate matters, both therapists and local workers view these services as an opportunity for individuals and families to deal more in depth with long-term issues. A crisis would appear in a number of cases to open the door to confront these matters, but there would be a resulting need for long-term intervention to properly resolve these matters. Thus, there appears to be somewhat of a contradiction between one aspect of the initiative, to intervene when there is a mental health crisis, and another, to work more in depth with mental health issues. The contradiction is not so much in the stated guidelines of the initiative, but in the approach taken to respond to different needs addressed by the program. No other intervention in the mental health continuum has the capability of offering in-depth mental health therapy.

A further observation appears relevant. There is an important difference in the type of intervention required if the crisis is at the level of the individual, than if it is at the level of the community. For the former, it is assumed that the mental health therapists (in collaboration with BFI/BHC workers) are responsible to intervene. When there is a community crisis (e.g., a cluster of suicides) the intervention requires broader components. Some interviewees suggested what they called a "SWAT" type intervention. This would imply that an external crisis team would go to the community for some time to work with community staff and community members to address the crisis. But community workers are clearly not prepared to deal with a crisis at the community level.

Consequently, aside from particular recommendations that will later be listed, a revision of the concept of crisis appears to be needed. This revision should address the differences between individual and community crisis, and its differential interventions. As well, it should seek to distinguish between short-term crisis interventions and therapeutic work with clients that require longer-term interventions. Some interviewees suggested that the crisis services mandate should be broader, more of a healing services orientation, and including traditional services, so people can have a choice.

A difficulty identified by a number of interviewees was that any person with a psychiatric diagnosis is not supposed to receive treatment from mental health therapists, because they are expected to receive psychiatric care. Mental health therapists try to get around this by emphasizing other aspects, e.g., for a clinically depressed individual the therapist will emphasize that he/she is coming to deal with existing relationship problems. As well, anything with addictions is not eligible. Even though this may be understandable from a funding stream perspective, it implies an artificial partitioning of individuals and families. This signals a broader problem, which is that the system seeks to fit the individuals and communities within its bureaucratic structure, instead of structuring itself to fit the needs of individuals and communities.

Another central theme that emerged was the potential threat of legal liability of practitioners, and ultimately of FNIHB. In the current system, the mental health services acting manager and the mental health therapists appear to carry legal liability and professional accountability at an arms length on behalf of FNIHB. This appears to be one of the rationales for using the contract system with mental health therapists and with the manager of the service. With the understanding that professional liability is an issue that cannot be minimized, it would be helpful for FNIHB to address this potential problem more transparently. Limiting organizational liability should not be a determining factor in the structuring of mental health services.

A series of relevant issues emerged in relation to the scope of FNIHB's responsibility for mental health in First Nations communities. From a health determinant model, upstream structural factors play an important role on mental health. Among others, the legacy of residential schools, the high unemployment rates, etc., were acknowledged by most interviewees as having a significant impact on the well-being of community members. It was recognized that to some extent these structural factors do not fall within the range of FNIHB's responsibilities. Nonetheless, effective mental health services need to address these issues in different ways (for example through case conferencing with social workers, employment counselors, housing managers, etc.). A major gap identified by a number of interviewees was the lack of an integrated mental health program that would provide a strategic approach to re-building mental health in communities. Portions of this approach are currently in place, although not necessarily well articulated or clearly strategically oriented. As some interviewees indicated, the strength for these services would be in a real comprehensive community approach with all of the different teams working together.

A combination of issues were raised that if addressed, would lead to a strategic and integrated mental health program. One is a more intentional implementation of community development models. Another is the need for research on best practices, culturally-centred mental health services, etc. A third issue is that services appear to be expert driven instead of milieu driven, not having a good perspective on a social environmental approach. Fourth, there is a lack of acknowledgement of power issues related to the hierarchical structure of the system that may lead to client passivity. Fifth, there is a perceived lack of integration in planning and service delivery at different levels: head office, regional and community.

A notion related to the integration of services that was frequently mentioned by interviewees was the importance of a mental health team. The need for more explicit formal working arrangements among BFI/BHC/NNADAP workers, mental health therapists, nurses, traditional healers, and physicians was emphasized. Interviewees suggested more case management and case conferencing approaches, sharing of information, and team building initiatives.

A resource center in Winnipeg, with a community-level crisis intervention capability was suggested. It could include clinical training, a place for the local workers to obtain skills, and ensure that the contribution agreements follow good clinical standards.

Traditional practices and traditional healers within mental health services was a particularly relevant issue discussed in many interviews. A number of interviewees proposed that traditional healers be considered in parallel to mental health practitioners, and as part of the mental health team. It was suggested that FNIHB would need to consult with communities and tribal councils in relation to issues of recognition of traditional healers, remuneration, participation in mental health team, etc.

4.8. Information

A number of different issues were raised in relation to information. The following is a summary of the main aspects.

Specifically related to crisis intervention/mental health services, information for accountability purposes appears to have improved significantly over the last several years. This has curtailed potential for abuse by service providers. On the other hand, some concerns were raised in relation to the degree of detail that is required. A main issue was the fact that FNIHB has access to detailed case information with clients names included (diagnostic assessment treatment plans, progress reports, termination reports). Although there have been no incidents of information leakage, the potential risk is there. There is also a perception matter to take into account, meaning that identifiable detailed case information of First Nations people being gathered in a central government department raises privacy concerns. Despite clients signing forms authorizing the release of information, a number of interviewees felt that clients might not realize the extent of what they are authorizing for release. Another issue raised was that the data requested is more oriented to one on one service and less to capacity building and community

development aspects of the therapist's job. As well, Tribal Councils with Contribution Agreements question the requirement to send both summary reports and raw data to FNIHB. Apparently under the Contribution Agreements, all files are owned by FNIHB. What appears to be at issue is that too much data can also be detrimental if matters like privacy, time required to gather it, lack of agreement on its need, actual use, etc., are not properly balanced.

There were also calls for more organized management of information for case management purposes. The idea was to have information that would support an integrated program. For example standardized intake processes across programs would be beneficial to avoid asking people for the same information every time. It would be a standardized process to capture the right information and capture people over time and over different issues that are connected. A centralized database for crisis intervention/mental health services has been implemented, but apparently its full potential has not been realized.

There appears to be a need to revise and identify the purposes of the information gathered, of collecting only the necessary information, and of creating a system that enables its broader use. From a general point of view, health organizations use information for three main purposes, operations, evaluation and research. The development of a proper information system for FNIHB's mental health services would involve identifying the operational needs, and the formative and summative (accountability) evaluation requirements. This must be done with the involvement of representatives from all stakeholders to ensure meeting the information requirements, to identify and correct potential for misuse, and to gain the commitment of those responsible for gathering the information.

4.9. FNIHB

Several themes appeared in conversations with different stakeholders. Despite different vantage points of the interviewees, there was high concordance in how FNIHB was seen from a system and management perspective.

One central aspect identified was that the internal organization of FNIHB's Manitoba Region. Particular to mental health programs, they are split in two separate sections (see Diagram 1). Crisis intervention/Mental health services falls is in one directorate, whereas BFI, BHC, and NNADAP are in a separate directorate. So the "mental health continuum" from an organizational structure perspective is divided in "stove-pipes." To add to the difficulties, there are apparent serious tensions between players in the different sections, thus significant aspects of communication are done through third parties. Some individuals indicated that because "there are lots of power issues among a few people" there seems to be a lack of teamwork at head office. Interviewees suggested that each section seems to need to get credit, must be able to say they fixed the problem, and simultaneously there is a tendency after each serious incident (e.g., suicide) to blame the other sections. In essence, FNIHB Manitoba Region is perceived as a rigid organization with a compartmentalized legacy that lacks the ability to look at itself as a whole.

Another issue mentioned was that the regional FNIHB office appears to be an organization working in crisis mode, tending to be short-term in its vision. A consequence of this would be its apparent tendency to focus on short-term, concrete, "band-aid" solutions. Some interviewees suggested that a shift to prevention takes leadership, and this is not apparent from head office.

Some mention was made of the inherent clash of cultures within FNIHB (mental health therapists, local workers, management, Tribal Councils, Communities, etc.). The point is not so much the conflict itself, but the lack of proper acknowledgement of this conflict and of the need to set up proper mechanisms to deal with it.

In several cases, interviewees indicated that what is seen in some communities is a reflection of what happens in FNIHB. The result is that in some communities there is minimal communication between BFI/BHC, NNADAP, and crisis intervention/mental health services, and minimal communication between nursing and any of those programs.

Although individuals working at head offices go to communities, a number of local workers reflected that it would be helpful if managers, coordinators, etc., would do regular visits, not only during crisis situations. This would enhance a sense of support and understanding about community realities and help improve the communication around issues of disagreement.

Some opposing views were heard in relation to what the accountability standards should be. One viewpoint argues that the clinical standards required for mental health therapists should also be required for local workers. Another viewpoint argues that accountability standards exist, but they cannot be the same for all mental health workers.

There is some agreement that the approach of FNIHB is somewhat reactive, where it is common to act after the fact as crisis intervention. The point raised by several interviewees was that these crises would be preventable if the mental health services continuum worked properly. Several argued that it is precisely the divisions within the department that curtail any seamless flow of work among the different sectors, thus failing in terms of prevention.

In terms of FNIHB at a national level, the lack of a national coordinator was highlighted. For example there are national medical, nursing, and dental officers, but there is no such position for mental health in Ottawa. This was thought to be a serious shortcoming in the way the whole mental health program is run.

There was repeated mention about the fact that "stove piping" also exists between the federal departments of FNIHB and Indian and Northern Affairs Canada, that indirectly affects mental health. As well, there is little coordination among provincial systems that in one way or the other deal with mental health issues, such as Child and Family Services, Justice Department, Education, etc.

In general the criticisms around FNIHB's management style were that it lacks a strategic macro-management view, at times is unnecessarily bogged down by micro-management practices, tends to have a reactive management mode, is too centralized in its ways of operating, lacks proper consultation channels with communities and tribal councils, and does not appear to have common management goals nor a clear common vision for mental health services.

4.10. Relations with Tribal Councils and Communities

Relations between FNIHB and Tribal Councils and communities are central to the provision of mental health services. There are formal and informal relations, both productive at times, but fraught with tensions and conflicting views at others. Perhaps the most evident picture that emerged is the divide between sectors, not necessarily in terms of the ultimate goals, but in relation to methods and practices.

One issue of dispute is that FNIHB perceives that Tribal Councils fail to adhere to the terms and conditions of the Contribution Agreements. On the other hand, Tribal Councils perceive that FNIHB is involved in micro-management. Communities tend to view FNIHB as not consulting and making decisions on its own. Regretfully, the levels of trust among different stakeholders are not necessarily the best. Nonetheless, there are examples of working relations with communities and Tribal Councils, in particular with BFI/BHC. As well, in crisis situations, FNIHB has been able to work well as a team together with the community. Recent interventions with Shamattawa First Nation, where FNIHB staff from different programs, as well as personnel from other government departments, together with Chief and Council and community workers, have demonstrated a very positive model of coordinated work.

As one interviewee mentioned, a proper governance model would help considerably in establishing the right balance between the role of the department, branch, communities, Tribal Councils, etc. The point is not that conflict could be eliminated, but that there be better formal and informal mechanisms for regional planning and for dealing with conflicting views and interests.

5. Recommendations

This review has been undertaken with the full recognition that current mental health programs and systems have been developed at least partially in response to challenges and difficulties that have arisen at different periods in the history of the organization. It is usually the case that certain arrangements, necessary when originally implemented, become outmoded as circumstances change and may not properly address current needs. In this review we have identified a series of structural and operational problems that reflect an organizational response to previously identified problems; the challenge for the organization now is to determine whether these systems are still required. Our conclusion is that further significant changes are necessary in order to the respond to the challenges identified above.

The evidence generated from numerous interviews with stakeholders throughout the system has suggested two general themes: That there is a vast amount of experience and excellent work from individuals working in different capacities for FNIHB; and at the same time there are organizational difficulties that appear to be hindering a more effective delivery of mental health services. The central problem appears to be that the current system forces communities and professional services to respond to bureaucratic needs, instead of structuring itself to fit the needs of individuals, professionals, and communities. It also appears that the budgetary structure and issues of financial accountability are taking a much more prominent role in the determination of programs and services than is necessary, and that this over-determination of mental health programming by fiscal issues results in decreased effectiveness of mental health interventions and increased cost to the system.

Over the last number of years, FNIHB took steps that successfully addressed a series of problems, as was described in the previous sections. Many of these interventions resolved problems, and taken separately, continue to work effectively. The problem now is more related to a lack of integration or articulation among these organizational operations or interventions. Many of the recommendations that follow identify procedures currently in place, but seek to integrate them within an overall coherent structure of mental health services.

A further difficulty that was observed during the review is the degree of internal dissension among some FNIHB personnel. It is difficult to determine to what extent this dissension is a product of structural issues, or to what extent it may be due to personality and turf protection factors. Most probably it is a combination of both. To a certain degree, this is to be expected from organizations in general. Nonetheless, when this dissension progresses to the point that it may hinder more effective delivery of services, it must be taken seriously and all those working for FNIHB should have no choice but to participate in organizational interventions such as mediations, organizational reviews, etc. Some resistance to the review was experienced, and this response underscores the need for leadership / cooperation and an organizational leadership that promotes effective teamwork over the preeminence of turf and individual interests. The recommendations that follow seek to provide a basis for proper organizational leadership, structures and

processes that may lead to a more integrated and participatory delivery model of mental health services to First Nations.

The recommendations are of two types, structural and specific to programs and services. To some degree they are independent, in the sense that many of the specific recommendations could be implemented without the broader suggested changes. However this review suggests that major structural changes within the organization are necessary if programs and services are to operate more effectively in the context of First Nations health. Specific recommendations are organized to reflect different responsibilities, programs and services within the organization.

5.1. Structural Recommendations

1. FNIHB Manitoba Region (FNIHBMR) requires a clear programmatic definition of their scope of responsibility in mental health services, as well as a clear definition of the scope of the mental health continuum, and the required linkages with other agencies and health programs. This work should be undertaken in consultation with First Nations authorities as well as other federal and provincial partners responsible for promoting mental health in First Nations communities.

2. FNIHBMR should create the position of a Mental Health Officer (MHO), responsible for the management of the entire mental health services continuum, ranging from BFI/BHC, NNADAP to Mental Health Services/Crisis Intervention. Managers responsible for specific programs and services on this continuum should have equal status within the organization and should report directly to the MHO.

3. FNIHBMR should lead a concerted effort with First Nations organizations and universities to improve the collection of epidemiological data on First Nation's mental health in Manitoba and should make use of this information for program planning and policy initiatives.

4. FNIHBMR should support and take part in the creation of a federal First Nations Mental Health Service Providers credentialing and regulatory body, together with key stakeholders (Assembly of First Nations, provincial and regional First Nations organizations, Universities, etc.). The goal would be that FNIHBMR and First Nations communities and organizations would eventually hire or contract with mental health providers accredited by this entity. Mental health providers would obtain professional liability insurance through this regulatory body.[3] (A grandfather clause would be incorporated for current service providers).

[3] We wish to acknowledge Dr. Jean Graveline of Brandon University for providing the main idea for this recommendation.

5.2. Specific Recommendations

General

5. There should be continued effort to adapt psychotherapeutic interventions to different First Nations cultural realities, in particular to develop culturally sensitive and appropriate practices. There should be support for the development of culturally appropriate approaches to psychotherapy.

6. Continue developing culturally appropriate educational programs to address problem solving, substance abuse, depression, anger, relationship conflicts, and stressful life events.

7. Assess the possibility of better integration of the mental health system with aboriginal healers. Issues that should be addressed in consultation with First Nations communities and organizations include: forms of healing recognized as legitimate, explanations of illness and healing efficacy, credibility of healers and practices, reimbursement, expectations of healers' role, notions of professional ethics and integrity. Traditional healers should be recognized as involved in mental health, and should be part of the mental health team. FNIHBMR would need to consult with communities and tribal councils in relation to issues of recognition of traditional healers, remuneration, participation in mental health team, etc.

8. Develop a more constructive engagement process to work with Tribal Councils and First Nations communities, acknowledging possible conflicting interests and different organizational approaches to promoting mental health in communities.

9. Support and develop further training for primary care providers to better detect and intervene in mental health disorders.

10. Mental health interventions should simultaneously address problems at the community and political level as well as at the individual level.

11. Develop new models of mental health practices that are more deeply rooted in traditional and emerging concepts of community.

12. Review of the concept of crisis and intervention strategies, addressing the differences between individual and community crisis, and develop appropriate interventions. As well, this review should seek to distinguish between short-term crisis interventions and therapeutic work with clients that requires longer-term interventions

13. Mental health crisis intervention services mandate should be broader to include more of a healing service orientation.

14. A more intentional implementation of community development models should be pursued.

15. Research on best practices in the field of culturally-centred mental health services should be reviewed and implemented as appropriate.

Regional Office

16. There should be ongoing and continual emphasis on communication between FNIHBMR staff at head office, local workers, and mental health therapists.

17. The mental health program should develop protocols for more integrated work with primary care providers such as nurses and physicians.

18. Enhance nurses' role within the mental health team.

19. Increase nurses' training in mental health issues.

20. Develop more explicit formal working arrangements among BFI/BHC/NNADAP workers, mental health therapists, nurses, traditional healers, and physicians. More case management and case conferencing approaches, sharing of information, and team building initiatives should be implemented.

21. Develop and implement protocols for information exchange and interventions with common clients with other agencies like CFS, Justice, Education systems, etc.

22. Develop and implement protocols for information exchange and interventions with common clients with psychiatric institutions and psychiatrists.

23. Review the need to send detailed and identifiable client information to FNIHBMR.

24. Conduct a thorough review of the purpose of mental health information gathered by FNIHBMR, acknowledging that the collection of information serves implicit political and cultural agendas.

25. Revise protocols for information collection and create a system that enables its broader use. The development of a proper information system for FNIHBMR's mental health services would involve identifying the operational needs, and the formative and summative (accountability) evaluation requirements. This should be done with the involvement of representatives from all stakeholders to ensure the information requirements are met, to identify and correct potential for misuse, and to gain the commitment of those responsible for gathering the information.

26. Address the issues of professional liability and establish a policy around it (the risk of liability should not be a determinant of how mental health services are structured). Seek legal counsel on actual risks for FNIHBMR, and derive a clear process to safeguard the organization, professionals, communities, Tribal Councils, etc.

Mental Health Therapists

27. There should be allowance for individuals, couples or families to pursue psychotherapy with the contracted mental health therapists beyond the crisis intervention period.

28. Develop better criteria for the supervision of mental health therapists, using their input to make supervision more clinically relevant.

29. Establish mechanisms for peer supervision among mental health therapists.

30. Organize periodic gatherings of mental health therapists for exchange of experience and network development.

31. Develop and implement a self-care protocol for mental health therapists.

32. Eliminate the bidding process for Standing Offer Agreements (SOAs). Implement a straightforward contract based on set criteria of educational degree, certification, experience, etc.

33. An orientation should be established before mental health therapists sign SOAs that would include at least one visit to the community, meetings with local workers, Chief and Council, briefings from Mental Health Officer, etc.

34. Whenever possible, the relocation of mental health therapists should be pursued strategically and with proper transition times.

35. Detailed and meaningful presentations to mental health therapists of the information that will be required from them should be conducted.

36. Ongoing input of mental health therapists in the development of reporting requirements and methods should be sought.

37. Continue and increase the trend of contracting qualified First Nations mental health therapists.

38. Mental health therapists should be encouraged to be involved in professional development that includes education in aboriginal culture.

39. Streamline the invoice process of mental health therapists and shorten the time it takes for actual payment

40. Establish a direct deposit system for payment of mental health therapists

Local Workers

41. Establish a differential pay scale for BFI/BHC and NNADAP workers based on experience and education/training. This compensation structure should provide incentive to community workers to undertake continuing education and long-term commitment to the community.

42. Develop training programs, including supervised practicum opportunities that would enable local workers to pursue formal educational degrees.

43. Provide an accreditation process for BFI/BHC and NNADAP workers in the context of a national First Nations Mental Health Workers Credentialing Body.

44. The training and hiring of youth and young adults as BFI/BHC and NNADAP workers should be encouraged.

45. Develop and implement a self-care protocol for BFI/BHC and NNADAP workers.

46. More explicit protocols should be established for mental health therapists to partake in capacity development and the supervision of local workers.

Appendix A – Document List

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Appendix B – Diagrams

FIRST NATIONS AND INUIT HEALTH BRANCH, MANITOBA REGION
ORGANIZATION CHART
ORGANIGRAMME
October 1, 2002

Appendix B - Diagram 1