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MENTAL WELLNESS TEAMS

KEY LEARNINGS FROM
8 PROJECTS

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INTRODUCTION

During the period 2007 through 2013, Health Canada through its National Anti-Drug Strategy has been working with First Nations and Inuit communities in the implementation of Mental Wellness Team (MWT) pilot projects.

This important work in the area of mental wellness is informed by the Mental Wellness Advisory Committee (MWAC), established in 2005. The goals of MWTs align with the five priority goals of MWAC's Strategic Action Plan, which are:

1. Coordinated continuum of mental wellness services;
2. Disseminate and share knowledge;
3. Support and recognize community as its own best resource;
4. Enhance mental wellness and allied services workforce;
5. Clarify and strengthen collaborative relationships

Eight pilot projects MWTs were funded in Atlantic Canada (3), Quebec, Ontario, Manitoba, Saskatchewan and British Columbia.

Each of these teams were created through their own unique, community-based approaches typically comprising multi-disciplinary teams providing a range of culturally safe mental health and addictions services and supports to their communities. A main emphasis in each team was to incorporate traditional, cultural, and mainstream clinical approaches to mental wellness services, enhancing the continuum of care from prevention to after-care. An integrated approach to service delivery involving multi-jurisdictions and sectors was encouraged.

As part of the development of the MWTs, a document entitled "A Guide to the Development of Mental Wellness Teams" was produced in 2008 and shared to outline suggestions for a process to develop, implement and evaluate mental wellness teams.

Building upon this document, and in keeping with goal two of the MWAC pillars, Health Canada has prioritized the development of a report based on the collective experience and lessons learned within each of these eight pilot projects.

Based on the wealth of knowledge that has been accumulated by the teams over the past five years, an updated version of this guide has been developed incorporating advice from the MWT "community of practice" and cadre of experienced community representatives.

The purpose of this document is to share some of the recommended steps, approaches and critical success factors suggested by the projects which are grounded in the real world, real time experience of these projects. It's intended to suggest and map potential avenues for others who may follow.

BACKGROUND

In 2005 Health Canada established the First Nations and Inuit Mental Wellness Advisory Committee (MWAC), which brought together key Aboriginal and non-Aboriginal partners, federal/provincial/territorial networks, and Aboriginal mental health and addictions organizations to develop a strategic action plan focused on improving the mental health outcomes of First Nations and Inuit.

MWAC's First Nations and Inuit Mental Wellness Strategic Action Plan identified five priority goals or pillars:

1. To support the development of a coordinated continuum of mental wellness services for and by First Nations and Inuit including traditional, cultural and mainstream approaches.
2. To disseminate and share knowledge about promising traditional, cultural and mainstream approaches to mental wellness.
3. To support and recognize the community as its own best resource by acknowledging diverse ways of knowing, and by developing community capacity to improve mental wellness.
4. To enhance the knowledge, skills, recruitment and retention of a mental wellness and allied services workforce able to provide effective and culturally safe services and supports for First Nations and Inuit.
5. To clarify and strengthen collaborative relationships between mental health, addictions and related human services and between federal, provincial, territorial and First Nations and Inuit delivered programs and services.

The development and implementation of Mental Wellness Teams were seen as one possible and potentially promising avenue to demonstrate the five pillars of this strategy.

In 2007, as part of Health Canada's National Anti-Drug Strategy, the Government of Canada, committed to enhancing the quality, effectiveness and accessibility of addictions services in First Nations and Inuit communities. This included an investment in Mental Wellness Teams in Inuit and First Nation communities.¹

Eight MWTs in six regions have been implemented since 2009: British Columbia, Ontario, Quebec, Manitoba, Saskatchewan and Atlantic (which includes one Inuit-specific MWT). In some cases, the pilot projects built upon existing programming.

The **eight (8) pilot projects** which were funded across Canada are as follows:

1. Tui'kn Partnership Mental Wellness Team, Nova Scotia
2. Maliseet Mental Wellness Team, New Brunswick
3. Raising the Spirit Mental Wellness Team, Northeastern Ontario
4. Mental Wellness Team Pilot Project, Lac-Simon/Kitcisakik, Quebec
5. Mapping the Way Mental Wellness Team, Nunatsiavut
6. Anishinabe Mekina Mino-Ayawin—Road to Good Health, Manitoba
7. White Raven Healing Lodge, Saskatchewan
8. Quu-asa Mental Wellness Team, Vancouver Island, British Columbia

¹ Team Approaches to Mental Wellness in First Nations and Inuit Communities, Dr. Patricia Wiebe, Danny Manitowabi, and Frank McNulty, Presentation to Ontario Psychiatric Outreach Program Retreat, September 3, 2009

OVERVIEW OF THE MENTAL WELLNESS TEAM CONCEPT

The Mental Wellness Teams (MWT) concept is a community-based and multi-disciplinary team approach to providing mental health and addictions services in First Nations and Inuit communities that blends or enhances traditional, cultural and mainstream approaches. The MWT approach is designed to complement and support efforts that are currently in place in First Nations on-reserve and Inuit communities.² These Mental Wellness Team pilot projects each comprise unique models which respond to their respective community strengths and needs but nonetheless share the goal of demonstrating the five pillars of the MWAC strategy.

Mental Wellness Teams are multi-disciplinary in nature and have flexible service delivery models spanning the whole spectrum of services from prevention to post-treatment follow up. Their goal is to enhance collaboration among clinical and community experts in order to increase and improve culturally safe mental health and addictions services. By design, they promote community engagement, community development and support self-determination with respect to mental wellness with the aim of improving health outcomes.

Key considerations in the development and implementation of Mental Wellness Teams include an understanding that there are different approaches between various Aboriginal and non-Aboriginal “ways of knowing” and among providers with different types of training, including those for the community as a whole, as well as individual clients. Mental Wellness Teams are intended to be owned, defined and driven by the communities served. A strong emphasis on capacity building in order to develop skills, enhance cultural safety and to develop inter-professionalism and client-centred care is also central to each team’s design.

More importantly, Mental Wellness Teams are intended to support an enhanced continuum of care by building partnerships across federal, provincial and territorial jurisdictions. Participation and commitment of provincial agencies and authorities is a critical underpinning of each pilot project.

HIGHLIGHTS FROM THE 2008 MENTAL WELLNESS TEAM “HOW TO” GUIDE

The 2008 “*A guide to the Development of Mental Wellness Teams*” provides an overview of the broader context as well as a compelling case and helpful direction based on a review of the existing literature. It focuses a lens on the convergence of community development and clinical approaches that best supports a culturally appropriate continuum of mental health and addictions at the community level. In particular, it describes the interplay of individual and community mental wellness, aspects of which derive from cultural revitalization, self-efficacy and individual and community level agency. The paper also briefly alludes to how broader determinants of health impact on individual and community wellness. It describes mental illness and addictions as well as the evolving understanding of concurrent disorders. As well, it focusses on concepts of mental wellness, which reflect an inter-connected and relationship-driven dimension.

² Proposed Evaluation Framework for Mental Wellness Team Approach to Mental Health and Addictions Services in Aboriginal Communities, Jill Anne Chouinard, Katherine Moreau, J. Bradley Cousins, Centre for Research on Educational and Community Services, University of Ottawa, June, 2009

The guide suggests that community development approaches would support clinical approaches and enhance collaboration between community para professionals and external clinicians. As noted in the paper: “It is anticipated that communities would benefit most from a team that includes a holistic mix of clinical and community elements and that is based on the self-identified needs and strengths of a fully engaged community.”

The paper further describes multi-disciplinary team composition embracing a mix of western clinical, community and cultural resources. Measures to support team effectiveness and *interprofessionalism* are also elaborated and suggested. Team functions would derive from needs and priorities as expressed by communities but would be heavily predicated on a model of integration, linkages, partnership and coordination.

Team goals as suggested in the paper focus on two levels: a micro level supporting individuals, and, by extension, their families in a recovery model approach; and, a macro level supporting community healing, self-determination and development which challenges community members to mobilize together to develop their own solutions.

This new approach to delivery of mental health and addictions services is unfolding in the context of a policy and programming environment that is not yet situated to support and encourage this dynamic. More work is needed at the community and organizational level to ensure policy, protocol and procedures are in place to foster the MWTs. That being said, it is important to note that the MWT in British Columbia had already been developing this type of team-based approach for several years prior to 2008.

Lastly the paper underscores the importance of evaluation in documenting the impacts and efficacy of such a comprehensive initiative as mental wellness teams. In particular: “Evaluating and strengthening the evidence base for team-based approaches remains one of the most significant next steps as Health Canada moves forward to develop and support mental wellness teams in First Nations and Inuit communities.”

It is with this in mind, that this report has been prepared to document lessons learned and the most useful approaches to consider in the development of Mental Wellness Teams based on the experiences of the eight pilot projects’ collective years of experience.

MENTAL WELLNESS TEAM PROGRAM LOGIC MODEL

The following program logic model shared with the regional pilot projects in 2010 provides a visual depiction of the intended objectives, activities and outcomes of the MWT concept.

FIGURE 1. National Mental Wellness Team Project Logic Model

Goal	To enhance the development of a coordinated continuum of mental wellness services for and by First Nations and Inuit that includes culturally safe traditional, cultural and mainstream approaches to determine what works in First Nations and Inuit communities, in response to direction given by the Mental Wellness Advisory Committee.			
Inputs	FTEs, O&M, Contributions			
Activities	Engage and collaborate with FN/I communities, F/P/T/A authorities and other organizations.	Coordinate and/or deliver culturally safe, client-centred, community-owned, defined and driven mental wellness programs and services.	Lead, develop and incorporate best, promising and innovative practices in mental wellness.	Build capacity: develop skills of community, cultural and clinical service providers, including cultural competence.
Outputs	Agreements, joint projects, working groups, councils, advisory groups, committees, strategic alliances, MOUs, formal partnerships.	Projects/activities, referrals, clients treated, counselling sessions, interactions between mental wellness service providers, coordinated service plans.	Policies, procedures, databases, protocols, guidelines, frameworks, reports, conferences, workshops, literature reviews, best practices, lessons learned.	Culturally relevant training material, training sessions (including mentoring and supervision sessions), culturally competent, trained workers.
Immediate Outcomes	Enhanced collaboration with First Nations and Inuit communities, F/P/T/A authorities and other organizations to develop First Nations/Inuit-specific approaches to mental wellness teams.	Improved continuum of culturally safe mental wellness services in FN/I communities. Enhanced collaboration between community, cultural and clinical service providers.	Increased use of best, promising and innovative practices.	Increased FN/I community ownership and capacity to deliver effective, culturally safe mental wellness services. Increased knowledge transfer between community, cultural and clinical service providers
Intermediate Outcomes	<ul style="list-style-type: none"> › Increased access to a range of mental wellness services including: outreach, assessment, treatment, counselling, case management and referral. › Increased community engagement on mental wellness and community wellness issues. › Improved collaboration amongst and strengthened support for mental wellness workers. › Improved treatment outcomes as a result of better continuity of care, more appropriate services, better quality services, and improved access to care. › Increased health information on mental wellness and community wellness issues. 			
Final Outcome	Contributes to the improved health status of FN/I individuals, families and communities through a strengthened continuum of culturally safe and relevant mental wellness programs and services.			

Each MWT was designed and implemented according to community strengths, needs and local infrastructure and service landscape. Team composition varied with some communities opting for a clinical services team approach focussed on individual counselling, or a community development approach that sought to build community ownership, capacity, and a culturally safe and coordinated continuum. No two service models were alike as each were designed to respond to the identified mental health and addictions needs of each community.

OVERVIEW OF INDIVIDUAL PROJECTS BY REGION

As mentioned, a variety of service models were designed in the context of these regional pilot projects. Each Mental Wellness Team pilot project has been implemented according to their respective community needs, strengths and priorities. Some have been built onto existing programs and services already closely aligned with the pillars outlined in the MWAC strategy while others were entirely new endeavours necessitating a significant community engagement phase to assess needs, build support and foster participatory design.

What they do share is a common commitment to enhancing the continuum of culturally safe mental health and addictions services, a capacity and willingness to try new approaches, and an innate sense of what is appropriate for their communities and context.

An overview of the eight pilot projects as implemented is outlined in the table “Overview of Mental Wellness Team Pilot Projects” in Appendix A. A summary table entitled “Figure 2 MWT Pilot Projects at a Glance” briefly describes their development approach, service orientation and partnerships.

From the table in Appendix A it can be seen that each region has interpreted and implemented the Mental Wellness Team concept in unique ways. Three projects (Tui’kn, White Raven and Nuw’-Chah-Nulth) built upon existing services or projects which had been funded through other program funding streams such as the Aboriginal Healing Foundation, Indian Residential Schools Support Program or Aboriginal Health Transition Fund. Others, such as those in Quebec and Ontario, built new Mental Wellness Team projects from the ground up through extensive consultation and engagement at the community level.

Some of the projects have been very creative and skillful in building or enhancing programs in partnership with provincial ministries or departments and their own organizational resources. These projects include Nunatsiavut’s Mapping the Way Project, the Maliseet Nations Mental Wellness Team, Quebec’s Mental Wellness Team and Manitoba’s Mental Wellness Team Anishnabe Mekina Mino-Ayawin.

Several of the projects focussed on the design and delivery of clinical services within their target population while others were more coordination focused, linking and leveraging existing community services and strengths, enhancing the continuum and mobilizing teams at the individual community level. All eight projects embedded a traditional or cultural approach as a central platform to their model.

Projects which have evolved or which were built upon existing services had the advantage of being able to leverage existing administrative infrastructure, governance structures, community development and engagement efforts and partner relationships. In this regard, they were somewhat better positioned to explore innovative approaches in cultural integration or to offer new services to their member First Nations.

Projects which were designed on new MWT models “from the ground up” encountered, at times, an underlying tension from existing service organizations who may have felt threatened by the role of the MWTs and a perception that these pilot projects would duplicate already existing services or divert resources away from them.

FIGURE 2. Mental Wellness Teams at a Glance

Project/Region	Development or design approach	Model or service orientation	Partnerships
Tui'kn, Atlantic	Re-establishment of program originally undertaken in Eskasoni and expansion to include four other First Nations	Aspects of clinical and community development approach in a cross sector case management model	Eskasoni First Nation funds one case manager position
Maliseet First Nations Mental Wellness, Atlantic	Expansion of Strengthening Our Next Generations project funded by the Aboriginal Health Transition Fund	Delivery of psychiatry services alongside community based teams; community capacity development in a culturally integrative approach	<ul style="list-style-type: none"> › Funded in partnership with New Brunswick Horizon Health Network › Regional Health Authority provides part-time psychiatrist and community mental health nurse positions
Mapping the Way, Nunatsiavut, Atlantic	Extensive nine-month planning phase to design the project	Clinical services, prevention programs and capacity building, focus on youth aged 6 to 24 years	<p>Staff resources and space from Nunatsiavut partnership; also with Labrador Grenfell, Crime Prevention Strategy funds</p> <p>Key partners include:</p> <ul style="list-style-type: none"> › Nunatsiavut Government › Mushuau Innu First Nation › Sheshatshiu Innu First Nation › Labrador-Grenfell Regional Health Authority, › Health Canada (Atlantic office and the Labrador Health Secretariat)
Mental Wellness Team, Québec	Community development approach	Clinical coaching, support and development of local capacity; networking and liaison; cultural and community services	<ul style="list-style-type: none"> › First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC) › Ministry of Health and Social Services of Quebec; › FNIH—Quebec region; › Lac Simon › Kitcisakik › Network of Health and social services of Abitibi-Temiscamingue
Raising the Spirit Mental Wellness Team, Ontario	Extensive community engagement and project planning phase	Specialized services and capacity building through a balance of western and traditional approaches	

Project/Region	Development or design approach	Model or service orientation	Partnerships
Anishnabe Mekina Mino-Ayawin, Manitoba	Competitive selection process with West Region Tribal Council formulating a project design in consultation with its member First Nations	Coordinated access to a continuum of community based, core wellness services including traditional, cultural and mainstream approaches	Prairie Mountain Regional Health Authority
White Raven Healing Centre, Saskatchewan	Evolution of a healing centre service model which has been established since 2003	Team based approach to the delivery of culturally safe therapeutic methods in both western and traditional approaches	Provincial funding partners
Nuu-Chah'Nulth Tribal Council Quu'asa Wellness Project	Evolution of Tribal Council mental health and addiction program, in particular cultural supports previously funded by Aboriginal Healing Foundation and Indian Residential Schools Support Program	Multi-disciplinary, culturally based holistic healing approach encompassing counselling, community capacity building and development	Provincial funding partners

The table entitled “Overview of Mental Wellness Team Pilot Projects” in Appendix A provides greater detail concerning each of these projects.

OVERVIEW OF REGIONAL PROJECT TIMELINES

It is helpful to have an overview of the chronology of events in developing both the Mental Wellness Team concept and, within each region, the respective teams.

An overall chronology of events which informed the pilot initiative are as follows:

- › 2001—The concept was originally proposed by the Northeast Mental Health Centre to FNIH ON Region for a “Mental Wellness Team”
- › 2005—Mental Wellness Advisory Committee (MWAC) established
- › 2007—National Anti-Drug Strategy (NADS) provided funding opportunity
- › 2007—MWT Concept Paper developed³
- › 2008—Nuu-chah-nulth Tribal Council hosted FNIHB which aided in further refinement of the concept.
- › 2008—At the request of the Mental Health Commission of Canada, a Guide to the Development of Mental Wellness Teams was developed.
- › 2008—Shared Care Conference, Victoria, BC attended by MWT regional and community leads in which further development of the potential initiative was discussed.

³ Early drafts of the Concept Paper were refined in discussion with FNIHB Atlantic Region, in the context of responding to how mental wellness had been identified as a priority by First Nations leadership, including the importance of including approaches which address the community as a whole. Feedback from the Mental Wellness Advisory Committee was also incorporated into the concept.

Each region and its development and implementation timetable are briefly described below:

British Columbia Region—Nuu-chah-nulth Tribal Council—Quu’asa Project

A proposal based on Cultural Healing to be integrated with existing services provided by Nuu-chah-nulth Tribal Council was presented to Health Canada in 2008, although mobilization had begun to some extent in late 2007 building upon previously established programs. Quu’asa Program was fully operational by the spring of 2008. Although the pilot phase of the project was evaluated for the period 2009 to 2012, services are ongoing.

Saskatchewan Region—White Raven Healing Centre

White Raven Healing Centre’s Proposal for “Culture Heals” builds upon previous integrative cultural programming which was already implemented within the Centre. The proposal was nonetheless framed and developed for the MWT pilot projects in July 2008 and submitted in December 2008. The project was implemented over the period 2009 through 2012 and both a process evaluation in 2011 and a summative evaluation in 2012 portray the key accomplishments and incremental activity undertaken in the context of the MWT pilot phase. Services developed in the pilot continue to be offered and evolve in response to community needs.

Manitoba Region—West Region Tribal Council’s Mental Wellness Team Pilot Project entitled “Anishinabe Mekina Mino-Ayawin (Road to Good Health)”

A Mental Wellness Team Proposal Submission was submitted by West Region Tribal Council’s Health Department in July, 2009. The Pilot Project Coordinator began work in December 2009 with a full round of community engagement completed during the period January 2010 through April 2010. During the period, April 2010 through November 2010, seven individual Community AMMA teams were established. The project is still active and underway with the pilot being evaluated over an implementation period described as Fall 2009 through Fall 2012.

Ontario Region—“Raising the spirit” Mental Wellness Team

During the period, July through September 2008, meetings were held with each First Nation to discuss the project and obtain Band Council Resolutions for both the community consultation process and for the development of the Mental Wellness Team Pilot Project.

In September 2008 a consultant was contracted to conduct the community engagement strategy and consultation process to explore the potential for a Mental Wellness Team for 10 First Nations which took place between October 2008 and January 2009.

By November 2008, a Terms of Reference for an Advisory Committee with representation from each community was drafted and finalized during the period, January through March 2009. Steering Committee representatives appointed by each of the participating First Nations began meeting in April 2009. Team recruitment took place over the six month period May through October 2009. The project was launched officially in March 2010 and a process evaluation was undertaken in the fall of 2011 with the final summative evaluation encompassing the pilot phase between the Fall of 2009 and 2012. The project is still operational at this point.

Quebec Region—Mental Wellness Team

The two participating First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC) and First Nations and Inuit Health (FNIH)—Quebec Region worked together in 2008–2009 to obtain funding for the implementation of a mental wellness pilot project in two remote First Nations communities in Quebec. A committee has subsequently been developed in which the Ministry of Health and Social Services of Quebec joined the two original partners.

The mental wellness pilot project spans four years, from 2009 to 2013, and has been implemented in three separate phases: 1—planning (April 2009 to October 2010); 2—creation of the Mental Wellness Team and implementation of its services (November 2010 to June 2012); 3—overall assessment (July 2012 to March 2013).

The pilot is over now, but the mental wellness team is still operational.

Atlantic Region—Nunatsiavut Mapping the Way

Essential milestones completed in designing and implementing this project included:

- › 2009—A contractor was hired to collaboratively research and develop a service delivery model for mental health and addiction services.
- › 2009—The Partnership submitted a proposal for a mobile clinical team to Northern and Aboriginal Crime Prevention Fund.
- › 2009—The contractor submitted the proposed Mental Wellness and Healing Service Delivery Model document & a Problematic Substance Use, Smoking and Gambling framework/strategy to Nunatsiavut Government and Health Canada.
- › 2010—The proposal for the mobile team was approved.
- › 2010—Team recruitment began.

The project was evaluated over its pilot phase of 2009 to 2012. It continues to operate.

Atlantic Region—Maliseet Nations Mental Wellness Team Pilot Project

Maliseet Nations Mental Wellness Team Pilot Project developed a framework and model for the delivery of mental health and addiction services via the following steps:

- › Submitted Letter Of Intent (early 2009)
- › Submitted proposal for Maliseet Nations Mental Wellness Team Pilot Project (August 2009)
- › Recruited Project Coordinator (Feb. 2010)

Thereafter the project was implemented and evaluated over the three year pilot period from 2010 through 2013. The project continues to offer services.

Atlantic Region—Tui'kn Partnership

Building upon a previous two year Case Management project entitled PAST (Personalized Action Strategy Team) funded by the Nova Scotia Gaming Foundation, a revised proposal expanding the project from one First Nation to five First Nations was submitted to FNIH in 2009.

Informal case management services were provided from April 2009 through September 2009 and expanded to a formal Case Management service in September 2009 with the hiring of a MA level Psychologist.

By October 2009 the Tui'kn Partnership was approved as a MWT Demonstration site, and hired additional staff (two Community-based MWT/CM Case Managers and an Administrative assistant/Data Analyst).

A process evaluation in 2011 identified weaknesses in the project which were not addressed by the summative evaluation in 2012, resulting in sunseting of the project in the 2012/2013 fiscal year.

KEY LEARNINGS FROM THE EXPERIENCES OF 8 PILOT PROJECTS

With both a proliferation of well written planning tools, community development toolkits, needs assessment manuals and program planning handbooks and an equally vast range of communities with unique histories, circumstances, cultures, needs, aspirations and dynamics, the obvious question is why pursue the development of a guide for Mental Wellness Teams.

Clearly, the real value in a document such as this resides in the collective wisdom of eight amazing pilot projects and their stories.

Although the 2008 guide suggests broad direction and important considerations based what is described in the literature, it is helpful to contrast that with the real world experience and insights of eight pilot projects as they near the end of three years of service delivery. They are in the best position to share what is workable and to suggest practical steps for others to consider.

PURPOSE OF THIS GUIDE

“Guide—one who leads others through unknown or unmapped territory; one who serves as a model for others.”

In many respects, the eight Pilot Projects have led in the development and implementation of an untested and unrefined concept, that of a Mental Wellness Team approach to the delivery of mental wellness services in First Nations communities. Over a three year period, communities have been engaged, objectives have been elaborated, projects have been designed, structures have been created, challenges have been encountered, and learnings have been accumulated.

The purpose, therefore, of this guide is to reflect back to communities, the collective wisdom gathered over the pilot phase and refine what was suggested in the 2008 document with a layer of “real world, real time” experiences.

One of the pillars from the MWAC strategy speaks to the dissemination and sharing of knowledge about promising traditional, cultural and mainstream approaches to mental wellness. This pillar encourages lessons learned from the pilot projects to be disseminated broadly to support teams in other jurisdictions in order to raise the quality of mental health and addictions services available across Canada. Each of the Mental Wellness Teams has documented numerous successes, promising practices, challenges, processes and findings via a number of evaluation reports, studies and presentations. This represents a first-hand body of knowledge about what works in the area of mental wellness and community engagement and development.

With this in mind, Health Canada has prioritized the development of a report summarizing key learnings and promising practices described by the eight pilot Mental Wellness Teams in the development and implementation of their various team models as an important aspect of this knowledge translation and dissemination. This practical guide would build on the 2008 paper entitled “A guide to the Development of Mental Wellness Teams” which examined the literature and described the essential concepts, context, evidence, and guidelines to consider in the development, implementation and evaluation of Mental Wellness Teams. At the time of the development of the 2008 paper, it was too early to incorporate what the teams had learned.

The newly revised guide will draw on key learnings and outcomes from the more than three years in which the Mental Wellness Teams have been operating and summarize some of the consistent suggested approaches, themes, lessons learned and recommendations for consideration in the development of a Mental Wellness Team model.

Accordingly, this guide is intended to serve as a helpful resource to those contemplating similar Mental Wellness Team concepts in their community's mental wellness strategies.

PREPARATION OF THIS GUIDE

DOCUMENT REVIEW

Information was gathered in two main ways: 1. review of the rich repository of pilot project proposals, evaluation reports, presentations, community of practice reports, overall evaluation framework materials, concept paper, the original "how to" guide and other associated documents; and 2. telephone interviews with Mental Wellness Team project coordinators and FNIHB regional representatives.

An initial discussion document framing key topics for exploration was developed and informed the development of questions for the telephone interviews.

The following types of documents were reviewed: formative evaluations, process evaluations, summative evaluations, performance measures strategy documents, as well as project presentations and information shared at two community of practice workshops. These document the development, implementation, impacts and outcomes from each pilot project and comprise a rich source of information with which to frame the proposed guide.

Forty different documents were reviewed in addition to the two following foundational documents:

- > "Mental Wellness Teams Concept Paper", September 20, 2007
- > "A guide to the Development of Mental Wellness Teams", Community Programs Directorate, First Nations and Inuit Health Branch, Health Canada, October 24, 2008

Other documents included:

- > Original proposals
- > Process Evaluations or Progress Reports
- > Outcome Evaluations
- > MWT Evaluation Resources
- > Community of Practice Reports
- > Presentations for Ottawa and BC Community of Practice Workshops

TELEPHONE INTERVIEWS

Telephone interviews were completed in the period January 16, 2013 to March 19, 2013. A list of MWT Program Coordinators and regional FNIHB representatives along with their contact information was provided by Health Canada. A set of interview questions (see Appendix B) was developed based on the preliminary document review and a summary of topics elaborated from this initial review.

Interview questions focussed on the following key areas:

- › Main challenges and mitigation strategies
- › Successes
- › Program planning elements and their prioritization
- › Better approaches in hindsight
- › Advice for others
- › Areas of unfulfilled potential
- › Future directions

Initial email contact was followed up by telephone in order to seek an interview and confirm the scheduled appointment. The following table depicts the interviews completed by region. The information gathered from interviews represents rich insights which both affirmed and challenged what was gleaned from the document review. Again, there were many compelling and consistent themes expressed. These will be described in the discussion section of the document.

TABLE 3. Telephone Interviews Completed

Region	MWT Program Coordinator	FNIHB Regional Contact
BC	Simon Read and team January 31, 2013	
Saskatchewan	Elaine Lavallee January 30, 2013	
Manitoba		Marcy Richard January 29, 2013
Ontario	Sharon Wabegijig, Diane Jacko and Steering Committee written submissions January 31, Feb	Frank McNulty January 18, 2013
Quebec	Proposes to use the information contained in the final evaluation report	Dominique Boucher March 6, 2013
Atlantic—Tui'kn	Daphne Hutt-Mcleod & Sharon Rudderham January 18, 2013	Gillian Bailey January 16, 2013 and January 18, 2013
Atlantic—Maliseet	Veronica Moonstream WolfEagle February 6, 2013	Gillian Bailey (see above)
Atlantic—Nunatsiavut	Zita White February 5, 2013	Gillian Bailey (see above)
Ontario Region—Sioux Lookout Zone	Lyn Button—Community Wellness Development Teams— Interview completed March 4, 2013	

Some regions elected to round out the discussion by inviting others such as their Steering Committee or Board Chairs and key staff members. The interviews took between 30 to 90 minutes and were conducted via telephone. One region also provided a written submission from notes taken at their Steering Committee meeting where these questions were discussed as part of their agenda.

KEY LESSONS LEARNED WHICH INFORM THE GUIDE

Before outlining recommended guidelines for the development of similar projects, it is important to describe key themes that emerged both from the document review and the telephone interviews. These themes reflect critical areas for consideration when undertaking the development of Mental Wellness Teams.

In this section, challenges and successes, key programming elements, lessons learned and advice for others are described along with areas projects felt they would have liked to develop further, as well as future considerations.

CHALLENGES ENCOUNTERED

Interview discussions revealed a number of important challenges encountered by projects as well as the various strategies projects employed to mitigate these challenges.

Service demands—Projects experienced more demand for their services and programs than resources and timeframes could permit. One approach to address this challenge was to teach and mentor other staff within communities to take on these roles, for example in cultural support, traditional counselling and sharing circles. Some projects found it difficult to address prevention-type approaches until the immediate downstream needs of individuals were being addressed in some way. Nonetheless, one team found that only individuals who have had their own personal healing journeys and who have the recognition of their peers can offer these kinds of activities.

Maintaining consistent community engagement both at the governance level and at the community services and activities level—Initial excitement generated by the launch of pilot projects was insufficient to maintain momentum for some projects which began to experience waning attendance at steering committee meetings and within community based program activities. Some of the efforts to increase community engagement included re-launching the project in communities which had been less involved, ongoing communications, the development of a promotional DVD, promoting access to resources and services, and creating opportunities for capacity building. This may have been related to some communities within a team having different immediate needs, and being at different stages of readiness for active involvement with others.

Human resources within projects—Effective defining of the competencies required, staff recruitment, attracting the right skill sets and retaining staff were challenges experienced by almost all of the projects. This was both within the communities, and among other staff trying to support the work of the teams. For some, the region in which their project is operating may be remote, isolated or semi isolated. Service needs can be high with very high-risk clients. The work is not easy, and neither is the travel and there is much potential for burnout and turnover in staff who may not be from the region. Staff vacancies were also endemic as individuals sought permanent positions, something that the pilot projects were not in a position to offer. Other projects experienced vacancies due to maternity leaves. To mitigate human resource challenges in communities, promotional campaigns could be conducted with First Nations youth to encourage them to study in the area of mental wellness and/or community development.

Various approaches were undertaken in order to address this challenge. In one project, an orientation package and process was developed so that any staffing changes were not as disruptive and new hires could be brought up to date in a timely manner. One project is pursuing an agreement with the province which would allow provincial professional staff to take a leave of absence and participate in secondments to the pilot project, as a solution for their human resources recruitment challenge. Another suggested broadening the qualifications and skill sets being sought while still others suggested innovative recruitment advertising.

It should be noted that staff turnover was a factor not only within the project teams but within communities, key partners and within Health Canada regional offices. There is a need for consistent, strong leadership throughout the life of the project amongst all stakeholders. Moreover, health human resources recruitment and retention challenges are not unique to the MWT pilot projects. This represents a much broader health sector issue.

Distances and differences between communities—Pilot projects expended significant resources in trying to adequately service communities across large and diverse geographic areas. Moreover for some of the newly developed projects, a clear challenge lay in accommodating the needs of communities with very different histories, cultures, aspirations and very different stages of development. Pilot projects were encouraged to use a community development approach, wherein larger, more well-resourced communities support the advancement of the collective, bringing smaller, less developed communities along. Results of this approach varied across regions. However, as one project experienced, community development must be viewed as a long term investment and a work in progress; more than one project implementing this approach is required before long-term, sustainable changes can be made. Finally, clustering communities with reasonably equivalent capacities, readiness and expectations was very difficult. As many project learned, communities served by the MWTs need to be at similar stages of readiness, governance, and engagement in order for the model to work well.

Funding challenges—A major challenge expressed by projects was in extending program resources to cover all communities and accommodate needs and growing service demand. This was particularly true of projects which did not have partnership funding in place. Other pilot projects, especially those which had evolved out of previously existing funded projects, were able to leverage financial resources from various partnerships and in fact, several had clinical positions which were provincially funded. This introduced new complexities, however, in a patchwork of project accountabilities, program and departmental mandates and priorities and in managing human resources who may report to provincial authorities. Foremost as a concern, however, was the need for sustainable funding beyond the pilot project's timelines.

Governance—Some projects felt their community governance and advisory representatives were disengaged at times, with some projects seeking a stronger role in communications from their advisory or steering committees, while others felt that these representatives could have assumed differing roles. As voiced by one respondent: *“Decision making needs to evolve beyond clinical and operational to long term community views.”* Striking the right balance was a key challenge. A few of their suggested approaches to mitigating this risk are highlighted in the section on *“Advice for Others”*. In one project where a community development approach was followed, the local planning team found the level of involvement required to implement this approach to be challenging at times and expressed a need for more support. When it comes to governance and decision making, some projects discovered that a balance is needed between encouraging community participation/engagement to build consensus, and empowering a smaller group or an individual to make executive decisions (e.g. around evaluation planning). Striking this balance was a challenge, with the need for constantly alternating between these two approaches, but necessary in order to maintain community engagement while also getting things done.

Political landscape—New projects especially found it a challenge to navigate the various political issues and tensions that change introduces. Perceived threats to the status quo and perceived competition for government funding emerged as sensitivities. Additionally, at times, steering committees tasked with looking at needs for a region as a whole found it hard to move beyond their usual posture of advocacy for their individual community’s needs. Moreover, the turnover in community leadership due to band elections meant that projects were continually engaging new leadership and seeking support from communities in their service catchment areas. This is an especially complex systemic problem not only for these pilot projects but any new initiative or undertaking within First Nation and Inuit communities.

Integrating cultural, community and clinical approaches—One project had challenges in integrating culture. The cultural and community worker had no support or counselling from someone like a cultural coach who could guide him, and for this reason the worker often felt isolated within the MWT. This project identified the need to have at least one other resource from a First Nations background on the MWT to balance the knowledge available for each approach (clinical and cultural) and provide mutual support.

Acknowledgement of the value of cultural healing—Mainstream systems, service partners and even community workers can be slow to acknowledge the value of cultural approaches. Considerable effort was spent informing, engaging, demonstrating and sharing the benefits of the integration of cultural approaches. This is described as both a challenge and a success by projects. As one project described: *“Traditional activities and practices are used on an individual basis and are not unanimously accepted in communities.”*

SUCSESSES AND PROMISING PRACTICES

Projects shared a number of successes, achievements or promising practices as follows:

Clear benefits to individual clients—Projects expressed their biggest successes as those directly related to client outcomes; for example:

- › Seeing their clients embracing a cultural approach as their path to wellness;
- › Supporting the most vulnerable individuals in client centred case management approaches;
- › Assisting homeless community members address their addictions and find their way off the streets to reconnect with their families;
- › Discovering an innovative way to connect with at risk youth in a community; and,
- › Supporting and empowering elder survivors in receiving a religious leader's apology related to their residential school experience.

An impact on partners' and external providers' understanding—One of the successes described by pilot projects relates to how they have been able to expand the understanding of concepts of historical trauma, residential schools and other complex contextual information among their partners in mental health and addictions, and thereby break down barriers. One of the ways some projects helped external partners, including provincial partners, to gain a better understanding of local community realities was to invite committee members to the participating communities to meet band council members, directors, coordinators and teams, and validate with them how their respective organizations can better assist in organizing mental health and addictions services.

Improved access to culturally safe services—From coordinated access to specialist services such as psychiatry, psychology or school occupational therapy to the provision of access to elders, ceremonialists and other cultural resources, and the knowledge exchange across these two modalities, communities and projects have described this as one of their key accomplishments. Increased access to knowledge keepers, traditional teachings, and personal support has been very well received at the community level. Cultural ways provide a receptive and safe channel to allow community members to take initial steps to seek help and move forward with the more clinical treatment approaches. As shared by one respondent: *"The cultural approaches and cultural safety are an intricate part to assist people to embark on their own healing journey"*.

Integration of cultural approaches—One of the biggest successes described by almost all of the projects is in integrating culture into mainstream counselling methods. One of the projects is fortunate to employ professional therapists who are all of First Nations descent, and has also developed close working relationships with approved NIHB therapists to ensure they take a holistic approach to counselling. Some of the therapists are using therapies such as cognitive behaviour therapy and integrating it with the advice of elders and ceremonies. In the project's physical environment, they have a ceremony room, an indoor sweat lodge and a medicines program with elders. They are also able to provide traditional and ceremonial services to patients in hospital and also have access to a palliative care room with ample room for extended family, an important community cultural accommodation not necessarily available in all hospitals. *"Everything that we do [in this way] is a success and promising practice. This is just something we do in our work and accept as normal. The holistic approach, incorporating traditional life stages with resource people who live the traditional lifestyle and teachings is a success."*

Knowledge exchange and transfer—Projects have offered opportunities for knowledge exchange through very well attended symposia, workshops and conferences and customized community capacity building and training. All of the training and capacity development offered to community front line workers within each MWT project is viewed as a key project success supporting long term community development. Some of the projects have also developed partnerships with academia in order to document and disseminate their approaches such as White Raven Healing Centre where they are publishing a paper entitled “Culture Heals” which focuses on the efficacy of culture integrated with therapeutic methods.

Capacity building—A common theme across all projects involved empowering communities by building their capacity or re-engaging their strengths in cultural and traditional approaches and supporting partners by building their knowledge and cultural competency about First Nation and Inuit community needs. For one project, they noted improved organization and coordination of social emergency response measures as a result of the project.

Intangible assets and intellectual property—the development of community approved project protocols, policies, forms, procedures and processes, especially those describing their cultural approach was as a key project accomplishment. Projects are also particularly proud of the body of knowledge around community wellness approaches that work, residing in the extensive formative and summative evaluation reports.

New pathways in the continuum—In one project with a focus on coordination, a key project success was in the establishment of new partner relationships and improved transitions in the continuum of care such as across the hospital and justice sectors

An opportunity to reorient community services—A success described by one project in particular, reflects the consciousness and newfound momentum at the community level to reorganize community level services and remove inefficient silo approaches, particularly in the area of crisis response and management. For some communities, mental health services have been longstanding in the community, but they have been offered through a classic clinical framework. With the mental wellness pilot project, this was the first time that the communities were consulted on the issues of mental health and addictions. One project, guided by a community development approach, was able to adapt its services to respond to the cultural and community dimensions, rather than follow a program delivery model where services are offered based on set program objectives.

As expressed by one region: *“Application by the MWT members of the community development approach broke the cycle of curative intervention and fostered joint efforts with a view to social change.”*

Partnership with the province—Projects experienced a perfect convergence of readiness on the part of both provincial partners and stakeholder communities to really embrace and actualize partnerships in their projects. In one project, the province sees that the MWT project could have an impact on the number of First Nation community members presenting in provincial institutions and hospitals. They are now in the process of formalizing protocols signed by provincial institutions and community leaders with clear roles and responsibilities which is a big accomplishment for the region. Other regions are pursuing the development of a formal agreement to sustain the increased access to Regional Health Authority services and planning next steps to build on the current level of interaction among partners. With these partnerships developed, some teams were able to benefit from the provincial resources, including provincial partners sharing models for staffing mechanisms.

As expressed in two other regions: *“The regional health authority is now at the table for every single meeting and has become a strong partner both engaging in and supporting training at the community level.”*

“Engagement of the health authority is a real strength. They are adapting services to meet the needs of the First Nations communities even though the province (NB) is strained funding wise. The Director of Mental Health and Addictions comes to all the meetings and has personally committed staff and resources. Five years ago this wouldn’t have happened.”

Evaluation—Evaluation was designed into projects right from the beginning and both the formative and summative evaluations allowed projects to share their accomplishments with communities, leadership, funding partners and other stakeholders and to adjust, where necessary, their project’s design and approach. This is described as one of the key successes of the projects.

The next section describes key planning elements which were critical to the pilot projects’ success.

PROGRAM PLANNING PRINCIPLES—CRITICAL TO PROJECT SUCCESS

A set of program design elements or planning principles chosen from key topics evident in the original document review were shared with telephone interview respondents to gauge and assess the degree to which these factors were critical or instrumental to their pilot project’s success.

These consistent themes included:

- › Community engagement
- › Program design
- › Partnership development
- › Governance
- › Human resources
- › Communications
- › Inter team dynamics & professionalism (team building)
- › Capacity building
- › Knowledge exchange and transfer
- › Integration of traditional or cultural approaches
- › Ensuring cultural safety
- › Evaluation and performance monitoring

Respondents were asked to prioritize from amongst this list, their top four critical success factors or planning pillars.

Interview respondents described the process of ranking these success factors as difficult as many saw them as holistically inter-twined. For example knowledge exchange and transfer around cultural approaches can lead to better integration of traditional and cultural approaches, which can improve inter team dynamics and professionalism, build capacity and ensure cultural safety. In a similar vein, program design is linked to community engagement and partnership development as these are the stakeholders who hold the information which must inform program design. Nonetheless, several regions shared their respective rankings with the disclaimer that each of these pillars is not necessarily isolated as a discrete function from their point of view. Others stated that they viewed the exercise somewhat akin to identifying “which child they loved most” as all are equally important.

TABLE 4. Top four critical success factors by regional MWT pilot project.

Region	Most important	2 nd most important	3 rd most important	4 th most important
Maliseet	Capacity building	Program design	Community engagement	Integration of traditional and cultural approaches
Tui'kn	Program design	Inter team dynamics and interprofessionalism	Knowledge exchange and transfer	Partnership development
Nunatsiavut	Partnership development/ Program Design	Community engagement/ Knowledge Exchange and Transfer	Inter-team dynamics and interprofessionalism	Integration of traditional and cultural approaches
Quebec	Partnership development and communications	Capacity building, knowledge exchange and transfer	Community engagement	Ensuring cultural safety, integration of traditional and cultural approaches
Ontario	Communications encompassing governance, partnership and community engagement	Knowledge exchange and transfer in order to foster integration of traditional and cultural approaches	Program design including: <ul style="list-style-type: none"> › evaluation › integration of traditional and cultural approaches, › knowledge exchange and transfer › human resources planning › inter-team dynamics and professionalism 	
Ontario (Steering committee)	Community engagement	Program design	Ensuring cultural safety	Capacity building
Manitoba	Integration of traditional and cultural approaches	Capacity building and community engagement together	Knowledge exchange and transfer	Program design & learning from each other
Saskatchewan	Integration of traditional and cultural approaches	Ensuring cultural safety	Inter-team dynamics and interprofessionalism	Community engagement
BC	Ensuring cultural safety	Integration of traditional and cultural approaches	Inter-team dynamics and interprofessionalism	Capacity building in indigenous knowledge and experience

From the table it can be seen that MWTs saw the following as the most critical success factors:

1. Community engagement
2. Integration of traditional and cultural approaches
3. Program design
4. Inter-team dynamics and inter-professionalism
5. Partnerships

Again, as highlighted by some of the interview respondents, the process of prioritization is not necessarily aligned with a holistic or balanced way of seeing things. Nonetheless, as described by one of the telephone interview respondents, it is clear: *“The key is to start from community and culture in the process of healing.”*

BETTER APPROACHES IN HINDSIGHT

When asked the question: “If you were to do it all over, what would you do differently?” teams had a variety of compelling responses reflecting their unique circumstances, challenges and new insights garnered along the way. A few consistent messages emerge:

EFFECTIVE ENGAGEMENT

1. **Work with communities that express readiness**—Some pilot projects expressed that if they had to do it all over again they would only undertake projects in the communities that were ready and receptive partners. Trying to serve all communities regardless of readiness was overly ambitious as projects found their resources too thinly spread across several communities.
2. **Formalize supports and resources for community governance structures**—Formal terms of reference and orientation materials and self-assessment or evaluation processes to support community steering or advisory committees are advisable. Such terms of references and processes should be designed and adopted by the advisory board or steering committee and reviewed periodically.
3. **Engage all communities annually**—An annual review and planning opportunity together with all partners and communities rather than informally one-on-one with communities is suggested as a more efficient and effective approach to ensuring the project stays on track and is responsive to community needs.
4. **Involve MWT members in initial planning and community consultations**—One project in particular implicated the mental wellness team through the successive hiring of two different teams: a local planning team and then the mental wellness team. The planning team initiated mobilization of the population and partners. Once the mental wellness team came on board, the team needed several months to integrate into the community, clarify their mandate and resume mobilisation. The team expressed that if they were to do it all over again, they would have had a least one mental wellness team member participate in the consultation phase.

ADMINISTRATION AND IMPLEMENTATION

1. **Resource effectively and clearly describe and define the “model”**—Enlist community support and membership for committees to carry out community based activities more efficiently; ensure all administrative, human and infrastructure resources are in place before beginning to deliver services. Service delivery models developed in collaboration with communities must be clearly described, defined and communicated. Roles and responsibilities of team and community collaborators, records keeping and project documentation are all a must before a project can begin delivering services.
2. **Strategize around human resources and team building**—Given the challenges apparent around this issue, there should be a real emphasis on strategies to attract and retain the right people such as innovative advertising (eg the Cree in Quebec region publish their opportunities in outdoor fishing and hunting magazines where the lifestyle and environment are featured as an attractive element of the position). Additionally, there is a real need to focus on team building as a means of supporting team members whose work can be quite challenging.
3. **Evaluation**—Plan for project evaluation in the earliest design stages. Find a way to evaluate governance structure and also to include the voices of those directly impacted by the services. Align evaluation with the start of the project rather than at year end and ensure an objective approach to evaluation team selection.

INTEGRATE THE APPROACH

1. **Structure as a health and social services project**—One pilot project saw merit in potentially aligning their project more closely with social services as many of the issues being managed in a client’s case management approach involved social services at the community level. By expanding beyond health, it would also reinforce the notion of the approach being broader than a strictly clinical care plan to encompass and embrace other departments at the community level.
2. **Cultivate closer collaboration with primary care**—Development of partnerships between the medical primary care practitioners and elders and traditional knowledge keepers in order to foster greater mutual understanding and acceptance is an area that bears further development as expressed by one of the pilot projects.
3. **Clinical and community development approaches go hand in hand**—The corollary to closer integration between traditional approaches and primary care is that that clinical and community development approaches must also go hand in hand.

ADVICE FOR OTHERS

From the clear vantage point of experience, pilots had this advice to offer to others.

USE CULTURE AS THE CENTREPIECE FOR CAPACITY BUILDING

1. **Incorporate culture from inception**—Take a holistic cultural approach in whichever nation this is being undertaken and incorporate the advice of elders; encourage all communities and let them know they have gifts within them to take on this work; have faith and know that the cultural approach can lead to many successes.
2. **Strengthen cultural and community capacity**—One project spoke about the need to build capacity in cultural and indigenous knowledge: *“We tend to let the burden fall to a few elders ... but we need to draw out people’s gifts. There are a lot of highly trained and experienced elders in the practice of delivering cultural support who have witnessed, experienced and participated over the years. We need to be drawing them out and providing opportunities for them to support along with others as this is important to broadening our base.”*

Another shared the following experience: *“We had an individual begin attending our events in the northern region. He attended workshops, groups, men’s gatherings. As he grew, shared and assisted in the events eventually he gained confidence to begin an Early Childhood Education program. He started to assist and volunteer in his community. This individual is now part of our team as he was the successful applicant for one of our openings. He now works with our clinical counsellor and is supported with on-the-job training and shadowing as a member of our team. From coming to our workshops as a participant, he is now facilitating our workshops. He is a good example of a young family man who is now a resource to his community.”*

Still another reinforced the notion of capacity building as the legacy system for a community over the long term: *“Capacity building is key to ensure you leave something in the communities that they have ownership of.”*

“The beautiful thing about this is that there is no wrong way of doing this. By sharing what you have seen or been taught you are going to the roots of cultural safety and accessibility. In the field of trauma, culture can become the resource and for those who employ it—it is a gift, resource and touchstone.”

3. **Respect all spiritual frameworks and recognize that traditional views are not homogeneous**—Acknowledged elders and traditional ways exist in all communities and by the same token, spirituality takes many forms both traditional and in organized faith communities. Traditional teachings from other places may not be as readily embraced as those that are locally acknowledged and recognized within communities and territories. It is important to also recognize that cultural approaches can incorporate every day community or land based practices.

TAKE A COMMUNITY DEVELOPMENT APPROACH

1. **Ensure a community development approach and build capacity along the way**—Begin with a respectful understanding of where a community is at and work with them as they craft their own solutions, elaborate their own plans and foster capacity building. This process of community engagement and mobilization may take longer but ultimately lay the foundation for more viable, long term solutions.
2. **Acknowledge community resources and strengths**—Go into the community knowing they are doing good work and take the time to find out what they are doing well. Adopt the attitude that the community is its own expert and the team’s role is to take direction from the community so that the team can help or contribute. Focus on a few things and try not to take on too much. All new employees who are working in the community for the first time should receive some degree of training on local operations, culture, and history.
3. **Community engagement and needs assessment**—Allow ample time (four to six months) for planning and engagement with all communities so they can participate in program design. Community information sessions and close communications with all partners and stakeholders both at the project’s early engagement phases and in the preparation of a thorough needs assessment are essential. Effective ongoing collaboration with partners is critical to project success.
4. **Solid management and governance**—Ideally key staff will be recruited from within the communities to be served and the steering committee drawn from those nominated or identified by acknowledged community processes. Ensure you have a strong Project Coordinator as well as a committed and dedicated Steering Committee with representatives who have a mandate to make decisions at the community level. It is essential to provide for mechanisms that help forge bonds between MWT members, for example, weekly team meetings, or one or two days a year in a team retreat. Good working relationships between the Project Coordinator and Steering Committee are essential. More importantly: *“Highlight how important it is to have committed and passionate individuals—this is more than a job—it is a privilege to be part of an individual’s healing journey.”*
5. **Document and share with communities the needs, priorities and plans as they are developed**—As a way of validating and staying on course, it would be helpful to document community engagement planning outcomes and agree upfront on regular reporting format, timeframes and process.

SHARE AND DISSEMINATE

1. **Celebrate project successes**—Celebrate the demonstrated successes with stakeholders such as reaching the target group with a range of culturally appropriate services; building community-level capacity and establishing new partnerships. Build on these strengths.
2. **Open to sharing**—Pilot projects have expressed a wonderful willingness to share their success and lessons learned, even the “not so successful” elements of their projects, not only in the context of this guide but throughout their work over the past few years. One project, for example, has hosted numerous groups who have come to learn how their model of service delivery works and how they are integrating culture in meaningful ways into their programming. *“We are always willing to help others who want to model their programs or centres after us.”*

AREAS OF UNFULFILLED POTENTIAL

Pilot projects described the following as areas they would like to have pursued, given additional time and resources:

Specialized professional services such as psychiatry—Projects perceive they may have only been able to address a small fraction of the service needs in this area.

Child and youth services—This is an area that is clearly underserved although provincial governments are moving to address this gap.

Recognition/response to physical health needs—Clients who are seeking mental wellness services are sometimes also co-presenting with unattended physical health needs.

Alternative therapies—Holistic healing may encompass complementary and alternative medicine in an integrative approach. This is an unexplored area but one which some communities seem receptive to.

Occupational therapy in schools—One project noted that these services were very well received, resulted in dramatic changes, and they identified high demand in this area.

Case management systems within communities—These should span not only health but social services and other sectors at the community level.

Closer integration with the medical community—Integration of cultural and traditional practices with mainstream methods is an area in which projects would wish to see further development. This is dependent on the development of strong, mutually understanding and trusting working relationships.

Culture as a way to engage at-risk youth—Many youth struggle with issues of identity, belonging and acceptance. There is a need to integrate cultural teachings and ceremonies into prevention and treatment efforts as a way to reach out to youth.

Expanding the continuum of services to include urban outreach—Community members may straddle both their home communities and urban communities. Services should endeavour to be seamless to restore family, connection and identity which are central aspects of wellbeing.

Additional resources are needed to ensure family centred approaches—Some projects are working with whole families who are dealing with trauma. Resources should reflect this area of need.

Wellness centres—Communities wish to have wellness centres to continue their healing and expand upon the concept of cultural healing camps. These centres would use a holistic approach and incorporate language and culture.

Planning for sustainability—To forestall dependence on a central project coordination function, more emphasis should have been placed on supporting community champions, according to one of the pilot projects. At a broader level, there may be a sustainability risk in having established a MWT as a clinical service model instead of as a change management and capacity building model. In all projects, planning for sustainability beyond the pilot phase should begin at project inception and should involve partnership development as a central mechanism.

FUTURE CONSIDERATIONS

Advice to those in a position to influence policy or program priorities was shared as follows:

Reorientation of focus—Over the long term, the focus needs to shift from crisis response to wellness promotion, prevention, awareness, education and collaboration

Holistic, cross sector approaches—Holistic strategies which emphasize integration across different departments or sectors in the community beyond health should be a broad direction in any future endeavors. Communities are recognizing that it entails a broader community level approach than health and social services.

Partnership—Most of the pilot projects galvanized excellent collaboration amongst partners of all levels of government and across numerous sectors. This should be a foundational premise in other projects going forward.

Be mindful and inclusive of all spiritual frameworks—A sole emphasis on traditional spirituality may neglect a community or population who place their faith and seek meaning in other forms of spirituality. Mental Wellness Teams of the future should ensure equal emphasis is embedded to embrace other forms of spirituality.

Timeframe conducive to a true community development approach—It is apparent that communities have put a lot of work into these pilot projects even as their attention and resources compete with numerous other priorities at the community level. The project's pilot timeframe of four years is not enough to realize meaningful impacts and systemic change. There must be a shift from "project" focus to more of a systemic long term approach especially as it relates to funding and sustainability. *"Teams need to be resourced to the level where they can make a difference."*

IMPLICATIONS FOR COMMUNITY WELLNESS DEVELOPMENT TEAMS

Almost concurrent with the both the work of the MWAC and consequent development, implementation and evaluation of the Mental Wellness Teams concept, emerged a much more acute mental wellness and addictions issue—that of prescription drug abuse within First Nations. The concept of Community Wellness Development Teams (CWDT) builds off the MWT model and originated in response to widespread abuse of prescribed pain killers, principally OxyContin, in the remote First Nations communities of Northwestern Ontario. Originally conceived in 2010 as “Addiction Referral Specialist Team”, the approach was broadened to reflect the fact that more than isolated interventions and referrals were needed to address the issue. There was clear recognition that community-wide responses must be developed and knowledge and capacity built within workers who were, heretofore, more familiar with alcohol abuse as the prime substance abuse issue within their communities.

The philosophy of the Community Wellness Development Team (CWDT) approach is based on the belief that First Nations themselves are in the best position to address the problems that affect them, in particular, problems that impact the entire community in the way that opioid addiction has impacted entire communities. It is built upon three key principles:

- › Community based—The community plan is developed and implemented from within the community with the involvement of community resources.
- › Community strengths—Communities have a rich set of skills that are fundamental to developing a response.
- › Community driven—Community participation and control is fundamental.⁴

These principles are in keeping with those which have evolved intuitively as wise approaches undertaken within the context of Mental Wellness Teams as follows:

- › Community engagement and participatory project design
- › Community buy in, support and ongoing input and guidance
- › Community capacity building
- › Building upon cultural strengths and existing community resources

Whereas the outcomes with Mental Wellness Teams apply generally to individual and community wellness, Community Wellness Development Teams must focus their lens more specifically on the problem of prescription drug abuse. Nonetheless, the foundational principles of community development, capacity building and cultural approaches remain the same across both endeavors.

Another particular difference is that Mental Wellness Teams have collectively and implicitly undertaken their work understanding that outcomes they are driving towards may only be evidenced in the long term, provided that a solid foundation has been built. Community Wellness Development Teams must respond in a much shorter timeframes to urgent and sometimes crisis situations within communities.

There are nonetheless a number of key parallels to be drawn between these initiatives which can inform and mutually reinforce both endeavors. They are described in the next section.

⁴ Community Wellness Development Team Toolkit

RECOMMENDED APPROACH

The ways in which a community may develop and structure a Mental Wellness Team are as varied as the community needs expressed and designs conceived. Nonetheless, the experience of the eight pilot projects has highlighted a number of common steps and critical success factors which should be considered. These are organized into key themes and described in this section.

PRINCIPLES OF COMMUNITY DEVELOPMENT

Sound principles of community development should form the basis of any new projects developed within First Nation or Inuit communities. A community development approach takes the view that projects and processes are community based, community paced and community led.

Begin with a respectful understanding of where a community is at and work with them as they craft their own solutions, elaborate their own plans and foster capacity building. This process of community engagement and mobilization may take longer but can ultimately lay the foundation for more viable, long term solutions.

The community engagement and needs assessment phase should allow ample time for planning and engagement with all communities so they can participate in program design. Community information sessions and close communications with all partners and stakeholders both at the project's early engagement phases and in the preparation of a thorough needs assessment are essential. Effective ongoing collaboration with community and partners are critical to project success.

ENGAGED COMMUNITIES

1. Begin with a community engagement strategy to assess interest, readiness, support and to develop appropriate processes to engage communities and stakeholders in design and planning. Take the time to build the relationships so that communities can feel comfortable in signalling their support when they are ready to commit to a project.
2. Community ownership of a project is best actualized through the design of appropriate governance models which reflect the diverse needs of participating communities. Ensure ample support for the governance model through culturally and community appropriate terms of reference, orientation and assessment materials.
3. Engage, check back and adjust at key milestones. In addition to ongoing communications, provide opportunities for annual planning with communities and stakeholders to ensure the project is on track.

PARTICIPATORY PROGRAM DESIGN

1. A needs assessment involving and predicated on community input to its design, process of gathering information, strengths, priorities and aspirations should be undertaken if at all possible as a starting point for program design. Proponents should be mindful that communities may already have a rich repository of previously completed health assessments, studies and reports to use as a starting point. Processes should be developed to check back with communities and validate findings of the needs assessment.

STRENGTHS BASED APPROACH, INTEGRATION AND CAPACITY

A large body of findings support the fact that cultural discontinuity in the form of various historical traumas such as colonialism and residential schools is a risk factor for individual, family, and community health and wellbeing.

Culture and cultural ways are perhaps the *most important* protective factor residing within communities and offer the best approach to supporting mental wellness.

INTEGRATION OF CULTURAL STRENGTHS

1. Acknowledge community resources and strengths and the fact that they are already doing good work. Take the time to find out what they are doing well and how they are doing this. Adopt the attitude that the community is its own expert and the team's role is to take direction from the community so that the team can help or contribute. Focus on a few things and try not to take on too much.
2. Incorporate culture from inception by taking a holistic cultural approach in whatever way it is expressed by the community. Incorporate the advice of elders; encourage all communities and let them know they have gifts within them to take on this work; have faith and know that the cultural approach can lead to many successes.

CAPACITY BUILDING AND KNOWLEDGE EXCHANGE

1. New projects should focus empowering communities by building their capacity or re-engaging their strengths in cultural and traditional approaches and supporting partners by building their knowledge and cultural competency about First Nation and Inuit community needs.
2. Projects should build upon the community development approach with responsive capacity building that fosters greater competencies and confidence within the community and its mental wellness workforce.
3. Cultivate close collaboration between the medical primary care practitioners and elders and traditional knowledge keepers in order to foster greater mutual understanding, acceptance, sharing and learning.
4. Projects should be structured as change management and capacity building models more so than service delivery models. Capacity building and knowledge exchange can create a longer term legacy within communities and should be an essential planning pillar.
5. Seek avenues for integration across jurisdictions and across sectors outside of health and mental health and addictions.

PEOPLE

It's a universal truth that the success of any project is often attributable to the dedicated people within it. There is a need for consistent, strong leadership throughout the life of the project amongst all stakeholders

GOVERNANCE

1. Community driven projects are best served by carefully selected steering committees or boards inclusive of broad perspectives, expertise and sectors outside of health, mental health and addictions. Balance insights through the participation of diverse thought leaders and influencers such as elders and youth.
2. Clear roles and responsibilities as well as governance training and governance assessment tools can support effective governance.

HUMAN RESOURCES

1. Strategize around human resources recruitment and retention. Various approaches can be undertaken such as creative recruitment strategies, agreements with provincial partners to second staff; broadening qualifications and skillsets being sought; and comprehensive orientation and team building processes. Inter-professional team building and structured team support should also be planned from inception.

PARTNERS

Few programs can be framed or succeed without partnerships. Formalized agreements and protocols are not always necessary. Just having a partner at the table to brainstorm and share ideas can be instrumental and informative.

PARTNERSHIP

1. Set out to establish and strengthen collaborative relationships across federal, provincial, territorial and First Nations and Inuit delivered mental health, addictions and related human services. Partnerships between and amongst health serving organizations are the necessary currency for future program planning and project design.

HEALTH CANADA SUPPORT

1. In addition to the funds which seeded and maintained the projects, the eight MWTs have benefitted from advice from regional FNIHB staff and coordination, evaluation support and opportunities for networking and building a community of practice in this new area of endeavour. More importantly, the flexibility and latitude to alter, adjust, and learn through trial and error were key underpinnings of the development of these projects.

FINAL WORD

The MWT pilot projects comprise a cadre of passionate and committed individuals. More than a “community of practice”; they are thought leaders, doers and champions for their communities. These individuals have the final say:

“I am truly impressed by the resilience of the communities in being able to work through so many intense crises and challenges and continually regain their footing and keep their pilot projects maintained and moving forward.”

“We are really charting our own course with regards to services that meet the needs in our communities, the opportunity to learn from each other with projects, programs and continued collaboration, regionally based training opportunities to enhance skills are all leading toward promising practices.”

“I hope that Health Canada will continue to recognize and emphasize the importance of mental health and addictions and solutions linked to the culture for our people. This has affected so many of our people so profoundly and extends to all aspects of the health and wellbeing of our communities.”

“Continue focus on cultural healing as the cornerstone and sharing of knowledge that is already there. Give enough resources towards healing to succeed. Empowering with capacity building is a must; the communities need the tools to unlock the gifts there too.”

“Emphasize the importance of leading with cultural methods in order to balance the losses of past generations and engage those who have been missed in the past. Every community is different, so while there can be a framework plan, the beginning must be strong on process to match community needs.”

APPENDIX A

OVERVIEW OF MENTAL WELLNESS TEAM PILOT PROJECTS

TABLE 1. Summary overview of the Mental Wellness Team Pilot Projects

Region/project	Communities served	Goals	Structure
Quebec/Equipe en mieux-être mental (Mental Wellness Team)	Kiticisakik & Lac Simon	Provide coaching, support and training to local resources, develop the continuum of mental health and addictions services with the provincial network and provide cultural and community services	<ul style="list-style-type: none"> › Clinical advisor › Social Worker › Cultural and community worker › Mental health worker
Ontario/Raising the Spirit Mental Wellness Team	<ul style="list-style-type: none"> › Dokis First Nation › Nipissing First Nation › Atikameksheng Anishnawbek First Nation › Whitefish River First Nation › Aundeck Omni Kaning First Nation › Sheguiandah First Nation › Wikwemikong Unceded Indian Reserve › M'Chigeeng First Nation › Sheshegwaning First Nation › Sagamok Anishnawbek First Nation 	<p>"The 10 participating First Nations are self-sufficient in addressing their concurrent, mental health and addiction issues, in ways that reflect the culture, attitudes and philosophies of the participating First Nations".</p> <p>Program Goals:</p> <ul style="list-style-type: none"> › Improve access to needed specialized services where gaps exist; › enhance knowledge, skills and capacities of community workers; › provide support via a team approach of consultation, clinical supervision, coaching and mentoring; and to improve health outcomes through community engagement and community driven design and development of this project. 	<p>Program Coordinator along with three staff members: Traditional Coordinator/Counsellor, Concurrent Recovery Specialist, and an Administrative Assistant. Traditional Advisory Circle provides cultural guidance to the program and monitors the Elder-in-Residence Program, coordinated by the Traditional Coordinator/Counselor. A 10-representative community Steering Committee guides the project.</p>
Atlantic/Nunatsiavut Mapping the Way, Mobile Multidisciplinary Mental Wellness Team	Hopedale, Sheshatshit, Nain and Natuashish	<p>Enhanced mental well-being of Labrador Aboriginal children, youth, adults and their families/caregivers; increased knowledge of effective clinical/intervention practices that address risk and protective factors and which are specific to Labrador's Inuit and Innu culture; better coordinated services within and across sectors and increased knowledge and skills of those providing and/or supporting the delivery of intervention (prevention and clinical) programs or initiatives.</p> <p>The project is comprised of capacity building, clinical mental health services, and prevention interventions for residents of four Labrador communities, aged 6–24 years, and their families.</p>	<p>The MWT is a multidisciplinary team based in Happy Valley/Goose Bay. The team includes two social workers (specializing in problematic substance use and intergenerational trauma), an occupational therapist, a clinical manager with extensive healing experience, a technical assistant and a project coordinator. The team also includes a youth outreach worker (part-time) and a Psychologist providing services on an as-needed basis. Each community establishes a Community Wellness Team to support and offer guidance and Cultural expertise/knowledge to the travelling team.</p>

Region/project	Communities served	Goals	Structure
<p>Atlantic/Maliseet Nations Mental Wellness Team 'Ciw Wolakomiksuwakon—For Healthy Mind, Body & Spirit Ntulsonawtik—My Path to Strength</p>	<p>Tobique—1,966 Woodstock—850 Kingsclear—894 St. Mary's—1,482 Oromocto—518 Madawaska—315</p>	<p>Vision: "We envision a Wolastoq Nation where the cultural values and traditions of the people that live and work in our communities, can come together with respect, honesty, and caring to build a unified healthy strong nation with an appreciation of the Wolastoq way of life, with a focus on youth and family."</p> <p>Program goals:</p> <ul style="list-style-type: none"> › To increase healthy lifestyles › To increase cultural knowledge › To have Chief and Council become more active and involved in the "wellness of the community". › To celebrate role models › To develop community culture › To foster community inclusiveness › To educate community members and health care providers about the role of the Mental Wellness Pilot Program and its delivery. <p>The Maliseet Nation Mental Wellness Team (MWT) Project grew from an AHTF project entitled "Strengthening Our Next Generations" (SONG). The project's overall purpose is to develop stronger capacity within Maliseet communities to improve mental wellness through involvement in mental health assessments, treatments and referral needs. This project includes an important commitment from Horizon Health Network, a New Brunswick Regional Health Authority (RHA), to provide professional support to the initiative.</p>	<p>Elder/Cultural and Spiritual Advisor—provides counseling and ceremonies</p> <p>Mental Health Nurse—collaboration with community mental health and addictions staff; point of contact for psychiatry and health authority mental health services</p> <p>Psychiatrist—provides services to clients one day a week in each community on a five week rotation schedule.</p> <p>Bi-monthly clinical and advisory team meetings. Core team meetings also held in conjunction with psychiatrist visits.</p> <p>The project is guided by a steering committee that meets approximately every six weeks.</p>

Region/project	Communities served	Goals	Structure
Atlantic/Tuik'n Partnership Mental Wellness	Eskasoni—4,042 Membertou—1,277 Waycobah—944 Wagmatcook—755 Potlotek—662	Create an approach to mental health that helps individuals, families and the communities restore and sustain balance and well-being. The MWT is guided by three goals: improve treatment outcomes for mental health and addictions problems; build capacity for mental wellness throughout each community; build partnerships to bring Western and Aboriginal approaches together in the design and delivery of mental health and addictions programming.	MWT team composition varies from community to community. May include NNADAP, mental health worker, community health representative, dietician, nurse Practitioner, psychiatrist, home and community care nurse and/or home care worker, family physician, traditional healer, probation/justice worker, Mi'kmaq Children and Family Services worker, welfare/social/housing department case worker, District Health Authority Mental Health and others as identified by community representatives and appropriate to the case management approach.
Manitoba/Anishinabe Mekina Mino-Ayawin (AMMA) (Road to Good Health)	Rolling River First Nation—505 Keeseekoowenin First Nation—421 Ebb and Flow First Nation—1,333 Pine Creek First Nation—1,158 O-Chi-Chak-Ko-Sipi First Nation, (Crane River)—542 Gambler First Nation—pop. 66 Skownan First Nation—695	Coordinate access to a continuum of community based, core wellness services which will include traditional, cultural and mainstream approaches. The focus will cover three areas (but not limited to): addictions (drugs, alcohol and gambling), mental illness (depression, PTSD, suicide, intergenerational issues) and family violence (including all forms of abuse). To provide individuals, families and communities with resources necessary to actively achieve and maintain a healthy lifestyle.	Each of the seven communities formed a MWT/AMMA Team comprised of various professionals and para-professionals in the areas of prevention, healing, treatment, education, community and family development, and training. A contact person from each of these teams form the AMMA contact team. The MWT coordinator also works with an AMMA Tribal Team from appropriate WRTC HD program coordinators and regional mental health resources. MWT project staff; AMMA coordinator; AMMA program assistant; contract Elder/traditional healer
Saskatchewan/White Raven Healing Centre	Musowpetung—215 Nekaneet—165 Pasqua—345 Piapot—500 Standing Buffalo—425 Wood Mountain—8 Carry the Kettle—645 Little Black Bear-Okanese—155 Peepeekisis—395 Starblanket—320 3,173	To address the gaps in the continuum of care and increase access to culturally competent, comprehensive, community-based MH/A services. Validation of the efficacy of cultural approaches in treatment and offer evidence based approaches and best practices to enhance the capacity to provide quality service.	MWT consists of a director—MSW, RSW, a clinical supervisor (registered psychologist and approved therapist), 3 Health Canada approved Therapists, two addictions counsellors, two resolution health support workers, two traditional advisors (Elders), a CISM/crisis worker, one administrative staff and a research team.

Region/project	Communities served	Goals	Structure
BC/Nuu'Chah'Nulth Tribal Council Quu'asa Wellness Project	<p>14 communities served:</p> <p>Southern Region: Ditidaht, Huu-ay-aht, Hupacasath, Tse-shaht, and Uchucklesaht</p> <p>Central Region: Ahousaht, Hesquiaht, Tla-o-qui-aht, Toquaht, and Ucluelet</p> <p>Northern Region: Ehattesaht, Kyuquot/Cheklesahht, Mowachat/Muchalaht, and Nuchatlaht</p> <p>Plus urban family members of above.</p>	<p>Increase collaboration with service providers among the 14 First Nations and other mental health services</p> <p>Integrate a multidisciplinary, balanced, culturally sensitive healing approach with traditional healing practices and western approaches of counselling</p> <p>Respectfully provide and exercise client-driven, culturally sensitive, strength based treatment</p>	<p>Integrated with full spectrum of Tribal Council services, including health transfer, NIHB, social programs, education and training, including some provincial services.</p> <p>Operates within Teechuktl (Mental Health) department of Tribal Council, which also has functions to coordinate MH supports, build capacity, provide clinical counselling directly, and manage NIHB and IRS supports.</p> <p>Coordinates as needed with other services at community level, Tribal Council and external Health Authority and provincial services.</p> <p>Coordinator, administrative assistant, senior cultural counsellor and three other counsellors based in Port Alberni. Three other Quu'asa counsellors work from decentralized offices serving groups of four or five communities in coordination with other Tribal Council services, provide local support and continuity.</p> <p>Team members are mobile, to collaborate for larger events.</p>

Source: MWT Updates, September 2011—self-prepared templates

APPENDIX B

DOCUMENTS REVIEWED

Documents reviewed included:

- › Mental Wellness Teams Concept Paper, September 20, 2007
- › A guide to the Development of Mental Wellness Teams, Community Programs Directorate, First Nations and Inuit Health Branch, Health Canada, October 24, 2008

Original proposals

- › Proposal re: Maliseet Nations Metal Wellness Team Pilot Project, August 2009
- › Tui'kn Partnership Mental Wellness Team Proposal, August 2009
- › Project to Implement a Mental Wellness Team in First Nations Communities—Quebec Region (July 2008)
- › Mental Wellness Team Pilot Project Proposal, Ontario Region, June 15, 2009
- › Mapping the Way in Labrador Aboriginal Communities, June 1, 2009
- › Saskatchewan/Manitoba Joint Proposal, "Culture Heals" Mental Wellness Teams Initiative, July 31, 2008
- › 2008 Nuu-Chah-Nulth Residential School Healing Proposal to Health Canada

Process Evaluations/Progress Reports

- › Process Evaluation, White Raven Healing Centre, Mental Wellness Team, October 2011
- › Evaluation Research Report, Mental Wellness Pilot Project, Phase 1: Planning, (April 2009 to October 2010), Kitcisakik & Lac Simon, Quebec Region
- › Tui'kn Mental Wellness Team Process Evaluation, October 6th, 2011
- › Process Evaluation of the Mental Wellness Team Pilot Project, prepared for the West Region Tribal Council Health Department, September 2011 West Region Tribal Council's Mental Wellness Team Pilot Project entitled "*Anishinabe Mekina Mino-Ayawin (Road to Good Health)*".
- › Formative Evaluation Report of the Raising the Spirit Mental Wellness Team, March 28, 2011
- › MWT Process Evaluation Findings, October 27, 2011
- › Tui'kn Annual MWT Project Update, June 2011
- › Overview Report Tui'kn Mental Wellness Team, September 2011
- › Nuu-Cha-Nulth Tribal Council, Quu'asa Wellness Pilot Project, Annual Report, 2010–2011

Outcome evaluations

- › Nuu-Cha-Nulth Tribal Council, Quu'asa Mental Wellness Pilot Project, Outcome Evaluation, July 2012 (BC)
- › Outcome evaluation of the Tui'kin Mental Wellness Team Pilot Project, August 22, 2012 (Atlantic)
- › Maliseet Nations, Mental Wellness Team Project, Evaluation Report, August 31, 2012 (Atlantic)
- › Raising the Spirit Mental Wellness Team, Summative Evaluation Report, November 2, 2012 (ON)
- › Statistical Report on White Raven Healing Centre Activities—2006–1012 & Outcome Evaluation, White Raven Healing Centre—Mental Wellness Team, October 2012 (SK)
- › An evaluation of the Mental Wellness Team Pilot Project Immediate Outcomes, Prepared for the West Region Tribal Council Health Department, August 23, 2012, G. Braha & Associates Ltd. (MB)
- › Final Evaluation Report, Mental Wellness Team Pilot Project 2009–2013 (QC)

MWT Evaluation resources

- › Proposed Evaluation Framework for Mental Wellness Team Approach to Mental Health and Addictions Services in Aboriginal Communities, June 2009
- › Draft Logic Model—Mental Wellness Team Pilot Projects, October, 2010
- › MWT Performance Measurement Strategy, November 2010
- › First Nations and Inuit Mental Wellness Team Pilot Projects: National Evaluation Guidelines, April 2011

Community of practice reports

- › Mental Wellness Teams Community of Practice Workshop Report, Ottawa, December 2010
- › Mental Wellness Teams Community of Practice Workshop Report, Victoria, December 2011

Presentations

- › Maliseet MWT Community of Practice report and update, Victoria, December 2011
- › Nuu-Cha-Nulth Tribal Council, Quu'asa Project Overview
- › Maliseet Nations Mental Wellness Team Pilot Project, From Strengthening Our Next Generation (SONG) to Aboriginal Health Transfer Fund (AHTF)
- › Mental Wellness Teams (MWT), Pilot Project Overviews, Manitoba Region, Anishinabe Mekina Mino-Ayawin, May 26 and 27, 2010, Ottawa
- › Mapping the Way: Mobile Multi-Disciplinary Clinical Team for Northern Labrador Aboriginal Communities, Presented by Michelle Kinney, Deputy Minister, Nunatsiavut Government, May 26 and 27, 2010
- › Raising the Spirit Mental Wellness Team, Presentation at Ottawa Evaluation Meeting, May 26, 2010
- › Mental Wellness Project, Quebec Region, May 26, 2010
- › Mental Wellness Teams (MWT), Pilot Project Overview, Saskatchewan Region/White Raven Healing Centre, May 26, 2010
- › Tui'kn Case Management/Mental Wellness Team Demonstration Project, Cape Breton, Nova Scotia, May 26, 2010
- › FNIH Mental Wellness Teams, Meeting of Regional Consultants and Community Research Partners, May 26, 2010
- › Mental Wellness Teams—Overview of National Evaluation Framework, May 27, 2010