Health Canada Santé Canada

Evaluation of First Nations and Inuit Health Branch's Brighter Futures and Building Healthy Communities Programs

Final Report

Presented to

Health Canada
Departmental Audit and Evaluation Committee

April 2006

Canada

ACTION PLAN - FINAL DRAFT

Brighter Futures/Building Healthy Communities

1. Evaluation Conclusion:		
• BF/BHC Initiatives, objectives, and mandates are relevant and continue to address FN/I needs. • Respondents report that programs delivered with BF/BHC funding positively benefit communities and their members. • Number of community members accessing BF/BHC programs has increased in recent years.		
Evaluation Recommendation:		
#1. That the Brighter Futures and Building Healthy Communities initiatives continue to be funded and supported.		
Program Response		
Current Status		
• The Brighter Futures and Building Healthy Communities initiatives are currently being funded. • A First Nations and Inuit Mental Wellness Advisory Committee (MWAC) has been established (first meeting will be in June, 2005), to oversee the development of a strategic action plan that will improve mental wellness outcomes among First Nations and Inuit.		
Action Required	**Time line**	**Lead**
• Continue to fund the Brighter Futures and Building Healthy Communities initiatives. Future directions will be determined by the mental wellness action plan.	On-going	Mental Heatlh and Addictions Division (MHAD)- HQ

2. Evaluation Conclusion:

- Sample communities are using mix of five components of BF, depending on community priorities
- Although communities may use BF resources to top-up other programs such as the Canada Prenatal Program and Aboriginal Head Start On Reserve, there is no evidence of duplication
- Smaller, more remote communities are challenged to deliver crisis intervention and a continuum of care due to limited resources, capacity, and access to training

Evaluation Recommendation:

#2. That Health Canada consolidate the Brighter Futures and Building Healthy Communities initiatives as a single funding program that allows each First Nation and Inuit community to address mental health, child development, parenting, healthy babies and/or injury prevention through community-based health and wellness services developed to respond to its needs, circumstances and priorities, and consider:

-using the goals and principles of the 2002 Mental Wellness Framework as a starting point to design the scope and content of a consolidated initiative
-moving the BHC community-based solvent abuse component under the NNADAP community prevention program, to address community substance abuse priorities
-renaming the consolidated initiative, e.g. “Community Wellness Initiative”
-publishing and distributing a formal policy document
-provide technical and financial support to First Nations and Inuit communities to identify a range of crisis management and intervention strategies that take into account community size and geographic circumstances

Program Response

Current Status

- Currently, many regions are effectively managing BF and BHC as a consolidated program already, in the sense that many communities do not differentiate between the programs when submitting reports.
- The new Community Programs Authority that was approved by Treasury Board with conditions in March, 2005, will support the consolidation of these programs, including consolidated schedules, reports, and performance measurement.
- A Mental Wellness Advisory Committee (MWAC) has been established (first meeting will be in June, 2005), to oversee the development of a strategic action plan that will improve mental wellness outcomes among First Nations and Inuit.
- The National Aboriginal Youth Suicide Prevention Strategy program framework will be finalized in June, 2005 and will support activities such as federal/provincial and community-based crisis response protocols, and crisis response and stabilization.

• Existing resources for mental health services for First Nations on-reserve and Inuit (including BF, BHC, provincial and territorial services, and NIHB mental health crisis counselling) are not adding up to a full continuum of care, both through lack of coordination and through insufficient resources. • The Transfer evaluation identified the need for new investments in holistic mental health programming, and identified mental health as the area most in need of a more seamless continuum of care. • Questions remain regarding current allocations for community-based solvent abuse prevention programming		
Action Required	**Time line**	**Lead**
• Engage ITK, AFN, FNIHB regions, Children and Youth and Chronic Disease Divisions of Community Programs Directorate, other stakeholders in discussions about the proposed consolidation of BF and BHC., and develop a plan for moving forward. • With advice from the First Nations and Inuit Mental Wellness Advisory Committee, work with partners, experts and stakeholders to develop a strategic action plan that will improve mental wellness outcomes among First Nations and Inuit. • Conduct a study of the allocation of resources to expenditures within community-based solvent abuse prevention programming, and the impact of transferring these resources CPD's Addictions programming.	By Sept 2006 By Sept 2006 By Sept 2006	MHAD - HQ

3. Evaluation Conclusion:

- Community-based, community-paced approach is supported by all First Nations and Inuit respondents and by a comprehensive literature review
- Flexibility to move between priorities has contributed to community-ownership, program responsiveness, program outcomes, etc.
- There is no one more effective service delivery model that would be the solution for all communities as their unique needs and circumstance must be respected and considered.
- There was no evidence that the initiatives based on the principles of flexibility, community-based and community-paced development have had negative effects on the cost-effectiveness of the program.
- A minority of the interviewees felt that the one-year term of funding agreements and delays in payments at the beginning of the fiscal year caused communities to adopt a short-term approach versus a holistic, long-term approach.

Evaluation Recommendation:

#3. That Health Canada retain the core values of the Brighter Futures program principles in the management of the consolidated initiative so that communities have ongoing flexibility to design wellness services and delivery models that address individual community needs, priorities and capacities, that are community based and community paced.

Program Response

Current Status

- BF (and BHC, where the two programs are already effectively consolidated) is currently being managed according to its core values.
- While "continuum of care" is a guiding value, it is not a program standard (i.e. there is no criteria requiring communities to ensure a continuum of care).
- The new Community Programs Authority will allow for multi-year funding.

Action Required	Time line	Lead
• same as for Recommendation #2		

4. Evaluation Conclusion:		
• First Nations and Inuit health care managers and providers are concerned that Health Canada will introduce policy and program changes without having a full appreciation of the implications of the changes for their communities or taking advantage of their collective knowledge, experience and insights.		
Evaluation Recommendation:		
#4. That Health Canada and First Nations and Inuit communities establish national and regional consultative mechanisms that would ensure an effective, on-going partnership and shared decision making between FNIHB, and First Nations and Inuit health services managers/directors in the implementation, management, monitoring and development of community wellness programs and services.		
Program Response		
Current Status		
• Regions consult with communities regarding community wellness program development, and the national office consults regularly with regions. • First Nation and Inuit health care managers also provide input to the Assembly of First Nations and the Inuit Tapiriit Kanatami, which is brought forward to the First Nations and Inuit Health Branch at the national level through senior bilaterals and through the Branch Executive Committee. • FNIHB has not been able to communicate the results of the BF/BHC evaluation in detail with communities pending final departmental approval of the evaluation.		
Action Required	**Time line**	**Lead**
• After appropriate approval, a communication strategy will be developed to support the release of the final evaluation report to communities. • FNIHB will continue to consult closely with First Nations and Inuit communities and health managers. • Consultations will be undertaken as appropriate regarding an action plan that is to be developed by the First Nations and Inuit Mental Wellness Advisory Committee. In addition to improving mental wellness outcomes generally, the plan will also provide advice for moving forward with BF and BHC as already established programs.	By December 2005 On-going By March 2007	MHAD - HQ

5. Evaluation Conclusion:
Few non-transfer communities have undertaken recent formal needs assessments and health planning, as a result: • Some First Nation and Inuit health programs have difficulty effectively accounting for their Brighter Futures and Building Healthy Communities activities within their communities and to FNIHB; • There is a risk that the Brighter Futures and Building Healthy Communities activities in some First Nation and Inuit communities are not as integrated with other health and wellness programs as they might be; and • In a few of communities program delivery has been impeded because the community's leadership and health program managers have different, even conflicting expectations. The lack of needs assessment and planning activities are sometimes due to a lack of technical capacity (knowledge, skills, tools) and resources. In other cases, it is the result of a decision that the cost of undertaking the planning would be too high in relation to the level of Brighter Futures and Building Healthy Communities funding received. A "one-size-fits-all" planning process is not effective or appropriate when the value of Brighter Futures and Building Healthy Communities funding to individual communities varies from a few thousand dollars to more than a hundred thousand dollars.
Evaluation Recommendation:
#5. That each First Nations and Inuit community prepare a multi-year "community wellness" plan, based on a current assessment of its health and wellness needs.
Program Response
Current Status
• HFA is carrying out a pilot project to test out graduated planning processes in non-transfer communities (Health Plan Demonstration Project - "A Health Plan for All Communities")*. Two demonstration sites have been selected per region for this project. • The implementation of the new performance measurement, reporting and evaluation mechanisms arising from the new program authorities will also provide opportunities to strengthen community wellness planning.

Action Required	Time line	Lead
• Monitor demonstration site project and evaluation/reporting process due next year. • Use findings from Health Plan Demonstration Project - "A Health Plan for All Communities" project to inform action on this BF/BHC recommendation. • Explore ways to increase support for community wellness planning when developing new performance measurement, reporting and evaluation mechanisms arising from the new Community Programs Authority and the Streamlining process.	By March 2006 By March 2007 By Sept 2006	MHAD - HQ BPMD - HQ

6. Evaluation Conclusion:		
• The First Nations and Inuit Health Branch has not published any statement of policy or priorities for either Brighter Futures or Building Healthy Communities since the initiatives were implemented in 1992 and 1994, respectively, and those documents are not in wide circulation. • The lack of standardised performance measures, reporting systems and baseline data did not allow for the quantitative assessment of the degree to which the Brighter Futures and Building Healthy Communities programs may have succeeded or failed in achieving their intended outcomes. • It would be very difficult to define and obtain agreement on a set of national performance indicators and outcomes measures for broadly defined health/wellness services especially given the variables involved (community size and geography, service deliver models, health transfer status; local priorities).		
Evaluation Recommendation:		
#6. That each First Nation and Inuit community prepare and publish an annual "community wellness" program report to community members that would include data and information about program performance, outcomes, and success.		
Program Response		
Current Status		
• All reporting requirements are currently being revisited under the authority renewal process. • HFA is carrying out a pilot project to test out graduated planning processes in non-transfer communities (Health Plan Demonstration Project - "A Health Plan for All Communities"). Two demonstration sites have been selected per region for this project. • Northwest Territories already do an annual 'community wellness report'. • Informal 'community wellness reports' exist in some regions.		
Action Required	**Time line**	**Lead**
• same as for Recommendation #5		

7. Evaluation Conclusion:

- FNIHB's enhanced accountability measures are appreciated by First Nations and Inuit health service managers, except that the reporting requirements are onerous in relation to the any benefits to either the communities or FNIHB that the respondents have observed.
- Reporting requirements such as formats, content, and level of detail varied from region to region and, in some instances, changed without consultation or modification to the contribution agreement. "One-size-fits-all" reporting requirements are not effective or appropriate when the value of Brighter Futures and Building Healthy Communities funding to individual communities varies from a few thousand dollars to more than a hundred thousand dollars.
- A community's capacity to deliver a continuum of care is hindered (but not prevented) by yearly funding which limits their capacity to implement long term plans.

Evaluation Recommendation:

#7. That Health Canada rationalize its reporting requirements and eliminate duplicate and repetitive requirements while ensuring that the report contents are meaningful to the operational, planning and evaluation needs of First Nation and Inuit communities and Health Canada

Program Response

Current Status

- A new FNIHB evaluation structure is currently being developed as part of the authority renewal process. Under the new structure, programs will report on three components: Management, Relevance and Results.
- FNIHB is also conducting a Streamlining exercise to rationalize reporting requirements.
- The new Community Programs Authority allows for multi-year funding.

Action Required	Time line	Lead
• Explore ways to increase support for community wellness reporting and planning when developing new performance measurement, reporting and evaluation mechanisms arising from the Community Programs Authority and the Streamlining process.	March 2007	MHAD - HQ BPMD - HQ
• Produce sufficient baseline data (eg. health outcomes, financial baseline data, funding allocated to each component, etc.), and ensure it is being communicated in a transparent manner.	March 2007	
• Initiate a standard reporting template for use by First Nation and Inuit communities.	Sept 2006	

8. Evaluation Conclusion:

- FNIHB's national and regional offices played positive roles in the initiative's roll-out, but that they now tend to limit their roles to financial administration and control and no longer play an active supportive role in relation to BF and BHC program development at the regional, or local level.
- Many of the communities with limited capacity in health and wellness programming would like to have, but are unable to obtain, technical, management, and planning from FNIHB.
- FNIHB national and regional office staff reductions, especially in terms of professional health staff and program development resources, limit its capacity to deliver development support to the communities. The effects of this limited capacity is felt in all communities but the greatest impact occurs in remote and isolated communities.

Evaluation Recommendation:

#8. That FNIHB establish and maintain a capacity to provide the First Nations and Inuit communities who request with technical and professional support for "community wellness" program planning, delivery and management.

Program Response

Current Status

- Currently, regions receive funding and PY for this activity.
- Direction of program is decided at the national level, in consultation with regions and other partners. Program management occurs at the regional level.
- There is a policy shift taking place moving towards 'co-management' with First Nations/Inuit communities. Under co-management, FNIHB would provide technical support to communities.

Action Required	Time line	Lead
• Consult on management practices across the country as practices vary from region to region. • Define roles and responsibilities of staff at HQ and regional offices. • Do an assessment of what capacity we currently have, nationally and regionally, to support communities. • Examine what is needed, nationally and regionally, to support community wellness program planning, delivery and management. This would involve an examination of what skills are needed. • Develop an action plan for building capacity within FNIHB so we are able to provide technical and professional support for "community wellness" program planning, delivery and management.	By Sept 2006 By Sept 2006 By Sept 2006 By September 2006 By March 2007	MHAD - HQ

9. Evaluation Conclusion:

- There are different components of the capacity building (i.e. education, training, infrastructure, tools, facilities, research, etc.) needed to strengthen service provider, institutional and First Nation and Inuit government capabilities to contribute to effective health services.
- There is an ongoing, but unmet, demand for professionally trained First Nation and Inuit health and wellness workers. This is due, in part, to the lack of opportunity for workers to obtain training leading to accreditation.
- The First Nations Community Wellness Worker Diploma Program (FNCWWDP) is a model of culturally appropriate and accessible training in the health field. However, few communities have the financial resources to retain staff once they have completed training that qualifies them for employment with larger, better-funded organizations

Evaluation Recommendation:

#9. That FNIHB, in partnership with First Nation and Inuit health services , support regionally-based research and development designed to enhance the capacity of First Nation and Inuit communities to develop, manage and deliver "community wellness" programming.

Program Response

Current Status

- The FNCWWDP is being looked at as a possible model for HHR; other good models exist.
- FNIHB has been allocated $100 million over five years to develop and implement an Aboriginal Health Human Resources Initiative (AHHRI).

Action Required	Time line	Lead
• Do an environmental scan of existing programs. • Investigate FNCWWDP and other models as a foundation for the development of a national Aboriginal employment and retention program. • Seek opportunities to build the capacity of wellness professionals and paraprofessionals through the AHHRI, based on existing promising approaches.	March 2006 March 2006 March 2006-March 2010	MHAD - HQ

10. Evaluation Conclusion:

- Communities have established partnerships at the community level, however, a minority of communities have established partnerships with other Aboriginal communities, or at the district/health region level. There was only one instance of a partnership at the provincial level (Nunavik).
- The residents of First Nations and Inuit communities are covered by provincial/ territorial health plans and all First Nations and Inuit health services are affected by, and affect provincial/territorial health services to some degree. First Nations, provincial and federal governments all have jurisdictional issues and concerns that have to be taken into account in planning and maintaining partnerships.

Evaluation Recommendation:

#10. That FNIHB regional offices and First Nations and Inuit communities work with provincial/ territorial health departments to establish permanent planning forums to encourage and complement planning and service delivery partnerships at the district/health regional level.

Program Response

Current Status

- Collaborative work is being done with Provinces and Territories to improve coordination of health and wellness services through the Blueprint initiative, the new First Nations and Inuit Mental Wellness Advisory Committee, FNIHB membership on FPT metna health and addictions networks, and regional FPT forums.
- FNIHB recently commissioned a scoping exercise of existing FPT colloborations in the provision of mental health and addictions services to First Nations and Inuit on-reserve.
- The National Aboriginal Youth Suicide Prevention Strategy will support FNIHB-regions and Provinces to develop crisis response protocols, and will encourage provincial and territorial involvement in regional planning/priorization sessions.

Action Required	Time line	Lead
• Continue to build partnerships with provinces and territories through current and planned activities. • Assess the ability of the First Nations and Inuit Mental Wellness Advisory Committee and the NAYSPS-funded crisis response protocols to improve coordination of mental health services. • Disseminate results of research into existing FPT collaborations. • Monitor the implications of the Blueprint initiative for improved FPT coordination of community wellness services.	By Sept 2006 and ongoing By Sept 2006 By Sept 2006 May 2006-Nov 2006	MHAD - HQ

* In response to the 1997 Auditor General of Canada's report, the Health Plan Demonstration Project (HPDP) was initiated. In 2001-2002, the demonstration project got underway with communities that reflected a broad mix of community type, population and remoteness factor, in various regions of the country. The HPDP is seen as another step towards increasing First Nations and Inuit communities' capacity to meet the health needs of members, increase accountability, and achieve integration of planning, services and reporting.

It is expected that the HPDP will demonstrate over the next fiscal years, the potential for measurable improvements in the health program delivery accountabilities. This will be accomplished through set program goals that are based on the health needs and priorities of the community and that will use indicators to determine the desired outcomes.

In 2005/06, the communities involved in the HPDP will implement the completed health plan. The challenges associated with this activity are mainly local leadership and capacity issues. In spite of the challenges, there are no risks associated with the activity.

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Evaluation of the Brighter Futures and Building Healthy Communities Initiatives

This report is presented to:

Health Canada
First Nations and Inuit Health Branch
Ottawa, Ontario

Prepared by
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Final Evaluation Report
March 31, 2005

EXECUTIVE SUMMARY

The Brighter Futures initiative, implemented in 1992, provides funding to First Nations and Inuit communities for community mental health, child development, injury prevention, parenting skills, and healthy babies' programs and services. Its overall goal is to support the well-being of First Nation and Inuit children, individuals and families through community-determined approaches.

The Building Healthy Communities initiative, which was introduced in 1994, provides funding to help First Nations and Inuit communities develop mental health crisis management services, as well as solvent abuse prevention and early identification programs.

This report presents the results of an evaluation of the two initiatives. The evaluation's overall goal was to determine whether the activities funded through Brighter Futures and Building Healthy Communities supported the achievement of the initiatives' objectives.

The evaluation was not designed or planned to compare the successes of specific Brighter Futures and Building Healthy Communities programs and services implemented by one community with those of other communities. Neither was it intended to determine whether those programs and services have been appropriately and effectively managed.

The evaluation gathered data through 23 community sites visits, as well as key informant interviews and focus groups, in each of the eight FNIHB regions. Additional data and information were gathered through a literature review, a file review and a survey of Brighter Futures and Building Healthy Communities program administrators and workers. The regional FNIHB offices were an important part of the evaluation process.

Key Findings

The evaluation looked at the core evaluation issues of relevance, success and effectiveness. In general terms, it concluded that:

- The Brighter Futures and Building Healthy Communities initiatives continue to be relevant today as many of the gaps and health issues being addressed by these programs, continue to exist, and are not being addressed in a meaningful way by other programs;

- The programs are generally successful in what they do, but some communities need assistance in creating a higher capacity to design and deliver their programs, particularly in the areas of crisis management and ensuring a "continuum of care;"

- There are some management and administrative problems, notably with respect to planning and to reporting, which continues to focus on transactions and events rather than benefits and outcomes;

- The majority of respondents put forward the view that the flexibility that communities now have to direct resources to address their particular needs was critical to the success they had achieved for two reasons. First, it helps to glue the various parts of their health services into a more cohesive and holistic community health program. Second, the flexibility has encouraged and allowed people to develop a sense of ownership and trust in their own community wellness programs, an important health determinant on its own; and

- Those communities that have an integrated and holistic approach to health care for their populations are seen to be generally more effective in delivering their Brighter Futures and Building Healthy Communities projects. However, no major changes in delivery practices were identified that would increase the overall efficiency in the delivery of the Brighter Futures and Building Healthy Communities initiatives.

Recommendations

Based on its findings, the evaluation recommends:

Continuing Relevance: That the Brighter Futures and Building Healthy Communities initiatives continue to be funded and supported.

Program Goals and Content: That Health Canada consolidate the Brighter Futures and Building Healthy Communities initiatives as a single funding program that allows each First Nation and Inuit community to address mental health, child development, parenting, healthy babies and/or injury prevention through community-based health and wellness services developed to respond to its needs, circumstances and priorities.

Program Principles: That Health Canada retains the core values of the Brighter Futures program principles in the management of the consolidated initiative so that communities have ongoing flexibility to design wellness services and delivery models that address individual community needs, priorities and capacities, that are community based and community paced.

Community Planning: That each First Nations and Inuit community prepare a multi-year "community wellness" plan, based on a current assessment of its health and wellness needs.

Reporting & Accountability: That each First Nation and Inuit community prepare and publish an annual "community wellness" program report to community members that would include data and information about program performance, outcomes, and

success and that Health Canada rationalize its reporting requirements and eliminate duplicate and repetitive requirements while ensuring that the report contents are meaningful to the operational, planning and evaluation needs of First Nation and Inuit communities and Health Canada.

FNIHB Role: That FNIHB establish and maintain a capacity to provide the First Nations and Inuit communities who request with technical and professional support for "community wellness" program planning, delivery and management.

Capacity Building: That FNIHB, in partnership with First Nation and Inuit health services, support regionally-based research and development designed to enhance the capacity of First Nation and Inuit communities to develop, manage and deliver "community wellness" programming.

Inter-jurisdictional Planning: That FNIHB regional offices and First Nations and Inuit communities work with provincial/ territorial health departments to establish permanent health planning forums that encourage and complement planing and service delivery partnerships at the district/health region level withing each province/territory.

TABLE OF CONTENTS

INTRODUCTION

EVALUATION PURPOSE & OBJECTIVES

The Brighter Futures and Building Healthy Communities initiatives are funding programs administered by Health Canada's First Nations and Inuit Health Branch. The Branch has a broad mandate to support community health promotion, primary care and other health services delivered by First Nations and Inuit communities.

The Brighter Futures initiative was introduced in 1992 to provide funding to First Nations and Inuit communities for programs and services that would encourage and support the well-being of First Nation and Inuit children, individuals and families through a community-determined approach. It funds programs in the areas of community mental health, child development, injury prevention, parenting skills, and healthy babies. [1]

The Building Healthy Communities initiative was implemented in 1994. It provides funding to help First Nations and Inuit communities develop community-based mental health crisis management programs, as well as solvent abuse prevention and early identification programs. [2]

This report presents the results of an evaluation of the Brighter Futures and Building Healthy Communities initiatives, neither of which has been the subject of any previous evaluation. The evaluation was done by Auguste Solutions & Associates between November 2003 and December 2004.

The overall goal of the evaluation, as set out in Health Canada's request for proposal (RFP) was to collect data on the types of activities supported by the Brighter Futures and Building Healthy Communities initiatives, as well as their results and impacts in order determined whether these activities supported the achievement of the initiatives' objectives.

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1 In February 1992, the federal government announced the national Brighter Futures Initiative comprising the announcement of the ratification of the Declaration on the Rights of Children, an action plan for Canadian children and the Child Development Initiative. The Child Development Initiative was led by Health Canada and involve five other federal departments and agencies. It was designed to address conditions that put children at risk. It had an original five-year budget of $500 million.

2 The Building Healthy Communities initiative also included funding for home care services, however, that component covered by this evaluation.

STRUCTURE OF THIS REPORT

This report is organized into nine sections:

Section 1: Background and Context. This section highlights background information about the socio-economic, geographic, and health status characteristics of First Nations and Inuit communities across Canada. This information is intended to provide context for understanding the initiatives, the programs and services implemented by First Nation and Inuit communities, and the analysis that was conducted as part of the evaluation.

Section 2: Evaluation Approach and Methodologies. This section reviews FNIHB's goals and objectives for the evaluation, the evaluation issues and questions that were addressed, the methods used by the evaluation team, and the methodological constraints and issues encountered by the evaluation team.

Section 3: Initiative Profiles. This section of the report describes the goals, objectives and principles established for the two initiatives, the approaches and activities that were used in their national and regional implementation, and current program management and administration processes and procedures. It also provides an overview of the Brighter Futures and Building Healthy Communities programs, projects, and activities that have been developed and delivered by the First Nations and Inuit communities participating in site visits conducted during the evaluation.

Section 4: Relevance. Section 4 of the report looks at the evaluation findings with respect to the clarity of the initiatives' policies and criteria and the continuing relevance of the program components, administrative procedures and structures, activities and outputs, and principles. It also examines whether the initiatives continue to address the needs of First Nations and Inuit communities.

Section 5: Success: This section discusses the degree of success that the First Nations and Inuit Health Branch has achieved in the national and regional implementation of the two initiatives. It also looks at the extent to which the initiatives have been implemented in a manner consistent with stated goals and principles, and delivered benefits consistent with their intended outcomes for First Nation and Inuit children, families, and communities, including intended outcomes in the areas of community participation, capacity building, flexibility, and training.

Section 6: Effectiveness: Section 6 reports on the evaluation findings about the effectiveness of strategies and structures used to implement the initiatives, and whether the most cost-effective and efficient approaches have been used to address the health needs of First Nation and Inuit children, families and communities.

Section 7: Lessons Learned. This section describes lessons learned about the implementation, management and delivery of the initiatives that were identified during the evaluation.

Section 8: Issues and Challenges. Section 8 describes significant issues and future challenges that were identified.

Section 9: Conclusions and Recommendations. The final section of the report summarizes the evaluation findings and presents recommendations for program improvements.

Section 1: BACKGROUND AND CONTEXT

This section of the report provides a high-level overview of the socio-economic, geographic and health status characteristics of First Nations and Inuit communities across Canada. The information is intended to provide a context for understanding the Brighter Futures and Building Healthy Communities initiatives, the programs and services that have been implemented by First Nation and Inuit communities, and the analysis that was conducted as part of this evaluation.

HEALTH STATUS

The general health status of First Nation and Inuit people is poor, but improving, in comparison to the Canadian population. These trends can be seen in the comparative life expectancy data for registered Indian populations (Table 1). The life expectancy for registered Indian males has been increasing at a rate somewhat higher than the increases for the general male population. The same general trend is seen for Indian females, although the year 2001 data indicates a short-term reversal of this pattern. [3]

Table 1: Comparative Life Expectancy - 1990-2001

	Males			Females		
Year	Registered Indians	Canadian	Gap	Registered Indians	Canadian	Gap
1990	66.9	74.3	7.4	74.0	80.8	6.8
1995	68.0	75.2	7.2	75.7	81.4	5.7
2000	68.9	76.3	7.4	76.6	81.8	5.2
2001	70.4	76.5	6.1	75.5	82.1	6.6

The life expectancy of Inuit populations is somewhat lower than First Nations and the general populations. Archibald and Grey reported that the 1995 life expectancy for Inuit in Nunavik was 63.7 years for males and 65.1 years for females. They also reported that the figures for Inuit populations in Nunavut were 66 years for males and 71 years for females. [4]

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3 Department of Indian Affairs and Northern Development. *Basic Departmental Data: 2003*.(Catalogue No. R12-7/2003E). March 2004

4 Archibald L & Grey R. *Evaluation of Models of Health Care Delivery in Inuit Regions*. Inuit Tapirisat of Canada. 2000.

The 2003 Health Canada report, *A Statistical Profile on the Health of First Nations in Canada*, provides a more detailed description of the health status and conditions of First Nation people on reserves in Canada based on 1999 and earlier data. The following are the health status "highlights" from that report:

- *In 1999, the infant mortality rate in First Nations was 8.0 deaths per 1,000 live births – 1.5 times the Canadian rate of 5.5. However, it has been falling steadily since 1979, when the rate was 27.6 deaths per 1,000 live births*
  [. . .].

- *First Nations and the Canadian populations had similar proportions of births with low birth weight in 1999; however, almost twice as many First Nations babies were classified as high birth weight than were recorded in Canada as a whole.*

- *In 1999, the crude mortality rate in the First Nations was 354.2 deaths per 100,000 population, down from 544.9 per 100,000 in the period 1991-1993. The four leading causes of death were injury and poisoning, circulatory diseases, cancer and respiratory diseases. For each of the causes of death, the rate has decreased over time, from 22.4% for cancer to 40.9% for respiratory diseases.*

- *The most common cause of death for First Nations people aged 1 to 44 was injury and poisoning. Among children under 10, deaths were primarily unintentional (accidental). Suicide and self-injury were the leading causes of death for youth and adults up to age 44. For First Nations aged 45 and older, circulatory disease was the most common cause of death. These trends parallel those for the Canadian population as a whole [. . .]. Notably, motor vehicle collisions were a leading cause of death in all First Nations age groups.*

- *The 1999 age-specific mortality rate in First Nations was higher in all age groups until the ages of 75 and over.*

- *With respect to suicide, all First Nations age groups up to age 65 are at increased risk, compared with the Canadian population [. . .]. First Nations males are at higher suicide risk than females. The greatest disparity with the Canadian rates is for females aged 15 to 24 and 25 to 39 (approximately eight and five times the Canadian rates, respectively).*

- *First Nations also had elevated rates, compared with the overall Canadian population for giardiasis (1.6 times higher), hepatitis A (5.3 times higher) and shigellosis (19.3 times higher)-all of which are serious infectious diseases requiring that provincial/territorial public health agencies be notified.*

- *In 1999, the rate of genital chlamydia was higher in the First Nations population, at 947.0 reported cases per 100,000 population - roughly seven times the Canadian rate of 138.2.*

- *The tuberculosis rate in the First Nations was 8 to 10 times that of the entire Canadian population in 1999. Overcrowded housing is associated with an increased risk of tuberculosis in a community.*[5]

Health status data for Inuit populations are not available in the detail of the data available for First Nations populations. The overall impression, however, is that the health indicators for Inuit communities would reflect the trend evident in the life expectancy data – improving, but still significantly behind both the Canadian and First Nation populations. For example, the 1999 infant mortality rate was 5.5 per 100,000 population for Canada and 8.0 per 100,000 for First Nations, the rate was 25.5 per 100,000 in Nunavik and 24.0 in Nunavut.

There is little information on the mental health status of First Nations and Inuit populations, however, it is generally accepted that the mental health status of First Nations and Inuit people is comparable to their general health status relative to the general Canadian population. [6] At a minimum then, the conditions and consequences of mental disorders highlighted by Health Canada's *A Report on Mental Illnesses in* Canada:

- *Mental illnesses indirectly affect all Canadians through illness in a family member, friend or colleague.*

    - *Twenty percent of Canadians will personally experience a mental illness during their lifetime.*

    - *Mental illnesses affect people of all ages, educational and income levels, and cultures.*

    - *The onset of most mental illnesses occurs during adolescence and young adulthood.*

    - *A complex interplay of genetic, biological, personality and environmental factors causes mental illnesses.*

    - *Mental illnesses can be treated effectively.*

    - *Mental illnesses are costly to the individual, the family, the health care system and the community.*

    - *The economic cost of mental illnesses in Canada was estimated to be at least $7.331 billion in 1993.*

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5 Health Canada. *A Statistical Profile on the Health of First Nations in Canada*. March, 2003. p. 21.

6 Kirmayer LJ, Brass GM, Tait CL. *The Mental Health of Aboriginal Peoples: Transformations of Identity and Community*. *Canadian Journal of Psychiatry*. Vol 45, 2000. p 607-616

- *Eight-six percent of hospitalizations for mental illness in Canada occur in general hospitals.*

- *In 1999, 3.8% of all admissions in general hospitals (1.5 million hospital days) were due to anxiety disorders, bipolar disorders, schizophrenia, major depression, personality disorders, eating disorders and suicidal behaviour.*

- *The stigma attached to mental illnesses presents a serious barrier not only to diagnosis and treatment but also to acceptance in the community.*

Unfortunately, there is not enough data available to estimate the extent to which the incidence and prevalence of mental illness experienced by First Nation and Inuit populations differ from the general population. There have been, however, some research projects completed over the past several years that examined different mental health issues in different First Nation or Inuit populations. While the results of this research do not necessarily reflect the experience of First Nation and Inuit populations generally, they do give some insight into their circumstances:

- A secondary analysis of the Santé Québec-Cree health survey, "found that higher levels of psychological distress were associated with younger age, female gender, early loss of parents or a relative, a smaller social network (less than five close friends or relatives)." [7] The analysis also found that people with more than an elementary school education, especially women, were more likely to report suffering elevated distress.

  In addition to identifying risks for greater distress, the research identified two protective factors. First, individuals who experienced a "good relationship with the community" were less likely to experience distress. Second, they observed that "spending more time in the bush" was associated with more positive mental health status, especially for men. The authors suggested traditional food hunting activities sustain "a way of life with significant social and spiritual meaning which contribute to well-being." [8]

- A research team studying the case files of residential school survivors from British Columbia found that about 75% of the sample had medical histories that included mental health issues. The most common disorders were post-traumatic stress disorder (PTSD) (64.2 %), substance abuse disorder (26.3%), major depression (21.1%) and dysthymic disorder (20%). A large proportion of the subjects were identified as having two or more disorders. For example, about

7 Kirmayer et al. *Op cit.*

8 Kirmayer et al. *Op cit.*

half of those diagnosed with PTSD also suffered from major depression, substance abuse, avoidance personality disorder, and/or another disorder. [9]

- A general survey of the health and well-being of the Inuit of Nunavik found relatively few concerns about physical health, but significant concern among the respondents about mental health issues including psychological distress, suicidal thoughts, and parasuicides, which includes attempted suicides, drug overdoses and self-inflicted injuries. [10]

- Another research project focussing on the Nunavik region examined the medical records of Inuit who died by suicide between 1982 and 1996 and a comparison group. It found that the people who had died by suicide were significantly more likely to have a lifetime diagnosis of depression, personality disorder and/or conduct disorder and to have experienced more severe nonpsychiatric illnesses and injuries. As a result of such medical histories, those that had committed suicide had much more contact with health care personnel and services than the control group. The authors suggested that this means that frontline medical personnel are in a good position to identify people at risk for suicide.[11]

Suicide rates, especially among young First Nations and Inuit people, have been a major concern for some time, and one of the motivations for creation of the Building Healthy Communities program in the mid-1990s. The available data indicates that these rates, controlling for age and gender, are significancy higher than the general suicide rate for Canadians. For example, in Manitoba, researchers found that the annual age-standardized suicide rates in the period 1988-1994 were 31.8 per 100,000 populations among Aboriginal people and 8 and 13.6 per 100,000 for non-Aboriginal people. [12] Significantly higher suicide rates have been reported in Nunavik (82 per 100,000) and Nunavut (77.4 per 100,000). [13]

It is important to recognize that the rates and risks of suicide vary greatly across the country, and from community to community. In Québec, for example, research conducted by the Culture & Mental Health Research Unit at the Institute of Community & Family Psychiatry with the Inuit communities of Nunavik, found high rates of suicidal ideation – thinking about suicide – and attempted suicide among adolescents and young adults, while the rates for the Québec Cree

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9 Corrado R and Cohen I. Mental Health Profiles for a Sample of British Columbia's Aboriginal Survivors of the Canadian Residential School System. The Aboriginal Healing Foundation. 2003.

10 Jette M. *A Health Profile of the Inuit of Nunavik: Report of the Sante Quebec Health Survey (1992)*. International Journal of Circumpolar Health.Vo. 57 Suppl 1. 1998. p. 630-5.

11 Boothroyd LJ, Kirmayer LJ, Spreng S, Malus M, Hodgins S. Completed Suicides among the Inuit of Northern Quebec 1982-1996: A Case-control Study. Canadian Medical Association Journal, Sept. 18, 2001. p. 749-755.

12 Malchy B, Enns MW, Young TK, Cox BJ. Suicide among Manitoba's Aboriginal People, 1988 to 1994. Canadian Medical Association Journal, 156(8) 1997. p. 1133-8.

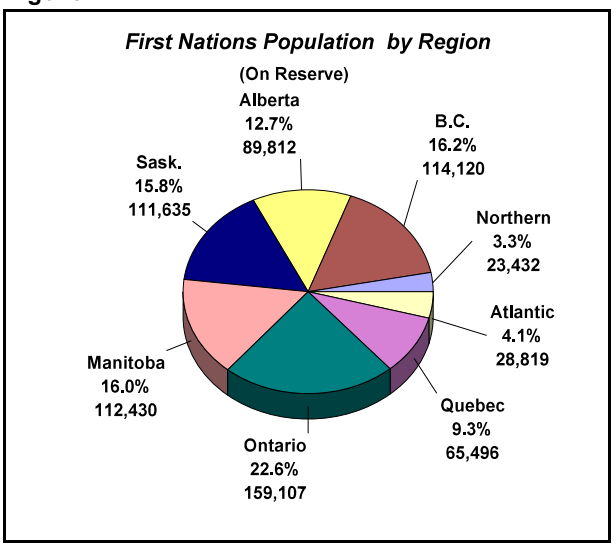
13 Archibald L & Grey R, *op cit.*

population were similar to the general Canadian rates. [14] Similarly, research with First Nations in British Columbia found that the rates of youth suicide in some communities were very high compared to the Canadian population, but that 111 of more than 200 Bands in the province had no youth suicides over a 5-year period. [15]

POPULATION TRENDS

Indian and Northern Affairs Canada reports that the 2002 registered Indian population was 704,851 (403,337 on-reserve; 301,524 off reserve) representing a 38% increase in the total population and a 32% increase in the on-reserve population since 1991. The Ontario region has the largest First Nation on-reserve population, followed by British Columbia, Manitoba, Saskatchewan and Alberta (Figure 1).

Figure 1



Looking ahead, INAC forecasts that the current rate of increase of the total First Nations population will slow down over the next 20 years (Figure 2). These projections include an

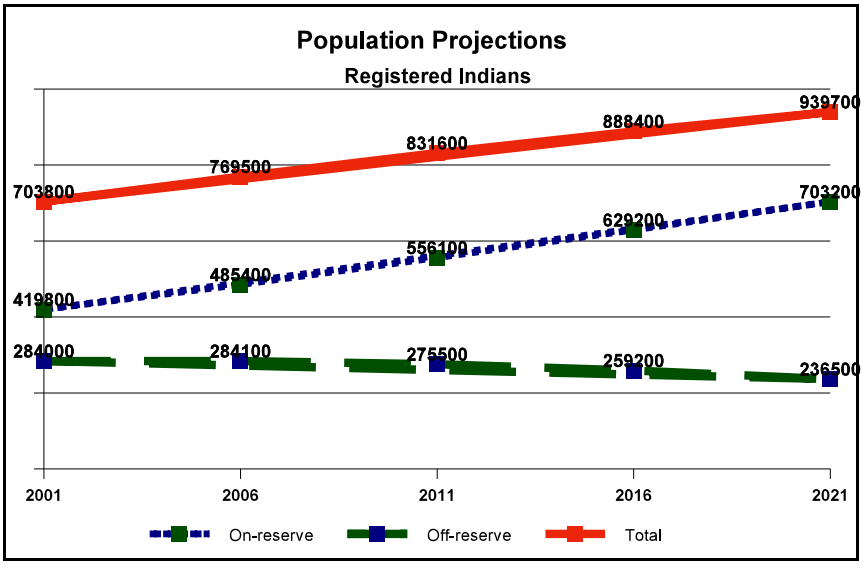
14 Kirmayer, Brass & Tait, *Op Cit.*

15 Chandler MJ. and Lalonde C. "Cultural Continuity as a Hedge Against Suicide in Canada's First Nations." Transcultural Psychiatry, 35.2. 1998) p.191-219.

assumption that the on-reserve population could increase substantially, in large part due a net migration to First Nations. [16]

Like the rest of the Canadian population, the First Nation population is aging as birth rates fall and life expectancy increases. While the trends are similar, there are significant differences between the two groups. For example, the 1999 First Nations rate was 23.0 births per 1,000 population, down from 27.5 in 1993, while the Canadian rate for 1999 was 11.1 births per 1,000 population. Similarly, the 2002 life expectancy estimates for the First Nations population was 68.9 years for males and 76.6 years for females, 7.4 years and 5.2 years, respectively, less than the life expectancy for the Canadian population. The life expectancy gap is, however, shrinking: In 1980 they were estimated at 10.9 years for men and 11.0 years for women. [17]

Figure 2: Population Projections - Registered Indians



GEOGRAPHIC LOCATION

Community size and location can have significant implications for access to health services with the residents of smaller, more remote communities having the greatest difficulty getting comprehensive health care. For example, a National Aboriginal Health Organization survey of

16 Department of Indian Affairs and Northern Development. *Basic Departmental Data: 2003.*(Catalogue No. R12-7/2003E). March 2004

17 Health Canada. A Statistical Profile on the Health of First Nations in Canada. (Undated) pp. 14-18.

First Nation people found that 85% of the respondents from non-isolated communities and 81% of those from semi-isolated communities reported having a regular doctor. Only 52% of those living in isolated/remote communities reported having a regular doctor. [18]

Health Canada classifies the geographic location of First Nations and Inuit communities by reference to the community's access by road to the nearest physician services:

- Non-isolated communities are less than 90 kilometres by road from physician services;
- Semi-isolated communities are more than 90 kilometres;
- Isolated communities have no road access to physician services and rely on scheduled flights; and
- Remote isolated communities have no scheduled air or road access to such services.

The Manitoba region has the largest proportion of First Nations that are classified as isolated or remote (40%), although when both Inuit and First Nations communities are counted, the Québec region has the highest proportion of isolated and remote communities (57%)

Table 2: Distribution of the First Nations and Inuit Communities by Region, 2002

	Non-isolated	Semi-isolated	Isolated	Remote isolated	Total
Pacific	153	31	14	8	206
Alberta	31	19	4	4	58
Saskatchewan	62	12	8	2	84
Manitoba	27	10	24	1	62
Ontario	78	12	27	7	124
Quebec	17	6	15	0	52
Atlantic	34	0	0	0	40
National	402	90	112	22	626

The circumstances of non-isolated communities vary greatly with respect to their access to health services. For example, First Nations, such as Kahnawake, and Siksika, that are adjacent to or within easy commuting distance of major cities have ready access to large hospitals, universities and other resources. However, non-isolated communities whose nearest medical services are located in smaller towns that experience significant health services challenges

18 First Nations Centre, National Aboriginal Health Organization. *What First Nations People Think About Their Health and Health Care. Summary Of Findings.* July 2003 www.naho.ca/firstnations/english/opinion_poll.php

including difficulties recruiting and retaining physicians, nurses and other health care providers may have health access problems similar to semi-isolated communities. [19]

Most Inuit communities are classified as isolated or remote. In Labrador, four of the six Inuit communities are isolated/remote having only air transport access to physician services. In the Nunavik Region, 12 of the 14 communities are isolated/remote, while in Nunavut at least 20 of the 26 communities rely on air service to access physician services.

Remote and isolated, and many semi-isolated communities, which are typically small communities, find it difficult to design and maintain health services. Even when they are able to justify and establish local services, these communities must deal with high staff turnover rates and the difficulty of recruiting qualified personnel who have the aptitude and knowledge appropriate to community needs. For example, nursing shortages in these communities are chronic: in 1999, about 45% of the nursing positions in remote First Nations communities were vacant or filled on a temporary basis. [20]

Another challenge facing remote communities, and small communities without ready access to urban-based services, is that health service delivery models have been designed based on urban assumptions. The concept of psychiatric rehabilitation, for example, is an important part of Canadian community mental health programming and philosophy. Unfortunately, it does not work in rural communities because it assumes that the community has a range of housing options available to meet the various and changing needs of patients, a range of employment opportunities, and can provide reasonable access to support services such as psychiatric hospitals or clinics, social work services and the like.[21] As remote communities cannot meet these basic assumptions, their residents face higher rates of hospitalization in institutions some distance from their home community. [22]

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19 Pong RW. Rural *Health/Telehealth: Synthesis Series*, Health Canada. 2002. (www.hc-sc.gc.ca/htf-fass)

20 Lemchuk-Favel L & Jock R. *Aboriginal Health Systems in Canada: Nine Case Studies*. Journal of Aboriginal Health. January 2004. 28-51.

21 Schmidt G. *Barriers to recovery in a First Nations community*. Canadian Journal of Community Mental Health. 2000 Fall; 19(2):75-87.

22 Dalrymple AJ, O'Doherty JJ, Nietschei KM. Comparative analysis of Native admissions and registrations to northwestern Ontario treatment facilities: hospital and community sectors. Can J Psychiatry. 1995 Oct; 40(8):467-73.

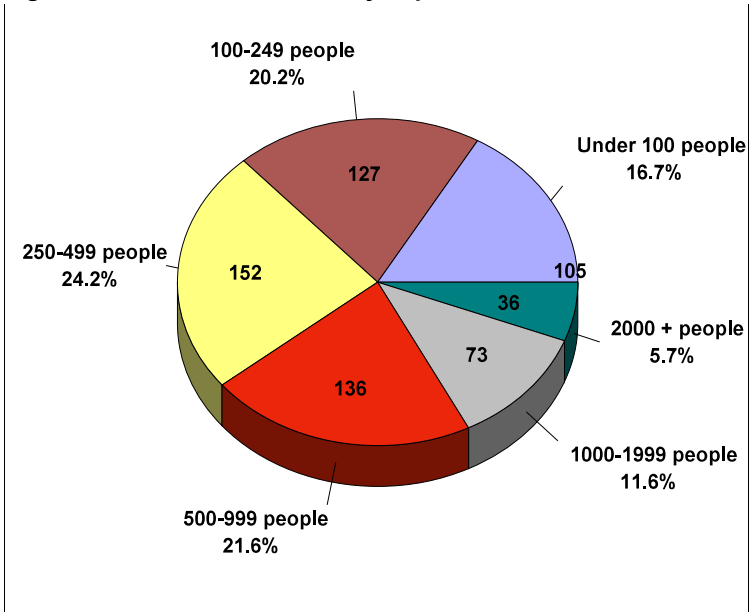
COMMUNITY SIZE

The population size of individual communities has significant implications for the development and maintenance of health and other services from two perspectives. First, a community's public revenues are directly related to its population base. Second, even if resources are not an issue, a smaller community simply may not have the sufficiently high volume of service demand to justify developing and maintaining comprehensive local health programs, unless it is possible and appropriate to assign multiple functions to individual health staff. If that is not possible, the option is to establish some form of partnership with other communities and/or outside health care services and agencies. [23]

First Nations Communities

About 37% of all First Nations communities have on-reserve populations of fewer than 250 people. And, another 24% have population of 250-499 residents. (Figure 3). A small proportion (5.7%) of the First Nations have on-serve populations of 2,000 of more. The largest of these is Six Nations with an on-reserve population of 13,967 and a total population of 21,618. (Table 3). The largest First Nation in the Atlantic region is Eskasoni (population: 2,995) and the largest in British Columbia is Squamish (population: 2,166).

Figure 3: On-reserve Community Population Size



23 Schmidt; Lemchuk-Favel L & Jock R. *Op Cit*

Table 3: Ten Largest First Nations

Community	Region	Population
Six Nations	Ontario	13967
Akwesasne	Ontario	7981
Blood	Alberta	7369
Kahanawake	Quebec	7225
Saddle Lake	Alberta	5665
Samson	Alberta	5040
Lac la Ronge	Saskatchewan	4536
Cross Lake	Manitoba	4345
Norway House	Manitoba	4200
Peter Ballantyne Cree Nation	Saskatchewan	3562

Inuit Communities

The following are profiles of Inuit communities in Labrador, Québec (Nunavik) Nunavut and the Northwest Territories (Inuvialuit):

- Labrador: Approximately 4,500 Inuit inhabit five northern coastal communities and more southern communities in Labrador. All of the communities have access to regular air service and marine transport, but none of the northern coastal communities have road access. Nain (population: 1,200) is the administrative centre for the coastal communities

- Nunavik: The region of Nunavik lies north of the 55th parallel in the province of Québec. The population of 9,000 Inuit live in 14 communities. Kuujjuaq (population: 1,500) is the regional administrative centre. The communities, each with a municipal council, are members of the Kativik Regional Authority which is responsible for municipal infrastructures and services.

- Nunavut: Nunavut has an Inuit population of 23,000 living in 26 communities. Iqaluit, the territorial capital, is the largest community with a population of over 5,000. The regional centres of Cambridge Bay and Rankin Inlet have populations of 1,300 and 2,700 respectively.

- Inuvialuit Region: The Inuvialuit region in the northwestern part of the Northwest Territories, has an Inuit population of 5,000 living in the four mainland and two island communities. Inuvik, the administrative centre for the region, has a total population of 3,000. The mainland communities are the only Inuit communities in Canada that have connecting roads to the south.

HEALTH SERVICES MANAGEMENT AND FUNDING

The residents of First Nations and Inuit communities have access to general medical services through their provincial or territorial health insurance plan. In addition, they can, in certain circumstances, obtain prescription drugs, vision and dental care, medical supplies and equipment and medical transportation through the federal Non-insured Health Benefits plan. [24] The Non-insured Health Benefits plan, which is administered through the FNIHB regional offices, also provides limited coverage of short-term crisis intervention counselling provided by licenced mental health professionals, principally psychologists and social workers.

First Nations and Inuit communities manage and deliver a variety of community-based public health services through their own government structures. These public health services may include:

- Primary Care;
- Communicable Disease Control;
- Brighter Futures;
- Community Health Representatives;
- Environmental Health Program, including water quality;
- Building Healthy Communities - Solvent Abuse Program ;
- Community Home Care;
- Building Healthy Communities - Mental Health Crisis Management;
- National Native Alcohol and Drug Abuse Program;
- Community Nursing;
- Canada Prenatal Nutrition Program;
- Health Promotion (diabetes prevention and control, tobacco control, FAS/FAE, HIV/AIDS); and/or
- Dental Therapy, where permitted under provincial/territorial regulations.

In most communities, these health services are delivered through a health centre or health office managed by the Band or local government council. Typically, the centres employ community health nurses, community health representatives, support staff and, in many cases, NNADAP counsellors. Depending on the community's size and health priorities, its health services may also employ staff specializing in mental health, community education and awareness, recreational programming or other health promotion-related activities. For example, health centres sometimes manage Head Start programs.

While local health centres are the primary vehicles for the delivery of community-based health services, many Tribal Councils or regional structures play roles in health services planning and management. In some cases, they may also have responsibility for some direct services.

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24 Health Canada. *Non-Insured Health Benefits: 2002/2003 Annual Report.* p 3: The Non-Insured Health Benefits (NIHB) Program provides approximately 735,000 registered Indians and Inuit with a limited range of medically necessary health-related goods and services not provided through other private or provincial/territorial health insurance plans.

Approximately 75% of the First Nations are members of Tribal Councils, [25] however, data that would identify the frequency and range of the health services roles fulfilled by Tribal Councils is not available.

First Nation and Inuit community health programs and services are funded through financial contribution programs administered by FNIHB through three types of agreements:

> General Agreements: Under these agreements communities administer FNIHB health programs under conditions that do not allow them to reallocate or redirect health resources. Funds are released to the communities through advances and monthly payments subject to the submission of quarterly financial reports and program reports for each funded program. The agreements are normally for one-year terms.
>
> Integrated Agreements: A community choosing to enter into integrated agreements must set up its own health management structure, develop a health plan approved by Health Canada, and establish a global budget for its health services. As long as mandatory services are provided, the community has the flexibility to change program objectives and activities and allocate resources between services according to its priorities. "Integrated" communities are required to submit reports on actual expenditures by program component, complete annual audits and prepare annual reports on services and program achievements. Integrated agreements can be from 3 to 5 years in duration, subject to annual budget renewal.
>
> Transfer Agreements: Under these arrangements, First Nations and Inuit communities south of the 60th parallel can choose to assume broad control of health services through three to five-year agreements that allow them to design programs and redirect resources to their priorities, as long as they deliver mandatory programs in the areas of environmental health, medical officer of health and professional nursing supervision services. Transfer communities are required to complete annual audits, annual reports, and program evaluations every five years. [26]

Health Canada reports that, in 2004, 48% of First Nations communities (see table 4) and 7 Inuit communities had entered into transfer agreements and 31% of First Nations communities had signed integrated agreements. The balance of the communities operate under general agreements. [27]

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25 Estimate based on listings on First Nations Profiles, Indian Affairs and Northern Development. sdiprod2.inac.gc.ca/FNProfiles/FNProfiles_home.htm

26 Health Canada. *Transfer of Health Programs to First Nations and Inuit Communities: Handbook 1 - An Introduction to Three Approaches*. Revised March 2004. P.23

27 Health Canada. *Status of First Nations Control Activity.* www.hc-sc.gc.ca/ fnihb-dgspni/fnihb/ bpm/hfa/transfer_status/ control_activity.htm

Section 2: EVALUATION APPROACH AND METHODOLOGIES

This section of the report highlights the scope and the approach of the Brighter Futures and the Building Healthy Communities evaluation. It also reviews the methodologies used.

EVALUATION MANAGEMENT

The First Nations and Inuit Health Branch established a departmental advisory committee to guide the management of the Brighter Futures and Building Healthy Communities evaluation. The committee consisted of headquarters staff responsible for the national management of the two initiatives, a departmental evaluation officer and four regional program managers with direct responsibilities for the initiatives.

The Advisory Committee's responsibilities included defining the evaluation requirements, assessing responses to the RFP, facilitating communications with regional offices and First Nations and Inuit communities participating in site visits, reviewing and approving the tools used by the evaluation team, as well as reviewing and approving reports produced by the evaluators.

EVALUATION SCOPE & OBJECTIVES

Health Canada, in the RFP, stated that the primary goal of the evaluation was to collect data on the type of activities supported by Brighter Futures and Building Healthy Communities, as well as their results and impacts in order to determine whether those activities supported the achievement of the initiatives' objectives. More specifically, the department wanted the evaluation to:

- Examine how the program rolled out including funding formula determination at the national level;
- Examine the different regional roll outs of initiatives including the funding formulas used to distribute funding between First Nations and Inuit communities;
- Determine how programs/project funding has contributed to the achievement of objectives and priorities, taking into account the change in priorities over the years;

- Examine how, over the years, the flexibility built into the programs has allowed communities to redirect funding towards new and emerging priorities; and

- Determine the overall Brighter Futures/Building Healthy Communities impact and cost-effectiveness.

In brief, the scope of the evaluation is to assess how the initiatives were implemented and managed by the First Nations and Inuit Health Branch. It was not designed or planned to assess or evaluate the success of the specific projects and services implemented by First Nation and Inuit communities using Building Healthy Communities and Brighter Future funding or to determine whether those projects and services have been appropriately and effectively managed.

Out of Scope Issues

Recognizing that "out-of-scope" issues may come to the attention of evaluators, Auguste Solutions & Associates has established an internal policy that it will inform the client of any significant matter that comes to the attention of a member of its evaluation team but falls which outside of the scope of evaluation, through a management letter.

EVALUATION ISSUES & QUESTIONS

The evaluation addresses the three primary evaluation issues: relevance; success; and effectiveness. For each of the primary issues the Advisory Committee and the evaluators developed a series of evaluation questions that focussed on the concerns surrounding the program. The issues and the associated questions are identified below.

Issue #1 – Relevance

The first issue addressed is whether the Brighter Futures and Building Healthy Communities initiatives continue to be consistent with departmental, First Nation and Inuit health and community priorities and if they realistically address actual needs.

In order to respond to the issue of relevance, the evaluation gathered data to answer the following seven questions:

1.1 Do the programs have clear policies and criteria at the national and regional levels?

1.2 Have First Nation and Inuit health and community needs and priorities been identified, and are these priorities and needs current?

1.3 Do each of the program components continue to accurately focus on and meet the issues, needs and priorities of First Nation and Inuit communities?

1.4 Are the programs' national and regional implementation, management and administrative procedures and structures reflective of and appropriate to the issues, needs and priorities of First Nation and Inuit communities?

1.5 Are the program's activities and outputs consistent with the programs' objectives and the intended outcomes?

1.6 With which national, provincial, territorial and community programs and services have the Brighter Futures and Building Health Communities been partnered?

1.7 To what extent are the objectives and mandate of the program still relevant?

Issue # 2 – Success

The second broad area of investigation for the evaluation focuses on whether the Brighter Futures and Building Healthy Communities initiatives are effective in meeting their objectives, within budget and without unwanted outcomes. The specific questions that were addressed here are:

2.1 Was the roll-out at the national level successful in providing the Regions with the resources and support needed to deliver the program to potential project holders?

2.2 Was the roll-out at the regional level successful in providing project holders with the resources and support needed to deliver the program First Nation and Inuit communities and their members?

2.3 Do projects and services respect the program's six stated principles?

2.4 Have First Nations and Inuit community participation levels in the Brighter Futures and Building Healthy Communities projects in their communities increased?

2.5 Have the project holders received the knowledge and support to adequately address each of the identified program objectives?

2.6 What community benefits and broader outcomes, both intended and unintended, resulted from delivering the program?

2.7 Did community, health, child worker and other personnel receive appropriate and accredited training, and did that training increase their capacity to respond to identified needs?

2.8 Were the programs flexible, community-based and community-paced, and did making the program flexible, community-based and/or community-paced affect the results and impacts of the delivery of the program?

Issues #3 – Effectiveness

The third area of inquiry concerned whether the First Nations and Inuit Health Branch had used the most appropriate and efficient means of achieving the initiatives' objectives, relative to alternative design and delivery approaches. This required that the evaluation team collect data and information to answer the following questions:

3.1 Are there more cost-effective program delivery alternatives to achieving the objectives and the intended results?

3.2 Did making the program flexible, community-based and/or community-paced affect the cost effectiveness of the program?

3.3 Are there other, more effective ways of helping First Nations & Inuit communities address the health needs of children and families?

METHODOLOGIES

For the evaluation of the Brighter Futures and Building Healthy Communities initiatives, the following data collection methodologies were used:

1. **Community-Based Assessments**: The evaluation conducted two sets of assessments:

   Innovative Approaches: Eight site visits (one per FNIHB region) involved communities that were selected from a short list of communities identified by the regional office as having innovative approaches at the community level.

   Random Sample Communities: Site visits were made to a stratified random sample of 15 communities to profile program activities, results and impacts. The sampling took into consideration the following factors: regional representation, urban versus remote; Tribal Council versus Band managed; First Nation and Inuit representation; and population size.

Participation was voluntary, and some communities chose not to participate. Communities who were under third party management or in the midst of an audit were excluded, to ensure that communities had sufficient capacity to participate in a case study.

2. **Surveys**: A mail survey of program administrators and workers was distributed to all First Nations and Inuit communities. Every community was included so as to maximize the representativeness of the respondents;

3. **Focus Groups**: Focus group sessions were held in each of the eight regions. The participants were FNIHB staff and representatives of First Nation and Inuit communities and organizations with current or past experience in implementing the initiatives or running community level programs;

4. **File Review**: The evaluation examined documents (strategic plans, communications materials, consultation reports, program progress reports, sample project files, forms, etc.) identified by FNIHB headquarters and regional staff and dealing with the implementation and management of the initiatives;

5. **Key Informant Interviews**: Face-to-face and telephone interviews of key informants in all eight regions were conducted using interview guides; and

6. **Literature Review**: The evaluation examined published Canadian research, studies and reports to assess the state of knowledge about the nature and incidence of mental health issues experienced by First Nations and Inuit people, and what might be known about the effectiveness of mental health services delivered to residents of First Nation and Inuit communities.

Community Assessments

Health Canada required that the evaluator conduct a series of community visits to gather information about the delivery all the Building Healthy Communities and Brighter Futures programs and services at the community level. Eight of these community sites (one per region) were selected by FNIHB regional offices as communities whose programs highlighted innovative approaches.

The eight “innovation” sites were:

- Sagkeeng First Nation, located about 130 kilometres northeast of Winnipeg, Manitoba, has an on-reserve population of about 3,000 members.

- Six Nations, a community of approximately 13,000, is located next to Brantford, Ontario (population: 90,000).

- Kahkewistahaw First Nation, about 160 kilometres east of Regina, has an on-reserve population of about 417.

- Siksika First Nation, located 90 kilometres south-east of Calgary, has a population of approximately 4,200 members on-reserve.

- Eagle Village First Nation (Kipawa), with an on-reserve population of 260, is situated about 15 kilometres from Temiscaming, QC, (population 3,000).

- Eskasoni First Nation, population 3,100, is located about 65 kilometres from Sydney, Nova Scotia.

- Yellowknifes Dene First Nation is made of three groups with a total population of about 1,200 members on and off reserve. The first group is the Dene Nation members living in Yellowknife, the second is the residents in N'Dilo, an island adjacent to Yellowknife, and the third is the residents of Dettah, a 30 minute drive from Yellowknife.

- Tsleil-Waututh (Burrard) First Nation, a community of about 220, is located within the City of North Vancouver.

Community site visits were also conducted in 15 communities identified by the evaluators using stratified random sampling. The purpose of the assessments was to describe programs and accomplishments over time, external influences that may have affected the programs' focus, the results and impacts of the activities in communities, and how funding reflects the BF/BHC objectives and priorities.

The First Nations and Inuit communities and organizations participating in the community assessment site visits were:

- Battlefords Tribal Council Indian Health Services, located in North Battleford (population: 13,692), serves the residents of the Ahtahkakoop, Little Pine, Lucky Man, Moosomin, Mosquito, Grizzly Bear's Head, Lean Man, Poundmaker, Red Pheasant and Sweetgrass First Nations (total on-reserve population 5,278), all located within 50 kilometres of the city.

- Meadow Lake Tribal Council Health and Social Development Authority, with its headquarters on the Flying Dust First Nation, provides services to the residents of the Birch Narrows, Buffalo River Dene, Canoe Lake Cree, Clearwater River Dene, English River, Flying Dust First Nation, Island Lake, Makwa Sahgaiehcan and Waterhen Lake First Nations (total on-reserve population of about 5,600). The Flying Dust First Nation is located adjacent to Meadow Lake, Saskatchewan (population: 6,200). Some of the member communities are classified as semi-isolated.

- Algonquins of Pikwakanagan (Golden Lake) is a transferred community with an on-reserve population of about 400, is located about 55 kilometres from Pembroke, Ontario (population 13,000).

- Chippewas of Sarnia (Aamjiwnaang), with a population of about 800, borders on the City of Sarnia (population: 70,000).

- Swan Lake First Nation, with an on-reserve population of about 520, is located in the southern Manitoba about 75 kilometres southwest of Winnipeg, Manitoba.

- Little Grand Rapids First Nation, located near the Manitoba-Ontario border about 270 kilometres northeast of Winnipeg, is only accessible by plane, then, depending on the season, by boat, snowmobile or helicopter from the air strip, across Family Lake, to the community. Little Grand has an on-reserve population of about 1150.

- Swan River First Nation, located about 50 kilometres west of Slave Lake, Alberta, (population: 6,600), has a population of about 400.

- Frog Lake First Nation is a Cree community of about 1,400 people located near the Alberta-Saskatchewan border, about 70 kilometres from St. Paul, Alberta, (population: 5,000).

- Kahnawake, with an on-reserve population of 7,225, is located adjacent to Montreal, Québec.

- Nunavik Regional Board of Health and Social Services, which has its headquarters in Kuujjuaq, Québec, coordinates health services for the residents of Kuujjuaq and 13 other Inuit communities with a total population of about 11,000. All of the communities are dependent on air transportation.

- Eel Ground First Nation, population 520 on-reserve, is located about 10 kilometres outside of Miramichi, New Brunswick (population 18,500).

- Dog Rib Rae First Nation, population 1,800 on-reserve, is about 100 kilometres from Yellowknife by year-round gravel road.

- Rankin Inlet (Kangiqtiniq), Nunavut, is a fly-in community of 2,200 people, 1,725 of whom are Inuit.

- Paq'tnkek (Afton) First Nation is a Mi'kmaq community of 335 located about 25 kilometres from Antigonish, Nova Scotia (population: 7,700).

- Westbank First Nation, located adjacent to Kelowna (population 100,000), has a population of just over 400.

In the course of conducting the community site visits, the evaluators interviewed 147 First Nations and Inuit Elders, managers, staff, Council members and others associated with the management and delivery of Brighter Futures and Building Healthy Communities programs.

Four of the communities that participated in community site visits have entered into health transfer arrangements, two have integrated agreements and the others have general contribution agreements (see Table 5, below)

Table 4: Type of Health Program Agreement

Agreement	Community
General	Chippewas of Sarnia (Aamjiwnaang) DogRib-Rae First Nation Eagle Village First Nation Eel Ground First Nation Frog Lake First Nation Little Grand Rapids First Nation Meadow Lake Tribal Council Health and Social Development Authority Nunavik Regional Board of Health and Social Services Paq'tnkek (Afton) First Nation Rankin Inlet (Kangiqtiniq) Sagkeeng First Nation Siksika First Nation Six Nations Swan Lake First Nation Swan River First Nation Tsleil-Waututh (Burrard) First Nation Yellowknifes Dene First Nation
Integrated	Kahkewistahaw First Nation Westbank First Nation
Transfer	Algonquins of Pikwakanagan Battlefords Tribal Council Indian Health Services Eskasoni First Nation Kahnawake

Survey

The evaluation team conducted a survey of Brighter Futures and Building Healthy Communities program administrators and workers. The questionnaires, one for administrators and one for workers, were designed by the FNIHB Evaluation Advisory Group based on instruments drafted by the evaluator. The questionnaires used a combination of closed and open items.

The issues addressed in the questionnaires included:

- The relative importance of the six program components funded under the initiatives;
- The types of organizations involved in running programs;
- Administrative practices and policies (administrators' questionnaire only);
- Changes in community conditions relative to intended benefits of the initiatives;
- Inter-agency/service planning and case management activities;
- Program strengths, benefits and challenges;
- Appropriateness of current programs and services;
- Frequency of service delivery for the six program components funded under the initiatives (workers' questionnaire only);
- Caseload/program participation trends (workers' questionnaire only); and,
- Involvement of traditional/cultural practices (workers' questionnaire only).

The survey questionnaires were distributed by mail to Brighter Futures/Building Healthy Communities contacts in each First Nation and Inuit community using mailing lists supplied by the project authority. The contact person was asked to direct the questionnaire to the appropriate individuals in the community. Respondents were invited to fax completed questionnaires to a toll-free fax.

Following the expiry of the response deadline identified in the questionnaire package, the evaluator conducted a telephone follow-up to encourage participation in the survey. In addition, regional FNIHB officials contacted the community representatives to encourage participation when the initial response rate fell short of expectations.

The evaluation team distributed 1,210 questionnaires and received 194 responses – a response rate of 16%. Responses were received from 90 administrators - the individuals with the principal responsibility for the management of Brighter Futures and/or Building Healthy Communities activities in their community and for reporting to the Band Council or local community authority and FNIHB - and 104 workers - individuals employed in planning, delivering and/or coordinating programs, services or activities supported by Brighter Futures / Building Healthy Communities funds. Because two or more responses were received from some communities, the 194 responses represent a total of 141 communities.

Focus Groups

Focus group sessions were held in each region involving individuals from Health Canada and/or First Nations and Inuit communities and organizations with experience in the implementation and delivery of Building Healthy Communities and Brighter Futures programming. The participants were identified by each FNIHB regional office.

Each session, which lasted about two hours and involved four to ten participants, dealt with the following questions:

- What was it like 10 or more years ago, before the BF/BHC programs were implemented within your region?
- What have been the most important developments over the last 10 years?
- If you were responsible for advising a group that is implementing the BF and BHC programs within a new region, what would be your advice to them?
- What are the programs' strengths, weaknesses, lessons learned and successes?

In all 40 individuals participated in the focus groups (8 Health Canada staff and 32 representatives of First Nation and Inuit communities and/or organizations.).

File Review

In addition to the materials provided by headquarters, the regional offices were asked to provide the evaluation team with copies of relevant documents, including:

- Internal and externally distributed regional policies and program criteria;
- Directives, practices and procedures used to manage, administer and control the programs, including check-lists and other tools;
- Documents provided to the communities to assist them in their applications for funding;
- Evaluation criteria and forms used to evaluate community proposals;
- Any management or other reports or studies that were completed by the regional office or First Nation or Inuit organization; and
- Documents that would help illustrate the evolution of the initiatives in the region.

In excess of 200 documents, reports and papers were provided by the national and regional office. The materials were reviewed by the evaluators to identify historical and current policies and practices.

Key Informants

The evaluation team interviewed key informants to gather information, impressions and opinions about the implementation, roll out, administration, impacts and future of the Brighter Futures and Building Healthy Communities initiatives. A majority of the interviews were conducted in person, but where that was not possible, the interviews were conducted by telephone. When telephone interviews were conducted, a copy of the interview guide was provided to the interviewee in advance of the interview.

The key informants, all individuals with experience in the implementation and management of the Brighter Futures and Building Healthy Communities initiatives and/or the delivery of programs under the initiatives, were identified by the project authority. They included:

- FNIHB headquarters program managers;
- Regional FNIHB officials;
- Representative Tribal Councils and provincial First Nation political organizations; and
- Individuals with responsibilities related to the delivery of Brighter Futures and Building Healthy Communities program services.

In all, the evaluation team interviewed 25 FNIHB staff members and 20 First Nation and Inuit community people including health services and other human services staff, elected officials, Elders and some “clients.”

Literature Review

The literature review was conducted to examine published research, studies and reports to assess the state of knowledge about the nature and incidence of mental health issues experienced by First Nations and Inuit people, and what might be known about the effectiveness of mental health services delivered to these populations. The scope of the review did not extend to the other issues covered by the Brighter Futures and Building Healthy Communities initiatives.

The evaluation team used two strategies to identify published research and reports relevant to the questions at hand. First, it searched the online databases published by PUBMed/Medline and Ingenta using the following key words: First Nations; Aboriginal; native; Canada; mental health; health promotion; treatment; psychiatric; psychological; heath promotion; and treatment. These searches identified a total of 70 articles published in Canadian and international professional and academic journals since 1993. The team then reviewed the article abstracts to eliminate items that were purely editorial in content or in which references to mental health-related material was incidental to the publication's content. This exercise reduced the number of titles to 51.

Second, the evaluation team searched the web sites of federal, provincial-territorial and regional government agencies responsible for mental health services, as well as those of university and independent research centres and institutes, Aboriginal representative organizations, professional associations and non-governmental agencies with an identified interest in Aboriginal health and/or mental health issues more generally. This search identified research and/or evaluation reports, bibliographies related to First Nations mental health issues, and reports of any major studies concerning the development and delivery of mental health services to First Nations. It did not gather program descriptions, public information and education materials.

A copy of the literature review is included in the annex to this report.

METHODOLOGICAL CONSTRAINTS & ISSUES

The following are methodological and data constraints that have had implications for the conduct of the evaluation and the preparation of this report.

Absence of Baseline Data: When the Brighter Futures and Building Healthy Communities initiatives were introduced there was no baseline data gathered on either the health conditions directly targeted by the initiatives or the health programs and services delivered by First Nations and Inuit communities at that time. As a consequence, a meaningful evaluation of the initiatives' outcome and impacts was not feasible.

Community Case Studies Not Fully Representative: One of the key goals of the evaluation was to "collect data on the type of activities supported by Brighter Futures and Building Healthy Communities" and Health Canada selected community site visits as the principal methodology to gather this data.

While a stratified random sample was used, community case studies were primarily designed to provide examples of what programming looks like on the ground, rather than to be fully representative. Participation was voluntary, and some communities chose not to participate. In

some cases, regions excluded communities who were under third party management or in the midst of an audit, in order to ensure that communities had sufficient capacity to participate in a case study. As a result, the communities that participated in the case studies tended to be larger and less remote. However, the community surveys were mailed to all First Nation and Inuit communities in order to maximize the representativeness of the respondents.

Table 6 compares the percentages of First Nations falling in six population ranges and the percentage of the 19 individual First Nations in the site visit sample with populations in those ranges.

Table 5: Population size of sample communities

	Population Size					
	<100	100-249	250-499	500-999	1000-1999	>2000
First Nations	16.7%	20.2%	24.2%	21.6%	11.6%	5.7%
Site Visit Sample	0.0%	5.3%	31.6%	15.8%	21.1%	26.3%

As can be seen, the larger communities are over-represented in the sample which contains no communities with populations under 100 and a significantly higher proportion of communities with populations over 1,000 than do First Nations generally. Indeed, almost 20% of the sample have populations of 3,000 or more. Because the Brighter Futures and Building Healthy Communities budget allocations for individual communities are population based, larger communities are more likely to have the resources to employ full-time staff and/or develop diversified programs and services.

The sample also over represents the urban communities in terms of geographic (isolation) characteristics. Health Canada classifies about one-third of the First Nation and Inuit communities as semi-isolated, isolated or remote. By comparison, all but two of the 20 individual communities included in the site visit sample would be classified as non-isolated. Further, about 20% of the sample are adjacent to, or within commuting distance of urban centres with populations of 100,000 or more.

In addition to the over-representation of larger, more urban communities, the community site visit sample favours communities that have had more positive program development and management experience. This is the result of at least three factors:

- First, a third of the sample were selected by FNIHB regional offices because the communities were known to have programs and services that were in some respect innovative or demonstrating a successful program approach.
- Second, while the other 15 communities were randomly selected by the evaluation team without any knowledge of their programs and activities, the selection process did exclude communities that were under third-party

management or in the midst of an audit that had the potential of resulting in third party management, in order to ensure that communities had sufficient capacity to participate in a case study.

- Finally, communities that were randomly selected were free to decided whether they would participate in site visits - nine decided that they would not participate.

These limitations in terms of representativeness are to be expected with this methodological approach, and were mitigated to the extent possible by the findings from the survey of all communities.

Interpretation of Qualitative Data: The evaluation is heavily dependent on the analysis and interpretation of qualitative data gathered through open-ended interviews and group processes. While the evaluators developed and used interview and focus group guides, the content and dynamics of the interviews and discussions varied considerably from region to region and site to site. For example, data collection during about half of the community site visits involved a series of individual interviews, while in four cases there were only meetings with groups. In the other cases, information was gathered through a combination of the individual and group interviews.

In the case of the focus groups, the mix of First Nation and Inuit representatives and FNIHB staff was different in every region, ranging from only First Nations/Inuit participants to only FNIHB staff. Finally, the participants in key informant interviews brought a variety of experience and perspectives to the interviews and that variety made it unrealistic to attempt to quantify their responses to questions and issues.

Under these circumstances, the evaluators were not able to reasonably quantify either individual or collective opinion data. For this reason, the evaluation has had to rely on relative terms to give the reader a sense of the weight of opinion on particular questions and issues. Specifically, the term “minority,” as in a minority of the respondents, means that one-third or less of the respondents held a particular view or position, while the term “majority” means that two-thirds or more of the respondents shared a particular view or opinion. The “divided,” as in the responses on this question were divided, meaning simply that there was no clear trend.

Northern Communities: At the request of FNIHB and ITK, and with their considerable support, the evaluation attempted to gather Inuit specific data through a special run of the national survey. In order to do this, FNIHB arranged for the translation of the questionnaire into Inuntituk. The evaluation team distributed the questionnaire to contacts in all Inuit communities after contacting each community by telephone. In addition, the team made two follow-up calls to encourage responses. Regrettably, fewer than five survey questionnaires were returned. As a result, the evaluation was unable to complete an Inuit-specific analysis. Not only was the sample too small, but reporting the results would have risked identifying individual communities and, possibly individual respondents.

Section 3: INITIATIVE PROFILES

This section of the report describes the goals, objectives and principles established for the two initiatives, the approaches and activities that were used in their national and regional implementation, and current program management and administration processes and procedures. It also includes an overview of the programs, projects, and activities that have been developed and delivered by First Nations and Inuit communities with the funding provided through Brighter Futures and Building Healthy Communities.

Historical Note

The *Agenda for First Nations and Inuit Mental Health* was completed, in June 1991, by a committee consisting of representatives from the Assembly of First Nations Health Commission, several First Nations and a Labrador Inuit community, as well as senior officials from Health Canada and Indian and Northern Affairs. The committee's work, which followed a two-year Health Canada study of the mental health status of First Nations populations, included a series of regional consultations. [28]

The Agenda was important because it laid the foundation for the mental health components of the Brighter Futures and Building Healthy Communities initiatives. For example, the scope of the activities, and the approaches supported through those initiatives, reflect the thinking that is evident in the committee's broad conceptualization of mental health:

> *Among the First Nations and Inuit communities the term mental health is used the broad sense of describing behaviours which make for harmonious cohesive community and the relative absence of multiple problem behaviours, such as family violence, substance abuse, juvenile delinquency, and self-destructive behaviour. It is more than the absence of illness, disease or dysfunction – it is the presence of a holistic, psychological wellness which is part of the full circle of mind, body, emotion and spirit, with respect for tradition, culture and language. This gives rise to creativity, imagination and growth, and enhances the capacity of the community, family group or individual to interact harmoniously and respond to illness and other adversity in healing ways that resolve conflicts constructively, promote improved function and the healthy development of children.*

28 A brief historical overview of the initiatives is included as Appendix B to this report.

> *Although this definition of "mental health" goes far beyond the general sense of absence of diagnosable psychiatric disorders, (which is really the area of mental illness), this limited area must still be included and addressed because of the individual, family and social burdens to which it gives rise.* [29]

In addition, the report established several program development and management principles that later became part of the Brighter Futures framework:

> *In order to meaningfully address the mental health situation of First Nations communities in accordance with policy program principles developed by First Nations and Inuit representatives, the federal government must commit and allocate new resources to First Nation and Inuit communities global, integrated, open and entirely flexible ways, and in pursuit of the five program goals of:*
>
> *a. community-based planning and programming,*
> *b. adequate and appropriate human resources availability,*
> *c. strengthening families,*
> *d. adequate and appropriate services for the mentally ill and disabled,*
> *e. collaborative policy and structure development.* [30]

Brighter Futures

On May 4,1992, the federal government announced the National Brighter Futures initiative. [31] The initiative included:

- The new Child Benefit program;
- The announcement of the ratification of the UN Declaration on the Rights of Children;
- An action plan for Canadian children; and

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29 Health and Welfare Canada. Agenda for First Nations and Inuit Mental Health: Report of the Steering Committee. June 1991. p. 6

30 *Ibid*. p. 30

31 Note: The term "Brighter Futures" was originally used to identify the national program, including the First Nations and Inuit component of the Child Development Initiative that is now commonly referred to as Brighter Futures. In this report, the original program is referred to as the "National Brighter Futures" initiative and the current FNIHB program as the "Brighter Futures" initiative.

- The Child Development initiative.

Through the Child Development Initiative, Health Canada received ongoing resources to provide financial support and technical assistance to First Nations and Inuit communities to develop programs and services in the areas of community mental health, child development, solvent abuse prevention and treatment, injury prevention, and healthy babies.

Following the announcement, Health Canada initiated consultations with representatives of First Nations and Inuit organizations and communities. These consultations led to the creation of a workgroup comprised of federal, First Nations and Inuit representatives to develop a framework document for the First Nations and Inuit component of the Child Development Initiative, now referred to simply as the Brighter Futures initiative.

The August 1993 *Program Framework for the First Nations and Inuit Component Brighter Futures Child Development Initiative* (the Framework) [32] describes the goals and intended outcomes for the initiative as a whole, and for each of its components. The document also identifies the kinds of programming, services, and activities that its drafters expected to be funded through the initiative.

> Note: While the original Brighter Futures initiative included a solvent abuse component, that issue is discussed under the Building Healthy Communities initiative because all community-based solvent abuse programming was consolidated under the latter initiative, when it was implemented in 1994.

Initiative Goals

The Framework states that the overall goal of the First Nations and Inuit Brighter Futures initiative was "to encourage and support the well-being of children, individuals and families through a community-determined approach."

Intended Outcomes

The Framework identified the following as the "desired" outcomes of the programs, services and activities that would be carried out under the various components:

- *Partnership and collaboration amongst government, First Nations and Inuit communities;*
- *Increase in the awareness of the conditions of risk in which many First Nations and Inuit children and families find themselves;*

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32 *Program Framework for the First Nations and Inuit Component Brighter Futures Child Development Initiative*. First Nations - Medical Services Branch Community Action Initiative Working Group. August 1993.

- *Culturally appropriate strategies that are responsive to children, individual, family and community needs;*

- *The development of accessible services that provide a continuum of care which may include promotion, prevention, treatment, support and aftercare;*

- *Increased capacity of First Nations and Inuit communities to successfully manage, enhance and deliver community-based services in a coordinated and integrated manner;*

- *Training, cross-cultural orientation and support to increase the knowledge and skills of personnel involved in service delivery to First Nations and Inuit communities; and*

- *A community-based evaluation process.*

As the statements of goals for the overall initiative and each of its components illustrate, the Brighter Futures initiative was expected to have a variety of health and wellness benefits for First Nations and Inuit individuals, families and communities. Importantly, most of the anticipated outcomes of the initiative were associated with improvements in the delivery of First Nations and Inuit health services rather than changes in the health status of the populations they serve.

Program Principles

The emphasis on program design and delivery seen in the desired outcomes of the initiative were reinforced in the Framework's statement of program principles:

- *Strengthening and supporting the Child/Family/Community through a holistic approach. Community wellness is the focus and it should be recognized that it is a distinct area integrated with other programs and services at the community level.*

- *Community-Based. The strength and success of community planning comes from the First Nations and Inuit communities ability to plan, design, implement and evaluate appropriate solutions within the necessary resources. First Nations and Inuit communities must also have the opportunity to develop programs responsive to their cultural needs.*

- *Community-Paced. Program development is to occur at the pace determined by each First Nation and Inuit community. There should be local control of programs and policies governing community-based initiatives. The regional differences in pace and funding constraints must be respected.*

- *Continuum of Care. Continuum of care is a range of programming from promotion and prevention to treatment, support and aftercare.*
- *Community-Wide Participation. The intent is to include and involve all community members in program development and implementation.*

- *Coordination and Linkage of Program Activities. The holistic approach is best accomplished when the program elements are coordinated and linked not only with each other, but with other community-based programs such as family violence, substance and alcohol prevention and treatment, and other social, health and educational programs.* [33]

Program Components

The following highlights the goals, intended outcomes and program scope for each of the current Brighter Futures components:

- Mental Health;
- Child Development;
- Injury Prevention;
- Healthy Babies; and
- Parenting.

Mental Health Component: The Brighter Futures Framework introduces the mental health component by stating that the definition of its goals, the activities that could be funded and the intended outcomes of those activities were based on the recommendations contained in the 1991 report *Agenda for First Nations and Inuit Mental Health*.

The Framework identifies both a goal and an aim for the Brighter Futures mental health component. The goal is to "promote the development of healthy communities through community mental health programs." The overall aim of the component is to "improve the quality of, and access to, culturally sensitive mental health services at the community level."

The Framework underlined that the mental health component , while closely linked to the intuitive's child development components, was not limited to children, but was to be accessible to all community members.

The examples of the activities that might be funded included training, planning, consultation and information exchange, promotion of linkages among health, child and family, education and other services, and "comprehensive community projects." Such activities were expected to achieve the following outcomes:

- *Appropriate and adequate community resources and programs to deal with community mental health and child wellness issues;*

33 Program Framework, *op cit.* Section 3

- *A range of services, which could include facilitating referrals, intervention, prevention, counselling, treatment and aftercare support services;*

- *An increased level of practice and awareness among community members of successful approaches to maintaining mental wellness, positive family relations, interpersonal communication, community relations and positive self-identity;*

- *Initiatives which address, in conjunction with other programs, the current high rate of suicide, homicides, acts of family violence, delinquency rates and hospitalization-institutionalization rates; and*

- *Training, cross cultural orientation and support to increase the knowledge and skills of personnel involved in service delivery to First Nations and Inuit communities.*[34]

Child Development Component: The goal of this component is to "enable First Nations and Inuit children to have a good start in their early stages of development and to ensure that they have the opportunity to achieve their full potential," while the aim is to "strengthen the existing child development network of social, health, medical, educational and cultural services."

The target population for the child development component of the initiative is "preschool to the school years." The kinds of activities that the Framework envisions might be funded included resource centers, toy lending libraries, infant stimulation programs, behavioural and developmental counselling involving parents and children.

Through the funded program and activities, the child development component was expected to achieve these outcomes:

- *Development of culturally appropriate child development service models;*

- *Strengthening of the First Nations and Inuit family;*

- *A range of child development services which could include: parent resource centres, toy lending libraries, infant stimulation programs, behaviour and developmental counselling involving parents and children, and also parents, children and educators; and*

- *Training, cross-cultural orientation and support to increase the knowledge and skills of personnel involved in service delivery to First Nations and Inuit communities.* [35]

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34 Program Framework, *op cit.* Section 4.2.1

35 Program Framework, *op cit.* Section 4.2.2

Injury Prevention Component: The injury prevention component of the Brighter Futures Initiative was intended to address both "intentional and unintentional injury." The term "intentional injury" is not defined in the Framework, but is understood here as referring to suicide, assaults and other violence. [36]

The goal of the injury prevention element is to reduce death and acute and long-term disability due to injuries among First Nations and Inuit children. It was intended that the resources available for child injury prevention would be used for activities such as: public education activities in First Nations and Inuit communities; elevating the priority given to injury prevention by families, communities health workers, and governments; training of community workers; identifying the main types of injury by geographical area; assisting First Nations and Inuit communities to develop appropriate legislation directed at injury prevention; and encouraging First Nation and Inuit agencies to establish injury prevention as a regular comprehensive preventative program.

The injury prevention component was expected to achieve the following outcomes:

- *Establishment of on-going surveillance mechanisms to measure the incidence and prevalence of injury-related death and acute and long-term disability among First Nations and Inuit children;*
- *Increased level of practice and awareness among parents, care givers, and community members of successful injury prevention and control programs;*
- *Training, cross-cultural orientation and support to increase the knowledge and skills of personnel involved in service delivery to First Nations and Inuit communities; and*
- *Development of strategies to reduce the current high rate of severe injuries and death among First Nations and Inuit communities.* [37]

Healthy Babies Component: The goal of the healthy babies component is to improve the physical, mental, social, health and well-being of First Nations and Inuit mothers and infants. The range of services and activities to achieve this goal include nutritional education, with particular reference to:

- *The promotion of breast-feeding and better maternal nutrition,*
- *Education about the importance of regular medical examinations during pregnancy,*

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36 Health Canada. *Unintentional and Intentional Injury Profile for Aboriginal People in Canada: 190-1999*. 2000. p iii: Unintentional injuries, often referred to as accidents, are those for which there is no intent to harm, either from the victim or someone else. Intentional injuries, in contrast, are those which are either self-inflicted or done by someone else (e.g. suicide or assault):

37 Program Framework, *op cit.* Section 4.2.4

- *Intensive education on the dangers of alcohol, tobacco, and other drug use during pregnancy,*
- *More intensive surveillance of prenatal infections,*
- *Training for community-based health workers; and*
- *Support for an enhancement of existing maternal and child care programs.*

The Framework identifies that the expected outcomes of these activities would be:

- *Increased parental awareness of factors associated with healthy babies;*
- *Enhanced pre- and post-natal programs; and*
- *Sustained behavioural change which increase the incidence of breast feeding and reduces the incidence of low birth weight; and*
- *Training, cross-cultural orientation and support to increase the knowledge and skills of personnel involved in service delivery to First Nations and Inuit communities.* [38]

Parenting Component: The goal of the parenting skills component of the Brighter Futures initiative is to promote culturally-appropriate First Nations and Inuit parenting skills by providing funding to support the development and delivery of parent training programs. Such programs and others would involve Elders in the delivery of training sessions and establish opportunities for mutual support among parents.

The target population for the component was parents of children aged two and older. The intended outcomes of the parenting skills component were identified as:

- *Enhanced parental self-esteem which contributes positively to the physical, mental and social well-being of their children;*
- *Development of culturally appropriate and traditional parenting skills programs;*
- *Increased awareness of positive traditional parenting skills;*
- *Strengthening of the First Nations and Inuit family unit; and*
- *Training, cross-cultural orientation and support to increase the knowledge and skills of personnel involved in service delivery to First Nations and Inuit communities.* [39]

Priorities

38 Program Framework, *op cit.* Section 4.2.5

39 Program Framework, *op cit.* Section 4.2.6

The Framework does not set out priorities for the implementation of the program components. Rather it suggests that each First Nation and Inuit community would have a wide discretion to focus planning and program activities on those components that best addressed its needs and priorities. However, the June 1992 Health Canada Treasury Board submission indicates that the department expected that the majority of the initiative's resources would be targeted to the mental health and children's development components (Table 6).

Table 6: Brighter Futures Ongoing Resource Allocations

Component	Budget	%
Mental Health & Child Development	$70.0 M	91.7%
Injury Prevention	$1.3 M	1.7%
Healthy Babies	$1.6 M	2.1%
Parenting Skills	$3.4 M	4.5%
Total	$76.3 M	

More than 90% of the ongoing funding was earmarked for the mental health and child development components combined. Presumably, the department did not make the specific allocation between the two, because the community mental health and child development components were developed as inter-related strategies, a perspective that was clearly highlighted in the Framework.

Building Healthy Communities

In June 1994, responding in part to growing concerns about suicide rates among First Nations and Inuit youth and the solvent abuse conditions such as those in Davis Inlet, the federal government announced the Building Healthy Communities initiative. The initiative provided programming resources to address what the Treasury Board submission referred to as "critical gaps with respect to mental health, solvent abuse and home nursing." Only the solvent abuse and mental health components of this initiative are covered by this evaluation.

Mental Health Crisis Management

The mental health crisis management component was allocated an annual budget of $30 million, ongoing. The program was intended to help address gaps in the range of mental health services and activities related to crisis intervention and aftercare for First Nations and Inuit communities by supporting:

- Access to counselling resources within and outside the community;
- Training for community members and caregivers to deal with crisis situations;
- Crisis intervention services such as assessment and counselling for individuals and families involved in suicide and other crises that traumatize a community;
- Aftercare and rehabilitation services such as post trauma intervention in caring for the survivors of crises to continue the healing process started at treatment centres; and
- Training community workers to provide the services described above in conjunction with professional mental health caregivers such as psychologists:

The goal was that First Nations and Inuit communities would receive support to implement mental health crisis management programs that would complement mental health prevention activities funded under Brighter Futures and NNADAP. Thus, where the Brighter Futures initiative supported long-term wellness programming closely linked to child development activities, the Building Healthy Communities component would support training, intervention, treatment and aftercare activities more focussed on dealing with suicides and other crises. Consistent with this orientation, the program planners, in submissions to Treasury Board and internal briefing materials, identified the expected outcomes of the mental health crisis management programs as:

- *A reduction over the long term in the number of suicide attempts and other violent crisis situations as a result of prevention and health promotion activities currently underway through NNADAP, BF and [Family Violence];*
- *A reduction in the number of suicides and in the number of repeated attempts by the same individuals, through a multi-disciplinary approach to crisis intervention; and*
- *Follow-up counselling for the affected individuals and their families to ease through a healing process and get them back and keep them on the road to recovery through an effective Aftercare Program.*

Following the announcement of the Building Healthy Communities initiative, First Nations and Inuit Health Branch consultations with the Assembly of First Nations and Inuit Tapiriit Kanatami led to the development of program guidelines, dated November 1994. Those guidelines included a statement of "principles" that were to guide the development of the programs:

- *Mental Health Agenda principles apply [. . .]*[40]

40 A copy of the statement referred to here, is attached as Appendix A.

- *Maximum direction from First Nations/Inuit.*
- *Maximum flexibility to enable regional [FNIHB]/First Nations/Inuit to design a program to address their needs.*
- *Allocations and program designed within the regions are determined and implemented in partnership with First Nations/Inuit.*
- *Consultations are to be developed using existing consultation processes nationally & within the regions*
- *Dovetail with existing [FNIHB] programs (Non-insured Health Benefits, Brighter Futures, NNADAP and Family Violence, etc.) and complement mental health prevention activities funded under other federal programs.* [41]

Solvent Abuse Component

The solvent abuse component of the Brighter Futures initiative was intended to achieve two goals: to develop early intervention programming to identify sniffers before problems become severe; and to provide solvent abuse treatment programs for youth. The largest portion of the resources were to have been dedicated to the establishment of two or more residential treatment centres. In 1992-93 solvent abuse funds were distributed through the regions to support planning activities, but the following year, the funds were held at the national-level to purchase treatment beds, create two “mobile intervention teams” and conduct a national solvent abuse survey.

The planned program, however, was not fully implemented. Instead, the Brighter Futures resources ($3.3M) were consolidated with Non-insured Health Benefits funds ($3.4M) and an additional $8.0M per year in new resources, under the solvent abuse component of the Building Healthy Communities initiative.

With the increased level of funding, the goals of the solvent abuse component shifted from an emphasis on residential treatment to an approach that balanced treatment and the development of community-level programming. In this vein, the goals of the new solvent abuse initiative were to:

- *Increase the ability of a community to identify issues surrounding solvent abuse and mobilize itself to respond appropriately to eliminate misuse. (Prevention and Community Development);*

41 Health Canada. Guidelines: Community Mental Health. November 1994 (Source First Nations and Inuit Health Branch files)

- *Identify, through a community-based method or system, those individuals who are in high risk situations and showing the early signs and symptoms of solvent abusive behaviour. (Early Identification and Intervention); and*

- *Establish a range of residential and community-based treatment resources (assessment, case management, detoxification, residential, day, and outpatient treatment, long-term hospice care, group home/respite centre services, aftercare, emergency response).*

These program goals reflect the “ideal solvent abuse continuum of care" described in the November 1994 document *Guidelines for the Development of a National Solvent Strategy*, which was based on the 1991 recommendations from a working group of headquarters and regional Health Canada staff and First Nations representatives familiar with solvent abuse issues.

Current Status

There has been no formal change in the program mandates of the Brighter Futures and Building Healthy Communities initiatives since their implementation, except that the solvent abuse component of Brighter Futures was transferred to Building Healthy Communities when the latter was implemented in 1994. The only national document produced after the mid-1990s that describes either the Brighter Futures or Building Healthy Communities initiative was the 2002 First Nations and Inuit Health Program Compendium. [42]

The Compendium’s description of the Building Healthy Communities initiative is generally consistent with the earlier program descriptions and policy statements reviewed during this evaluation. However, the statements about the Brighter Futures initiative varied from earlier policy statements in at least two respects. First, the compendium speaks about supporting the optimal health and social development of “infants, toddlers and preschool age children” and states that the “program is directed at children aged 0-6.” The Framework, however, makes no reference to any particular target age group, except that it says that the parenting skills program targets the parents of children aged two and up.
Second, the compendium describes the mental health component of the Brighter Futures initiative as including support for “mental health crisis intervention, training for community members in dealing with traumatic situations, and aftercare services to support individuals and families.” The Framework, however, stated that the goal of the Brighter Futures mental health

42 Health Canada. *The First Nations and Inuit Health Program Compendium*. March 2002. The introduction to the Compendium states, in part: This document serves as the main information source compiling Health Canada’s programs that are available to First Nations and Inuit. It forms the basis by which First Nations and Inuit will select the programs to be delivered in their community through Health Services Transfer, Integrated Community-based Health Services, or Self-Government while at the same time keeping them informed on the programs’ reporting requirements. It will be used to complete health transfer agreements, program accountability descriptions and reporting requirements for each of FNIHB’s health programs.

component was to “promote the development of healthy communities through community mental health programs.”

While the Compendium was not intended to be an ‘official’ policy statement, the differences between it and earlier official statements are important because the compendium is a more recent document and presents itself as a formal summary of Health Canada programs. For the vast majority of First Nations and Inuit Health Branch personnel and for First Nations and Inuit community health services staff who have been involved in the programs for less than seven or eight years, the Compendium may be the only readily available policy document.

INITIATIVE IMPLEMENTATION

The following provides an overview of the activities undertaken by FNIHB’s national and regional offices to facilitate the implementation the Brighter Futures and Building Healthy Communities.

Brighter Futures

The implementation plans for the Brighter Futures initiative called for the national office to play a role in monitoring and evaluating work plans and programs in the regions, and to manage and coordinate national activities including policy and program development. For their part, the regional offices, in partnership with First Nations and Inuit communities, were expected to develop strategic plans based on the Framework, establish funding allocation formulas and administer funding agreements.

National

Following the announcement of the Brighter Futures initiative in May 1992, FNIHB headquarters established a working group, the First Nations-Medical Services Branch Community Action Initiative Working Group, to develop recommendations for the implementation and management of the initiative. The group’s membership included representatives of the Assembly of First Nations, the Inuit Women’s Association, four provincial First Nations organizations, a number of individual First Nations, FHNIB’s national and regional offices, and Indian and Northern Affairs Canada.

By September 1992, the working group had prepared and circulated a draft *Program Framework for the First Nations and Inuit Component: Brighter Futures Child Development Initiative* (the Framework). The draft Framework, which was approved by the working group

without substantive change in August 1993, was intended "to provide Health Canada, Medical Services Branch, First Nations and Inuit communities and others with information on the program framework for the First Nations and Inuit component of the Brighter Futures Initiative." To that end, the draft Framework laid out program principles (see page 34, above), the national goals for the initiative, and eligibility and funding criteria, the scope of activities that could be funded, expected outcomes and evaluation parameters.

The Framework also set out a general orientation for the initiative's implementation:

> *Implementation of the First Nations and Inuit component of the Brighter Futures initiative is being undertaken in partnership with government, First Nations and Inuit communities. Program development and implementation is a fully collaborative process at both the national and regional levels. The collaborative process involves the establishment of strategic directions and allocation procedures. First Nations and Inuit involvement will be defined by their organizational mandates as determined by their respective leadership*.

In line with this commitment to partnership, FNIHB initiated strategic planning consultations with First Nations and Inuit communities within each of the regions and allocated a majority of the 1992-93 funds to the regions to provide financial assistance to First Nations and Inuit communities and organizations participating in these processes.

The strategic planning process was conceived as a bottom-up process with First Nations and Inuit communities developing their plans and submitting these to the regional office for review and incorporation in the regional strategic plan. The regional plans, in turn, were to be submitted to the national office, triggering the release of funds for the 1993-1994 fiscal year. The national office was not expected to approve or endorse plans, although the process called for national directors and coordinators to review them and provide feedback, as appropriate.

An August 1993 initiative "briefing package" states that "First Nations and [FNIHB] regions will be encouraged to provide annual updates to the strategic plan" that were to be used for the mid-term evaluation.

In addition to coordinating the development of the Framework and initiating the regional strategic planning process, the national office was allocated funds to manage national projects such as conferences, consultations, research, and the development of training and public education materials. About 7% of the contribution funds available for community mental health, child development, injury prevention, healthy babies and parenting skills in 1992-93 were retained by headquarters for this purpose.

The national office was also responsible for coordinating national and regional activities related to the evaluation of the Child Development initiative, of which the First Nations and Inuit

Brighter Futures initiative was a part. [43] In addition to the formal evaluation of the Child Development initiative, the implementation plans for the FNIHB Brighter Futures initiative called for regional offices to include an evaluation component in their regional plans and for First Nations and Inuit Communities to do the same.

Regional

With the overall guidance provided by the Framework, each of the regions was expected to develop its own strategic plan/program framework in partnership with First Nations and Inuit communities. The plans were to address the six program elements and include information on:

- A description of how the initiative would be implemented;
- A preliminary indication of how desired outcomes would be achieved;
- The scope of activities that could be carried out;
- An outline of proposed evaluation measures;
- A description of how funding would be allocated with the region; and,
- A description of a process to provide funds for communities in crisis.

All the regions began their planning processes in the Fall of 1992 and filed the required reports with FNIHB headquarters sometime during the 1993-94 fiscal year. In the preparation of these reports, each region used a consultative/planning process adapted to its circumstances and the requirements of the First Nations/Inuit representative organizations in the region.

The Pacific region's process was initiated, in September 1992, by a meeting of BC First Nations that was convened by the First Nations Congress. Through that meeting, First Nations and the FNIHB agreed that each Zone (Vancouver Island, South Mainland, Northeast and Northwest) would adopt its own funding allocation and implementation strategy. To support these efforts, FNIHB assigned Brighter Futures coordinating roles to regional and zone staff. In addition, five First Nations Coordinators were employed through contribution agreements. These people, collectively, served as the Brighter Futures Task Force to coordinate regional level planning.

The Alberta region developed its strategic plan by inviting all First Nations to submit plans for their communities based on the principles, goals, possible activities and other factors set out in the Framework.

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43 An interdepartmental evaluation of CDI(Child Development Initiative) in April 1996 examined the relevance and success of CDI, as well as its resourcing, cost-effectiveness and alternatives to it. The evaluation found that CDI's objectives and mandate are still relevant.. Source: Health Canada. Pilot Performance Report For the period ending March 31, 1997. P.69

In Saskatchewan, the regional office initiated consultations with the Federation of Saskatchewan Indian Nations (FSIN) on how the initiative was to be implemented and managed. Through the consultations, a funding formula and program approval processes for the first year were established, based on the recommendations of the FSIN Health and Social Development Commission.

Building on its 1992/93 planning activities, the FSIN Health and Social Development Commission, in June 1993, set out a strategy for the Brighter Futures initiative for the region. In addition, Health Canada and Indian Affairs in the Saskatchewan region adapted the co-management relationship established for the Family Violence initiative, consolidating planning for funding available from the two departments, including Brighter Futures, and a First Nations consultation process, coordinated by FSIN and involving Tribal Councils and Bands. A June 1993 call letter issued by the Saskatchewan regional office said, in part:

> *At this point it can be reported that a management relationship between MSB and INAC is well established. Also , the FSIN coordinated consultation process has evolved into a steering committee consisting of one representative per Tribal Council , and one representative of each nonaligned Band. This committee is effectively taking hold of all planning and decision-making relative to the Family Violence Initiative, as well as to the Brighter Futures Initiative, with which [it] is now combined.*

Following the announcement of the Brighter Futures initiative, the Assembly of Manitoba Chiefs (AMC) began discussions with the regional office on how the initiative was to be implemented and managed. Those discussions led to the creation, by the AMC Health Committee, of the Brighter Futures Initiative Working Group consisting of representatives of First Nations with participation from Health Canada and Indian and Northern Affairs. The working group, now known as the Manitoba Community Wellness Working Group, was given a number of tasks, including:

- Determining a formula for the distribution of contribution funding;
- Developing a statement of work for the 1992-93 contribution agreements;
- Preparing an information package to assist communities in their implementation planning;
- Adapting the national Brighter Futures Framework to reflect Manitoba's perspective; and
- Developing a regional strategic plan.

The Council of Yukon Indians initiated planning in September 1992 with a meeting of the 14 First Nations Communities in the region. This was followed by a similar meeting in November at which it was agreed that contribution funds would be used to hire territorial contractors and community level advisors to facilitate and coordinate the development of local and regional plans. The regional plan was presented for review and approval to the Chief and Council and a community meeting in each First Nation.

Resource Allocations

National

Table 7 displays the national funding and allocations for the Brighter Futures initiative from its inception, in 1992-93, to 2003-2004. Table 8 shows the same information for the Building Healthy Communities initiative, which was introduced in 1994-95. Although there was a small adjustment to the funding levels in 1999-2000, the annual budgets for both programs effectively peaked in 1997-98.

Table 7: Brighter Futures Funding and Allocation 1992-2004

Funding ($ Millions)	92-93	93-94	94-95	95-96	96-97	97-98	98-99	99-00	00-01	01-02	02-03	03-04
Original Allocation	11.3	18.0	30.5	40.5	76.6	76.6	76.6	76.6	76.6	76.6	76.6	76.6
Transfer - Solvent Abuse				-3.4	-3.4	-3.4	-3.4	-3.4	-3.4	-3.4	-3.4	-3.4
Transfer - CPNP				-0.9	-3.4	-3.4	-3.4	-3.4	-3.4	-3.4	-3.4	-3.4
Transfer - BHC Mental Health					-10.3	-10.3	-10.3	-10.3	-10.3	-10.3	-10.3	-10.3
Transfer - Remaining Commitments					-13.4	-9.5	-9.5	-9.5	-9.5	-9.5	-9.5	-9.5
Contributions Growth								0.7	0.7	0.7	0.7	0.7
Other	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Total Funds	**11.6**	**18.2**	**30.7**	**36.4**	**46.3**	**50.2**	**50.2**	**50.9**	**50.9**	**50.9**	**50.9**	**50.9**

Allocations ($ Millions)	92-93	93-94	94-95	95-96	96-97	97-98	98-99	99-00	00-01	01-02	02-03	03-04
Salaries & Operations	3.2	3.5	3.4	3.0	3.0	3.0	3.0	3.1	3.1	3.1	3.1	3.1
Contributions - Regional	7.0	10.4	22.4	32.2	42.1	46.0	46.0	46.7	46.7	46.7	46.7	46.7

Unlike the Brighter Futures initiative, which had made provision for allocations for salary and operating costs and for national level contribution funds, the Building Healthy Communities initiative allocated all the available mental health resources to regional contribution funds (Table 8).

Table 8: Building Healthy Communities (Mental Health) Funding and Allocation 1994-2004

Funding ($ Millions)	92-93	93-94	94-95	95-96	96-97	97-98	98-99	99-00	00-01	01-02	02-03	03-04
Original Allocation			19.6	25.6	15.3	19.6	24.6	24.6	24.6	24.6	24.6	24.6
Transfer - BHC Mental Health			2.8	3.0	10.3	10.3	10.3	10.3	10.3	10.3	10.3	10.3
Internal reallocation			2.8	2.8	4.3	4.3	4.3	4.3	4.3	4.3	4.3	4.3
Contributions Growth								0.6	0.6	0.6	0.6	0.6
Total Funds			**25.2**	**31.4**	**29.9**	**34.2**	**39.2**	**39.8**	**39.8**	**39.8**	**39.8**	**39.8**

Allocations ($ Millions)	92-93	93-94	94-95	95-96	96-97	97-98	98-99	99-00	00-01	01-02	02-03	03-04
Salaries & Operations			6.1									

In 1992-1993, the Brighter Futures contribution funds available to the regions ($7.0 million) were allocated based on the "modified Berger" formula:

- 20% of the funds were divided equally among the regions;
- 70% of the total was allocated based on the total First Nation and Inuit population within the region; and
- 10% was allocated based on the number of communities in the region. [44]

A similar formula was used to make regional allocations in 1993-1994. Following consultations with national First Nations and Inuit organizations, the regional allocation formula for 1994-95 was modified to include a "remoteness factor":

- $4,000 was allocated for each remote/isolated and isolated community and $2000 for each semi isolated community in each region;
- 15% of the balance after the isolation factor was divided among the regions based on the number of recognized communities in each region; and
- 85% of the balance after the isolation factor was divided among the regions based on the total registered population in each region. [45]

The results of applying this formula in 1994-95 are shown in Table 9.

Table 9: 1994-95 Regional Brighter Futures Allocations

Region	Amount ($Millions)	% of Total
Atlantic	1.10	5.0%
Quebec	2.21	10.0%
Ontario	4.64	21.1%
Manitoba	2.93	13.3%
Saskatchewan	2.98	13.5%
Alberta	2.33	10.6%
British Columbia	4.00	18.1%
North	1.86	8.4%
Total	**22.05**	

44 Program Framework for the First Nations and Inuit Component: Brighter Futures Child Development Initiative, August 1993. P 13

45 Health Canada. *1993-94 Year End Final Report on the First Nation and Inuit Component of the Brighter Futures Initiative*. P.2

This general approach, with adjustments to the value of the remoteness factor, continues to be used to allocate both Brighter Futures and Building Healthy Communities contribution funding among the regions.

Regional

In 1992-93, the first year of the initiative, a majority of the regional funds were used to support planning and program development activities at the regional, Tribal Council and/or community level. By 1993-94, all the regions, in consultation with First Nations and Inuit communities, had developed resource allocation plans that assigned small portions of the Brighter Futures contribution funds available to regional level planning and coordination activities carried out by provincial/territorial representative organizations, leaving the balance for allocation to communities.

Without exception, the regional allocations to individual communities have been determined by population-based formulas rather than comparative need or project review procedures such as are used by the Aboriginal Healing Foundation. The original formulas were variations on the 'modified Berger' formula or the national allocations formula that incorporates a remoteness factor. During the mid-1990s there were some adjustments in the values assigned to the different factors, especially the values assigned to the isolation factor, included in the formulas. By 1999-200, however, the allocations to individual communities and Tribal Councils were stabilized. Over the past four to five years there have been no changes in the regional allocation formulas.

When the Building Healthy Communities initiative was introduced in 1994-95, regional offices, again in consultation with First Nations and Inuit communities, used the Brighter Futures population-based formulas to allocate mental health and substance abuse resources to individual communities.

MANAGEMENT AND ADMINISTRATION

National

Since the roll-out of the Brighter Futures and Building Healthy Communities initiatives, the national office's role in their ongoing management has largely been limited to budgetary and general oversight. The majority of the responsibility for managing and delivering these and other community health funding programs was decentralized by 1996. [46]

While FNIHB headquarters plays a relatively minor role in the management of Brighter Futures and Building Healthy Communities contributions, it has maintained a planning and development capacity through the Mental Health/Addictions Division of the Community Programs Directorate. In addition to Brighter Futures and Building Healthy Communities, the Division's is responsible for the following programs: NNADAP; Solvent Abuse; Tobacco Control; Indian Residential Schools Health Support; Crisis Management; Suicide Prevention; and Innu Healing.

In recent years, the Division's Brighter Futures and Building Healthy Communities-related activities have included:

- Support for, and participation in, the development of the AFN-ITK-FNIHB Mental Wellness Framework;
- Financial contributions to national events (e.g., Native Mental Association annual conferences) community education publications (e.g., a video on suicide prevention) and other activities related to Brighter Futures and/or Building Healthy Communities objectives; and
- Planning, coordination and funding of the Brighter Futures and Building Healthy Communities evaluation.

Regional

Each of the eight FNIHB regional offices assigned a program officer the responsibility to manage Brighter Futures and Building Healthy Communities. The officers' specific responsibilities vary from region to region, reflecting variations in office organization, as well as regional geographic, political and demographic circumstances. Most of the program managers involved in the Brighter Futures and Building Healthy Communities initiatives also carry responsibilities for other community health programs, such as NNADAP, Home Care and CPNP, and use the same planning and administrative processes and procedures for all the programs.

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46 1997 Report of the Auditor General, Chapter 13: Health Canada - First Nations Health, para.13.25

Unlike the seven 'south of 60' regions, the Northern Secretariat does not directly administer the Brighter Futures and Building Healthy Communities initiatives or other FNIHB programs. In the Northwest Territories and Nunavut, the territorial governments deliver federal health promotion programs under Consolidated Contribution Agreements. In the Yukon, the Council of Yukon First Nations manages the Aboriginal Diabetes Initiative for the territory's 14 First Nations and self-governing First Nations manage the programs and services that are eligible for transfer. The Northern Secretariat manages the balance of the health programs and services provided to Yukon First Nations.

The Northern Secretariat was created in the fall of 1998. Its mandate is to support a "single window" approach to facilitating optimum delivery of federal health programs and services in the territories in partnership with territorial governments, First Nations, Inuit and other territorial stakeholders to improve the health status of territorial residents and strengthen their capacity to deliver a broad range of health promotion and illness prevention programs.

COMMUNITY DELIVERY

This section of the report describes the delivery of Brighter Futures and Building Healthy Communities program's services at the community level based on information collected in the course of 23 community site visits, augmented by information from the survey, the file review, key informant interviews, and focus group discussions.

Program Management

The survey of Brighter Futures and Building Healthy Communities program administrators and workers asked respondents to identify the type of organization that employed them. Their responses (Table 10) indicate that the vast majority of their Brighter Futures and Building Healthy Communities programs are managed at the Band/local government level.

Table 10: Type of organization employing the respondent

Organiztion Type	#	%
Band or local government	149	77%
Tribal Council	6	3%
Health care board	19	10%
Other	6	3%
Combination of more than 1 choice	13	7%
Total	193	100%

A similar pattern of program governance was seen in the 23 communities visited during the evaluation. The majority of these programs (19) were directly managed by the Band or local government. The management structures of the other four are:

- The Morning Sky Health and Wellness Centre is responsible for delivering community health services, include programs and activities supported through Brighter Futures and Building Healthy Communities, to the residents of Frog Lake. The Centre is governed by a not-for-profit corporation under the direction of a five-member board appointed by the Chief and Council. The Chief and the Council member holding the health portfolio sit as ex-officio officers of the Board of Directors. The Morning Star Health and Wellness Society, which was incorporated in 2001, is thought to be a unique governance model for the management of First Nation health services.

- The Nunavik Regional Board of Health and Social Services (NRBHSS), located in Kuujjuaq, Nunavik (Qc), was created in 1995 to manage the delivery of health and social programs in the 14 communities within the Nunavik area. The total population of Nunavik is about 11,000 permanent residents, of which about 90% are Inuit. [47] The NRBHSS manages a total budget of $50 million for health services, with funding coming from both the federal and provincial governments. The NRBHSS does not deliver direct services; rather it provides support and coordination services to the communities and services providers, including the Ungava Tulattavik Health Centre, the Innulitsivik Health Centre, the 'Centres local de services communautaires (CLSC), [48] rehabilitation centres, hospitals, and long term care centres and other service providers.

- The Battlefords Tribal Council (BTC) Indian Health Services was incorporated in June 992. Funded through a five-year Health Services Transfer Agreement with FNIHB, BTC Indian Health services are directed by a Board made up by the Chiefs of the seven member First Nations: Little Pine, Lucky Man, Mosquito, Moosomin, Poundmaker, Red Pheasant, and Sweetgrass. In 1998, the BTC Indian Health Services achieved accreditation from the Canadian Council of Health Services Accreditation (CCHSA). The services are provided both within the communities and at the Battlefords Family Health Centre which is located in North Battleford and opened in July 2000. The Centre houses nursing services, a doctor, dental services, addictions services, and FAS/FAE support services, as well as hospital liaison services.

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47 Nunavik Regional Board of Health and Social Services: 2002/2003 Annual Report.

48 Centres Locaux de Services Communautaires, or local community service centres, which are locally managed organizations that are components of to Quebec's provincial health and social services system, provide front-line social and health services as well as physical rehabilitation and social integration programs in communities throughout the province. The services that individual CLSC offer vary.

- The Meadow Lake Tribal Council (MLTC) represents nine (9) First Nations situated between the 50th and 60th parallel in Saskatchewan whose total registered population (on and off reserve) is 10,969. The smallest community has 317 members on-reserve and the largest has 799 members on-reserve. [49] The MLTC Health and Social Development Authority oversees primary care, community health development and social development for the nine communities. The Authority provides second level support including community staff training, community development support, technical and advisory support as well as reporting to FNIHB.

Services and Activities

This section of the report provides an overview, but not a comprehensive inventory, of the programs, activities and services delivered by the First Nation and Inuit communities and health care organizations that were participants in the community site visits. This information was augmented by the reports, descriptions and commentary gathered through key informant interviews and the focus group process.

Note: The evaluators selected the examples used in the following descriptions only to illustrate the kinds of programs and services that First Nations and Inuit communities offer under the Brighter Futures and Building Healthy Communities initiatives Reference to a program or service does not indicate that the evaluators have formed an opinion about the program's or service's effectiveness.

One of the challenges of reviewing and summarizing the Brighter Futures/Building Healthy Communities programs and services delivered by First Nations and Inuit communities is that many of the activities are designed to serve multiple objectives. This is true of some of the formally structured and professional services, but is especially true of the programs and activities managed by health and wellness staff in smaller communities.

For example, the Swan River First Nation health centre supports the hot meals program in the local high school. Such a service is most immediately identifiable as child development activity, but the community's health staff see it as an important mental health-related activity because it gives them the opportunity to interact with youth and monitor their social and emotional situation, and informally intervene when appropriate.

Because some programs have two or more purposes, Brighter Futures and Building Healthy Communities activities may appear under more than one heading in the following discussion.

49 Statistical population information was gathered from the community profiles found within the publications section of the INAC website, http://www.ainc-inac.gc.ca/ .

Mental Health

The Brighter Futures and the Building Healthy Communities mental health components have distinct, but closely related, goals. The former focuses on the general well-being of children, families and communities and the latter on suicide and crisis intervention. There is no evidence that First Nation and Inuit communities and agencies maintain separate mental health program streams corresponding to the two funding programs. Rather, consistent with the operational and planning principles established nationally and regionally programs have been developed and combined to respond to the identified community needs in both areas within the limits of the resources available to them.

The information gathered through community site visits, key informant interviews and focus groups indicates that First Nations and Inuit communities have given priority to broadly defined community wellness objectives in their Brighter Futures and Building Healthy Communities program planning. That is to say, the communities have tended to develop programming strategies that address the general well-being of individuals, families, and communities as much through community development/community building activities as through interventions targeting particular developmental, emotional, or mental health "issues." This integrated approach is consistent with the definition of mental health contained in the 1991 *Agenda for First Nations and Inuit Mental Health* (see p. 31)

The mental health and wellness services delivered in the communities fall, roughly, into these categories: counselling services, information and awareness programs, crisis intervention, and wellness activities.

Counselling and Related Services

The communities that participated in site visits offer a range of mental health services, including individual and family counselling, suicide prevention, support groups, sharing circles, workshops and/or crisis intervention services. A number of different models for the delivery of mental health services are used. About 20% of participating communities have established clinical programs that employ a mix of professionally licenced and paraprofessional staff, while about 25% have recruited paraprofessional staff, variously called community counsellors, mental health workers or wellness workers who are usually residents of the community. The others rely on referrals to provincial/territorial or contracted services

Five examples of professionally staffed programs were identified during the 23 community site visits: Six Nations; Siksika; Eskasoni; Burrard; and Eel Ground:

- Six Nations maintains two mental health programs - one for children and the other for the general population. The Children's Mental Health Service is administered by Child and Family Services and employs licenced social workers and others who offer a range of clinical services for children: psycho-social assessments; behaviour management planning; support for parents, schools and foster parents; referral and advocacy services; community education and awareness programs; and counselling assistance to external and internal staff.

The community's Mental Health Services is an accredited mental health program with a professional staff, including a psychiatrist. The agency provides crisis response services to Band members residing in the community, case management services, adult and child psychiatric assessments and consultations, and client advocacy. It is also involved in promoting community awareness and understanding of mental health issues.

- The Siksika Health Services has established a mental health clinic staffed by a clinical psychologist who provides general mental health services, as well as educational assessments for the Head Start program and schools. The mental health team includes a community counsellor, who focuses on services to families, and the NNADAP counsellor. The close coordination between the mental health staff and the NNADAP counsellor allows the program to respond to the needs of individuals dealing with both addictions and mental health issues (dual diagnosis/comorbidity).

- Eskasoni's Mental Health and Social Work Services employs a team of licensed social workers and psychologists, as well as community counsellors, to deliver individual and family counselling and treatment services. The agency also participates in the community's crisis intervention team.

- Burrard employed a holistic approach where all social, health and wellness services are combined together within one directorate. Band members and their families are provided with a true continuum of mental, health and wellnes care.

- The Eel Ground Child and Family Services agency has been given a mandate, and Building Healthy Communities funding, to hire a full-time counsellor/mental health worker to provide services to individuals and families who would not normally be eligible for the agency services. The program is staffed by licensed social workers and trained child services personnel. This approach to delivering mental health services was taken to ensure that any counsellor recruited to provide such services is qualified and able to work in a professional environment with the appropriate supervision and support.

A more common approach to delivering mental health and crisis intervention services is the recruitment of community counsellors or wellness workers. This model was seen in Manitoba, two Saskatchewan communities, and one Ontario community. While these workers provide counselling and crisis intervention from time to time, the larger part of their activities tend to focus on referral, advocacy and community education and awareness activities. For example:

- The Sagkeeng Wellness Counselling Program consists of a mental health worker, two Brighter Futures/Building Healthy Communities counsellors and a traditional healer, as well as two NNADAP counsellors.

- The Pikwakanagan Health Services employs a mental health outreach worker/nurse who provides mental and emotional support, referral and advocacy services and some individual, group and family counselling. The worker also

organizes workshops on issues such as self-esteem and mother-daughter relationships.

- The Meadow Lake Tribal Council Health and Social Development Authority, which has established mental health as the top priority for its Brighter Futures and Building Healthy Communities program, has introduced a strategy in which each of its member communities employ a community wellness worker who provides education, prevention, intervention, crisis management, and treatment for community members. Their program differs from others in that there are team coordinators at the Tribal Council level who provide supervision, training, case management and other developmental services to the frontline staff.

The balance of the communities visited during the evaluation do not have staff dedicated to mental health/wellness services, but rely on provincial/territorial programs and/or external contracted services. The Kahkewistahaw First Nation Health Centre, for example, has contracted a private practitioner who provides services to the community two days a week with her time divided equally between individual and family counselling and participation in planning and delivering other mental health-related activities. The contract, which has been in place for many years, is one that the community's health staff feel has been very productive. Other communities that have used similar arrangements have not had similar success due to difficulty recruiting and retaining suitable private practitioners.

Information and Awareness

All of the communities for which information was obtained deliver workshops and similar events intended to increase people's knowledge about the nature of, and available responses to, personal and family concerns including suicide and suicide prevention, anger management, grief management, family violence, depression, spousal and dating relationships, stress management, healing and others.

As already mentioned, most community counsellors, mental health workers and wellness workers have responsibilities in these areas and each of the professional agencies visited have staff involved in such work. Other communities, however, have given a priority to activities in this area:

- The Nunavik Regional Board of Health and Social Services, for example, has allocated Building Healthy Communities resources to the CLSCs to employ community wellness coordinators in each of the 14 municipalities served by the organization. The coordinators plan and facilitate community awareness and wellness promotion activities for all community residents. These activities are not limited to dealing with mental health issues, and they take a holistic approach to health and health promotion.

- The Eagle Village Mental Health and Wellness Program, funded in part through the Building Healthy Communities initiative, promotes individual and group healing and wellness, through workshops, education activities and cultural teachings. The activities and programs it supports include organizing and

facilitating community group activities, social and information support services for Elders, encouraging sports and recreational activities among youth, and events that provide youth the opportunity to learn about their culture, language, traditions and history. The centre has also delivered youth oriented workshops dealing with issues such as peer pressure, stress management, and child abuse.

- The Afton First Nation has established a regular program of community weekend and evening workshops through a series of partnerships with provincial government and community agencies in the Antigonish area of Nova Scotia. This approach allows the community to take advantage of a range of expertise and to build relationships with service organizations. The relationships help people get services when they need them because the agencies and their staff are known in the community.

Wellness Activities

The majority of the communities include some "wellness" events and activities in their annual program plans. Such events and activities tend to have community development, cultural and/or recreational content, but are delivered as part of the health program because they have the potential of increasing positive, healthy behaviours for participants and the community. For example, Kahkewistahaw's health team sponsored a 17- week course in traditional shawl making for 34 girls. During the course, Elders and others joined them to talk about traditions, community issues and other matters of interest to the teens. At the end of the course, the girls presented their shawls at the Round Dance, were honoured by the singers and recognised by the community.

The program managers report that through the project the girls learned about their culture and traditions, which has had a positive impact on their pride and self-esteem, and has allowed them to learn new social skills. It also allowed the members of the health team to regularly interact with the teenagers, who may have been difficult to reach otherwise, to address abuse, violence, sexuality, self management and other issues in a safe and welcoming environment.

The list of wellness events and activities mentioned by respondents in interviews and focus groups included summer camps, cultural/traditions learning opportunities for youth, social and recreational activities for Elders and/or disabled people, and community feasts. These kinds of activities are supported because it is believed that, whatever other benefits they offer, they help build a sense of community and reduce social isolation.

Typically, such activities are supported though a number of different sources in the communities, not only Brighter Futures/Building Healthy Communities. For example, the Meadow Lake Tribal Council hosted the 2003 Saskatchewan First Nation Summer Games, Brighter Futures/Building Healthy Communities and other programs, such as NNADAP, participated by offering healthy living related information and ensured that first aid, nursing services and drinking water were always available for spectators and participants.

Other examples of wellness activities include:

- Kahnawake allocates funding to a variety of programs and activities that have the objective of promoting, particularly among youth, participation in educational and recreational activities that foster self-esteem, improved social skills and enhanced mental health/wellness. Such activities range from sports programs to a drama club and the "Our Gang" program that offers children an after-school program of social, life skills and recreational programming.

- The West Bank First Nation organizes an annual youth camp, which targets youth at risk, employs older youth to supervise a range of activities under the leadership of a youth counsellor. Political leaders, Elders and traditional leaders organize and lead camp events that seek to better integrate the youth in the community. The counsellor also provides social support to the youth throughout the year.

- The Swan River Health Centre plays a key role in organizing, and allocates some Brighter Futures funding to help with the costs of an annual three-day camp that allows Swan River families to have fun together in a setting that is similar to how the people of Swan River used to live. Those attending participate in traditional and cultural activities, share in camp maintenance and meal preparation, take part in games and events such as a youth-Elder race. The camp experience is intended to promote pride in identity, to help maintain traditional beliefs and practices and to contribute to healing. The Health Centre staff feel that the event is a growing success - each year more families attend and, more importantly, volunteer to help with planning, organizing and running the camp. They believe that the experience is contributing to the repair of rifts and tensions within the Swan River community.

Crisis Intervention

Few of the communities that participated in the site visits have established crisis intervention protocols/services. Most rely on ad hoc responses to events, although all have, at some point, organized community wide and/or health staff training in suicide and other crisis intervention.

The community site visits identified these examples of formal crisis intervention procedures:

- Kahnawake provides regular suicide prevention and intervention training for service providers and the general community. The community has also developed a crisis management strategy so that Peacekeepers, emergency service personnel, health care providers and others can be mobilized to deal with critical incidents.

- The Six Nations Mental Health Services provides 24-hour mental health crisis response services to registered Band members residing on Six Nations Grand River Territory.

- Eskasoni First Nation has established a crisis intervention protocol and team. The protocol sets out the responsibilities of the crisis response team coordinator

and team members, identifies the skills required for coordinators and team members and provides guidance with respect to issues such as debriefing for crisis responders. The Eskasoni crisis response strategy was developed in the mid-1990s, through a project sponsored by the Union of Nova Scotia Indians and led by that organization's Mental Health/Brighter Futures Coordinator. (Note: The crisis intervention program is not funded by Building Healthy Communities, although the community's Mental Health and Social Work Service, which is funded under that initiative, participates in the program and provides followup counselling and support, as needed.

- The Sagkeeng First Nation counselling team, consisting of a mental health worker, Brighter Futures/Building Healthy Communities counsellors, a traditional healer and NNADAP counsellors and others, provide crisis intervention that focuses on the individual, the family and the community as a whole.

Child Development

Twenty of the 23 communities participating in the evaluation community site visits deliver programs, services, and activities that address child development issues through Brighter Futures funding. As the following examples illustrate, communities, many of which give priority to child development, have implemented a wide variety of program models reflecting a range of understandings about needs and solutions:

- The Eagle Village First Nation has organized school-based "Stop Bullying" sessions for both native and non-native students. It also sponsors summer and after-school programs and activities for children and youth.

- Kahnawake offers programs designed to meet more than one objective. For example, the "Our Gang" after-school program, a drama club and a variety of recreational and cultural events and activities are used to contribute to the positive growth and development for children and youth, as well as the development and maintenance of their general mental health.

- Nunavik communities offer child and youth development programs and activities ranging from teaching traditional throat singing to after-school computer clubs. Other projects have included school reentry programs for drop-out students, activities designed to encourage positive social and academic performances, programs offering children and youth the opportunity to learn and participate in traditional hunting and survival, cultural and heritage activities, summer camps that blend recreational, cultural learning, and social skills development activities, and projects that bring together youth and Elders to enhance inter-generational understanding, promote cultural learning, and encourage positive social interactions.

- Brighter Futures resources are used by the Battlefords Tribal Council to support school breakfast programs and to make contributions toward recreational and support programs.

- The Kahkewistahaw Health Centre offers five-day summer camps in which children can begin to address difficult issues such as abuse and violence in age-appropriate ways and in a positive, supportive and fun environment. The program also gives health staff an opportunity identify children who could benefit from mental health, health or social services. The summer camp program is delivered with the assistance of volunteers.

- The Aamjiwnaang First Nation Health Centre offers child development programs and activities targeting preschool and elementary school age children including a toy lending library, a clothing exchange program for younger children and a document resource centre for parents, a math learning program for 4-6 year-old children and a regularly scheduled parent-child crafts program to promote positive parent-child and child-child social interaction. The community also maintains a youth drop-in centre staffed by a social worker and, during the summer months, delivers a day camp program for children ages 6-12. Program staff reported that the camp, which used to focus on recreational activities, lost some popularity after its content was changed to include a focus on the development of personal, social and life skills, but that once parents gained a better understanding of the intent of the revised program, it is regaining popularity.

- In addition to its clinical services, the Six Nations Children's Mental Health Service maintains a youth drop-in centre, and, three times a year, sponsors a family fun night to encourage and celebrate family life.

- The Pikwakanagan Health Centre Brighter Futures programs focus on physical activity to encourage participation and motivate the community to get active and stay healthy. The children's social and recreational activities for children include t-ball, mini softball and girls' and boys' basketball, an annual 5-week summer day camp that offers arts and crafts, workshops, recreation and certified swimming program. The program for teenagers and youth offers activities such as basketball clinic for ages 10-18 during the school year and a summer softball league.

- The Siksika Health Promotion program uses Brighter Futures resources to enhance the Head Start program, and support a variety of school-based initiatives including programs to reduce violence and promote positive relationships in elementary schools and an annual summer camp to improve social and physical skills for special needs students.

- The Eskasoni Mental Health and Social Work program provides staff support and assistance to a range of school-based programs in addition to making a significant investment in family counselling services.

One of the themes that runs through the child development programming offered by the communities participating in the site visits is their emphasis on exposing children and teenagers to their cultural heritage and traditions through, for example, teaching language and traditional skills (hunting, drumming, meal preparation, crafts, etc.) and by involving Elders in the planning and delivery of programs.

Injury Prevention

Injury prevention was not identified as a major program component for any of the communities participating in the site visits, although 17 of the 23 do include injury prevention in their programs. The Siksika Nation offered the only example of a strategy to build injury prevention into the general planning. The Siksika Health Promotions Team leader coordinates and chairs the Injury Prevention Coalition Group that has representation from several agencies and departments including Health Promotions and Fire and Safety. The group meets six times a year to review reports of injuries and consider and recommend way to promote injury prevention. For example, when the group identified an increase in the rate of dog bite cases, especially cases where children were the victims, the community initiated an awareness campaign to alert both parents and dog owners of the risk and of ways of reducing the risk.

Those communities that bring a health promotion perspective to their program design were the most likely to include child injury prevention activities, usually as part of other programs. For example: Kahnawake's community health representatives and nurses promote the use of seat belts and infant and child car safety seats, and bicycle safety as part of their educational and awareness services. Other examples of this approach are:

- The Eagle Village Health Centre has offered K-6 students injury prevention workshops to deal with water safety, bicycle safety, choking and suffocation intervention, ATV safety and burn prevention. It also sponsors summer demonstrations and events designed to promote bicycle and water safety. In addition to these child-oriented injury prevention activities, the community has provided basic first aid and CPR training for parents, a program that is considered to be particularly important when families are on the land and emergency services are not available.

- The Kahkewistahaw summer camp program builds injury risk awareness and prevention into its fun-recreational activities, as do the Frog Lake and Swan River First Nations.

- The Battlefords Tribal Council Indian Health Services, and the communities served by that agency, promote child injury prevention through prenatal courses in which expectant parents receive car seats and instruction in their proper use, as well as supporting bicycle rodeos and bike safety inspections, first aid courses for parents and babysitting courses.

Healthy Babies

All of the communities participating in the site visits deliver prenatal and postnatal healthcare, nutritional, and support services for expectant and new mothers through community nursing and the Canada Prenatal Nutrition Program (CPNP). [50] In Ontario, at least one of the participating communities has received provincial funding for healthy baby services. [51] Several communities report using Brighter Futures resources to supplement or enhance these programs. In addition, six of the 23 communities participating in the site visits reported that they use Brighter Future resources to deliver services that go beyond those provided through CPNP:

- Eagle Village provides a Lots for Tots Program that provides that involves parents and their young children in weekly sessions of floor exercises, free play, singing and storytelling and other activities designed to enhance parent-child interactions and child socialization skills.
- In recent years, some Nunavik communities have allocated Brighter Futures resources to projects designed to support improved nutrition for infants and babies in the child care programs.
- The Aamjiwnaang First Nation Health Centre has used its Brighter Futures funding to support a baby weigh-in program and provide fresh food for expectant mothers, as well as community education workshops on subjects such as breast-feeding, child safety, FAS/FAE and nutrition.
- The Six Nations Healthy Lifestyles Initiative, a component of the Health Centre's Health Promotion and Nutrition Services, sponsors a series of nutrition workshops and courses including baby food making, canning and preserving workshops, traditional and contemporary healthy cooking classes, and a community kitchen program for teenage mothers.
- The Swan River Health Centre sponsors a weekly Moms & Tots play group for stay at home parents with preschool children.
- The Frog Lake Morning Sky Health & Wellness Centre uses Brighter Futures and CNCP resources to support the community's annual Celebration of Moms and New Babies event.

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50 The Canada Prenatal Nutrition Program's goal is to reduce the incidence of unhealthy birth weights, improve the health of both infant and mother and encourage breastfeeding. It funds services that provide food supplementation, nutrition counselling, support, education, referral and counselling on health and lifestyle issues. Source: Health Canada: www.phac-aspc.gc.ca/ dca-dea/programs-mes/ cpnp_goals_e.html

51 The Aboriginal Healing and Wellness Strategy provides funding for Aboriginal healthy babies services delivered by Aboriginal health organizations including First Nations health services. Its 2002-2003 annual report indicates that the Strategy provided for 140 FTE's associated with healthy babies services.

Parenting

In addition to the parenting skills development opportunities that are provided through prenatal programming, more than 80% of the communities where site visits were conducted during this evaluation deliver parenting courses and support activities of some kind. The range of these activities is illustrated by the following examples:

- Kahnawake offers a support group for parents of children with ADHD. Through the program, parents benefit from interacting with other parents living in similar situations, as well as learning more about ADHD and ways of helping their children and themselves from subject-experts. The community's health service agencies also organize and facilitate general parenting workshops and parent support events.

- The Eagle Village Health Centre has sent one of its team members for training so that the worker can deliver Nobody's Perfect workshops in the community and provide parents with the resources to assist him with specific needs. [52]

- The Aamjiwnaang First Nation's health services program delivers parenting classes, including Nobody's Perfect courses, as well as organizing parents' night-out and other activities that provide support and respite for parents.

- The Six Nations Children's Mental Health Service provides support and counselling for parents as part of its clinical services for children.

- The Siksika Health Promotions team organizes and facilitates an annual cycle of some parenting workshops in each of the 10 neighbourhoods within the Siksika community. The full program consists of three phases with four weekly evening sessions in each phase. The phase one curriculum covers self-awareness (identifying basic needs; taking care of yourself), communications (effective listening and talking), traditional parenting, positive discipline and problem solving, and healthy sexuality. The second phase covers self-esteem for the parent and the child, stress management, sibling rivalry, gender roles and spousal relationships, while the third phase deals with child development, residential schools, prejudice, women's health issues and FAS/FAE parenting. Siksika Elders participate in the sessions as resource people and teachers.

- Eskasoni's Mental Health and Social Work Services offers a structured parenting program based on behavioural contracting models and specialized counselling and support for parents at risk of intervention by Child and Family Services.

- Eel Ground's Child and Family Services has been allocated Brighter Futures funds so that the agency can provide preventative respite support and other

52 "Nobody's Perfect" is a education and support program for parents with infants and pre-school children. It was developed by Health Canada and the Departments of Health of the Atlantic provinces in the late 1980's. The materials were revised and up-dated in 1997.

services for parents in situations where the family is at risk, but does not qualify for child protection services.

Solvent Abuse

Solvent abuse was not identified as a significant problem in any of the communities visited during the evaluation, except to the extent that it is one of several substance abuse and addictions issues. As a result, all but the Nova Scotia communities, report that they address solvent abuse prevention and intervention through general alcohol and drug addiction services. The only specialized solvent abuse prevention program identified through community site visits is offered at Eskasoni, and 10 other Nova Scotia First Nations, by the Native Alcohol & Drug Abuse Counselling Association of Nova Scotia (NADACA).

NADACA is the primary addiction treatment and counselling agency for 11 of the Nova Scotia First Nations. The agency runs two treatment centers and has counsellors located in each of the communities it serves. In addition, the organization offers a solvent abuse prevention program from its head office at Eskasoni. The solvent abuse coordinator provides advice and support to addictions councilors in the communities and facilitates referrals to treatment or specialized counselling as required.

The coordinator also delivers a school-based program in each of the communities served by NADACA. The program includes information and educational activities to help teachers and students understand the risks associated with solvent abuse and the behaviours and symptoms that might indicate that someone is a solvent user. In addition to the educational activities, the coordinator is actively engaged in promoting healthy lifestyle decisions among young people through, among other things, a “peer-to-peer” program that supports individual development and mutual support among students.

Community Program Priorities

Based on their descriptions of programs and services, the communities participating in site visits, collectively, have tended to give priority to:

- Community mental health strategies using some combination of counselling/clinical services, community education, wellness promotion and activities designed to “strengthen community,” and
- Child development services and/or parenting programs.

Healthy babies, injury prevention, and solvent abuse have comparatively low priority, although all communities report that they have services that address these issues if not through Brighter Futures and Building Healthy Communities then through Head Start, community nursing, community health representative services, CPNP or NNADAP.

The survey asked Brighter Futures and Building Healthy Communities workers to indicate the frequency with which each of the Brighter Futures/Building Healthy Community components was delivered in their communities. The responses to this item indicate that suicide intervention, treatment and aftercare, as well as child injury programs, have relatively low priority, but are, nevertheless, regularly scheduled activities in the large majority of the communities represented by the respondents. (Table 11)

Table 11: Frequency of program delivery

	On-going	Once or Twice a Week	Once or Twice a Month	Not Available
Crisis Intervention	61	3	23	7
Healthy Babies Programs	59	10	20	3
Mental Health Counselling Services	57	6	23	10
Youth Programs	56	14	18	8
Child Development Programs	48	12	30	4
Suicide Intervention, Treatment & Aftercare	45	2	28	20
Parenting Skills Programs	41	4	41	9
Mental Health Public Education Programs	31	5	42	13

Section 4: ISSUE #1 - - - RELEVANCE

Section 4 of the report looks at the evaluation findings with respect to the clarity of the initiatives' policies and criteria and the continuing relevance of the initiatives' program components, administrative procedures and structures, activities and outputs, and principles. It also examines whether the initiatives continue to address the needs of First Nations and Inuit communities.

CLARITY OF POLICIES AND CRITERIA

Evaluation Question #1.1

Do the programs have clear policies and criteria at the national and regional levels?

Discussion

Program Orientation

The 1993 Brighter Futures Framework and the November 1994 guidelines for the mental health component of Building Healthy Communities initiative are the source policy documents for the initiatives. The file reviews and interviews with regional and headquarters staffs failed to identify any subsequent published policy or operational program direction. The only recent document to set out the scope and priorities of the initiatives is the First Nations and Inuit Health Program Compendium, 2002. Although it is not a formal statement of policy, the compendium is currently in use by FNIHB staff and has been distributed to First Nations and Inuit staff in at least one region.

The following table displays the goals for each of the program components from the 2002 compendium and the component goals as they were stated in the Brighter Futures Framework or, in the case of Mental Health Crisis Management, documents supporting the 1994 Treasury Board Submission.

Table 12: Comparison of Goal Statements

2002 Compendium	Source Documents
Mental Health - Brighter Futures	
The mental health component includes support for mental health crisis intervention, training for community members in dealing with traumatic situations, and aftercare services to support individuals and families. It promotes prevention and early intervention programs in First Nations and Inuit communities through education and research.	The goal of the community mental health element is to promote the development of healthy communities through community mental health programs.
Mental Health Crisis Intervention	
This component provides a variety of activities related to mental health crisis intervention including assessment, counselling programs, referrals for treatment and follow-up treatment, aftercare and rehabilitation to individuals and communities in crisis; culturally sensitive training for community members and caregivers and community education and awareness of the nature of mental health and suicide.	**1**. Implement a Mental Health Crisis Management Program in First Nations and Inuit communities that will complement mental health prevention activities currently funded under Brighter Futures, NNADAP and FV; **2**. Work in partnership with First Nations and Inuit communities, to provide them with the necessary tools to tackle the problems of hopelessness and suicide targeting communities most in need; **3** Provide crisis intervention, aftercare and training for caregivers and community members to deal with issues like suicide.
Child Development	
This component is aimed at reducing health risk to children through prevention and promotion activities.	The goal of the child development element is to enable First Nations and Inuit children to have a good start in their early stages of development. Also to ensure that they have the opportunity to achieve their full potential.
Healthy Babies	
The focus is to improve the physical, mental and social health and well-being of First Nations and Inuit mothers and infants. This includes education and nutrition, as well as maternal and child health.	The goals of the healthy babies element is improve the physical, mental, social, health and well-being of First Nations and Inuit mothers and infants.
Injury Prevention	
The focus is to promote public awareness and prevention activities related to injuries in First Nations and Inuit communities. The intent is to reduce death and/or acute and long-term disability due to injuries	The goal of the Injury Prevention element is to reduce death and acute and long-term disability due to injuries among First Nations and Inuit children.

2002 Compendium	Source Documents
Parenting Skills	
The focus is to develop and promote culturally appropriate First Nation and Inuit parenting skills	The goal of the parenting skills element is to promote culturally-appropriate First Nations and Inuit parenting skills.

It is noted that the Compendium's goal statements for Brighter Futures mental health and child development components differ significantly from the goal statements in the Brighter Futures Framework.

In the case of Brighter Futures mental health component, the Compendium statement is a substantial reformulation of program goals away from a broad "community development" orientation set out in the Framework to the "crisis intervention" orientation assigned to the mental health crisis management component of the Building Healthy Communities initiative:

1. *Implement a Mental Health Crisis Management Program in First Nations and Inuit communities that will complement mental health prevention activities currently funded under Brighter Futures, NNADAP and FV;*

2. *Work in partnership with First Nations and Inuit communities, to provide them with the necessary tools to tackle the problems of hopelessness and suicide targeting communities most in need;*

3. *Provide crisis intervention, aftercare and training for caregivers and community members to deal with issues like suicide.*

At the same time, the Compendium expands the mandate of the Building Healthy Communities component by adding a public education theme that was not evident in the source materials:

> *This component provides a variety of activities related to mental health crisis intervention including assessment, counselling of programs, referrals for treatment and follow-up treatment, aftercare and rehabilitation to individuals and communities in crisis; culturally sensitive training for community members and caregivers and community education and awareness of the nature of mental health and suicide* (emphasis added).

The shift from a flexible, community development orientation toward more "clinical" objectives is also seen in the goals the compendium assigns to the child development component. The Brighter Futures Framework said:

> *The goal of the child development element is to enable First Nations and Inuit children to have a good start in their early stages of development. Also to ensure that they have the opportunity to achieve their full potential.*

The compendium, however, says:

> *This component is aimed at reducing health risk to children through prevention and promotion activities.*

Assuming that the Compendium reflects FNIHB's most recent thinking about Brighter Futures and Building Healthy Communities goals, it suggests that there has been a shift in policy "in practice" that blurs the goals of the two mental health components and diminishes, maybe even negates, the breadth of the Brighter Futures community mental health and child development components.

At the very least, the shift potentially reduces the programming flexibility available to First Nation and Inuit communities. For example, an observer relying on the compendium's statement of the goals of the Brighter Future's mental health component is likely to conclude that a program that provides community group activities, social and information support services for Elders and recreational and cultural activities for youth should not be supported.

Indeed, FNIHB headquarters and regional staff participating in key informants interviews expressed reservations, or more typically, reported that their colleagues and superiors had reservations about the relevance of many of the activities and programs being delivered by under the BF/BHC initiatives. These expressions of concern were most often directed toward activities and programs that involved some form of recreational activity, or that targeted the community in general rather than individuals seen as needing treatment interventions.

Communities, however, have been supporting recreational and cultural activities since the inception of the Brighter Futures initiative based on arguments that such activities enhance individual personal social esteem, promote interaction among community members, and encourage healthy life styles. An analysis of the 1993 regional strategic plans found that 44 (16%) of 276 mental health proposals focussed on community cultural or recreational activities and 82 (28%) of 293 child development proposals fell in a category called "Recreational Development."

For communities that have focussed their Brighter Futures/ Building Healthy Communities resources on clinically-oriented mental health services and/or health risk reduction for children, the policy direction underlying the Compendium is not a limiting factor. However, for those that have adopted a community development and wellness model, the shift is limiting.

Program Criteria

The community site visits and key informant interviews revealed that there is some confusion about the scope and criteria of the Brighter Futures initiative. Specifically, at least 25% of the communities participating in site visits believed there is an expectation that all the communities must deliver programs and activities under all five program components. However, when this question was raised in key informants interviews with FNIHB respondents, only a few respondents in one region indicated that they expected that all components had to be addressed in some fashion.

Further, the language of the Brighter Futures schedules to contributions agreements, at least in one region, clearly give communities the flexibility to focus on fewer than the five components:

> *4. In order to carry out the Objectives, the [recipient] shall:*
> *(1) deliver culturally appropriate and holistic community-based projects and programs to community members and in partnership with community leadership in the following component(s) of the Brighter Futures program:*
>
> *(a) mental health; and/or*
> *(b) child development; and/or*
> *(c) healthy babies; and/or*
> *(d) injury prevention; and/or*
> *(e) parenting skills;* (emphasis added)

The evaluators' review of the Framework, the 2002 Compendium and other descriptive documents found that they contained no reference to a requirement that every community had to deliver all components. The only related comment is found in the Framework which stipulated that the 1993 regional strategic plans had to "encompass all six program elements."

The evaluators also encountered different interpretations about the age criteria for Brighter Futures programs. In two cases, it was reported that child development, and possibly other program component resources, were only to be used for children aged six and younger. In another case, the respondents thought that the age range was 18 years and younger, meaning that programs that targeted adults or Elders would not be eligible for funding.

Again, a review of FNIHB documents found nothing that would suggest that such age criteria were in force. Indeed, the Framework, in its description of the scope of child development activities, says: "These activities could range across the preschool years into the school years, ensuring long term effectiveness for the developmental approach."

Findings

- The First Nations and Inuit Health Branch has not published any statement of policy or priorities for either Brighter Futures or Building Healthy Communities since the initiatives were implemented in 1992 and 1994, respectively, and those documents are not in wide circulation.
- There appears to have been a shift in FNIHB's understanding of the goals of the mental health and child development away from a broad community development orientation to a narrower clinical/medical model.
- There is uncertainty among some First Nation and Inuit program managers and workers about the kinds of activities that are eligible for funding.

IDENTIFYING NEEDS

Evaluation Question #1.2

Have First Nation and Inuit health and communities needs and priorities been identified; and are these priorities and needs current?

Discussion

Since the inception of initiatives, there has been no formal documentation of community needs and priorities undertaken in the context of the Brighter Futures and Building Healthy Communities goals and intended outcomes outside of the activities associated with the annual contribution agreement renewal cycle.

A minority of the 23 communities visited during the evaluation reported that they have conducted structured community health assessments and developed a health services plan in the last five years. Of those that have developed plans, four of them did so in the context of establishing health transfer agreements. Only two non-transfer communities reported having any plans to do such work. The majority of the smaller and non-transfer communities reported that, while they have not conducted formal needs assessments, they do monitor health services needs through informal processes and day-to-day interaction with the community residents.

Whether they have completed formal assessments or relied on less-structured alternatives such as spontaneous comments and informal discussions with community members, the health program personnel in the 23 communities expressed the view that they have an appreciation of the needs and priorities in their particular area of responsibility. At the same time, a minority of the respondents voiced concern that not all health and wellness issues and needs, such as abuse, alcoholism, violence and depression, have been openly identified or discussed in the community. These individuals felt that a formal needs assessment, one that ensured confidentiality, would help identify these priorities and allow service providers to address underlying needs and issues within the community.

Findings

- Few non-transfer communities have undertaken formal needs assessments and health planning, other than assessments that might have been done a decade ago when the Brighter Futures initiative was being implemented.

- As a result of the lack of health program planning generally and for Brighter Futures and Building Healthy Communities programs:
  - Some First Nation and Inuit health programs have difficulty effectively accounting for their Brighter Futures and Building Healthy Communities activities within their communities and to FNIHB;

  - There is a risk that the Brighter Futures and Building Healthy Communities activities in some First Nation and Inuit communities are not as integrated with other health and wellness programs as they might be; and

  - In a few of communities program delivery has been impeded because the community's leadership and health program managers have different, even conflicting expectations.

- The lack of needs assessment and planning activities is sometimes due to a lack of technical capacity (knowledge, skills, tools) and resources. In other cases, it is the result of a decision that the cost of undertaking the planning would be too high in relation to the level of Brighter Futures and Building Healthy Communities funding received.

- A community's capacity to deliver a continuum of care is hindered, but not prevented, by yearly funding which limits their capacity to implement consistent, long term plans.

- A "one-size-fits-all" planning process is not effective or appropriate when the value of Brighter Futures and Building Healthy Communities funding to individual communities varies from a few thousand dollars to more than a hundred thousand dollars.

CONTINUING RELEVANCE OF PROGRAM COMPONENTS

Evaluation Question #1.3

Do each of the program components continue to accurately focus on and meet the issues, needs and priorities of First Nation and Inuit communities?

Discussion

The Focus

The broad consensus of the First Nations and Inuit participants in community site visits, key informant interviews and focus groups is that the issues and needs that the Brighter Futures and Building Healthy Communities components were designed to address remain problems, although significant gains have been made. There was also a general consensus that the relative importance of particular components may shift over time and vary from community to community.

The survey did not ask about whether the initiatives continue to focus on community needs, but it did ask workers to indicate the extent to which a number of services were delivered in their community through Brighter Futures/Building Healthy Community. The last column in table 13 identifies the percentage of respondents who reported that their communities provide the listed services at least once a month.

Table 13: Percentage of surveyed communities providing service

Program Area	Ongoing	Once or Twice a Week	Once or Twice a Month	Not Available	Total	% providing a service
Healthy Babies Programs	59	10	20	3	92	96.7%
Child Development Programs	48	12	30	4	94	95.7%
Crisis Intervention Services	61	3	23	7	94	92.6%
Parenting Skills Programs	41	4	41	9	95	90.5%
Mental Health Counselling	57	6	23	10	96	89.6%
Mental Health Public Education	31	5	42	13	91	85.7%
Suicide Intervention, Treatment, Aftercare	45	2	28	20	95	78.9%
Child Injury Prevention Programs	31	4	35	20	90	77.8%

Note: Respondents representing 141 communities participated in the survey. Not all respondents, however, completed all of the items in the survey. In the case of the item asking whether their community offered the services listed in Table 13, the respondents represented only 101 of the 141 communities.

In the case of the solvent abuse component, the majority of the First Nations and Inuit respondents, while acknowledging that solvent abuse is still a problem, even an urgent problem in some communities said that other addictions' issues – prescription drug abuse, gambling, hard drugs and alcohol abuse – are usually more pressing.

Meeting Needs and Priorities

While there is a consensus that the seven Brighter Futures and Building Healthy Communities components focus on real and current needs, the evidence gathered during this evaluation identified three sets of concerns about whether the components "meet" those needs and community priorities:

- A minority of the respondents believe that other health programs offer more appropriate vehicles for meeting the needs addressed by the healthy babies, child development, parenting and solvent abuse components;
- A majority of the respondents believe that the scope of the Building Healthy Communities components - mental health crisis management and solvent abuse - are too narrow; and
- A majority believe that the available funding is not enough to support the kinds of services needed to fully meet current and emerging needs.

Appropriate Vehicles: The respondents in site visits, key informant interviews and focus groups voiced a variety of opinions about whether the Brighter Futures and Building Healthy Communities initiatives were the most appropriate way of addressing child development, injury prevention, parenting, healthy babies and solvent abuse needs:

- Child development - A minority of the First Nations and FNIHB respondents believe that child development needs are, or should be, addressed through Head Start. The majority, however, see Head Start as only one element in their child development efforts, noting that the program has not been implemented in all communities and only serves children aged 6 and under.[53] A majority of the communities participating in site visits reported they were delivering child development-related activities, including a minority that used Brighter Futures resources to enhance Head Start programs.

  The survey found that 92 of the 101 communities represented by the respondents (Table 15, above) reported that they deliver child development services. It should also be noted that "providing child development services" was ranked as the second most important program goal for survey respondents (Table 16, below).

- Injury Prevention - A minority of the First Nations and Inuit respondents thought that child injury prevention could be adequately addressed through CPNP, community nursing, Head Start and/ or other programs. On the other hand, about half of the communities participating in site visits and 70 of the 101 communities represented by the survey respondents (Table 15, above) report that they deliver some level of injury prevention services.

53 In 2000-2001, Health Canada reported that there were 341 project sites nationally. Source: Health Canada. *Aboriginal Head Start On Reserve Program • 2000-2001 Annual Report*. 2003.

- Parenting - A minority of the First Nations and Inuit respondents suggested that Head Start and prenatal/postnatal programs were able to meet the goals assigned to the parenting skills component of the Brighter Futures initiative. The majority, however, reported that parenting programming and services remained important elements, even priorities, in their overall program. The survey found that 95 of the 101 communities represented by the respondents (Table 15, above) deliver parenting skills programs as part of their Brighter Futures activities.

- Health Babies - A minority of the First Nations and FNIHB respondents thought that CPNP services were addressing the healthy babies goals identified under the Brighter Futures initiative. About half of the communities participating in site visits reported using Brighter Futures funds to enhance CPNP programs, while a minority support healthy babies activities that they say would not be covered by CPNP. Interestingly, the survey respondents rated healthy babies services quite highly, both in terms of the number of communities delivering such programs (Table 13 above) and their "most important program goals" ranking. (Table 14).

- Solvent Abuse - A majority of the First Nations and Inuit respondents suggested that solvent abuse prevention services would be better delivered through NNADAP. This position is consistent with the 1998 NNADAP General Review recommended that "the solvent abuse program be integrated into the overall NNADAP program to enhance success of both programs." [54]

Table 14:Rank order of three most important program goals

	Level of Importance			
	1st	2nd	3rd	Rating
Promoting mental health services in the community	80	30	23	323
Providing child development programs	41	31	32	217
Providing "healthy babies" programs	23	27	15	138
Providing general crisis intervention services	15	23	33	124
Providing parenting skills programs	9	27	30	111
Providing suicide intervention	9	20	22	89
Providing solvent use prevention programs	2	17	18	58
Other	12	5	7	53
Providing child injury prevention programs	3	9	12	39

Note: Explanation of the ranking system: The survey questionnaire asked respondents to indicate whether they "strongly agreed," "agreed, "disagreed" or "strongly disagreed" that their community had the right program goals In the analysis of this data, "strongly agree" responses were assigned a value of 2, "agree" a value of 1, "disagree" a value of -1 and "strongly disagree" a value of -2.

54 Health Canada. *National Native Alcohol and Drug Abuse Program General Review*. 1998. P. 89

Scope: As noted earlier, the Building Healthy Communities initiative's mental health crisis management component is focussed on achieving three goals:

- *A reduction over the long term in the number of suicide attempts and other violent crisis situations as a result of prevention and health promotion activities currently underway through NNADAP, BF and FV.*

- *A reduction in the number of suicides and in the number of repeated attempts by the same individuals, through a multi-disciplinary approach to crisis intervention.*

- *Follow-up counselling for the affected individuals and their families to ease through a healing process and get them back and keep them on the road to recovery through an effective Aftercare Program.*

The majority of the respondents from both First Nations and Inuit communities and FNIHB believe the focus of the three goals is too narrow. Generally, they argue that the initiative's emphasis on crisis intervention in suicide and other violent incidents should be replaced with one that also supports programming responses to a full range of mental health/mental illness and healing issues.

While the evaluators did not ask respondents about their views on the contents of the Mental Wellness Framework prepared by the Assembly of First Nations, Inuit Tapiriit Kanatami, and First Nations & Inuit Health Branch in 2002, it is apparent from our interviews that the Mental Wellness Framework vision of mental health services better captures community hopes than does the mental health component of either the Brighter Futures or Building healthy Communities. The Mental Health Framework described the elements of a comprehensive program as follows:

I. Training / Capacity Building

Ongoing training and capacity building is recognized as an essential element of mental wellness services and where appropriate, accredited to meet minimum standards.

Skill development could include, but is not limited to, assessment and intervention techniques, program planning and case management, community development, promotion, prevention, assessment and intervention.

Options for delivering training are encouraged. This can include in-service training, on-the-job training, job shadowing, classroom training, skill and knowledge transfer through mentoring opportunities, accredited courses, the development and implementation of culturally appropriate curriculum, distance education programs, other information technology avenues for learning.

II Promotion / Prevention

Promotion and prevention activities include public education, awareness and community development activities taken to reduce health and social problems and to prevent the development of serious mental illness. Includes actions taken

to prevent problems from occurring, improve health and well-being and allow for the development of favourable conditions to encourage healthy lifestyles.

III Treatment

Treatment services must include the following components:

> *Early / Short Term Intervention: Includes early detection, screening and assessment of problems and immediate, short term intervention of problems as soon as they appear.*
>
> *Crisis Intervention: Including actions taken as an immediate response to crisis to stabilize and ensure the safety of the individual, family and community.*
>
> *Long Term Healing: Identification, assessment and treatment of identified mental wellness problems aimed at stabilising and providing long term solutions.*
>
> *Aftercare: Includes case management over time, long term interventions and follow-up, ideally situated within the community, to ensure continued stability and optimum quality of life.*

IV Rehabilitation

Life long learning and healing aimed at addressing long term developmental or acquired limitations to maximize quality of life.

V Evaluation

Ensuring program integrity and sustainability for all program elements, i.e. for training, promotion, prevention, treatment, and rehabilitation. This may include: developing and implementing standards of practice; developing and implementing roles and responsibilities, determining best practices; scope of duties; ensuring the implementation of safe and ethical guidelines; and ensuring that evaluation processes must be transparent at all levels. [55]

The challenge of meeting the Building Healthy Communities mental health crisis management goals was highlighted by the survey results. When asked whether they agreed that their community had the right programs in place to "intervene to reduce the number of suicide attempts and other violent crisis situations" or to "provide crisis intervention, aftercare and training for caregivers and communities to deal with crisis" the respondents tended to disagree (Table 15).

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55 *Mental Wellness Framework: A Discussion Document for Comprehensive Culturally Appropriate Mental Health Services in First Nations and Inuit Communities*. Mental Health Working Group – Assembly of First Nations (AFN), Inuit Tapiriit Kanatami (ITK), First Nations & Inuit Health Branch (FNIHB). 2002. p. 4-5.

Specifically, 25.5% of the respondents “somewhat” or “strongly” disagreed that their communities had the right programs to provide crisis intervention related services and about 24% disagreed that they had the programs to intervene in suicides attempts and other violent incidents. By way of comparison, only 7.8% of the respondents “somewhat” or “strongly” disagreed that their communities had the right programs to “increase awareness, knowledge and skills in mental health, child development, healthy babies, injury prevention and parenting skills

Table 15: Are the right programs in place?

	Rating
Increase awareness, knowledge and skills in mental health, child development, healthy babies, injury prevention and parenting skills.	270
Encourage and support the well-being of children, individuals and families through a community determined approach.	266
Improve the health of children by promoting better coordination of health services.	264
Assist children and parents to develop positive attitudes, values and skills that has relevance in their culture.	257
Provide culturally appropriate prevention and promotion activities in your community.	256
Improve the quality of, and access to, culturally sensitive wellness services at the community level to help create healthy family and community environments.	243
Support community development and provide opportunities for the community to find their own solutions to better health.	237
Help people get specialized counselling or treatment when they experience mental health problems.	236
Inform people about how to reduce the risk of children being injured.	223
Provide youth and families with alcohol, solvent, drug or substance abuse services and treatment when they need it.	205
Increase awareness and understanding about solvent abuse as well as offer alternatives for a healthier lifestyle.	179
Intervene to reduce the number of suicide attempts and other violent crisis situations.	157
Provide crisis intervention, aftercare and training for caregivers and communities to deal with crisis.	140

Funding: There was a broad consensus, approaching unanimity, among First Nations and Inuit respondents that the program components fail to meet the needs and priorities of communities because the funding levels are not sufficient. They pointed to a number of factors that contribute to the resource pressures they face:

- Growing community memberships as a result of high birth rates and the recognition of people who had previously been denied their status rights;
- Demographic changes including single parent and young families and the proportion of the population who are seniors;

- Non-aboriginal persons living on-reserve;
- As people have become more aware of health and healing issues, and the community environment has changed to support people who seek help, consumer demand for Brighter Futures, Building Healthy Communities and other health and wellness services increases;
- As the number of discrete health programs expand and more emphasis is placed on reporting and accountability for each of them, the planning, management and administrative burden on health directors and staff have increased significantly; and
- The staffing, training, support and infrastructure resources needed to establish and maintain effective mental health crisis management services are greater than the funding available to most communities.

Findings

- The Brighter Futures and Building Healthy Communities initiatives continue to address current health and wellness needs, recognizing that such needs vary from community to community.
- Although the goals of Brighter Futures components are similar to those of targeted programs such as CPNP and Head Start, the age criteria and other restrictions governing them are too narrow to address the community needs and priorities with respect to child development, healthy babies, parenting and injury prevention,
- While communities may allocate Brighter Futures resources to enhance ('top-up') activities that are primarily funded under another program, there is no evidence that there is duplication of the services that are delivered at the community level.
- In the case of Building Healthy Communities, it was identified that the solvent abuse component should be widened to substance abuse as not all communities are currently living with serious solvent abuse problems, but other types of substance abuse problems do exist in their communities.
- The crisis management component of Building Healthy Communities was identified as relevant and required, but difficult to address by most communities due to limited resources, capacity and/or access to training, as well as intervening factors including community size and relative isolation.

- The mental health crisis management component of the Building Healthy Communities initiative is too narrow in its emphasis on suicide and other violent crisis.

- There is a widely held view that the solvent abuse component of the Building Healthy Communities initiative should be integrated into the NNADAP program.

IMPLEMENTATION & MANAGEMENT

Evaluation Question #1.4

Are the programs' national and regional implementation, management and administrative procedures and structures reflective of, and appropriate to, the issues, needs and priorities of First Nation and Inuit communities?

Discussion

National

First Nation and Inuit health service personnel and other representatives have had little or no interaction with the national office with respect to the implementation or ongoing management of the Brighter Futures and Building Healthy Communities initiatives.

The majority of the FNIHB regional staff feel that the organization's headquarters is largely disengaged from the substantive aspects of developing, maintaining and managing health services and programs, including Brighter Futures and Building Healthy Communities. Instead, they report that the national office has focussed its energies and resources on accountability and financial control.

Following the roll-out of the Brighter Futures and Building Healthy Communities initiatives, the national office's role in ongoing management has largely been limited to budgetary and general oversight. By 1996, the majority of the responsibility for managing and delivering these and other community health funding programs was decentralized to regional offices. [56]

The process of decentralization was consistent with the central thrust of the health transfer policy: to significantly increase the degree of autonomy that First Nations exercise in the

56 1997 Report of the Auditor General, Chapter 13: Health Canada - First Nations Health, para.13.25

healthcare field. In response to this direction, FNIHB management, in March 1994, decided that the Branch would begin to plan all of its activities with the following goals in mind:

- *The devolution of all existing First Nations and Inuit Health Branch health resources to First Nation and Inuit control within a time frame to be determined during consultations with First Nation and Inuit communities;*
- *Moving Health Canada's First Nations and Inuit Health Branch out of the health care service delivery business;*
- *The transfer of knowledge and capacity to First Nation and Inuit communities so that they can manage and administer their health resources; and*
- *A refocused role for First Nations and Inuit Health Branch; and a refocused role for Health Canada which will take into account First Nations and Inuit Health Branch's strategic direction.* [57]

One of the consequences of the "re-focussing" of the Branch's role, according to FNIHB and First Nations key informants familiar with the developments through the mid-to late-1990's, was a move away from employing health professionals and toward the development of an operational culture that may have promoted a sense that FNIHB regional staff were to play diminishing roles in program management and delivery. One FNIHB employee recalls a senior regional manager advising staff in the mid-1990s that the Branch's goal was to "go out of business" before the end of the decade.

During this same period FNIHB, like other federal organizations, was attempting to "achieve results" within the budgetary constraints that were required by the Government's deficit reduction goals. Under these conditions, regional operations were allocated fixed budget envelopes with the flexibility to move resources between programs as necessary. Faced with ongoing commitments to maintain contributions to First Nations and Inuit communities and rising costs for Non-insured Health Benefits, FNIHB key informants indicate that there was considerable pressure to reduce staff and related operating costs.

Regional

The First Nations and Inuit representatives responsible for managing Brighter Futures and Building Healthy Communities report that the majority of their interaction with FNIHB regional office staff focuses on the administration of the annual funding cycle and reporting, including financial controls and audits. Consistent with this, the majority of their responses to questions about the regional office and the role it played in their programs typically turned to concerns about reporting requirements. In addition, a minority of the First Nations and Inuit respondents, notably individuals responsible for health services in smaller rural and semi-isolated.

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57 Health Canada. Ten Years of Health Transfer First Nation and Inuit Control, History of Transfer. /www.hc-sc.gc.ca/fnihb-dgspni/fnihb/bpm/hfa/ten_years_health_transfer/index.htm

communities, thought that FNIHB should be proactive in providing technical and consultative health service delivery and development support to First Nations and Inuit Communities.

Reporting: The 1997 Auditor General's report on Health Canada's First Nations programming highlighted deficiencies in the department's management of contribution agreements and other funding arrangements. It said, for example: "Based on our examination of programs delivered under separate contribution agreements, we found that once the contribution agreements are signed, the link between the Department and the community tends to disappear." The audit found that significant percentages of files lacked specific plans and activity reports. (Table 18). Based on these observations, the Auditor General said:

> *13.40 The Department should ensure that the contribution agreements are clear about specific objectives and activities that the First Nation will undertake. It should encourage First Nations to define measures of success.*
>
> *13.44 The Department should ensure that it receives the activity reports required under contribution agreements. It should work with First Nations to improve these activity reports so that they provide information on results achieved.* [58]

The 2000 Auditor General's follow-up report noted improvements, largely due to improved reporting on the Brighter Futures program (see Table 16), but continuing problems overall: “The success we noted in the Brighter Futures program needs to be carried over to other programs.” [59] The report also noted that, although the department had worked with some First Nations to obtain information on results, most of the reports were simply lists of activities. In response to the Auditor General’s recommendations that Health Canada should ensure that it receives all the required activity reports, and that it works with First Nations to improve the reports to obtain information on results, the department responded that it would:

> *[work] with First Nations to develop and implement tools to improve program reporting and completion rates. At the same time, the Department will continue to work with First Nations to find ways of developing the capacity to ensure that all communities are able to use the reporting tools and the data being reported and are capable of analysing the impact of activities on community health programs. Monitoring and follow-up requirements will be incorporated in the planned automation of the national contribution system to regulate the receipt of activity reports.* [60]

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58 1997 Report of the Auditor General, Chapter 13: Health Canada - First Nations Health.

59 2000 Report of the Auditor General of Canada, Chapter 15: Health Canada - First Nations Health: Follow-up. Para. 15.32

60 *Ibid*. para. 15.33

The file reviews and interviews conducted for the evaluation found no evidence that the planned reporting tools had been developed or implemented.

Table 16: Exhibit 15.4: Assessment of Contribution Agreements , 2000 Auditor General Report

Program	Agreements with clear objectives and activities for the specific communities		Agreements with activity reports	
	1997 Audit	2000 Follow-up	1997 Audit	2000 Follow-up
Community Health Representatives	15%	28%	39%	41%
National Native Alcohol and Drug Abuse Program	19%	28%	32%	44%
Brighter Futures	59%	61%	32%	71%
Building Healthy Communities	59%	50%	27%	48%
For all Programs	38%	42%	33%	51%

Reporting requirements vary from region to region with respect to their formats, the information to be provided and the level of detail to be included, as well as the nature and volume of supporting documents needed. The field work conducted for this evaluation did not include an examination of the degree of compliance with Brighter Futures and Building Healthy Communities reporting requirements in any region. The evaluators did note, however, that the reports from communities participating in site visits and operating under general contribution agreements can still be best characterized as lists of activities undertaken, providing little or no information on the results or outcomes of those activities.

The following reporting issues were identified by the First Nations and Inuit respondents representing non-transfer communities:

- Changes in requirements: In one region in particular, reporting requirements and formats were changed without notice, without amendments to the contribution agreements and close to the reporting deadlines. This placed unanticipated administrative burdens on the communities because staff required training to prepare the reports according to new FNIHB standards and, in some cases,

reports had to be re-written as the changes were only announced late in the process after staff had already written their reports.

- Financial details: In one region, First Nations and Inuit respondents reported that they were required to provide copies of invoices and receipts for every expenditure made on an activity by activity basis to support every interim financial report. The effort needed to file such reports, the First Nations and Inuit respondents said, was unnecessarily burdensome and often led to delays in payments.

- Volume of Reporting: While acknowledging the importance and benefits of program and financial reporting, a majority of First Nations and Inuit respondents felt that commutative volume of reporting under all the FNIHB programs was burdensome.

- Relevancy and Utility: A majority of the First Nations and Inuit respondents across the regions felt that program reporting was largely an irrelevant activity because the information they provided was destined only to be filed and was not used for any productive purpose.

Release of Funds: Program managers and administrators at the community level consistently report concerns associated with the delays in the release of funds at the beginning of each fiscal year under non-transfer arrangements. The difficulties are most severe for programs where the funds are transferred to the community through a regional or Tribal Council structure that does not have the resources to cash manage, or to assume the risk of releasing funds to the community before receiving transfers the government.

Technical Support: As already noted, a minority of the First Nations and Inuit respondents, particularly individuals with program management and planning responsibilities in smaller communities, thought that FNIHB could and should be more involved in providing technical and consultative support. Their perception is that, as the implementation of the health transfer policy has progressed, the regional offices have reduced their professional health staff complements and other resources that were once available to support First Nations and Inuit health services. They noted that the socio-economic circumstances and program infrastructures of communities vary and that some have greater need of support from the regional level then others. In the words of one respondent: "You cannot assume that because some First Nations are ready and willing to transfer that [FNIHB] support is no longer needed."

The following is a sampling of the activities that First Nations and Inuit respondents used as examples of the kind of FNIHB regional office support they are seeking:

- Facilitating events and networks that would provide First Nations and Inuit community health and wellness program managers and service providers with ongoing opportunities to share experience and lessons learned (national conferences, quarterly or semi-annual regional/district workshops dealing with issues identified by communities);

- Developing and maintaining a list of licenced mental health practitioners (Note: While it was not specifically referenced, the Saskatchewan regional initiative that solicited proposals from, and screened, mental health practitioners offering their services to First Nations, might be an example of such a service. The Manitoba region's Non-insured Health Benefits standing offer arrangements with a therapist could be another.);

- Developing and maintaining a list of qualified health and mental health program development, health planning and other consultants;

- Facilitating access to medical, child development and health care specialists who would be available for telephone or email consultations to assist in individual cases; and

- Working with First Nations and Inuit communities to introduce strategies to ensure political leadership, health directors and others have the planning and administrative skills and support structures necessary to deliver health services.

Findings

- The changes in FNIHB regional office resources, notably the reductions in professional health staff and program development resources, have limited FNIHB's capacity to provide program support to First Nations and Inuit health services.

- FNIHB's enhanced accountability measures are appreciated by First Nations and Inuit health service managers, except that the reporting requirements are onerous in relation to any benefits to either communities or FNIHB that the respondents have observed.

- Reporting requirements such as formats, content, and level of detail varied from region to region.

- In some instances, reporting requirements changed without consultation with communities and without modifications to contribution agreements creating additional administrative burdens on communities.

- Contribution agreements do not clearly identify the reporting requirements, leaving communities vulnerable to FNIHB changes.

- "One-size-fits-all" reporting requirements are not effective or appropriate when the value of Brighter Futures and Building Healthy Communities funding to individual communities varies from a few thousand dollars to more than a hundred thousand dollars,

- There is a lack of transparency in the administration of the Brighter Futures and Building Healthy Communities initiatives and programs.

PROGRAM ACTIVITIES AND OUTPUTS

Evaluation Question #1.5

Are the program's activities and outputs consistent with the programs' objectives and the intended outcomes?

Discussion

The Brighter Futures Framework and source policy documents for the Building Healthy Communities initiative identify three types of intended outcomes:

- Services - the development and delivery of services, programs, initiatives or strategies addressing the goals identified for each component;
- Behaviour - changes in individual, family and community behaviour, awareness or health status
- Training - training, cross-cultural orientation and support to increase the knowledge and skills of personnel involved in service delivery to First Nations and Inuit communities

The evaluation reviewed the activities, services and programs delivered by the First Nations and Inuit communities participating in the site visits to assess whether they are consistent with the initiatives' goals and intended outcomes. Specifically, it asked whether it would be reasonable to conclude that the activities would, or could, produce the intended outcomes. The evaluation does not consider the number of communities that provided any particular service or program, nor make any assumptions or claims about their effectiveness.

The tables included in this section identify, for ease of reference, the goals and intended service and behaviour outcomes for each of the components (see Section 3: Initiative Profiles) and a list of the kinds of "activities and outputs" that were described by the communities. Details of the activities and outputs can be found under the heading Services Activities, beginning at page 53, above. The question of training outcomes is treated separately.

Mental Health

As note earlier, the majority of the First Nations and Inuit communities participating in the site visits have not developed separate activities and programs to address the distinct, but related mental health objectives of the two initiatives. The descriptions of the communities' programs, however, do reveal two program orientations:

- The first focuses on interventions by professional and paraprofessional mental health staff and/or traditional healers to help individuals, families and groups at risk of, or suffering, a mental health-related problem to overcome the problem.

- The second emphasizes community development, community building and health promotion programs and activities to create conditions that foster healthy individual, family and community lifestyles.

These approaches are not mutually exclusive; indeed, the incorporation of both is a central theme of the *Framework for Mental Wellness*.

Elements of both approaches are evident in the Brighter Futures and Building Healthy Communities supported activities (outputs) delivered by the communities participating in the site visits (Table 17 & 18). Each of the activities can reasonably be seen to contribute to one or more of the identified goals and outcomes.

Table 17: Mental Health - Brighter Futures

Goal: To promote the development of healthy communities through community mental health programs.	
Intended Outcomes	**Activities & Outputs**
<u>Services</u> • A range of services, which could include facilitating referrals, intervention, prevention, counselling, treatment and aftercare support services. • Appropriate and adequate community resources and programs to deal with community mental health and child wellness issues. • Initiatives which address, in conjunction with other programs, the current high rate of suicide, homicides, acts of family violence, delinquency rates and hospitalization- institutionalization rates. <u>Behaviour</u> • An increased level of practice and awareness among community members of successful approaches to maintaining mental wellness, positive family relations,	• Purchase-of-service arrangements with licensed psychologists and social workers to provide regular counselling and assessments. • Information and awareness workshops to inform the community about the nature and consequences of mental health issues, available programs and services, and individual, family and community coping and prevention strategies; • Mental health and/or family service agencies. • Community mental health/wellness counsellors. • Women's and men's support groups. • Group and community recreational and cultural activities designed to promote overall community health. • Wellness and community building

Table 17: Mental Health - Brighter Futures

interpersonal communication, community relations and positive self-identity	activities and programs such cultural camps for youth; community events designed to celebrate cultural heritage and community achievements.

The activities delivered by communities under the mental health crisis management component re consistent with its goals and intended outcomes, as already reported. However, it must be noted that about half of the communities participating in the site visits do not have a formal crisis intervention protocol/plan in place. Further, some of the communities that do plans in place reported that their programs are do not meet the needs of the community or the crisis intervention teams.

Table 18: Mental Health Crisis Management

Goals: 1. To implement a Mental Health Crisis Management Program in First Nations and Inuit communities that will complement mental health prevention activities currently funded under Brighter Futures, NNADAP and FV. 2. To work in partnership with First Nations and Inuit communities, to provide them with the necessary tools to tackle the problems of hopelessness and suicide targeting communities most in need. 3. To provide crisis intervention, aftercare and training for caregivers and community members to deal with issues like suicide.	
Intended Outcomes	**Activities & Outputs**
• A reduction in the number of suicides and in the number of repeated attempts by the same individuals, through a multi-disciplinary approach to crisis intervention. • Follow-up counselling for the affected individuals and their families to ease through a healing process and get them back and keep them on the road to recovery through an effective aftercare program. • A reduction over the long term in the number of suicide attempts and other violent crisis situations as a result of prevention and health promotion activities currently underway through NNADAP, BF and FV.	• Community crisis intervention teams. • Purchase-of-service arrangements with licensed psychologists and social workers to provide assessment, crisis counselling, follow-up and after care. • Information and awareness workshops to inform the community about the suicide risk factors, indicators, intervention, prevention and treatment. • Community mental health/wellness counsellors. • Mental health and family service agencies. • Youth camps. • Group and community recreational and cultural activities designed to promote overall community health. • Wellness and community building activities and programs such as cultural

Table 18: Mental Health Crisis Management

	camps for youth; community events designed to celebrate cultural heritage and community achievements.

Solvent Abuse

The solvent abuse activities delivered by the First Nation and Inuit communities participating in site visits are consistent with the goals and objectives of the Building Healthy Communities initiative. It is noted that a minority of communities participating in the site visits reported delivering activities under this component. The only comprehensive prevention and early identification/intervention program identified during the community site visits is delivered by the Native Alcohol & Drug Abuse Counselling Association of Nova Scotia.

Table 19: Solvent Abuse

Goal: 1. Increase the ability of a community to identify issues surrounding solvent abuse and mobilize itself to respond appropriately to eliminate misuse. (Prevention and Community Development) 2. Identify, through a community-based method or system, those individuals who are in high risk situations and showing the early signs and symptoms of solvent abuse behaviour. (Early Identification and Intervention) 3. Establish a range of residential and community-based treatment resources (assessment, case management, detoxification, residential, day and outpatient treatment, long-term hospice care, group home/respite centre services, aftercare, emergency response)	
Intended Outcomes	**Activities & Outputs**
• None identified	• Community information workshops. • Information and awareness presentations and campaigns in schools. • Peer counselling programs training students to help themselves and other prevent solvent abuse. • Support for and participation in drug and alcohol awareness events. • Youth drop in centre providing information and referral services for personal problems including solvent abuse.

Child Development

Many of the child development activities described by the communities participating in the site visits targeted school age children. While child development programs and services are sometimes understood to be focussed on children ages 0-6, the Brighter Futures initiative does not impose such a limitation. Under these circumstances, the kinds of activities that were identified during this evaluation are considered to be consistent with the goals and intended outcomes of the child development component.

Table 20: Child Development

Goal: To enable First Nations and Inuit children to have a good start in their early stages of development and to ensure that they have the opportunity to achieve their full potential.	
Intended Outcomes	**Activities & Outputs**
<u>Services</u> • Development of culturally appropriate child development service models. • A range of child development services which could include: parent resource centres, toy lending libraries, infant stimulation programs, behaviour and developmental counselling involving parents and children, and also parents, children and educators. <u>Behaviour</u> • Strengthening of the First Nations and Inuit family.	• School-based programs promoting positive behaviour and staying in school. • Support for programs assisting school re-entry for students who have dropped out or been removed from regular education programs. • Funding and human resources to enhance Head Start programs. • Play and learning groups for pre-school children and their facilities. • Toy and document lending services. • Enhancements and support for Head Start programs. • School breakfast and lunch programs. • Encouragement of positive lifestyles through individual and group recreational and cultural activities. • Youth centres and after school programs. • Community events and activities to promote family involvement. • Educational assessments. • Counselling services for children and their families. • Summer camps.

Injury Prevention

Not all of the communities participating in community site visits deliver injury prevention activities through Brighter Futures. Where such services were delivered, the activities are consistent with the goals and objectives of the Brighter Futures initiative. It is noted, however, that the evaluation team did not identify any activities that would contribute to the establishment of "ongoing surveillance mechanisms to measure the incidence and prevalence of injury-related death and acute and long-term disability among First Nations and Inuit children."

Table 21: Injury Prevention

Goal: To reduce death and acute and long-term disability due to injuries among First Nations and Inuit children.	
Intended Outcomes	**Activities & Outputs**
Services • Establishment of on-going surveillance mechanisms to measure the incidence and prevalence of injury-related death and acute and long-term disability among First Nations and Inuit children. • Development of strategies to reduce the current high rate of severe injuries and death among First Nations and Inuit communities. Behaviour • Increased level of practice and awareness among parents, care givers, and community members of successful injury prevention and control programs.	• Community safety audits. • Bicycle safety reviews. • Water and boating safety programs. • Snowmobile safety education. • Promotion of the use of safety car seat for children and infants. • Halloween safety instruction. • First aid and CPR instruction for parents, community members and health promotion staff. • Baby sitting training.

Healthy Babies

The majority of the communities participating in the community site visits deliver healthy babies programs and services supported by Brighter Futures funds, often in conjunction with resources available from CPNP or other sources. The healthy babies activities identified during the evaluation are consistent with the Brighter Futures goals and intended outcomes.

Table 22: Healthy Babies

Goal: To improve the physical, mental, social, health and well-being of First Nations and Inuit mothers and infants.	
Intended Outcomes	**Activities & Outputs**
Services • Enhanced pre- and post-natal programs. Behaviour • Increased parental awareness of factors associated with healthy babies. • Sustained behavioural change which increase the incidence of breast feeding and reduces the incidence of low birth weight.	• Parent-tot programs. • Facilitation and support for pre and postnatal programs. • Support for CPNP activities. • Education about traditional birth and infant care practices and values. • Support for breast-feeding mothers. • Organization and promotion of well-baby clinics. • Promoting good nutritional services in daycare centres. • Training workshops to teach parents how to preserve and prepare nutritional means and foods, including traditional foods.

Parenting

The majority of the communities visited during the evaluation provide programs and services intended to help people develop or improve their parenting skills through training and educational opportunities A number of communities also offer counselling services for parents that are having difficulties or whose children are at-risk and/or programs to encourage family-oriented social and recreation activities. The parenting services and programs identified during the evaluation are consistent with the Brighter Futures goals and intended outcomes.

Table 23: Parenting

Goal: To promote culturally-appropriate First Nations and Inuit parenting skills.	
Intended Outcomes	**Activities & Outputs**
Services • Development of culturally appropriate and traditional parenting skills programs. Behaviour • Enhanced parental self-esteem which contributes positively to the physical, mental and social well-being of their children. • Increased awareness of positive traditional parenting skills.	• Structured parenting programs, such as Nobody's Perfect or locally designed programs, for parents with children of all ages; • Support groups for parents with special needs or whose children have special needs; • Respite services for parents at risk; • Family counselling; • Positive parenting workshops;

Table 23: Parenting

• Strengthening of the First Nations and Inuit family unit.	• Events and activities promoting family activities.

Training

The Brighter Futures Framework identified "training, cross-cultural orientation and support to increase the knowledge and skills of personnel involved in service delivery to First Nations and Inuit communities" as an intended outcome for each of the initiative's components. "Training community workers to provide the services [. . .] in conjunction with professional mental health caregivers such as psychologists" is an intended outcome of the Building Healthy Communities mental health crisis management component.

All of the communities participating in the site visits reported providing some training for their health care and mental health staff, largely through training workshops and courses such as grief counselling, suicide prevention, crisis intervention, critical incident debriefing, and facilitator training for programs like Nobody's Perfect. In Manitoba, initiative resources have been used to support the development of the First Nations Community Wellness Diploma program.

All of the reported training activities were directly related to the goals and intended outcomes of one or more of the Brighter Futures/Building Healthy components.

Findings

- Although the specific content and mix of programs and services vary greatly from one community to another, the Brighter Futures and Building Healthy Communities activities and outputs described by First Nations and Inuit service providers participating in the community site visits are reasonably related to the intended program outcomes.
- The majority of the communities have developed program approaches that simultaneously address the Brighter Futures initiative's community mental health goals and the Building Healthy Communities initiative's mental health crisis management goals.
- The mental health program developed by the First Nations and Inuit communities participating tend to reflect one of two broad orientations:
  - Clinical – services that focus on providing psycho-social treatment and/or traditional healing to individuals who have been identified by themselves or others as having some personal, emotional or family problem.

- Health Promotion/Community Development – programs that focus on providing educational, cultural, social and recreational services that promote individual resiliency and community-building.

PROGRAM LINKAGES AND PARTNERSHIP

Evaluation Question #1.6

With which national, provincial, territorial and community programs and services have the Brighter Futures and Building Health Communities been partnered?

Discussion

The community site visits did not identify any national or provincial/territorial partnership initiatives specific to Brighter Futures and Building Healthy Communities.

At the community level, partnerships with NNADAP, schools, law-enforcement agencies, childcare/protection agencies, and other community-based programs are common. In addition, at least six communities (Eel Ground; Burrard; North Battleford, Yellowknifes Dene, Golden Lake and Six Nations) have established formal working partnerships with regional/l district health care providers, such as hospitals.

A minority of the communities participating in the site visits have established or participate in formal planning and/or case management arrangements with local hospitals or regional health authorities. Eel Ground and neighbouring First Nations and the Miramichi Hospital, for example, have established a joint coordinating committee and First Nations patients liaison service.

Survey respondents were asked to identify whether they regularly participate in planning and/or case management activities with the staff of the other agencies and services. The responses reveal significant involvement with community health services (91.3%) and NNADAP (86.4%), but more limited involvement with policing services (48.9%) and provincial/territorial mental health services (48.9%).

The evaluation team identified one example of a First Nations-provincial government partnership that is linked Building Healthy Communities and Brighter Futures goals - Ontario's Aboriginal

Healing and Wellness Strategy. The program is directed by a Joint Management Committee that is made up of co-chairs, 18 representatives of First Nations/Aboriginal organizations, and

an Elder and 8 representatives of the participating provincial ministries Community and Social Services, Health and Long-Term Care, the Native Affairs Secretariat, and Ontario Women's

Table 24: Frequency of planning/case management activities

Activities	#
Community health services	166
NNADAP	159
Schools	145
Addiction services	132
Canada Prenatal Nutritional Program (CPNP)	131
Fetal Alcohol Syndrome (FAS)	125
Childcare/ child development program	121
Solvent abuse program	99
Child protection services	95
Policing services	92
Provincial/territorial mental health services	90
Other	49
None	1

Directorate).

The organization's describes its mandate as follows

> *The Aboriginal Healing and Wellness Strategy responded to the identified issues through the development of two related components.*
>
> *The Strategy has fostered community-designed and delivered programming using both immediate and long-term measures. It includes preventing family violence through community awareness, education and counselling; providing crisis intervention for women and children at risk; and addressing underlying mental/emotional issues that contribute to violence and dysfunction.*
>
> *The Strategy has designed a framework to improve Aboriginal Health by establishing programmes and services that deliver culturally-appropriate and community-based primary care, health education and outreach; support crisis intervention teams (to respond to high rates of suicide) and substance/solvent abuse treatment centres. This framework includes mechanisms to improve access to health services by establishing translation services, out-patient medical hostels, and health advocacy, and by identifying legislative, policy and program barriers which affect Aboriginal health.*
>
> *In addition, the Strategy promotes networking and integration. This includes promoting co-operation among communities to*

maximize use of resources. Linkages among Aboriginal programmes and between Aboriginal and non-Aboriginal communities are encouraged to enhance continuity and reduce duplication. An Information Clearing House has been established to collect and disseminate Aboriginal-specific information on health and family violence. A co-ordination office has been established to facilitate recruitment of professional staff for Aboriginal Communities in health and social services fields.

Among other things, the Strategy supports "community wellness workers" who develop and deliver local programming to reduce or prevent family and community violence in about 75 First Nations communities and a Healthy Babies/Children program that is intended to "improve the long term health prospects of children aged 0 - 6 years" through "pre-and post-natal screening and assessment, home visiting, service co-ordination and support for service integration."

Findings

- Communities are more likely to establish partnerships at the community level with other programs and service delivery agents.
- A minority of the communities participating in community site visits have established partnerships with other Aboriginal communities, usually through Tribal Councils, for the delivery of Brighter Futures and Building Healthy Communities services.
- Fewer than 15% of the communities visited had established formal working relationships with local hospitals or "regional" health boards.
- There was only one instance of provincial level partnerships and linkages identified within the sample of communities participating in site visits - Nunavik Regional Board of Health and Social Services.

PROGRAM RELEVANCE

Evaluation Question #1.7

To what extent are the objectives and mandate of the program still relevant?

Discussion

First Nation, Inuit and other health services personnel working in the communities see all five components of the Brighter Futures initiative and the mental health component of the Building Healthy Communities initiative as having continuing relevance in the development and delivery of community health/community wellness services. The majority of these respondents were vigorous in their advocacy of this view, arguing that they need greater investment, not less, in the programs and activities they are now able to deliver under the program.

It is noted that the general orientation, principles and goals of the initiatives are consistent with the characteristics of effective Aboriginal health services identified by researchers. Lemchuk-Favel and Jock, for example, report that responsive, sustainable, accessible, and client-focussed Aboriginal health systems share these characteristics:

- *Self-empowerment - Aboriginal ownership and control of health services:*
- *Holistic Approach - Holism and wellness are integrated into community program design, from patient care through to administrative integration of health and social services and integrated planning with housing, training, justice, and corrections, schools and other community-based services.*
- *Synergy of Traditional and Western Health Philosophies - Traditional healing practices may be combined with western medical approaches to develop uniquely Aboriginal health care approaches.*
- *Primary Care - The health system is organized around primary care delivered by multi disciplinary teams with linkages to external health resources.*
- *Collaborations With Provincial Services - Working linkages exist with external health care systems (provincial/territorial).*
- *Integrated Health Service Delivery - Partnerships between Aboriginal communities exist where they can achieve economies of scale.*
- *Administrative Reform - The health system is accountable to both the community and the funders.* [61]

The Regina-Qu'appelle Health Region commissioned two "best practices" papers. One analysed the best practices associated with "centres of excellence" and the other the best practices of leading Aboriginal health and healing programs in Canada. In its report "Improving *First Nations and Métis Health Outcomes: A Call to Collaborative Action," the region says that the best practices that apply to Aboriginal health and healing programs are:*

61 Lemchuk-Favel L & Jock R. *Aboriginal Health Systems in Canada: Nine Case Studies*. Journal of Aboriginal Health. January 2004. 28-51

- *The Goal is Equity - The program strives to achieve equitable health and social outcomes for Aboriginal people. Roles and group processes are based on equity and fairness;*

- *The Underlying Concept of Health is Holistic - All aspects of the program are based on a holistic concept of health that 1) takes into account physical, emotional, mental and spiritual dimensions of health, and 2) recognizes the interconnectedness of individuals, families, communities, and the environment;*

- *The Programs are Rooted in Culture - All aspects of the program (staffing, facilities, governance, programs, etc.) recognize and affirm Aboriginal cultures and identity. This includes the active involvement of Elders and traditional healers, and the importance of traditional healing and indigenous knowledge to the endeavour;*

- *The Strategies are Founded on a Recognition of the Importance of Cooperation and Partnerships - All aspects of the program recognize and affirm that interdisciplinary, multi-sectoral cooperation and partnerships are the foundation for successful Aboriginal health and healing initiatives.*

- *The Community has Voice - Programs are community-based, they reflect the priorities of the community, and they are accountable to the community. Policies and governance assure not only community involvement, but community voice and community responsibility for program directions.* [62]

Findings

- Respondents feel that, overall, the objectives and mandate of the initiatives are still relevant to their community.

- The Brighter Futures/Building Healthy Communities "approach," which allows the programs to be community-based and community-paced, was supported by all First Nations and Inuit respondents and by the literature review.[63]

- A majority of all respondents feel that a more comprehensive and holistic approach to mental health is needed than what is outlined in Building Healthy Communities.

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62 Regina Qu'Appelle Health Region. *Improving First Nations and Métis Health Outcomes: A Call to Collaborative Action.* 2000.

63 See Appendix C.

Section 5: ISSUE #2 - - - SUCCESS

This section discusses the degree of success that the First Nations and Inuit Health Branch has achieved in the national and regional implementation of the two initiatives. It also looks at the extent to which the initiatives have been implemented in a manner consistent with stated goals and principles, and delivered benefits consistent with their intended outcomes for First Nation and Inuit children, families, and communities, including intended outcomes in the areas of community participation, capacity building, flexibility, and training.

NATIONAL IMPLEMENTATION

Evaluation Question #2.1

Was the roll-out at the national level successful in providing the Regions with the resources and support needed to deliver the program to potential project holders?

Discussion

Only a small minority of respondents in the key informant interviews were familiar with the national level implementation strategy. Those that were observed that headquarters had played a beneficial role in the first few years following program implementation, but that its contribution since the mid-to late 1990s has been confined to resource allocation and the introduction of improved accountability measures for all FNIHB funding programs.

Finding

- It was found that headquarters played a positive role in the programs' roll-out but that it has not recently played an active supportive role in terms of Brighter Futures/Building Healthy Communities.

REGIONAL IMPLEMENTATION

Evaluation Question #2.2

Was the roll-out at the regional level successful in providing project holders with the resources and support needed to deliver the program First Nation and Inuit communities and their members?

Discussion

Once again, only a minority of the respondents were familiar with the implementation of programs in the early and mid-nineties and this group tended to be positive in its assessment of the initiative's implementation.

Overall, however, First Nations and Inuit health service respondents report that the regional contribution to program development at the community level has been low to negligible for the past several years. One exception to this generalization is the Manitoba region that has maintained regional-First Nations consultative and planning structures with particular emphasis on mental health issues and training for First Nations service providers.

FNIHB regional offices experienced significant resource cuts since the mid-nineties due to a refocusing of the department's approach to delivering health services to First Nations and Inuit communities. Both community representatives and FNIHB staff voiced the opinion that the staff reductions had a negative impact on the regional offices' capacity to support communities in the delivery of their programs.

It was also reported that the changes in the FNIHB role from service provider to funding manager over the past decade has significantly reduced its capacity to provide technical health and heath planning support to First Nations and Inuit communities and health services organizations.

Findings

- The regions played a positive role during the initiatives' roll-out, but a majority communities report that they now receive little support from the FNIHB regional offices.
- FNIHB regional office staff reductions since the programs' inception, especially in terms of professional health staff, limits its capacity to support the communities for the delivery of the programs.

PROGRAM PRINCIPLES

Evaluation Question #2.3

Do projects and services respect the program's six stated principles?

Discussion

The development and delivery of the Brighter Futures and Building Healthy Communities initiatives respect the six program principles set out in the 1992 Program Framework:

- Strengthening and supporting the Child/Family/Community through a holistic approach;
- Community-Based;
- Community-Paced;
- Continuum of Care;
- Community-Wide Participation; and
- Coordination and Linkage of Program Activities.

Strengthening and supporting children, family and community through a holistic approach

The concept of a “holistic approach” is not defined in any of the Brighter Futures and Building Healthy Communities policy or program documents except that the coordination and linkages’ principle says that it is “best accomplished when program elements are coordinated and linked not only with each other, but with other [. . .] programs.” In practice, the people interviewed for this evaluation understood the term “holistic”as referring to approaches that respect and incorporate First Nation and Inuit cultural values and traditions.

The majority of First Nations and Inuit and FNIHB respondents said that Brighter Futures and Building Healthy communities do respect the holistic principle in this sense. According to respondents, culture and tradition are incorporated in programs in three ways. The most common practice identified during site visits is to involve respected Elders as teachers and guides in developing and delivering community wellness workshops, support groups, parenting programs, prenatal courses, youth and other programs. Elders also serve as mentors for health services staff. A minority of the communities report involving traditional healers and healing practices in counselling services, as, for example, the Sagkeeng First Nation has.

The survey asked Brighter Futures and Building Healthy Communities workers (n: 109) to indicate how often their program or service includes traditional activities. The responses (Table 25) indicate that the majority of the 101 communities represented in the sample regularly involve Elders at least once a month. A significant proportion (37.6%) have programs that make regular referrals to traditional healers.

Table 25: Frequency of Traditional Activities

	Ongoing	Once or twice a week	Once or twice a month	Not available	Missing
Elders providing counselling and advice.	45 (41.3%)	2 (1.8%)	28 (25.7%)	19 (17.4%)	15 (13.8%)
Teaching traditional arts and skills.	39 (35.8%)	4 (3.7%)	28 (25.7%)	9 (8.3%)	29 (26.6%)
Referrals to traditional healers.	41 (37.6%)	2 (1.8%)	16 (14.7%)	19 (17.4%)	31 (28.4%)
Other traditional knowledge and practices.	31 (34.9%)	3 (1.8%)	12 (14.7%)	7 (18.3%)	56 (30.3%)

In addition to involving Elders in health and wellness programs, a minority of the participating communities allocate Brighter Futures resources to activities designed to educate children, youth and adults about their community's history, culture, medicines and language. For example, Inuvik communities organize programs that see Elders teaching traditional hunting and survival skills and the Kahkewistahaw First Nation organized a 17-week program teaching young girls traditional shawl making. As well, many health service programs report that they contribute to organizing traditional events and ceremonies, helping to maintain their culture as a normal and integral part of community life.

Finally, the majority of the participating communities give priority to employing health care staff who are members of their own or another First Nation/Inuit community.

While the majority of the respondents equated "holistic" with incorporating culture and traditional practices in their programs, a minority also referred to having adopted "wellness" and community development models in their overall health program planning and delivery. The descriptions of the wellness programs emphasized activities that balance physical and mental health interventions with activities that aim to help individuals, families and communities maintain and build on their strengths.

This approach is consistent with the focus on "community wellness" that is part of the description of the holistic principle. It is also consistent with the conclusions and observations of a number of researchers, including Chandler and Lalonde whose study of youth suicides in BC First Nations found significant linkages between the mental health status of community members and the degree of self autonomy that the community has achieved in terms of public services, including health services, cultural institutions and government, [64] and Kirmayer, Brass

64 Chandler MJ. and Lalonde C. "Cultural continuity as a hedge against suicide in Canada's First Nations." Transcultural Psychiatry 35.2 (1998): 191-219.

& Tait whose research among the Cree in Québec found that individuals who experienced "good relationship with the community" were less likely to experience distress .[65] The potential of a wellness/community development model is suggested by the conclusions reached by Elias and Greyeyes:

> *We are of the opinion that no amount of clinical intervention, or awareness-raising, or public and professional education, or workshops, or conferences, or manuals will change these hopeless conditions. All of the activities may [be] necessary to respond to the current crisis, but at best they can only ameliorate the situation for people who are casualties from years of neglect. In our opinion the real solution to this desperate situation is the transformation of communities so that they provide children with security, belonging, opportunities for learning and growth, and help with daily challenges and disappointments, and become safe places where everyone may belong and feel accepted, and have opportunities to learn, to be productive, to be recognized and appreciated, to be creative, to experience intimacy, and to enjoy special interests and past-times. There is no quick fix or easy solution. The situation calls for a long-term developmental undertaking.* [66]

Community-based and Community-paced

The "community-based" and "community-paced" principles are examined in detail under the heading Flexibility, page 114. The discussion there concludes that First Nations and Inuit community programs and activities respect both principles.

Continuum of care

The Framework says a "continuum of care is a range of programming from promotion and prevention to treatment, support and aftercare." While a majority of the respondents reported that First Nations and Inuit communities delivered services that respected the continuum of care principle, the minority raised concerns about their ability to do so because of funding limitations. The consensus of opinion might best be summarized as confidence in the ability of First Nations and Inuit communities to deliver a continuum of care, subject to a number of qualifications.

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65 Kirmayer LJ, Brass GM, Tait CÉCILE LEBLANC. The mental health of Aboriginal peoples: transformations of identity and community. Can J Psychiatry. 2000 Sep; 45(7):607-16.

66 Elias JK and Greyeyes BJ. An Environmental Scan of Mental Health Services in Firs Nations Communities in Canada for the Assembly of First Nations. 1999. P. 35

The first qualification, the one most frequently identified by First Nation and Inuit respondents, is the lack of sufficient funds to implement and maintain the required services, especially in more rural, isolated and remote communities that cannot readily access provincial/territorial hospital and community treatment programs or the specialized aftercare support services that may be needed.

In the North, a number of respondents said that, in addition to the challenges imposed by the levels of available funding, the one-year term of the contribution agreements prevent communities from undertaking long term planning, hindering their efforts to implement services that provide a continuum of care.

A second qualification is that, whether urban or rural, a significant minority of First Nations and Inuit communities report that provincial/territorial health services, particularly psychiatric-mental health services, are either unresponsive to the residents of First Nation and Inuit communities, or the interventions are insensitive to the cultural and social needs. In addition, few communities have access to programs and services for children dealing with severe developmental problems.

The ability of some communities to deliver a continuum of care in mental health is also limited because they have not developed or have difficulty maintaining effective crisis intervention and management programs.

Kirmayer et al highlight the continuum of care challenge facing First Nation and Inuit communities. They reviewed research literature to identify effective suicide prevention strategies for First Nations and Inuit communities in Québec and concluded that effective suicide prevention has to be part of a "multi-faceted mental health promotion strategy that is the responsibility of the whole community" with a central coordinating capacity. More specifically, it says that effective primary suicide prevention programs in First Nations and Inuit communities should include:

- Training youth to act as peer counsellors;
- A school curriculum with mental health and cultural heritage components;
- Recreational and sports programs;
- Workshops on life skills, problem solving, and communication;
- Parenting skills workshops;
- Support groups for individuals and families at risk;
- Cultural programs for the community at large;
- Collaboration between community workers in health, social services and education; and
- Training in mental health promotion for lay and professional helpers.

In addition to these activities, the researchers recommend that intervention services should be part of the prevention strategy and that the intervention component provide training for primary care providers; a regional crisis hotline; immediate crisis intervention services; and, assessment and intervention services for the parents of youth at risk.

Community-wide participation

The intent of "community-wide participation" principle is that all community members be involved in Brighter Futures and Building Healthy Communities program development and implementation. A minority of the communities participating in the site visits report regular participation in the form of volunteer work in planning and delivering specific activities, and to a lesser extent in program development.

Coordination and linkage of program activities

The coordination principle calls for the program component to be "coordinated and linked not only with each other, but with other community-based programs such as family violence, substance and alcohol prevention and treatment, and other social, health and educational programs." As described under the heading Program Linkages and Partnerships, page 94, survey respondents and participant in site visits, key informant interviews and focus groups report that Brighter Futures and Building Healthy Communities activities are commonly linked to other community services, especially NNADAP, schools, child and families services, and social services, as well as police and safety services.

In addition, a majority of the First Nations and Inuit communities participating in the site visits have assigned the responsibility for developing and delivering Brighter Futures and Building Healthy Communities activities to their health centres or agencies, a circumstance that activity promotes coordination and integration of the initiatives' components with each other and with other health services.

Findings

- Overall, the projects and services respect the programs' six stated principles.
- A community's capacity to deliver a continuum of care is linked directly with its financial resources, especially for the smaller communities and, in some cases, its capacity is hindered (but not prevented) by the one-year term of funding which limits their capacity to implement long term plans.

COMMUNITY PARTICIPATION

Evaluation Question #2.4

Have First Nations and Inuit community participation levels in the Brighter Futures and Building Healthy Communities projects in their communities increased?

Discussion

Respondents in interviews conducted during site visits and those participating in focus groups spoke of community participation from two perspectives:

Participation in planning and delivering programs and activities: A minority of communities report increased participation in the form of volunteer work in planning and delivering specific activities, such as community-wide cultural events, workshops, school programs, etc. A majority of the communities reported their programs have not been designed to promote volunteer involvement.

Participation as consumers of programs and services: A majority of the communities report continuing increases in participation as measured by caseload statistics, workshop attendance, registration for parenting programs, etc. This is attributable to factors such as increased trust in the availability of services and programs offered at the community level, services that are tailored to community needs and requirements, and increases in the community's population.

A significant minority of the participants in community site visits reported that, in their experience, consistency and continuity were critical factors in promoting participation; that people needed to see that the service providers are committed to carrying through on their projects. In their view, it was necessary to allow people to develop confidence in them and their services through hearing positives from those who have already participated.

The survey asked Brighter Futures and Building Healthy Communities workers to indicate whether the number of people using programs and services under each of the initiatives' components had changed over the past five years (Table 26). The survey respondents generally agree with the views expressed by those participating in community site visits, key informant interviews and focus groups - demand for services has increased, especially with respect to mental health, healthy babies, child development and parenting skills.

Table 26: Trends in program participation of 5 years.

	Increased	About the same	Decreased	Don't know	Missing
Mental Health Services	78	14	3	5	24
Healthy Babies	75	18	2	5	24
Child Development	71	23	1	4	25
Parenting Skills	69	19	4	8	24
Crisis Intervention	57	30	2	10	25
Solvent Abuse - Prevention	45	33	4	15	27
Injury Prevention	39	32	2	23	28

Overall, respondents were most likely to report increased participation in health promotion and wellness activities and most likely to report decreases in participation in crisis intervention, solvent abuse and injury prevention activities and services.

Findings

- Participation in programs and services under all Brighter Futures/Building Healthy Communities components has increased in recent years, especially in community wellness programs.
- Community participation is closely linked with consistency in services and service providers as well as positive word of mouth from past participants.

CAPACITY BUILDING

Evaluation Question #2.5

Have the project holders received the knowledge and support to adequately address each of the identified program objectives?

Discussion

During the implementation of the Brighter Futures program (1992 to 1994) Health Canada's regional offices provided First Nations and Inuit program planners a measure of support, such as model curricula for parenting and community awareness programs, and opportunities for

training. However, the level of support for capacity building at the community level has diminished greatly since the mid-1990s. Currently, only the Manitoba region supports a training and planning strategy that involves many, but not all of the First Nations communities in that region.

Information gathered during community site visits and key informant interviews revealed little interaction between FNIHB personnel and community program managers and workers outside of contacts and interactions required in the administration of the funding arrangements. At the same time, about half of the respondents, especially those working in smaller communities, felt that FHINB could make a positive contribution to their communities and their programs by providing technical and advisory assistance in areas where they themselves lacked knowledge, experience, and skills.

It is noted that the Auditor General also saw a need for FNIHB to provide more support to "build First Nations' capacity to meet their reporting requirements." [67]

Some of the capacity building needs identified by the First Nation and Inuit respondents centred on direct services, most notably, the need to train First Nations and Inuit workers. Others identified needs around program management and development: creating opportunities for communities to share experience and lessons learned with other First Nations and Inuit health care providers; and help identifying and recruiting appropriate and effective external resources such as therapists, experts to participate in workshops, or consultants to assist in program development; administrative and management skills and others.

In general terms the smaller the community and more distant it is from an urban centre that has a variety of post-secondary education institutions and other "capacity builders," the more likely it is that the community health staff will report a need for increased support to off-set the gaps in their knowledge and skills.

To say that a person or group has the capacity to do something means that they have not only the appropriate knowledge and skills, but the right tools, organizational infrastructure, facilities, etc. For example, health promotion programs need reliable access to more than individual offices and examination rooms if they are to deliver community education programs and facilitate group activities. First Nation and Inuit communities, especially smaller and more rural/remote communities often lack the tools, infrastructures and facilities they need to deliver quality health care and health promotion/wellness programming.

Findings

- Communities with limited capacity in health and wellness programming tend to look to FNIHB for support.

67 2000 Report of the Auditor General of Canada, Chapter 15: Health Canada - First Nations Health: Follow-up. Para. 15.32

- The gaps in the health program development and delivery capacities of communities is greatest in more remote communities, but is also a significant issue in smaller, rural communities.

COMMUNITY OUTCOMES

Evaluation Question #2.6

What community benefits and broader outcomes, both intended and unintended, resulted from delivering the program?

Discussion

In the absence of performance measurement standards and reporting systems, program managers and service providers in the communities where site visits were conducted provided anecdotal information about program benefits and outcomes. The following is a sampling of frequently referenced benefits:

- Community residents have a better understanding of mental health and other health issues, they are more prepared to the talk about them and to seek assistance was necessary;
- More parents are participating in programs with kids – more parental involvement;
- It is increasingly likely that fathers, as well as mothers, participate in parenting workshops and functions;
- People in the community have a sense of ownership in health services;
- Registrations and caseloads for health promotion, family and mental health services that are delivered in communities are steadily increasing;
- More youth are completing high school education;
- Communities and their political leadership are more willing to recognize and work toward addressing community health and mental health issues; and
- Stronger sense of community/community empowerment.

In order to assess the degree to which community programs have contributed to the achievement of initiatives' outcomes, the survey asked program administrators and workers involved in the delivery of Brighter Futures/Building Healthy Communities programs and services in First Nations and Inuit communities whether they 'strongly agreed,' 'somewhat agreed,' 'somewhat disagreed,' or 'strongly disagree' that specific positive outcomes have been achieved. The responses were strongly positive overall, with 75 to 90% of the respondents indicating that they 'strongly agreed' or 'somewhat agreed' that the improvements have taken place.

Looking at the range of outcomes that were identified in the survey, respondents were most likely to express the opinion that significant improvements have been achieved in the promotion of the health of infants and children (56.8% strongly agree), greater support for programming in response to a health need by community leaders and human service organizations (52.1% strongly agree), and better general health services in the communities (51% strongly agree).

Keeping in mind that the overall responses indicate a strong belief that there has been general improvements over the past 5-10 years, it is noted that respondents were least likely to express strong agreement that with the following statements:

- Overall, the community has better mental health services. (33.9% strongly agree).
- The community is better able to deal with threatened or attempted suicides. (32.6% strongly agree).
- Overall, community members know more about what can be done to have good mental health and how to get help if they need it. (24.9% strongly agree).
- The community is better prepared to organize and deliver community-based mental health crisis management programs, should the need arise. (23% strongly agree).

The development and maintenance of First Nations and Inuit health and mental health programs are the intended outcomes of each of the Brighter Futures and Building Healthy Communities program components. For this reason, the survey asked respondents whether their community had the right programs in place to address the components. The responses reveal that program administrators and workers have a generally high level of confidence that the right programs are in place to address the components.

The rankings indicate that the respondents are reasonably confident that their communities have the right programs in place to address and promote general community wellness:

- Increasing awareness, knowledge and skills in mental health, child development, healthy babies, injury prevention and parenting skills.
- Encouraging and supporting the well-being of children, individuals and families through a community determined approach.

- Improving the health of children by promoting better coordination of health services.
- Assisting children and parents to develop positive attitudes, values and skills that have relevance in their culture.
- Providing culturally appropriate prevention and promotion activities in your community.

The respondents were least likely to agree that the right programs were in place to:

- Increase awareness and understanding about solvent abuse as well as offer alternatives for a healthier lifestyle.
- Intervene to reduce the number of suicide attempts and other violent crisis situations.
- Provide crisis intervention, aftercare and training for caregivers and communities to deal with crisis.

Findings

- The lack of standardised performance measurement and reporting systems and baseline data do not allow for the quantitative assessment of the degree to which the Brighter Futures and Building Healthy Communities programs may have succeeded or failed in achieving their intended outcomes.
- The majority of First Nation and Inuit respondents report that their Brighter Futures and Building Healthy Communities programs have produced positive outcomes in terms of general individual, family and community health, as well as in terms of establishing appropriate health and wellness services.
- Despite an overall confidence in their programs, the opinions expressed by First Nations and Inuit respondents in interviews and the survey indicate that they have significantly lower levels of confidence that mental health and crisis management services are the right ones for their communities or that they are producing the kind of positive individual, family and community outcomes they should.

TRAINING

Evaluation Question #2.7

Did community, health, child worker and other personnel receive appropriate and accredited training; and did that training increase their capacity to respond to identified needs?

Discussion

The experience that communities have had with respect to obtaining training and other forms of support and development for health services personnel appears to be a function of community size and resource base. Larger communities, those with populations of 2,500 or more, have been relatively successful in attracting accredited health and mental health personnel and ensuring that they have access to continuing training through workshops, conferences and the like.

Smaller communities, especially those with fewer than 1,000 population, have difficulty attracting qualified personnel and, because the staff most often function in a variety of roles, face significant challenges in identifying appropriate training opportunities. When opportunities are identified, the lack of backup personnel to relieve staff while they attend training and limited funding make it difficult to take advantage of training opportunities.

By and large, the training opportunities that have been available to Brighter Futures and Building Healthy Communities community workers are short, specialized courses, such as crisis intervention, critical incident debriefing, facilitator training for package programs, such as Nobody's Perfect, grief counselling and the like. Very few of these training packages were designed to prepare workers to deliver culturally appropriate health services in First Nation and Inuit communities. Fewer yet lead to any form of accreditation.

There have been a number of initiatives undertaken to develop certificate, diploma and degree level training for aboriginal social work and counselling staff at educational institutions across the country. A leading example of such initiatives is the First Nations Community Wellness Worker Diploma program offered by the University of Manitoba in a partnership with the Manitoba Community Wellness Working Group that was established by the Assembly of Manitoba Chiefs.

While concerns about the availability of appropriate training are common, the majority of survey respondents strongly or somewhat agreed with the statements that said that health-care and mental health staff is better trained and qualified then they were 5-10 years ago.

The literature reviewed for the evaluation identified some of the training challenges that First Nation and Inuit respondents in this evaluation talked about:

- An Aboriginal Nurses Association survey of its members reported that Aboriginal nurses deal with critical mental health issues, alcohol and substance abuse issues, violence, abuse and post-traumatic effects, issues that are not effectively addressed through existing nursing training and professional development. [68]

- Minore and Boone, based on their research in Northern Ontario, concluded those existing training programs for health personnel, which concentrate on developing clinical skills, but do not prepare students to actually function in First Nation health care services. They argued that professional training needs to be adapted to "ensure that the full potential of the health human resources available – professional and paraprofessional – are realized and applied to meet the needs of otherwise under-served client populations." [69]

- Hogan and Barlow reviewed the outcomes of counsellor training programs that had been delivered in two First Nations in southern Alberta. The researchers noted that the past educational experiences of students, especially their residential school experience, was a matter that had to be addressed in training program design and delivery. This, the authors say, would include processes and opportunities for student healing within the training curriculum. They also noted that issues surrounding the tension between the desire to preserve traditional culture while simultaneously participating in mainstream education had to be addressed.

- Clements's research, which focussed on the training needs of First Nations mental-health workers in Manitoba. identified six areas that a curriculum would need to cover: counselling skills; mental health theory and practice; writing and agency skills; public education skills; community development skills; and spiritual/traditional training. The research also pointed out that community mental health workers in First Nations also need continuing working relationships with their community team (Elders, the general public) and also with mainstream mental health specialists for ongoing training supervision and consultation. [70]

- The report of Health Canada's Manitoba Region's Mental Health Services Review reported that acceptable training opportunities were available to First Nations health/wellness workers, but there were a number of impediments to

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68 *Aboriginal Nursing Educational Needs Analysis: Results of a National Survey (Final Report)*, Aboriginal Nurses Association of Canada, Ottawa, October 2002

69 Minore B, Boone M. *Realizing potential: improving interdisciplinary professional/paraprofessional health care teams in Canada's northern aboriginal communities through education*. Journal of Interprofessional Care.Vol 16(2) 2002. p. 139-47.

70 Clements K. *Assessing the Training Needs of First Nations Mental Health Workers in Manitoba* (Master's Thesis , Dept. of Anthropology , University of Manitoba) 1997

training, including financial restraints and the difficulty of scheduling training when workers had no backup. [71]

Findings

- There is an ongoing, but unmet, demand for professionally trained First Nation and Inuit health and wellness workers.
- There are few reasonably available opportunities for currently employed community workers to obtain training leading to accreditation.
- The First Nations Community Wellness Worker Diploma Program is a model for First Nation-educational institution-government partnerships to deliver culturally appropriate and accessible training in the health field.

FLEXIBILITY

Evaluation Question #2.8

Were the programs flexible, community-based and community-paced; and did making the program flexible, community-based and/or community-paced affect the results and impacts of the delivery of the program?

Discussion

There is a broad consensus that FNIHB and First Nation and Inuit communities have administered Brighter Futures and Building Healthy Communities programs in a manner that was flexible – that promoted community-based and community-paced program design and delivery. The majority of the key informants and the participants in community site visits report that, in their experience, these factors have been central to the success of their programs and activities and are a major part of the reason that Brighter Futures and Building Healthy Communities programs and services have been well received by the people who benefit from them.

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71 Mignone J, O'Neil JD, Wilkie C. *Mental Health Services Review: First Nations and Inuit Health Branch, Manitoba Region*. Centre for Aboriginal Health, University of Manitoba. 2003.

From their perspective, flexibility means a number of different things.

For one, it means having choices about how to organize the delivery of Brighter Futures and Building Healthy Communities programs in a way that is consistent with how their health services are organized. For example, communities participating in the site visits have tended to adopt one of two broad approaches to management and delivering of their Brighter Futures and Building Healthy Communities programs:

- Integrated: These communities tend to integrate their Brighter Futures and Building Healthy Communities funding with their other health and wellness services. This approach allows them to provide mental health, child development, parenting, injury prevention and/or healthy baby activities, some of which may enhance other services, or otherwise fill the gaps between a series of health programs and projects; or,

- Targeted Programs: These communities tend to "stovepipe" their health programs and activities, treating each as a related, but separate, program with its own management and service delivery structure.

These two significantly different approaches to the design and delivery Brighter Futures and Building Healthy Communities services, both of which were appropriate to the capacity and ability of different communities, reflect the strength of the program principles of flexibility and being paced to the abilities of the community.

The respondents also spoke of flexibility in terms of their ability to use the funding, the Brighter Futures funding in particular, to fill the health services gaps they experience, helping to glue the various parts of their health services into a more cohesive community health program. For example, it means that a community health centre was able to expand the intake of a Head Start parenting program to include the parents of children aged 6 and older, whose children are in day care. It also means that health services are able to contribute to the organization community events where those events promote inter-generational contacts or increased parent-child interaction.

The use of Brighter Futures and Building Healthy Communities funding to fill gaps or enhance other health programs is consistent with the purposes of each initiative. The 1992 Framework document says, in part, that Brighter Futures "is not intended to duplicate or replace existing programs, but rather to complement those already in place or support new initiatives (emphasis added), while the Building Healthy Communities initiative is intended to help address gaps in the range of mental health services and activities related to crisis intervention and aftercare.

Other benefits attributed to the integration approach include:

- A reduction in the number of client referrals from program to programs;

- More efficient use of human resources;

- Services and activities that are less likely to stigmatize participants as having a serious personal problem; and

- Health services that are proactive in the community and that fosters a sense of community ownership.

A minority of the community health officials and services providers, FNIHB officials and others that were interviewed during the conduct of the evaluation presented opinions and preferences for having Brighter Futures and Building Healthy Communities focus on mental health, or less frequently, another of the program components. These respondents tended to argue that their prime area of interest and focus was under-resourced, and that they could do so much more to meet the needs of their patients and clients if funding was reallocated. However, the reality is that Brighter Futures and Building Healthy Communities resources in many communities do fill gaps within and between health programs. If funding were to be reallocated to one area, it would increase the gaps that exist elsewhere.

Yet a third aspect of flexibility, it the ability it gives health services to respond to emerging issues. For example, one community found that a relatively sudden increase in employment opportunities led to disruptions in family life and acting-out behaviour by many children. The health service was able to respond to this development by organizing anger management courses. In another case, a community was able to introduce a defensive driving course when a tragic car accident pointed to the need, and community support for some concrete action.

A majority of the First Nations and Inuit respondents addressing the issue of flexibility talked about how their communities have developed a sense of ownership and trust in community wellness programs, in part because those programs were able to shift and respond to changing circumstances and the community, in part because people understood that the decisions about what services to offer, how and when, were made locally. In this regard it is important to note, that the literature review conducted as part of this evaluation highlighted evidence from a number of sources that there are significant linkages between the mental health status of community members and the degree of self autonomy that the community has achieved; that building community, decolonization, self sufficiency, political autonomy, and similar expressions of self-determination are important contributors to the well-being of First Nations and Inuit individuals and communities.

Findings

- Communities have had the flexibility to develop programs that are directly responsive to local priories and that are implemented at the community's pace; and

- Making the programs flexible, community based and community paced has positively impacted program outcomes as communities are able to focus on their specific needs and priorities within their own pace.

Section 6: ISSUE #3 - - - EFFECTIVENESS

Section 6 reports the evaluation findings about the effectiveness of strategies and structures used to implement the initiatives, and whether the most cost-effective and efficient approaches have been used to address the health needs of First Nation and Inuit children, families and communities.

EFFICIENCY & APPROPRIATENESS

Evaluation Question #3.1

Are the most appropriate and efficient means being used to achieve objectives, relative to alternative design and delivery approaches?

Discussion

While programs are delivered using different methods (professional services models; para-professional models; blends of paid and volunteer staff; local program structures; regional/Tribe Council organizations; direct Band administration; health boards; etc.), the evaluation team did not identify any models or approaches that were clearly more cost-efficient or cost-effective than others. This is not say that one or more of the models would not represent more cost-effective strategies, only that there is not sufficient information available to make even preliminary observations in this regard.

Communities reported that their capacity to deliver appropriate and efficient projects and services did not only rely on program guidelines and requirements, but also on financial limitations and access to qualified and trained staff and resources.

A minority of First Nations and Inuit respondents felt that the limited financial resources made it such that funding had to be used efficiently as the community needs are so great and waste could simply not be permitted.

Findings

- Most communities are using means that they have identified as efficient and appropriate to their community needs within the limitations of their financial resources, capacity, access to qualified professionals when required, and Brighter Futures/Building Healthy Communities guidelines.

- Appropriate and efficient can sometimes be contradictory as the most appropriate workshop may be very costly and therefore present the most appropriate solution for a few individuals but perhaps not present the most efficient use of resources for the community as a whole.

PROGRAM DELIVERY ALTERNATIVES

Evaluation Question #3.2

Are there more cost-effective program delivery alternatives to achieving the objectives and the intended results?

Discussion

There is a broad consensus that the programs have been administered in a manner that was flexible and promoted community-based and community-paced program design and delivery. Key informant and community program personnel were generally of the view that these factors were central to the success of their programs and activities.

Respondents did not identify any more cost-effective alternative to program delivery. First Nations and Inuit participants in key informant interviews and community visits reported that the lack of resources made it such that they were only touching the tip of the problem and not addressing the underlying issues causing the problem. They argued that because resource limitations forced them to adopt short term approaches to problem solving, instead of a longer-term, more holistic approaches to healing, services would end up being costlier in the long run.

Findings

- Interviewees, service providers and community members did not identify options that would be more cost-effective for program delivery.

- First Nations and Inuit respondents felt that funding limitations caused communities to adopt a short-term approach versus a holistic long term approach, leading to reduced cost-effectiveness in the long term for addressing community health needs and priorities.

FLEXIBILITY

Evaluation Question #3.3

Did making the program flexible, community-based and/or community-paced affect the cost effectiveness of the program?

Discussion

The evaluation team found no evidence that the implementation of the Brighter Futures and Building Healthy Communities initiatives based on the principles of flexibility and community-based and community-based development have had either positive or negative effects of the cost-effectiveness of the programs.

Finding

- The evaluation team found no evidence that the implementation of the Brighter Futures and Building Healthy Communities initiatives based on the principles of flexibility and community-based and community-based development have had either positive or negative effects of the cost-effectiveness of the programs.

POSSIBLE ALTERNATIVES

Evaluation Question #3.4

Are there other, but more effective ways of helping First Nations & Inuit communities address the health needs of children and families?

Discussion

While programs are delivered using different methods (professional services models; para-professional models; blends of paid and volunteer staff; local program structures; regional/Tribal Council organizations; direct Band administration; health boards; etc.), the evaluation team did not identify any models or approaches that were clearly more cost-efficient or cost-effective than others. This is not say that one or more of the models would not represent more cost-effective strategies, only that there is not sufficient information available to make even preliminary observations in this regard.

It has been identified, however, that smaller communities are at a disadvantage when delivering Brighter Futures/Building Healthy Communities since funding is allocated according to community population. For example, in a community of about 350 residents, it is not possible or cost-effective to deliver the same level of services that are available in a larger community. There are simply not enough people, for example, to justify a full-time psychiatrist or a parent support group for a specific issue.

Larger communities, however, also encounter their own obstacles such as the additional management and administrative costs due to the size of the required service organisations as well as the probability of a higher number of issues and needs being present in the community. For example, it is much more likely, statistically, for a larger community to require a support group for parents of children with Down's syndrome than it is in a smaller community.

As discussed in previous sections, the community's geographical location also has an important impact on its capacity to access specialised resources, share costs with other services, communities and/or organisations, as well as the cost the community will incur to secure certain resources.

Findings

- It cannot be generalised that one more effective model is the solution for all communities. Their unique needs and environments must be respected and considered.

- Some communities could benefit from a more effective approach but there is presently not enough information available to determine such models on a case by case basis.

Section 7: LESSONS LEARNED

This section describes lessons learned about the implementation, management and delivery of the initiatives that were identified during the evaluation.

Program Management and Planning

The Brighter Futures Framework advocates an ongoing partnership between Health Canada and First Nations and Inuit communities in the development and management of programs and services. The Manitoba Community Wellness Working Group (MCWWG) is an example of such partnership that is reported to be working effectively for both groups. The 2001/2002 terms of reference for the working group stated that its mandate was to:

- *Function as a monitoring group for the Brighter Futures Initiative, Building Healthy Communities program, and the Canada Prenatal Nutrition Program;*
- *Advocate for First Nations, wellness development and training needs;*
- *Function as a clearinghouse for information;*
- *Make regular reports to the Assembly of Manitoba Chiefs Health Committee regarding regional community wellness program and long-term development of Brighter Futures Initiative, Building Healthy Communities Initiative, and the Canada Prenatal Nutrition Program.*

The working group membership consists of six Tribal Council representatives, two representatives of non-affiliated Bands and an Elder as voting members. In addition, Tribal Council Health Authorities or Bands who have transferred third level services have observer status at the working group, and FNIHB representatives - the BF/BHC coordinator, Non-insured Health Benefits mental health services manager, and an administrative assistant/recorder - participate as ex officio members.

Continuum of Care Partnerships

Because the members of First Nations and Inuit communities receive insured health services through provincial/territorial health systems, the ability of their community health services to deliver services consistent with the continuum of care principle is often dependant on the development of effective working relations with local provincial/territorial health services. One example of a First Nations-provincial health care partnership that is reported to have improved access to health services is the relationship established between the Eel Ground and neighbouring First Nations and the Miramichi Hospital. Through their shared efforts, the hospital board has established a permanent First Nations Advisory Committee and programs community

liaison workers, who are able to support First Nations patients during their hospitalization, participate in and facilitate in discharge planning and advocate on behalf of patients and their families.

Section 8: ISSUES & CHALLENGES

In the course of the evaluation, a number of issues and challenges that warrant particular reference were identified.

Anonymity

Brighter Futures, Building Healthy Communities and other First Nations and Inuit workers whose duties include counselling frequently spoke of the difficulties they encounter because of the lack of anonymity fro themselves and their clients. This, they report, has a variety of impacts. For one, the people who might benefit from services may avoid contact with the counsellor because they will be easily identified by others in the community as having problems. For another, clients have difficulty trusting that their privacy and confidences will be respected and tend to assume that the counsellor, or others involved in circles or other group activities, are the source of any rumour of their difficulties. Finally, counselling staff can feel isolated, even rejected, within their own community.

These issues have been identified by many researchers who have studied mental health services in First Nations and Inuit communities. For example, Kirmayer, based on his experience studying mental health issues in Québec First Nation and Inuit communities, wrote:

> *As a result of size, family ties, and shared history, there is little opportunity for the sort of privacy and anonymity that is part of the professional mental health or social service practitioners' role in big cities. This anonymity has both ethical and practical uses: it provides privacy and safety for clients who wish to confess to embarrassing matters and it allows the helper to have some respite from being constantly 'on the job'. In small communities, helpers are often related to the people they are helping and have no way to step back for a while from their role; this can rapidly lead to burn out .*[72]

Solutions to this challenge are difficult to come by. Maar, in her report on services in rural north Ontario discussed the problem of confidentiality and described on approach to reducing its impact:

> *With mental health workers who are socially entrenched in the community they serve, clients of the mental health program often perceive confidentiality as an issue. In First Nations communities, family relationships are an important aspect of community life.*

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72 Kirmayer LJ. Research and Clinical Perspectives on Mental Health in Native Communities in Widening the Circle: Collaborative Research for Mental Health Promotion in Native Communities. McGill University & Culture & Mental Health Research Unit. 1998.

Most individuals have well-established relationships extended family networks. Clients and community health care workers often share one another's history. For some people, this can lead to a particularly therapeutic environment. However, for others, these close community and kinship ties become a barrier to accessing services, particularly mental health services. As a result, a significant number of clients in the Manitoulin area welcome referrals to the integrated regional services providers of Mnaamodzawin Health and Noojmowin Teg. Clients are given the additional choice of meeting professionals in their home community clinic, the client's home, or another health centre. This significantly improves clients' access to mental health services compared with other, more common service provision models. [73]

It is observed that the anonymity concerns were less pronounced for counsellors who were not residents of the community they served. For many, if not most, smaller and more rural and isolated/remote communities, however, the option of giving clients a choice of using regional services, as is the case in the Manitoulin area, or access to counsellors who do not live in the communities are not readily available.

It was also observed health staff whose jobs in the community were identified with broader health and wellness activities, but included individual counselling, were less likely to identify anonymity as a problem.

Staff Recruitment and Retention

First Nations and Inuit communities face a range of well-documented challenges in recruiting and retaining qualified wellness and mental health staff. For example, a review of projects supported by the Health Transition Fund found that a number of projects were unable to locate or retain staff, even with the provision of special incentives.[74] A team examining the retention rates of physicians and nurses in Alaska reported that the lack of adequate facilities, professional isolation, limited support services, inadequate organizational settings, excessive workloads and time demands, limited earning potential, lack of social, cultural and educational opportunities, and spousal influence were factors that contributed to high turn over rates, especially for staff recruited from outside of the communities.

The challenges associated with recruiting and retaining qualified staff is not limited to “outside” professionals. For example, a Health Transition Fund project reported difficulties recruiting and retaining a local workforce, partially because some employees preferred part-time work so that they could meet family responsibilities and accommodate traditional activities, while others left because of personal crisis and other problems.

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73 Maar M. Clearing the Path for Community Health Empowerment: Integrating Health Care Services at an Aboriginal Health Access Centre in Rural North Central Ontario. Journal of Aboriginal Health. January 2004.

74 Dion Stout M & Kipling GD. Aboriginal Health: Synthesis Series. Health Canada. 2002.

Employee burnout has been identified as a factor in employee retention in this evaluation and several studies and reports. The causes of frontline staff burnout include large workloads, few opportunities to step out of one's "professional" role, the difficulties of being both a helper and a community member.

Staff Qualifications

The evaluation has observed that the staff involved in developing and delivering health and wellness services in First Nation and Inuit communities bring a wide-range of personal, educational and training backgrounds to their work as community nurses, community health representatives, counsellors, Brighter Futures/ Building Healthy Communities staff and other positions. The individuals who occupy some of these positions must have professional credentials, but many staff many are appointed based on ad hoc considerations or factors not directly related to the requirements of the position.

Given the variety of program approaches that were identified in this evaluation, the need to adapt programs and services to local needs and circumstances and other staffing challenges, it would be difficult, even inappropriate, to consider prescribing minimum educational/training qualifications for Brighter Futures and Building Healthy Communities workers. At the same time, a minority of the respondents in this evaluation identified concerns related to the inadequacy or absence of guidelines and qualifications for First Nations and Inuit health service providers. These concerns ranged from community health nurses who reported that their clinical training did not adequately prepare them to manage and participate in community wellness and development programs, to people who felt that "life experience" alone was not sufficient preparation to assume responsibilities as a mental health worker.

Some of these issues can, and should be, dealt with through the development of new education and training programs or adaption of existing programs. Training programs, however, may not be a sufficient solution, even in the long term, and will do nothing to help communities who must make important staffing decisions now.

In the short term, it might be helpful is First Nations and Inuit health organizations and services, with FNIHB support, were to develop skill set guidelines for common Brighter Futures and Building Healthy Communities activities. Such guidelines would identify the abilities that people need to develop and/or deliver those activities and the methods that might be used to assess whether candidates possess those skills.

Recreation Programs

A significant number of First Nations and Inuit communities participating in the site visits have allocated Brighter Futures resources to support recreational and cultural activities (sports and sporting events, arts and crafts, community celebrations/events, summer camps for children and youth, youth centres, Elders' social and recreational programs, etc.). In key informant interviews, the FNIHB respondents who commented on this tended to have reservations about whether it was appropriate to support these activities, especially recreational activities, using Brighter Futures funding, although none stated that it was unacceptable.

For their part, First Nation and Inuit program managers and service providers participating in interviews and focus groups, some of whom seemed to be aware that Health Canada officials might question using Brighter Futures resources for recreational and cultural services, spoke of their value in one or more of the following terms:

- Too many First Nations and Inuit people – children, youth, adults and Elders – are physically inactive increasing the risk of and severity of diseases such as Type-2 diabetes, cardiac and circulatory disorders, obesity, chronic depression, etc. Given this reality, it is good policy to promote active physical life styles that help prevent such diseases, or reduce their severity.

- There are few, if any, constructive recreational outlets for children and youth in most First Nations and Inuit communities leaving them to spend their time in front of the television or "hanging around." Those most concerned with the needs of children and youth spoke of trying to develop the kinds of opportunities and resources that are offered in urban areas through organizations such as the Boys & Girls Club and similar social-recreational services.

- Helping children and youth pursue their recreational (organized sports such as hockey, t-ball, and basketball, the visual or preforming arts, crafts, group outings, summer camps, etc) and cultural (drumming, dance, crafts, etc) interests supports socially positive behaviours and increases their involvement with family members and adult role models.

- Recreational and cultural activities, most of which depend on some degree of community participation/voluntarism, increase the level of interaction among people and help to strengthen and heal the community. (Note: This argument is supported by research in Aboriginal and non-Aboriginal communities which indicates that individuals with significant social connections in the community and with family are at less risk of mental disorder, including suicide.[75])

75 Kirmayer LJ. Research and Clinical Perspectives on Mental Health in Native Communities. in Widening the Circle: Collaborative Research for Mental Health Promotion in Native Communities. Institute of Community of Family Psychiatry. 1998.

Section 9: CONCLUSIONS AND RECOMMENDATIONS

This final section of the report presents the conclusions and preliminary recommendations for program improvements complete with some of the implications associated with the recommendations.

CONCLUSIONS

The evaluation of the Brighter Futures and Building Healthy Communities initiatives addressed three broad issues:

- **Relevance**: Do the initiatives continue to be consistent with departmental priorities, First Nation and Inuit health and community priorities; and do they realistically address actual needs?
- **Success**: Are the initiatives effective in meeting its objectives, within budget and without unwanted outcomes?
- **Cost-effectiveness**: Are the most appropriate and efficient means being used to achieve objectives, relative to alternative design and delivery approaches?

The following sections highlight the evaluators' high level conclusions with respect to each of these issues.

Relevance

With some qualifications, the evaluation has found that the Brighter Futures and Building Healthy Communities initiatives continue to be relevant to departmental, as well as, First Nations and Inuit community priorities, recognizing that the circumstances and needs of communities vary greatly, even within regions and districts within regions.

The qualifications are:

- Not all communities are currently living with serious solvent abuse problems, but the majority of them are trying to deal with longstanding (alcohol) and emerging (prescription drug abuse,[76] hard drugs) substance abuse problems.

- The crisis management and intervention component of Building Healthy Communities was identified as relevant and required, but difficult to address by many communities due to limited resources, capacity and/or access to training and intervening factors including community size and relative isolation.

Success

FNIHB Implementation and Management

The evaluation found that there is a general consensus that FNIHB's national and regional offices played positive roles in the initiative's roll-out, but that the organization tends to limit its role to financial administration and control and no longer plays an active supportive role in relation to Brighter Futures/Building Healthy Communities program development at the regional, or local level. FNIHB and First Nation/Inuit respondents attribute this change to reductions in regional medical and program development staff reductions that limits the capacity of regional offices to support the communities for the delivery of the programs.

While FNIHB's capacity to provide support to communities has diminished, First Nation and Inuit health service managers and providers, especially in smaller, more rural and isolated communities continue to look to the Branch for assistance on a range of professional practice, planning and management and administrative issues.

Program Principles

With two qualifications, the evaluation found that First Nation and Inuit Brighter Futures and Building Healthy Communities activities and programs respect the six program principles set out in the Brighter Futures Framework. The qualifications are:

- A minority of communities report having developed or maintained strategies to sustain community participation in the development and implementation of services; however, the majority report that community participation in the Brighter Futures and Building Healthy Communities programs and services has grown significantly over the years.

- A community's capacity to deliver a continuum of care is linked directly with its financial resources, geographic circumstances and population size.

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76 Wardman D, Hhan N and el-Guebaly N. *Prescription Medication Use Among an Aboriginal Population Accessing Addiction Treatment*. Canadian Journal of Psychiatry. Vol 27. 2002. p 355-360.

Outcomes

The Brighter Futures and Building Healthy Communities initiatives have three types of intended outcomes: healthier children, families and communities; effective and culturally-appropriate services; and, training health workers. The evaluation was unable to measures these outcomes due to a lack of baseline data or an alternate standard. It did, however, gather opinion data from First Nation and Inuit respondents and FNIHB staff that led to the following observations:

- The majority of First Nations and Inuit respondents report that the Brighter Futures and Building Healthy Communities programs have produced positive health and wellness outcomes for individuals and communities.

- The majority of the respondents report that culturally-appropriate programs have been established in their communities.

- The majority of First Nation and Inuit respondents believe that health workers are better trained and more effective then ten years ago, but report that there is a variety of ongoing and unmet training and staff development needs.

Effectiveness

The evaluation did not identify any evidence of program ineffectiveness or inefficiencies unique the Brighter Futures and Building Healthy Communities initiaves; nor was it able to identify more effective, alternate delivery models

RECOMMENDATIONS

An analysis of the findings for each of the eighteen evaluation questions identified six broad areas for which recommendations have been developed:

- Continuing Relevance;
- Program Goals and Content;
- Program Principles;
- Implementation Partnership;
- FNIHB's Role;
- Planning;
- Reporting and Accountability;
- Capacity Building; and
- Inter-jurisdictional Planning.

The following sections summarize the evaluation findings related to each of these issues and present the recommendations for action going forward.

Continuing Relevance

Findings

- Brighter Futures and Building Healthy Communities initiatives are relevant and continue to address First Nations and Inuit Community health and wellness needs, recognizing that such needs vary from community to community.
- Respondents report that the objectives and mandate of the initiatives are still relevant to their community.
- Overall, respondents report that the programs that are delivered with Brighter Futures and Building Healthy Communities funding positively benefit the communities and their members.
- The numbers of community members participating in Brighter Futures and Building Healthy Communities programs and services have increased in recent years.

Recommendation

#1. That the Brighter Futures and Building Healthy Communities initiatives continue to be funded and supported.

Program Goals and Content

Findings

- Although the specific content and mix of programs and services vary from one community to another and not all communities deliver all the initiatives' components, the activities and outputs, as described by First Nations and Inuit service providers, are related to the intended program outcomes. However, evaluation did not attempt to measure whether or to what extent the described programs and services achieved the intended outcomes.
- A majority of the First Nations and Inuit respondents report that the strength of the Brighter Futures initiative is the flexibility it allows them to allocate resources

to meet their priorities through programs and services that promotes "community ownership."

- The majority of the communities already moved toward consolidation of mental health services having developed program approaches that simultaneously address the Brighter Futures community mental health goals and the Building Healthy Communities mental health crisis management goals.

- The mental health program developed by the First Nations and Inuit communities tend to reflect one of two broad orientations:

    - Clinical – services that focus on providing psycho-social treatment and/or traditional healing to individuals who have been identified by themselves or others as having some personal, emotional or family problems.

    - Health Promotion/Community Development – programs that focus on providing educational, cultural, social and recreational services that promote individual resiliency and community-building.

- A majority of First Nations and Inuit respondents say that the solvent abuse component of the Building Healthy Communities initiative should be widened to 'substance' abuse as not all communities are currently living with serious solvent abuse problems, but other types of substance abuse problems do exist in their communities.

- There is a widely held view that the solvent abuse component of the Building Healthy Communities initiative should be integrated into the NNADAP program

- The crisis management and intervention component of Building Healthy Communities was identified as relevant and required, but difficult to address by many communities due to limited resources, capacity and/or access to training and intervening factors including community size and relative isolation.

- Some respondents feel that a more comprehensive and holistic approach to mental health is needed than what is outlined in Building Healthy Communities.

- Some intended program outcomes, such as implementing crisis management teams, are limited by the communities limited resources (financial and otherwise), capacity and access to support and training.

- Although the goals of Brighter Futures components are similar to those of targeted programs, such as CPNP and Head Start, the age criteria and other restrictions governing the other programs are too narrow to address the community needs and priorities with respect to child development, healthy babies, parenting and injury prevention,

- While communities may allocate Brighter Futures resources to enhance ('top-up') activities that are primarily funded under another program, there is no

evidence that there is duplication of the services that are delivered at the community level.

Recommendations

#2. *That Health Canada consolidate the Brighter Futures and Building Healthy Communities initiatives as a single funding program that allows each First Nation and Inuit community to address mental health, child development, parenting, healthy babies and/or injury prevention through community-based health and wellness services developed to respond to its needs, circumstances and priorities.*

In its implementation of these recommendations, Health Canada should consider:

a) Using the goals and program principles of the 2002 Mental Wellness Framework developed by AFN, ITK and FNIHB [77] as a starting point in designing the scope and content of the consolidated initiative of the Brighter Futures and Building Health Communities Initiatives.

b) Moving the resources for the solvent abuse component of the Building Healthy Communities initiative under Addictions as a "substance abuse" component that would allow First Nations and Inuit communities to address prescription drug abuse and other forms of substance abuse, as well as solvent abuse, depending on the community's needs.

c) Renaming the consolidated initiative to better reflect its goals, e.g., "Community Wellness Initiative."

d) Publishing and distributing a formal policy document that would, among other things:

- Identify the initiative's goals and principles, reflecting the consolidation of the Brighter Futures and Building Healthy Communities initiative;
- Specify that communities have the discretion to implement programs and activities that focus on one or more of the initiative's components (ie., communities would not be required to implement all components); and
- Specify that the communities have the discretion to deliver programs and services to all community members, without age restrictions.

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77 *Mental Wellness Framework: A Discussion Document for Comprehensive Culturally Appropriate Mental Health Services in First Nations and Inuit Communities*. Mental Health Working Group – Assembly of First Nations (AFN), Inuit Tapiriit Kanatami (ITK), First Nations & Inuit Health Branch (FNIHB). 2002

e) Providing technical and financial support to First Nations and Inuit communities regionally-based to identify a range First Nation/Inuit crisis management and intervention strategies that take into account community size and geographic circumstances.

Program Principles

Findings

- The Brighter Futures/Building Healthy Communities "approach," which allows the programs to be community-based and community-paced, was supported by all First Nations and Inuit respondents and by research documents that were included in the literature review.

- The program principles have given the communities and regions the flexibility to develop programs that are directly responsive to local priorities and implemented at the community's pace.

- Making the programs flexible (community based and community paced) has positively impacted program outcomes because communities are able to focus on their specific needs and priorities at their own pace.

- Most communities are using means that they have identified as efficient and appropriate to their community needs within the limitations of their financial resources, capacity, access to qualified professionals when required, and Brighter Futures/Building Healthy Communities guidelines.

- Appropriate and efficient can sometimes be contradictory as the most appropriate workshop may be very costly and therefore present the most appropriate solution for a few individuals but perhaps not present the most efficient use of resources for the community as a whole

- The evaluation team did not identify a program delivery model that would be more effective for communities generally.

- A minority of interviewees felt that the one-year term of the funding agreements and delays in payments at the beginning of the fiscal year caused communities to adopt a short-term approach versus a holistic long-term approach, leading to reduced cost-effectiveness in the long term for addressing community health needs and priorities.

- The evaluation team found no evidence that the implementation of the Brighter Futures and Building Healthy Communities initiatives based on the principles of flexibility and community-based and community-paced development have had negative effects on the cost-effectiveness of the programs.

- There is no one, more effective service delivery model that would be the solution for all communities: their unique needs and circumstances must be respected and considered.

- Some communities could benefit from a more effective approach but there is presently not enough information available to determine such models on a case by case basis.

Recommendation

#3. *That Health Canada retain the core values of the Brighter Futures program principles in the management of the consolidated initiative so that communities have ongoing flexibility to design wellness services and delivery models that address individual community needs, priorities and capacities, that are community based and community paced.*

In its implementation of this recommendation, Health Canada should consider:

a) Undertaking consultations with First Nations and Inuit communities at the national, regional and community levels to renew the specifics of the six principles:

- Strengthening and supporting the Child/Family/Community through a holistic approach;
- Community-Based;
- Community-Paced;
- Continuum of Care;
- Community-Wide Participation; and
- Coordination and Linkage of Program Activities[78]

78 See page 34 for the full statement of the Brighter Futures program principles

Implementation Partnership

Finding

- First Nations and Inuit health care managers and providers are concerned that Health Canada will introduce policy and program changes without having a full appreciation of the implications of the changes for their communities or taking advantage of their collective knowledge, experience and insights.

Recommendation

#4. *That Health Canada and First Nations and Inuit communities establish national and regional consultative mechanisms that would ensure an effective, on-going partnership and shared decision making between FNIHB and First Nations and Inuit health services managers/directors in the implementation, management, monitoring and development of community wellness programs and services.*

Community Planning

Findings

- Few non-transfer communities have undertaken formal needs assessments and health planning, other than assessments that might have been done a decade ago when the Brighter Futures initiative was being implemented.
- As a result of the lack of health program planning generally and for Brighter Futures and Building Healthy Communities programs:
  - Some First Nation and Inuit health programs have difficulty effectively accounting for their Brighter Futures and Building Healthy Communities activities within their communities and to FNIHB;
  - There is a risk that the Brighter Futures and Building Healthy Communities activities in some First Nation and Inuit communities are not as integrated with other health and wellness programs as they might be; and
  - In a few of communities program delivery has been impeded because the community's leadership and health program managers have different, even conflicting expectations.
- The lack of needs assessment and planning activities are sometimes due to a lack of technical capacity (knowledge, skills, tools) and resources. In other cases, it is the result of a decision that the cost of undertaking the planning

would be too high in relation to the level of Brighter Futures and Building Healthy Communities funding received.

- A community's capacity to deliver a continuum of care is hindered, but not prevented, by yearly funding which limits their capacity to implement consistent, long term plans.

- A "one-size-fits-all" planning process is not effective or appropriate when the value of Brighter Futures and Building Healthy Communities funding to individual communities varies from a few thousand dollars to more than a hundred thousand dollars,

Recommendation

#5. *That each First Nations and Inuit community prepare a multi-year "community wellness" plan, based on a current assessment of its health and wellness needs.*

In its implementation of this recommendation, Health Canada should consider:

a) Developing, in partnership with First Nation and Inuit communities, minimum requirements for "community wellness" program plans that take into consideration community size, funding levels and other health and emergency preparedness planning considerations;

b) Providing First Nation and Inuit community leaders and health program managers with financial and technical assistance, including training and tool kits, for implementing the planning process.

c) Developing, in partnership with First Nations and Inuit health organizations, strategic community wellness plans supporting community-level plans.

Reporting & Accountability

Findings

- FNIHB's enhanced accountability measures are appreciated by First Nations and Inuit health service managers, except that the reporting requirements are onerous in relation to the any benefits to either the communities or FNIHB that the respondents have observed.

- The First Nations and Inuit Health Branch has not published any statement of policy or priorities for either Brighter Futures or Building Healthy Communities

since the initiatives were implemented in 1992 and 1994, respectively, and those documents are not in wide circulation.

- There appears to have been a shift in FNIHB's understanding of the goals of the mental health and child development away from a broad community development orientation to a narrower clinical/medical model.
- There is uncertainty among some First Nation and Inuit program managers and workers about the kinds of activities that are eligible for funding.
- Reporting requirements such as formats, content, and level of detail varied from region to region.
- In some instances, reporting requirements changed without consultation with communities, sometimes late in the fiscal year, and without modifications to contribution agreements creating additional administrative burdens on communities.
- Contribution agreements do not clearly indicate what are the reporting requirements, leaving communities vulnerable to FNIHB changes.
- A community's capacity to deliver a continuum of care is hindered (but not prevented) by yearly funding which limits their capacity to implement long term plans.
- The lack of standardised performance measures, reporting systems and baseline data did not allow for the quantitative assessment of the degree to which the Brighter Futures and Building Healthy Communities programs may have succeeded or failed in achieving their intended outcomes.
- If would be very difficult to define and obtain agreement on a set of national performance indicators and outcomes measures for broadly defined health/wellness services especially given the variables involved (community size and geography, service deliver models, health transfer status; local priorities)
- "One-size-fits-all" reporting requirements are not effective or appropriate when the value of Brighter Futures and Building Healthy Communities funding to individual communities varies from a few thousand dollars to more than a hundred thousand dollars,
- There is a lack of transparency in the administration of the Brighter Futures and Building Healthy Communities initiatives and programs..

Recommendation

#6. That each First Nation and Inuit community prepare and publish an annual "community wellness" program report to community members that would include data and information about program performance, outcomes, and success.

#7. That Health Canada rationalize its reporting requirements and eliminate duplicate and repetitive requirements while ensuring that the report contents are meaningful to the operational, planning and evaluation needs of First Nation and Inuit communities and Health Canada;

In its implementation of recommendations #6 and #7, Health Canada should consider:

a) Developing, in partnership with First Nations and Inuit communities, minimum requirements for annual reports;

b) Accepting the annual report as the program report for purposes of any contribution agreement.

c) Providing First Nations and Inuit community leaders and health program managers with financial and technical assistance, including training and tool kits, for implementing the reporting process.

d) Developing a process that would use "community wellness" program plans and annual reports to identify national baseline data to help assess the extent to which the initiative succeeds in achieving its intended outcomes .

e) Distributing to all First Nations and Inuit communities, and publishing on its website throughout the life of the initiative, statements of the program's procedures (reporting requirements, financial accountably and management requirements, etc).

f) Publishing, on its website, a current summary statement of the each community's program plan and the amount of the annual funding it receives under the consolidated initiative

g) Preparing and publishing national and regional annual reports that would, among other things, account for FNIHB activities in the areas covered by the initiative and provide program performance, outcomes, and success data and information.

FNIHB Role

Findings

- FNIHB's national and regional offices played positive roles in the initiative's roll-out, but that they now tend to limit their roles to financial administration and control and no longer plays an active supportive role in relation to Brighter Future and Building Healthy Communities program development at the regional, or local level.

- FNIHB national and regional office staff reductions, especially in terms of professional health staff and program development resources, limit its capacity to deliver development support to the communities.

- Many of the communities with limited capacity in health and wellness programming would like to have, but are unable to obtain, technical, management, and planning from FNIHB.

- The gaps in the health program development and delivery capacities that are greatest in remote and isolated communities, but are significant in smaller, rural communities.

Recommendation

#8. *That FNIHB establish and maintain a capacity to provide the First Nations and Inuit communities who request with technical and professional support for "community wellness" program planning, delivery and management.*

In its implementation of this recommendation, Health Canada should consider:

a) Employing, or contracting, program development and planning resources in FNIHB regional offices whose duties would be confined to providing advice and technical assistance to First Nation and Inuit managers with responsibilities for health care planning and development.

Capacity Building

Findings

- There are different components of the capacity building (i.e. education, training, infrastructure, tools, facilities, research, etc.) needed to strengthen service provider, institutional and First Nation and Inuit government capabilities to contribute to effective health services.

- The gaps in the health program development and delivery capacities of communities is greatest in smaller and more remote communities, but is also a significant issue in smaller, rural communities.

- There is an ongoing, but unmet, demand for professionally trained First Nation and Inuit health and wellness workers.

- There are few opportunities for currently employed community workers to obtain training leading to accreditation.

- The First Nations Community Wellness Worker Diploma Program is a model for First Nation-educational institution-government partnerships to deliver culturally appropriate and accessible training in the health field.

- The crisis management and intervention component of Building Healthy Communities was identified as relevant and required, but difficult to address by many communities due to limited resources, capacity and/or access to training and intervening factors including community size and relative isolation.

- Few communities have the financial resources to retain staff once they have completed training that qualifies them for employment with larger, better-funded organizations.

Recommendation

#9. *That FNIHB, in partnership with First Nation and Inuit health services , support regionally-based research and development designed to enhance the capacity of First Nation and Inuit communities to develop, manage and deliver "community wellness" programming*.

In its implementation of this recommendation, Health Canada should consider:

a) Supporting partnerships among First Nation and Inuit organizations, post-secondary educational institutions, provincial/territorial health agencies and professional associations to develop and deliver training and planning support services to First Nation and Inuit health care planners, managers and providers.

b) Developing partnerships with regional and national First Nation and Inuit health service organizations to conduct research and development to define the basic requirements (capacity) for delivery of "community wellness" programs, including equipment, supply and facilities standards, as well as program delivery and management infrastructure models appropriate to the circumstances of different categories of First Nations communities: small rural, remote, etc.

c) Establishing a "best practices" or "exemplary" program initiative that would annually produce case studies highlighting successful "community wellness" program and/or delivery models.

d) Providing financial and technical support to First Nations and Inuit health care managers and providers to develop vehicles that would provide practical opportunities for information sharing, peer support and peer learning.

e) Developing, in partnership with First Nations and Inuit communities, training strategies, including training standards, that would ensure that First Nation and Inuit health care providers can obtain accredited training, appropriate to their needs and circumstances.

Inter-jurisdictional Planning

Findings

- Communities have established partnerships at the community level with other programs and service delivery agents.
- A minority of the communities have established partnerships with other Aboriginal communities, usually through Tribal Councils, for the delivery of Brighter Futures and Building Healthy Communities services.
- Fewer than 15% of the communities visited had established formal working relationships at the district/health region level within the provincial/territorial health care system.
- The residents of First Nations and Inuit communities are covered by provincial/ territorial health plans and all First Nations and Inuit health services are affected by and affect provincial/territorial health services to some degree.
- There was only one instance of provincial level, as opposed to the district/health region level, partnerships and linkages identified within the sample of communities participating in site visits - Nunavik Regional Board of Health and Social Services.
- First Nations, provincial and federal governments all have jurisdictional issues and concerns that have to be taken into account in planning and maintaining partnerships.

Recommendation

#10. *That FNIHB regional offices and First Nations and Inuit communities work with provincial/ territorial health departments to establish permanent planning forums to encourage and complement planning and service delivery partnerships at the district/health region level.*

In its implementation of this recommendation, Health Canada should consider:

a) Developing, in partnership with First Nations and Inuit communities, appropriate regional strategies for initiating discussions leading to provincial-territorial planning mechanisms.

b) Involving other federal departments with programs and responsibilities relative to community wellness programming in the First Nation/Inuit-federal-provincial/territorial planning mechanisms.

APPENDICES

Appendix A: Mental Health Agenda Principles

Reference Footnote 40: The following is the text of the statement of Mental Health Agenda principles referred to in the document entitled *Guidelines: Community Mental Health*, November 1994,

Guiding Policy Principles

It is therefore recommended that the following over-riding PRINCIPLES guide the development of First Nations and Inuit Mental Health Policy:

1. It is recognized that the preconditions to achieving mental health for all include adequate infrastructure, economic development and education.

2. Federal responsibility for First Nations and Inuit mental health includes providing the capacity for First Nations and Inuit communities to assess, plan, design, implement and evaluate culturally and community appropriate solutions with the necessary resourcing.

3. Mental health program development is to occur at the pace determined by each First Nation and Inuit community and local control of programs and policies governing community-based initiatives and the regional differences in pace must be respected.

4. In accordance with the BNA Act, 1867 section 91 (24), the federal government has the responsibility for resolving jurisdictional barriers which may impede First Nations and Inuit in implementing their solutions.

5. The continuum of care in mental health services includes a balance among the five essential services advocated by the World Health Organization (WHO): promotion, prevention, treatment, support and aftercare.

(Source: Health and Welfare Canada. *Agenda for First Nations and Inuit Mental Health: Report of the Steering Committee*. June 24, 1991. P.5)

Appendix B: HISTORICAL NOTES

This brief historical review covers the major events in the development, implementation and Health Canada's First Nation Inuit and Health Branch's (FNIHB) delivery of the Brighter Futures and Building Healthy Communities initiatives from 1988, the year that the Health Transfer policy was announced, to the present. It also identifies some of the federal initiatives and other developments that may have influenced the focus of the BF/BHC programs.

A graphic presentation of these developments and events is attached to this report.

THE INITIATIVES

The *Agenda for First Nations and Inuit Mental Health*, completed in June 1991, provided the foundation for the child development and mental health components of the Brighter Futures initiative. It was completed by a steering committee consisting of representatives from the Assembly First Nations Health Commission and senior officials from Health Canada and Indian and Northern Affairs.

The committee's membership was subsequently enlarged to include representatives from several First Nations and a Labrador Inuit community. The committee's work, which followed a two-year study of the mental health status of First Nations populations, included a series of regional consultations.

The committee's definition of mental health was;

> *Among the First Nations and Inuit communities the term mental health is used the broad sense of describing behaviours which make for harmonious cohesive community and the relative absence of multiple problem behaviours, such as family violence, substance abuse, juvenile delinquency, and self-destructive behaviour. It is more than the absence of illness, disease or dysfunction – it is the presence of a holistic, psychological wellness which is part of the full circle of mind, body, emotion and spirit, with respect for tradition, culture and language. This gives rise to creativity, imagination and growth, and enhances the capacity of the community, family group or individual to interact harmoniously and respond to illness and other adversity in healing ways that resolve conflicts constructively, promote improved function and the healthy development of children.*
>
> *Although this definition of "mental health" goes far beyond the general sense of absence of diagnosable psychiatric disorders,*

(which is really the area of mental illness), this limited area must still be included in address because of the individual, family and social burdens to which it gives rise

The report concluded by saying;

In order to meaningfully address the federal health situation of First Nations communities in accordance with policy program principles developed by First Nations and Inuit representatives, the federal government must commit and allocate new resources to First Nation and Inuit communities global, integrated, open and entirely flexible ways, and in pursuit of the five program goals of:

a. community-based planning and programming,

b. adequate and appropriate human resources availability,

c. strengthening families,

d. adequate and appropriate services for the mentally ill and disabled,

e. collaborative policy and structure development.

In February 1992, the federal government announced the Brighter Futures initiative. It consisted of the Child Benefit program, the announcement of the ratification of the Declaration on the Rights of Children, an action plan for Canadian children and the Child Development Initiative. This was a multifaceted, multi-departmental strategy in which Health Canada played a major role.

As part of the broader Child Development Initiative (CDI), Health Canada received ongoing resources to provide financial support to First Nations and Inuit programs in the areas of community mental-health, child development, solvent abuse prevention and treatment, injury prevention, parenting skills and Healthy Babies. The mental health and child development components of the First Nations and Inuit CDI program were planned as interrelated strategies intended to improve the knowledge and skills of people working in the areas of mental health, child development and family living, as well as to develop model community-based mental health projects.

Following the announcement of the new program, Health Canada established a workgroup comprised of federal, First Nations and Inuit representatives to develop a Framework for what is now know as the Brighter Futures initiative. This process led to the adoption of the *Program Framework for the First Nations and Inuit Component Brighter Futures Child Development Initiative* in August 1993. The document, consistent with the recommendations contained in the *Agenda for First Nations and Inuit Mental Health,* set out the following operational principles for Brighter Futures activities:

- *Strengthening and supporting the Child/Family/Community through a holistic approach. Community wellness is the focus and it should be recognized that it is a distinct area integrated with other programs and services at the community level.*

- *Community-Based. The strength and success of community planning comes from the First Nations and Inuit communities ability to plan, design, implement and evaluate appropriate solutions within the necessary resources. First Nations and Inuit communities must also have the opportunity to develop programs responsive to their cultural needs.*

- *Community-Paced. Program development is to occur at the pace determined by each First Nation and Inuit community. There should be local control of programs and policies governing community-based initiatives. The regional differences in pace and funding constraints must be respected.*

- *Continuum of Care. Continuum of care is a range of programming from promotion and prevention to treatment, support and aftercare.*

- *Community-Wide Participation. The intent is to include and involve all community members in program development and implementation.*

- *Coordination and Linkage of Program Activities. The holistic approach is best accomplished when the program elements are coordinated and linked not only with each other, but with other community-based programs such as family violence, substance and alcohol prevention and treatment, and other social, health and educational programs.*

The Framework also detailed the goals, the scope of eligible activities and the expected outcomes for each of the program components. It also provided direction with respect to issues such as program and funding eligibility criteria and resource allocations.

The 5-year budget allocation for the Brighter Futures program totalled $281 million. The largest portion of those resources – $145 million – was allocated to the community mental-health/child development component. A small portion of the resources was retained at headquarters for national level activities, while the balance was distributed to regions based on a formula that took into the consideration the First Nations and Inuit population data and the number of "remote" communities. In accordance with the overall plan, each regional office subsequently established formulas for the allocation of resources to reach the communities in consultation with First Nations and Inuit political organizations and community representatives.

In the fiscal year 1992-93, the Medical Services Branch implemented regional strategic planning processes that incorporated consultation with First Nation and Inuit communities in each of the regions. In addition, it allocated resources to provide financial assistance to First Nations and Inuit communities to undertake their own consultations and to develop plans for future activities and programs.

In June 1994, responding in part to the growing concerns about suicide rates, especially among First Nations and Inuit youth, **the federal government announced the Building Healthy Communities initiative**. The initiative provided programming resources ($30 million per year) to address "critical gaps with respect to mental health, solvent abuse and home nursing."

The Mental Health Crisis Management component of the initiative, which was designed to be administered in conjunction with Brighter Futures, was tended to provide:

- Access to counselling resources within and outside the community;
- Training for community members and caregivers to deal with crisis situations;
- Crisis intervention services such as assessment counselling of individuals and families involved in suicide and other crises that traumatize a community;
- Aftercare and rehabilitation services such as post trauma intervention in caring for the survivors of crises to continue the healing process started treatment centers; and
- Training community workers to provide the services described above conjunction with professional mental health caregivers such as psychologists:

There has been no change in the program mandates of the Brighter Futures and Building Healthily Communities initiatives since their implementation, except that the solvent abuse component of Brighter Futures was transferred to Building Healthy Communities when the latter were implemented in 1994.

INTERVENING DEVELOPMENTS AND EVENTS

Health Transfer

In March 1988, the federal government announced the Health Transfer Policy for transferring health program responsibilities, and the associated funding, to First Nations. The policy provides a framework through which First Nations can, if they chose, assume control of health services.

The first agreement under the transfer policy was signed by the Attikamek-Montagnais in July 1989. By 1994, 122 communities had entered into transfer arrangements; and by 2003 the number had risen to 293 communities.

First Nations operating under transfer arrangements developed and managed health services within a broadly defined accountability structure. This meant, for example, that "transferred" First Nations have the discretion to allocate transferred health care resources, such as Brighter Future and Building Healthy Communities resources to other priorities.

FNIHB Branch Reorientation

The implementation of the transfer policy offered First Nations opportunities to significantly increase the degree of autonomy they can exercise in the healthcare field. It has also had implications for the structure and operations of the First Nations and Inuit Health Branch, and on its operating budget.

In March 1994, the Branch's Departmental Executive Committee decided that it would begin to plan all of its activities with the following goals in mind:

- The devolution of all existing First Nations and Inuit Health Branch health resources to First Nation and Inuit control within a time frame to be determined during consultations with First Nation and Inuit communities;
- Moving Health Canada's First Nations and Inuit Health Branch out of the health care service delivery business;
- The transfer of knowledge and capacity to First Nation and Inuit communities so that they can manage and administer their health resources;
- A refocused role for First Nations and Inuit Health Branch; and a refocused role for Health Canada which will take into account First Nations and Inuit Health Branch's strategic direction.

Targeted Initiatives

Between 1997 and 2000, FNIHB implemented a number of initiatives targeting specific conditions affecting the health and wellness of First Nations and Inuit people. In 1998 the Aboriginal Head Start program was expanded to First Nations communities (AHS On-reserve); in 1998-99, the Tobacco Reduction and Fetal Alcohol Syndrome/Fetal Alcohol Effects (FAS/E) initiatives were announced and in 1999, an initiative to expand the Canadian Prenatal Nutrition Program was launched.

NNADAP Review

In 1998, Health Canada completed the a "general review" of the national Native Alcohol and Drug Addictions Program (NNADAP). Among its many observations and recommendations, the report highlighted the need for coordination and/or integration of addictions, health, social and other human services . With respect to mental health the report observed: "It is difficult and

perhaps impossible to reach or to maintain a perfect balance in the relationship between mental health programs and addictions programs. It is more important to recognize the need for such balance and to strive for the recognition of the roles that both programs need to play in developing healthy individuals, families, communities and Nations."

Enhanced Accountability and Reporting

The 1997 Auditor General's report on Health Canada's First Nations programming highlighted deficiencies in the department's management of contribution agreements and other funding arrangements. It said, for example: "Based on our examination of programs delivered under separate contribution agreements, we found that once the contribution agreements are signed, the link between the Department and the community tends to disappear."

The 2002 Auditor General's follow-up report noted improvements, but continuing problems, in these and other areas affecting the administration of programs such as Brighter Futures and Building Healthy Communities. These reports and other factors have led the Branch to take steps to increase the financial and program monitoring of First Nations' health services.

Royal Commission on Aboriginal Peoples

The work of the Royal Commission, from its inception through to the release of its final report in 1996, had a significant impact on First Nations populations, organizations and governments. Among other things, the commission gave voice to long-standing grievances and increased expectations for solutions to issues such as the quality of health care, including mental health care. In addition, the commission processes have given confidence to First Nations and Inuit leaders and health care providers seeking to contribute to community development and healing processes that incorporate traditional practices and respect their diverse cultures.

Aboriginal Healing Foundation

Since its creation in 1998, the foundation has supported some 1,300 projects and programs. Many, if not most, of these initiatives have dealt with "mental health" as it was defined in the *Agenda for First Nations and Inuit Mental Health*. Many of these projects have created expectations for ongoing mental health services for which there is currently no funding available either through the federal government or First Nations.

Mental Wellness Framework

The Mental Wellness Framework: a Discussion Document for Comprehensive Culturally Appropriate Mental Health Services in First Nations and Inuit Communities (2002) was prepared by an AFN-ITK-FNIHB working group that was created to review mental health issues and make recommendations for the future development of community-based mental health services. This Framework was intended, in part, to help federal government, AFN and ITK advocate for mental health as a mandatory program area.

The elements of a mental health strategy, as envisioned by the Framework, would include program components in the following areas:

- Training / capacity building;
- Promotion / prevention;
- Treatment (early intervention, crisis intervention, long term healing, and aftercare),
- Rehabilitation, and
- Evaluation and research.

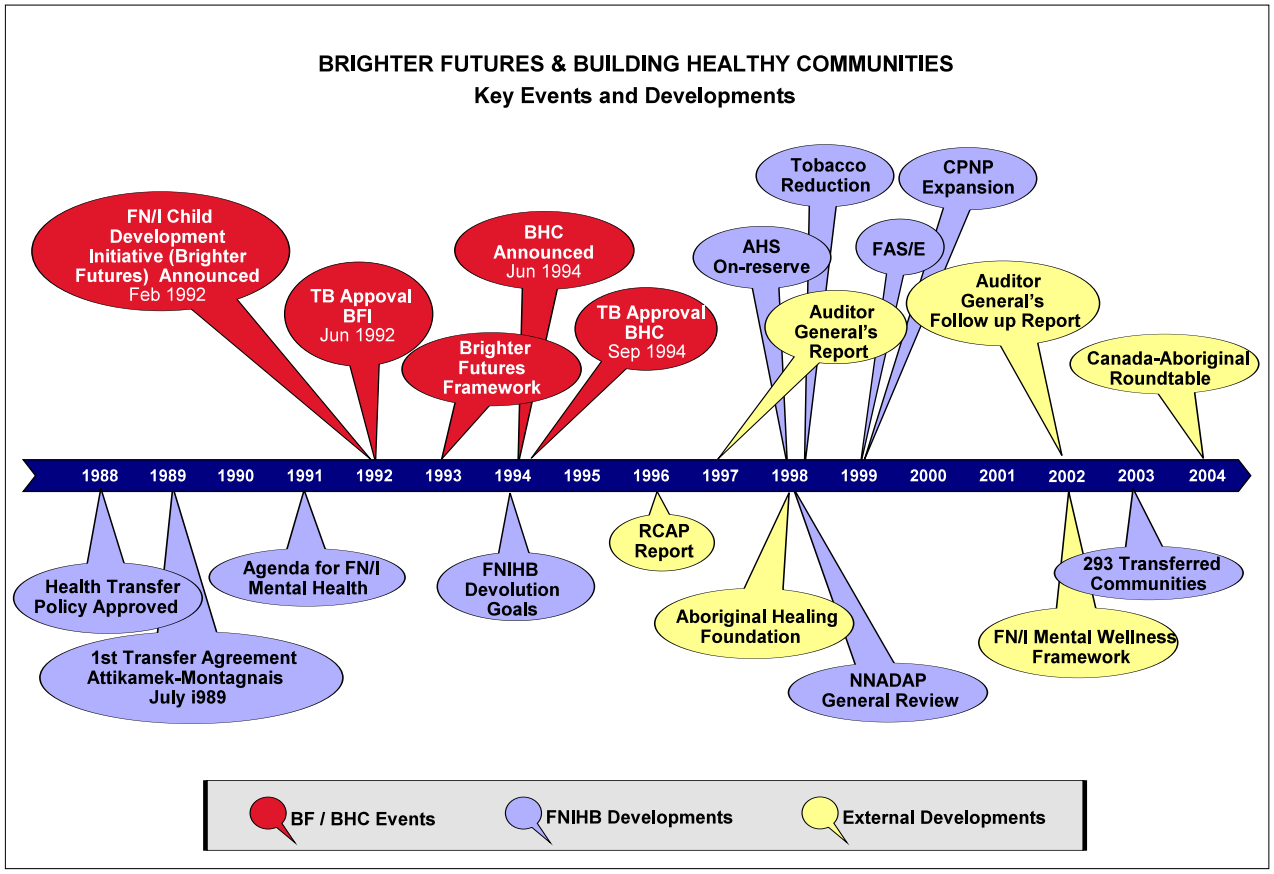
Canada-Aboriginal Peoples Roundtable

On April 19, 2004, Prime Minister Paul Martin met with leaders of the five national organizations: the Assembly of First Nations, the Inuit Tapiriit Kanatami, the Métis National Council, the Native Women's Association of Canada, and the Congress of Aboriginal Peoples. At the conclusion of the roundtable, the Prime Minister made a commitment to conduct "sector-specific policy roundtables" on key issues raised during the event, one of which was mental health.

In addition, roundtable participants called for actions to implement a holistic approach (not pan Aboriginal approaches) to health and wellness that balances western medicine and their cultural values and traditional knowledge of medicine and healing. There was also reference to the need to ensure that Aboriginal children have a good start in life and to focus on healthy children's development.

ANNEX A

This diagram presents some of the principal events and decisions identified within this short historical review.



Appendix C: LITERATURE REVIEW

This literature review was conducted as part of the Brighter Futures / Building Healthy Communities evaluation. It examines published research, studies and reports to assess the state of knowledge in two broad areas. First, it looks at available data on the nature and incidence of mental health issues experienced by First Nations and Inuit people. Second it examines what might be known about the effectiveness of mental health services delivered to residents of First Nation and Inuit communities.

Search Method

The evaluation team used two strategies to identify published research and reports relevant to the questions at hand. First, it searched the online databases published by PUBMed/Medline and Ingenta using the following key words: First Nations; Aboriginal; native; Canada; mental health; health promotion; treatment; psychiatric; psychological; heath promotion; and treatment. These searches identified a total of 70 articles published in Canadian and international professional and academic journals since 1993.

The team then reviewed the article abstracts to eliminate items that were purely editorial in content or in which references to mental health-related material was incidental to the publication's content. This exercise reduced the number of all titles to 51.

Second, the evaluation team searched the web sites of federal, provincial-territorial and regional government agencies responsible for mental health services, as well as those of university and independent research centres and institutes, Aboriginal representative organizations, professional associations and non-governmental agencies with an identified interest in Aboriginal health and/or mental health issues more generally.

This search was undertaken to identify research and/or evaluation reports, bibliographies related to First Nations mental health issues, and reports of any major studies concerning the development and delivery of mental health services to First Nations. The search did not gather program descriptions, public information and education materials.

An bibliography, including abstracts or summaries drawn for the text of the publication, listing the publications were identified using these methods is attached as Appendix A.

General Observation

The literature search indicates that there has been little formal research on First Nations and Inuit mental health. By way of illustration, a PubMed/Medline search using the key words "mental health" and Canada produced 1037 hits; the number of hits fell to a total of 15 when the search criteria were expended by adding "Aboriginal" for a second search, and then "First Nations" for a third.

A minority of the journal publications identified in the search reported original data collection and findings and none of them directly reported the results of evaluation studies dealing with First Nations mental health programs, other than a few suicide prevention initiatives. The results of the web site searches produced similar results.

Analysis

One member of the evaluation team collected and read each of the identified publications to extract information and data relevant to the mental health component of the Brighter Futures / Building Healthy Communities evaluation. The results of that analysis are highlighted below.

FIRST NATIONS AND INUIT MENTAL HEALTH STATUS

Data on the mental health status of Canadians is not readily available. Most estimates of the incidence and prevalence of mental illness/disorders in the general population are based on hospital discharge data and epidemiological surveys and research projects. Using data of this kind, Health Canada estimates that 3 percent of Canadians experience a mental illness during their lifetime. (Health Canada, 2002)

General Status

Kirmayer (1998) reports that there have been few epidemiology studies examining the prevalence of mental disorders within Aboriginal populations. Two of the research reports were published in the early 1970s and suggested that the prevalence of disorders varied from levels comparable to the general population to up to twice those of neighbouring non-Aboriginal communities. Perhaps the best that can be said at this time is that it would be reasonable to assume that the mental health status of First Nations and Inuit people is comparable to their general health status relative to the general Canadian population.

There have, however, been a number of recent studies that have looked into the mental health experience of specific groups:

- A Culture and Mental Health Unit located in Montreal (Kirmayer, Brass & Tait) , in a secondary analysis of the Santé Québec Cree health survey, found that higher levels of psychological distress were associated with younger age, female gender, early loss of parents or a relative, a smaller social network (less than five close friends or relatives). They also report people who had completed education beyond the elementary school level, especially women, were more likely to report suffering elevated distress. The authors suggest that, in the case of middle-aged respondents, this phenomenon might be the consequence of negative residential school experience. Better educated younger women, they speculate, might experience distress as a result of role conflicts: the pressures associated with the demands and expectations of their work/study responsibilities competing with child-rearing and other family responsibilities. In addition to identifying risks for greater distress, the research identified two protective factors. First, individuals who experienced “good relationship with the community” were less likely to experience distress. Second, they observed that “spending more time in the bush” was associated with more positive status, especially for men. The beneficial effect of time in the bush was clearest for men. The authors note that the Cree participating in the survey practice traditional food hunting activities that sustain “a way of life with significant social and spiritual meaning which contribute to well-being.”

- Boothroyd et al did a case-control study of 71 Inuit people who died by suicide between 1982 and 1996 and 71 population-based control subjects matched for sex, community of residence and age within 1 year. Among other things, the team found that people who had died by suicide were significantly more likely to have a lifetime diagnosis of depression, personality disorder and/or conduct disorder and to have experienced more severe nonpsychiatric illnesses and injuries. As a result of such medical histories those that had committed suicide had much more contact with health care personnel and services than the control group. The authors suggest that this means that frontline medical personnel are in a good position to identify people at risk for suicide.

- Jette that a general survey of health and well-being of the Inuit of Nunavik found relatively few concerns about physical health, but significant concern among the respondents about mental health issues including "psychological distress, suicidal thoughts, and parasuicides"

- Corrado and Cohen studied the case files of 127 residential school survivors from British Columbia and found that about 75% of the files contained information about the subjects' current mental health. That information revealed that most common disorders were post-traumatic stress disorder (PTSD) (64.2 per cent), substance abuse disorder (26.3 per cent), major depression (21.1 per cent) and dysthymic disorder (20 per cent). As these figures suggest, a large proportion of the subjects were identified as having two or more disorders. For example, about half of those diagnosed with PTSD, also suffered from one or more of the following: major depression; substance abuse disorder; avoidance personality disorder; and/or another disorder.

  Twenty-two percent of the case files included mental health treatment recommendations, including cognitive therapy (46.4 per cent), residential counselling (28.4 per cent), cognitive-behavioural treatment (25 per cent) and treatment to deal with a negative self-image (10.7 per cent).

- Examinations of the general health status of Aboriginal populations often highlight the mental health dimensions of other illness and health concerns. Allard, Wilkens and Berthelot, for example, report that accidental deaths and suicides account of 40% of the relatively high early mortality rates in populations that comprise a high proportion of Aboriginal people. Daniel et al (2004) found evidence of potential mental health consequences associated with smoking among the residents of a First Nation community. In their discussion of their findings they note that the rate of cigarette use among Aboriginal populations is much higher than the Canadian norm. Iwasaki, Bartlett and O'Neil noted that diabetes, as well as other health, social and economic factors, contributed to elevated stress levels among Aboriginal women suffering form diabetes. Similarly, Daniel et al (2001) found evidence of depression and reduced mastery among residents of a First Nations community who were diagnosed as suffering or at high risk of suffering type-2 diabetes. Again, there is a high incidence of type-2 diabetes among Aboriginal populations.

Suicide

Suicide rates, especially among young First Nations and Inuit people, have been a focus of concern for some time and one of the motivations for creation of the Building Healthy Communities program in the mid-1990s. The available data indicates that these rates, controlling for age and gender, are significancy higher than the general suicide rate (Brant). For example, in Manitoba, researchers found that the age-standardized suicide rates in the period 1988-1994 were 31.8 and 13.6 per 100,000 populations per year among aboriginal and nonaboriginal people, respectively (Malchy), while Archibald and Grey report significantly elevated rates for the Inuit regions: Nunavik 82, Nunavut 77.4, and NWT 18.

It is important to recognize that the rates and risks of suicide appear to vary greatly across the country and from community to community. In Québec, for example, research conducted by the Culture & Mental Health Research Unit at the Institute of Community & Family Psychiatry, with the Inuit communities of Nunavik (Northern Québec), found high rates of suicidal ideation and attempted suicide among adolescents and young adults, while the Cree population did not (Kirmayer, Brass & Tait). Chandler and Lalonde's research with First Nations in British Columbia identifies large variations in suicide rates between various communities. Their study found that the rates in some commuinties were very high compared to the general Canadian population, but that there were no youth suicides over a 5-year period in 111 of the more than 200 bands. The 111 bands accounted for just under half of all BC First Nations youth.

There is also evidence that understandings about suicide based on the general population may not be a sound basis for understanding suicide among Aboriginal youth. Enns et al examined suicidal intent in a group of 77 adolescents who had been hospitalized after attempting suicide and found evidence that indicated that hopelessness was the significant predictor of suicide intent for Caucasian patients, while depressed mood was the only significant predictor in the Aboriginal group.

Factors Affecting Mental Health Status

A number of reports and studies have attempted to shed light on the factors that contribute to the elevated prevalence and incidence of mental illness disorders among First Nations and Inuit people. The strongest theme emerging from this literature relates to the implications of the cultural-political status of First Nations and Inuit peoples and communities.

In "The Mental Health of Aboriginal Peoples: Transformations of Identity and Community," Kirmayer, Brass and Tait write that colonization and cultural contact have had complex and often devastating effects on the community structures, mental health status and individual and collective identities. They, and others (Bartlett; Elias; Chandler & Lalonde) argue that a community's health is linked to the degree of local control and cultural continuity it enjoys.

Research by Chandler and Lalonde has provided some quantitative evidence in support of this view. They examined whether "cultural-continuity" – one's sense of your community's long-term survival – might serve as a protective factor against suicide. More specifically, they undertook to "demonstrate that the risk of suicide in First Nations youth is strongly associated with the ways in which these young persons undertake to construct and defend a sense of identity that allows them to survive as continuous or numerically identifiable persons despite often dramatic individual and cultural change." The researchers argue that common explanations for youth suicide – depression, social isolation or other personal or interpersonal factors – are inadequate and poor predictors of suicide rates. In order to test their hypothesis, they gathered data on suicides and community factors for all BC First Nations. The "community" variables were:

a) evidence that particular bands had taken steps to secure aboriginal title to their traditional lands;

b) evidence of having taken back from government agencies certain rights of self government;

c) community-controlled educational services;

d) community-controlled police and fire protection services;

e) community-controlled health delivery services; and

f) evidence of recognized "cultural facilities" to help preserve and enrich their cultural lives.

The researchers concluded that the greater the presence of these conditions in a community was associated with a "clinically important" reduction in the youth suicide rate and are important protective factors."The presence of self-government, for example, was associated with an 85% reduction in the relative risk of suicide. For the remaining variables, the percentage reductions in relative risk were: Land Claims 41%; Education 52%; Health 29%; Cultural Facilities 23%; and Police/Fire 20%."

Factors Affecting Program Success

The literature identifies a variety of factors associated with the success of mental health and wellness services in First Nations and Inuit communities.

Scale

The size of a community has a range of implications for mental health and other services and most First Nations and Inuit communities are small. Forty-three (43) percent of First Nations communities in the provinces and Yukon have populations of 400 or less, and 34 per cent have populations between 401 and 1,000 (Lemchuk-Favel). Regardless of their geographic location, communities with small populations cannot practically develop and maintain autonomous mental health programs. They are often restricted to programming that has individual staff fulfilling two or more functions (Kirmayer, 1998) and/or taking other measures such as establishing multi-community programs through Tribal Councils or regional health services, or by establishing formal partnerships with provincial or non-governmental agencies (Schmidt; Lemchuk-Favel).

Remoteness

Remote communities, which are typically small communities as well, face additional challenges. Health Canada reports that 35 per cent of First Nations communities are classified as remote, meaning that they have to travel more than 90 kilometres to reach hospital and/or physician services. Further, about 60% of these communities are dependant on air transportation to get health care professionals into the community or to get patients to outside services, including emergency services.

Even when they are able to justify and establish local services, remote communities must deal with high staff turnover rates and the difficulty of recruiting qualified personnel who have the aptitude and knowledge appropriate to community needs. For example, nursing shortages in these communities are chronic. In 1999, about 45 per cent of the nursing positions in remote First Nations communities in the provinces were vacant or filled on a temporary basis (Lemchuk-Favel)

Another challenge facing remote communities, and many small communities with ready access to urban-based services, is that many of the generally accepted mental health service models do not meet their needs. The concept of psychiatric rehabilitation, for example, is an important part of community mental health programming and philosophy. Unfortunately, like many mental health strategics, it is based on a set of urban assumptions, including the assumptions that the community has a range of housing options available to meet the various and changing needs of patients, a range of employment opportunities, and can provide reasonable access to support services such as psychiatry hospitals or clinics, social work services and the like (Schmidt). As remote communities cannot meet these basic assumptions, their residents face higher rates of hospitalization (Dairymple).

One isolated community is trying to deal with this problem by introducing a specialized service. The Régie régionale de la santé et des services sociaux de Nunavik, with support from the Health Transition Fund, has developed a program it describes as an integrated system for persons with severe and persistent mental problems. Working with local service providers, it

has opened a “re-integration centre” in Inukjuak. The centre provides 24-hour care in a structured setting for individuals in need of any of the following: short-term residential care; long-term residential care: respite care; crisis intervention; day programs; and, community follow-up (Dion Stout & Kipling, 2002).

Anonymity

As a result of community size and family ties, service providers and clients in many First nations and Inuit communities do not have the benefit of the sort of privacy and anonymity that is available to their counterparts in larger and urban settings. It has been observed that when mental health workers are members of the community they serve, clients often feel that their privacy and confidentiality are at risk. At the same time, the lack of anonymity, can place significant pressures on workers, even leave them isolated in their own communities. While circumstances where clients and care workers share one another's history and social life may provide a therapeutic environment for some, it very often a barrier to help-seeking for people with mental health concerns. In these circumstances, people who are able to do so may choose to seek help outside of the community services (Kirmayer, 1998; Maar).

Hiring and Retention of Health Care Staff

The literature suggests that First Nations and Inuit health services face major problems recruiting and retaining qualified health personnel (Lemchuk-Favel; Dion Stout; Minore and Boone). A review of projects supported by the Health Transition Fund found that a number of projects were unable to locate or retain staff, even with the provision of special incentives. By way of illustration of the staffing challenges encountered, especially in the North, a project in Nunavut could not be implemented because managers were simply unable to hire a nurse practitioner for a key position. Similarity, a Lakeland Regional Health Authority project was unable to attract suitable candidates for the position of settlement nurse. They believed that this was due, in part, to the professional isolation the incumbent would have to deal with. Similar staff recruitment experiences were reported by a number of other HTF projects. (Dion Stout)

Researchers in Manitoba report that, over a period of 20 years, most physicians recruited to an agency providing services to First Nations stayed less than 2 years. The most common reason for early departure was difficulties with the administration (Kelly). A team examining the retention rates of physicians and nurses in Alaska reported that the lack of adequate medical facilities, professional isolation, limited support services, inadequate organizational settings, excessive workloads and time demands, limited earning potential, lack of social, cultural and educational opportunities, and spousal influence were factors that contributed to early departures in that jurisdiction (Fisher).

The challenges associated with recruiting and retaining qualified staff is not limited to “outside” professionals. One Health Transition Fund project has also encountered difficulties recruiting

and retaining a local workforce. Project managers reported that some employees preferred part-time work so that they could meet family responsibilities and accommodate traditional activities, while others left because of personal crisis and other problems. This led the final report to propose that a minimum of six to eight months be allocated to the recruitment process in small communities without experienced personnel, and that on-the-job training be provided as part of this process (Dion Stout & Kipling, 2002).

Researchers familiar with the delivery of health services in Inuit and northern communities have observed that health services in remote communities are often delivered by transient personnel working with local community workers who are under-trained, unsupported and frequently placed in an untenable social situation while working in their own communities and among their own kin (Kirmayer, 1998). Not the kind of conditions that support sound program delivery or working conditions deigned to encourage staff retention.

Employee burnout was identified has been identified as a factor in employee retention in several studies and reports, including the report on the development of the Nunavik re-integration centre. The authors of that report recommended that health professionals involved in the initiative should "rotate" in and out of the community on a regular basis. (Dion Stout & Kipling, 2002). Lane concluded that frontline staff burnout in healing programs is due to workloads and the difficulties of maintaining professional boundaries. Clements, in her examination of the training needs of First Nations mental health workers in Manitoba also found that staff burnout due to issues arising from the workers simultaneous role as a helper and a community member was a major concern.

Language

Language is an important consideration in the delivery of any services, but particularly so in the area of mental health. Few people are comfortable discussing their emotions and intimate thoughts in a second language, even if they are proficient in their second language. Researchers working in Northern Québec report that few health professionals speak local languages, a situation that can be a barrier to services (Kirmayer, 1998; Kaufert). The use of translators in a clinical setting, the only alternative when the mental health worker does not speak the patient's language, can be awkward. In addition, translation can be unreliable even when the translator has the relevant technical knowledge (Manson, Cattarinicha).

Culture

The culture and traditions of First Nations and Inuit communities and related issues are frequently referenced in publications dealing with mental health. These references range from observations that affirm the importance of culturally appropriate services (e.g., Mussell) to those the explore complex ethnological debates and research (e.g., Kirmayer, Fletcher, Corin & Boothroyd; Adleson, 2000).

The cultures of First Nations or Inuit communities have a variety of implications for the development and delivery of mental health services, as different cultures have different understandings about what constitutes mental health and acceptable forms of intervention. For example, Kirmayer, Fletcher, Corin and Boothroyd examined the concepts of mental health and illness among the Inuit of Nunavik to document their knowledge and practices, as well as to help inform mental health workers and planners. Their research led them to recommend both community education programs to improve the recognition, treatment and rehabilitation of people with major psychiatric disorders and the development of enhanced community and professional intervention services for people facing life crises.

Cattarinicha, Gibson and Cave found that standard instruments for assessing mental capacity were inappropriate for use with Aboriginal seniors in Alberta because the content of instruments was not culturally informed or relevant. They also report that the structure of the instruments did not lend itself well to the assessment of some Aboriginal seniors whose traditional ethics encompass values such as non-competitiveness.

Minde and Minde study of children in a northern Québec Cree community suggests that standard diagnostic classifications may not be effective assessment tools for Aboriginal populations. Their research found that “51% of the children did not qualify for a DSM-III-R diagnosis but their frequently severe behavioural symptoms could be categorized by using 5 types of socio-cultural disturbances,” leading them to conclude that there is “a need to develop a diagnostic classification for child psychiatric disorders for aboriginal children.”

Hotson, MacDonald and Martin, reporting on their research on palliative care for First Nations residents in northern Manitoba, observe that culturally sensitive care includes ensuring that patients have access to traditional services, if requested. The researchers concluded that it is not necessary for medical personnel of know the details of the cultural or traditional ways of caring for a patient, provided they are wiling to accept guidance from the patient and others. Nevertheless, they suggested that community-based orientation of outside health care providers should provide for more culturally appropriate care. The recommendations for “community-based” orientations reflected the finding that each community has its own unique beliefs and circumstances. Kelly, who studied non-Aboriginal physicians practising in Manitoba First Nations, similarly recommended that physicians receive “formal orientation to the history and politics of the community, followed by mentoring and feedback from other health care providers and First Nations' community members could help new physicians as they begin practice in Native communities.”

The fact that cultures, cultural beliefs and expectations about traditional healing practices vary considerably from community to community was noted in several publications (Benoit et al, 2003; Brady; Brant; Couture; Grey; Lemchuk-Favel; Kirmayer, 1998; Smye). Adelson (1998) reports that the healing practices of contemporary Cree communities incorporate ideas from Cree traditions, Christianity, pan-Indianism and popular psychology. Similarly, individuals may or may not share the dominate cultural beliefs and expectations of their community. (Hotson MacDonald and Martin). Further, like all cultures, First Nations and Inuit cultures are continually evolving and changing. Indeed, some observers suggest that the most striking fact about the recent history of most Aboriginal communities is the rapidity with which social and cultural change has occurred, an experience that has challenged Aboriginal identity and resulted in dramatic generation gaps.

Mental Health Program and Service Issues

The literature examined for this report identified and examined a number of issues that have direct implications for the design, development and delivery of mental health services in First Nations and Inuit communities.

Traditional and Healing

There is a comparatively large volume of writing that deals with traditional healing and knowledge, although much of it is ethnological or anthropological in orientation. Few publications have examined questions relating to the role of traditional healing practices in mental health programs specifically, and none of them report on research examining the outcomes for individuals or communities.

That being said, there appears to be a substantial consensus in the literature that the incorporation of traditional teachings and practices has benefits for individuals and communities, especially in terms of affirming identity and self-empowerment.

The interim report of the Aboriginal Healing Foundation found that many of its funded projects supported traditional healing and the increased involvement of healers, Elders and cultural teachings. A few of the projects combine traditional and western approaches to healing. The report's authors felt that more information about the blending of traditional and western approaches is need.

While some projects that focussed on the therapeutic aspect of traditional healing, many others involved culture and tradition in a supportive role: Elders teaching traditional ways in schools; on-the-land excursions and camps; or social activities such as feasts and dances to bring people together. In some cases, opportunities to celebrate community history and culture were seen as a way of overcoming conflict within the community. The authors concluded that "Overall, it is clear that cultural activities enhance personal and community pride and well-being, as well as providing a solid base for healing." (Kishk Anaquot Health Research).

In "Mapping the Healing Experience," Lane identifies five areas of activities in which traditional beliefs and practices play a significant role: participation traditional healing cultural activities; culturally based wilderness camps and programs; treatment and healing programs; counselling and work; and, community development. The report also provides several examples of recent healing programs that illustrate the different approaches.

Kirmayer (1998) and Wardham, in a number of publications discuss the development and implications of the "pan-Indian" healing approaches that blend traditional practices, such as the sweat lodge and healing circles, with mainstream treatment and psychotherapeutic methods. Many of these approaches have been developed and popularized by Aboriginal-run treatment centres.

A report prepared for the National Aboriginal Health Organization examines the nature and scope of traditional medicine and healing knowledge and practice, as well as exploring issues ranging from the ethics to intellectual property rights and the question of whether Elders and healers should be compensated. The report includes a summary of a national consultation with Aboriginal Elders that produced a similarly wide range of recommendations. (Martin Hill)

Training

The subject of training for mental health personnel and related disciplines is treated from a number of perspectives in the literature.

An Aboriginal Nurses Association study reported that Aboriginal nurses deal with critical mental health issues, alcohol and substance abuse issues, violence, abuse and post-traumatic effects. The survey of the associations' membership identified a need for a safe learning environment where nurses in similar working conditions could work together. The study recommended the creation a specialized summer school program for Aboriginal and non-aboriginal nurses working in First Nations and Inuit communities, one designed to address gaps in existing nursing training and professional development (ANAC).

Minore and Boone report that health care services in First Nations in Northern Ontario are typically delivered by small, interdisciplinary teams of professionals, most of whom are non-aboriginal, working with paraprofessional recruited in the community. They say that this model has been adopted to compensate for the lack of professionals willing to work in remote communities, and as a way of addressing cross-cultural barriers. In their view, it is the only workable model available at this time. Based on their research in Northern Ontario, they report that existing training programs for health personnel concentrate on developing of clinical skills, but do not prepare students to actually function in such settings and fail to prepare professionals to work effectively in this environment and that health science education programs need to develop training that does so to "ensure that the full potential of the health human resources available – professional and paraprofessional – are realized and applied to meet the needs of otherwise under-served client populations."

Hogan and Barlow reviewed the outcomes of counsellor training programs that had been delivered in two First Nations in southern Alberta. One of the programs was designed to prepare paraprofessional student counsellors and the other was a two-year social work diploma program. Program curricula were based on an existing social services diploma curriculum from the Mount Royal College. Data collection for the research included reviews of documents, including student evaluations of instructors, key informant interviews with administrators, coordinators and instructors, and student focus groups. The researchers noted that the past educational experiences of students, especially their residential school experience, was a matter that had to be addressed in training program design and delivery. This, the authors say, would include processes and opportunities for student healing within the training curriculum. They also noted that issues surrounding the tension between the desire to preserve traditional culture, while participating in mainstream education had to be the address. The report concludes that the counsellor training programs provided training consistent with the students

learning aspirations and that they could provide “a bridge to higher educational opportunities.” Nevertheless, there was a continuing challenge to develop the programs from a First Nations cultural base and a need to incorporate concepts of healing and a holistic approach to learning.

Research focussing on the training needs of First Nations mental-health workers in Manitoba identified six areas that a curriculum would need to cover: counselling skills; mental health theory and practice; writing and agency skills; public education skills; community development skills; and spiritual/traditional training. The research also pointed out that community mental health workers in First Nations also need continuing working relationships with their community team (Elders, the general public) and also with mainstream mental health specialists for ongoing training supervision and consultation (Clements)

The report of Health Canada’s Manitoba Region’s Mental Health Services Review states that there was a unanimous consensus among key informants in the research about the importance of ongoing training for community workers. While the investigators reported that acceptable training opportunities were available, they found that the there were a number of impediments to training, including financial restraints and the difficulty of scheduling training when workers had no backup. They also indicated that workers saw the lack of any formal recognition of training achievements, whether through salary scales that recognized and rewarded training or accreditation/licencing opportunities that might enhance their ability to seek professional advancement or improved compensation, as a limitation (Migone, O’Neil and Wilkie).

OPPORTUNITIES FOR IMPROVEMENT

Several of the publications examined in this literature review offered proposed recommendations for ways to improve the overall mental health status of First Nations and Inuit people and communities, or ways to improve the quality and accessibility of mental health services for this population. The following briefly highlights those proposals and recommendations

Community Development & Self-determination

As previously noted, Chandler and Lalonde argue that there are significant linkages between the mental health status of community members and the degree of self autonomy that the community has achieved. Other sources echo this theme, arguing that building community, decolonization, self sufficiency, political autonomy, and similar expressions of self-determination important contributors to the well-being of First Nations and Inuit individuals and communities. Accordingly, they argue that community development, effective self-government and other forms of empowerment are key to community healing and individual wellness (Adelson, 1998; Dickson; Dion Stout & Kipling, 2003; Hanson; Kristiann; Simpson & Cargo; Smye & Mussell).

Suicide Prevention

Kirmayer, Boothroyd, Laliberté and Simpson reviewed research literature in order to identify effective suicide prevention strategies for First Nations and Inuit communities in Québec. The information and publications were collected from university databases, various governmental and non-governmental organizations concerned with suicide and suicide prevention and other sources, including the Royal Commission on Aboriginal Peoples. The search strategy was designed to identify programs that were developed or adapted for Aboriginal populations and/or remote communities, that included measures targeting youth, and that incorporated general mental health promotion: 29 programs were identified. The list includes several jurisdictions other than Canada. Based on the program descriptions and available evaluations, the team selected 9 as appropriate models for consideration by First Nations and Inuit communities.

The report concluded that effective suicide prevention has to be part of a "multi-faceted mental health promotion strategy that is the responsibility of the whole community" with a central coordinating capacity. More specifically, it says that effective primary suicide prevention programs in First Nations and Inuit communities should include: training youth to act as peer counsellors; a school curriculum with mental health and cultural heritage components; recreational and sports programs; workshops on life skills, problem solving, and communication; parenting skills workshops; support groups for individuals and families at risk; cultural programs for the community at large; collaboration between community workers in health, social services and education; and training in mental health promotion for lay and professional helpers. In addition to these activities, the researchers recommend that intervention services should be part of the prevention strategy and that the intervention component provide training for primary care providers; a regional crisis hotline; immediate crisis intervention services; and, assessment and intervention services for the parents of youth at risk.

In its report *Acting on What We Know: Preventing Youth Suicide in First Nations*, the Adisory Group on Suicide Prevention made 30 recommendations for improved suicide prevention and intervention services to First nations. The recommendations covered a range of funding, research and development issues, including a that" Health Canada, in partnership with First Nations, establish demonstration projects, using a formal community development methodology, to engage communities for the purpose of developing interventions that utilize a community's existing abilities, resources, and strengths to assist youth at risk, and that facilitators skilled in these approaches be used to guide the process." It further proposed that communities that lacked the internal capacity to develop such strategies be supported in recruiting outside facilitators to help them in the development process (Health Canada, circa 2003).

Best Practices

None of the publications reviewed in this exercise identified best practices for mental health programs in First Nations and Inuit communities. Keeping in mind that the general direction of the development of First Nations and Inuit mental health services emphasizes integrated

holistic approaches, the factors that might be associated with effective health and wellness programs more generally are thought to have immediate relevance here.

Lemchuk-Favel and Jock report that established responsive, sustainable, accessible, and client-focussed Aboriginal health systems share these characteristics:

- Self-empowerment - Aboriginal ownership and control of health services:
- Holistic Approach - Holism and wellness are integrated into community program design, from patient care through to administrative integration of health and social services and integrated planning with housing, training, justice, and corrections, schools and other community-based services.
- Synergy of Traditional and Western Health Philosophies - Traditional healing practices may be combined with western medical approaches to develop uniquely Aboriginal health care approaches.
- Primary Care - The health system is organized around primary care delivered by multi disciplinary teams with linkages to external health resources.
- Collaborations With Provincial Services - Working linkages exist with external health care systems (provincial/territorial).
- Integrated Health Service Delivery - Partnerships between Aboriginal communities exist where they can achieve economies of scale.
- Administrative Reform - The health system is accountable to both the community and the funders.

The Regina-Qu'appelle Health Region commissioned two "best practices" papers. One analyzed the best practices associated with "centres of excellence" and the other the best practices of leading Aboriginal health and healing programs in Canada. In its report "Improving First Nations and Métis Health Outcomes: A Call to Collaborative Action," the region says that the best practices that apply to Aboriginal health and healing programs are:

- The Goal is Equity - The program strives to achieve equitable health and social outcomes for Aboriginal people. Roles and group processes are based on equity and fairness;
- The Underlying Concept of Health is Holistic - All aspects of the program are based on a holistic concept of health that 1) takes into account physical, emotional, mental and spiritual dimensions of health, and 2) recognizes the interconnectedness of individuals, families, communities, and the environment;
- The Programs are Rooted in Culture - All aspects of the program (staffing, facilities, governance, programs, etc.) recognize and affirm Aboriginal cultures and identity. This includes the active involvement of Elders and traditional healers, and the importance of traditional healing and indigenous knowledge to the endeavour;

- The Strategies are Founded on a Recognition of the Importance of Cooperation and Partnerships - All aspects of the program recognize and affirm that interdisciplinary, multi-sectoral cooperation and partnerships are the foundation for successful Aboriginal health and healing initiatives.

- The Community has Voice - Programs are community-based, they reflect the priorities of the community, and they are accountable to the community. Policies and governance assure not only community involvement, but community voice and community responsibility for program directions.

1. Abbey S. and Hood E. Psychiatric consultation in the Eastern Canadian Arctic: mental health issues in Inuit women in the Eastern Arctic. Canadian Journal of Psychiatry, Vol. 38. No. 1, pp. 32-35.

2. Aboriginal Nurses Association of Canada. Aboriginal Nursing Educational Needs Analysis: Results of a National Survey (Final Report), Aboriginal Nurses Association of Canada, Ottawa, October 2002

3. Adelson N. Social Health and Community Healing. *Widening the Circle: Collaborative Research for Mental Health Promotion in Native Communities*. Institute of Community of Family Psychiatry of the Sir Mortimer B. Davis-Jewish General Hospital. September 1998.

   Healing is as much a personal and spiritual phenomenon as it is a process of social and political recuperation. While this session focuses primarily on the active processes of healing, the underlying premise is that healing has as much to do with overcoming personal trauma as it does with the vitality of communities, and with the very essence of identity in an increasingly complex Canadian Native reality. While indigenous/ spiritual healing is generating some debate at the community level, it is at the same time gaining acceptance and adherents in more and more communities across Quebec—in other words, there is a variety of responses to the growing healing movement.

4. Adelson N. 'Being Alive Well' Health and the Politics of Cree Well-Being Anthropological Horizons. University of Toronto Press. 2000.

   "Being Alive Well": Health and the Politics of Cree Well-Being is a critical medical anthropological analysis of health theory in the social sciences with specific reference to the James Bay Cree of northern Québec. In it the author argues that definitions of health are not simply reflections of physiological soundness but convey broader cultural and political realities. The book begins with a treatise on the study of health in the social sciences and a call for a broader understanding of the cultural parameters of any definition of health.

   Following a chapter that outlines the history of the Whapmagoostui (Great Whale River) region and the people, Adelson presents the underlying symbolic foundations of a Cree concept of health, or “Miyupimaatisiiun.” The core of this book is an ethnographic study of the Whapmagoostui Cree and their particular concept of "health" (miyupimaatisiiun or "being alive well"). That concept is mediated by history, cultural practices, and the contemporary world of the Cree, including their fundamental concerns about their land and culture. In the contemporary context, health - or more specifically, "being alive well" - for the Cree of Great Whale is an intimate fusion of social, political, and personal well-being, thus linking individual bodies to a larger

socio-political reality. (Publishers Note)

5. Allard YE, Wilkins R, Berthelot JM. Premature mortality in health regions with high aboriginal populations. *Health Rep*. 2004 Jan;15(1):51-60.

   Objectives: Potential years of life lost (PYLL) before age 75 in health regions with a relatively high proportion of Aboriginal residents is compared, by cause of death, with all other health regions.

   Data Sources: The findings are based on mortality data for 1995 through 1997 from the Canadian Vital Statistics Database, and on population estimates for 1995, 1996 and 1997 at the health region level.

   Analytical Techniques: PYLL was calculated by age and sex for two groups of health regions: the 18 with a high proportion (19% or more) of Aboriginal residents and the remaining 120, which had smaller proportions of Aboriginal residents. PYLL rate differences and rate ratios were used to compare the two groups.

   Main Results: The PYLL rate per 1,000 person-years at risk for all causes of death was about 50% greater in the high-Aboriginal health regions than in the other group. Almost 40% of total PYLL in high-Aboriginal health regions was attributable to injuries, notably, suicide and motor vehicles accidents.

6. Archibald L & Grey R. Evaluation of models of health care delivery in Inuit regions. Inuit Tapirisat of Canada/ Health Canada 2000

7. Bartlett JG. Involuntary cultural change, stress phenomenon and aboriginal health status. Can J Public Health. 2003 May-Jun;94(3):165-7, 232.

8. Benoit C, Carroll D, Chaudhry M. In search of a healing place: Aboriginal women in Vancouver's Downtown Eastside. Soc Sci Med. 2003 Feb;56(4):821-33 (Department of Sociology, University of Victoria, P.O. Box 3050, Victoria, BC, Canada V8W 3P5. cbenoit@uvic.ca)

   Research on general health service delivery in urban areas of Canada shows that Aboriginal people face formidable barriers in accessing culturally appropriate and timely care. Over the past decade, Urban Aboriginal Health Centres (UAHCs) have emerged to address the unmet health concerns of Aboriginal people living in metropolitan areas of the country. The purpose of this research was to address the gap in social science literature on how the health care concerns of Aboriginal women are being met by UAHCs. The research aimed to give voice to Aboriginal women by asking them whether the appropriate professional services and educational programs they need to address their health care needs were being provided in the inner city. A case-study approach was used whereby three separate focus groups were conducted with Aboriginal women who were clients of the Vancouver Native Health Society

(VNHS), its sister organization, Sheway, or residents of Vancouver's Downtown Eastside (DTES). In addition, twenty-five semi-structured interviews were conducted with VNHS staff, health providers, government representatives, and community leaders in health care (total n=61). The findings indicate that despite efforts from various quarters to articulate the health and social concerns of the country's marginalised populations, such has not been the case for Aboriginal women living in one of Canada's most prosperous cities. Many Aboriginal women expressed a strong desire for a Healing Place, based on a model of care where their health concerns are addressed in an integrated manner, where they are respected and given the opportunity to shape and influence decision-making about services that impact their own healing.

9. Boone M, Minore B, Katt M, Kinch P. Strength through sharing: interdisciplinary teamwork in providing health and social services to northern native communities. Can J Commun Ment Health. 1997 Fall-Autumn;16(2):15-28.

   The delivery of health and social services in Canada's northern First Nations is undermined by the fact that professionals from outside and para-professionals from the communities often fail to respect one another's capabilities or to understand one another's roles and, consequently, do not work well together. This paper explores the personal, professional, and situational causes, using examples of mental health care in the Sioux Lookout Zone of northwestern Ontario. Arguing that an interdisciplinary team approach is the ideal and, perhaps, the only real way in which essential services can be delivered, the authors suggest ways to achieve more effective collaboration.

10. Boothroyd LJ, Kirmayer LJ, Spreng S, Malus M, Hodgins S. Completed suicides among the Inuit of northern Québec, 1982-1996:a case-control study. CMAJ Sept. 18, 2001; 165 (6) 749-755

    Background: The rate of completed suicide among Inuit in Canada has been alarmingly high in recent years, and the suicide rate among Inuit in northern Québec has increased since 1982. Our objectives were to describe the characteristics of Inuit people who died by suicide in Nunavik between 1982 and 1996, and to identify the antecedents and correlates of completed suicide.

    Methods: We carried out a case-control study of 71 people who died by suicide between 1982 and 1996 and 71 population-based living control subjects matched for sex, community of residence and age within 1 year. Comprehensive medical charts were reviewed for data on socio-demographic characteristics, medical and psychiatric history, childhood separations and family history, and use of health care services.

    Results: Most of the case subjects were single males aged 15 to 24 years. The two principal means of suicide were hanging (in 39 cases [54.9%]) and gunshot (in 21 cases [29.6%]). About 33% had been in contact with medical personnel in the month before their death. The case subjects were significantly more likely than the control subjects to have received a lifetime psychiatric diagnosis (one or more of depression, personality disorder or conduct disorder) (odds ratio [OR] 4.3 [95% confidence interval

(CI) 1.2-15.2]) and to have had a history of psychiatric symptoms, disorder (including solvent sniffing) or treatment (OR 3.5 [95% CI 1.4-8.7]). The case subjects had experienced more severe types of nonpsychiatric illnesses and injuries than the control subjects (p = 0.04). The case subjects had more lifetime contacts with health care services than the control subjects (p = 0.01) and were more likely than the control subjects to have had contact with health care services in the year before death of the case subject (p = 0.03), even when psychiatric diagnoses were controlled for in conditional regression analysis (OR 1.02 [95% CI 1.01-1.04] and 5.0 [95% CI 1.07-23.7] respectively).

Interpretation: Since case subjects had frequent contact with health care services, frontline medical personnel may be in a position to identify people at risk for suicide.

11. Brady M. Culture in treatment, culture as treatment. A critical appraisal of developments in addictions programs for indigenous North Americans and Australians. Soc Sci Med. 1995 Dec;41(11):1487-98. (Australian Institute of Aboriginal and Torres Strait Islander Studies, Canberra, Australia.)

    Indigenous people in Australia and in North America have been creating innovative interventions in the addictions field for several years now--incorporating traditional healing practices and cultural values into otherwise western programs--although this process is more developed in Canada and the U.S. than it is in Australia. Through a process of cultural diffusion, Australian Aborigines have incorporated many ideas from Native Canadian treatment models. As a result, residential treatment utilizing adapted forms of the 12 steps of Alcoholics Anonymous is being promoted by indigenous Australians. This paper examines comparative material on the uses of culture as a form of healing and traces the rationale for the argument that cultural wholeness can serve as a preventive, or even curing agent in drug and alcohol abuse. This is a qualitative leap from the now universally accepted notion that treatment and rehabilitation for native people should be culturally appropriate. There are, however, certain dilemmas confronting native treatment directors attempting these syncretic approaches, given aspects of cultural contexts which can serve to foster drug and alcohol use rather than discourage it. Additionally, North American Indians have at their disposal a rich heritage of communal healing techniques; some (such as the sweat lodge) have been adapted and incorporated into the treatment both of solvent abuse by adolescents, and alcohol abuse by adults. In Australia on the other hand, traditional healing techniques have been less amenable to adaptation. On neither continent are indigenous people attempting to adapt recent mainstream models of intervention to suit their needs (such as Brief Intervention) which is currently receiving international attention in addictions research and treatment.

12. Cattarinich X, Gibson N, Cave AJ. Assessing mental capacity in Canadian Aboriginal seniors. Soc Sci Med. 2001 Dec;53(11):1469-79. (Department of Sociology, Faculty of Graduate Studies and Research, University of Alberta, Edmonton, Canada.)

    In recent years, researchers and practitioners have begun to modify existing cognitive assessment instruments and develop new tools in order to increase the accuracy of

mental capacity evaluations among seniors in cross-cultural settings. Based on a review of the literature and consultations with members of the Aboriginal capacity assessment committee at the Royal Alexandra Hospital in Edmonton, Canada, during the summer of 1998, the authors argue that both the process by which capacity assessments are conducted and the content of the assessment instruments are problematic. The article summarizes the difficulties that differing degrees of acculturation within and between Aboriginal groups create for cognitive evaluations. It recommends steps that mental health professionals can follow to develop meaningful assessment strategies for Aboriginal seniors that reflect both the content and the interactional processes that characterize their traditional cultural orientations.

13. Chandler MJ. and Lalonde C. "Cultural continuity as a hedge against suicide in Canada's First Nations." Transcultural Psychiatry 35.2 (1998): 191-219.

14. Clements K. Assessing the Training Needs of First Nations Mental Health Workers in Manitoba (Master's Thesis , Dept. of Anthropology , University of Manitoba) 1997

    In the past there have been few mental health services in Manitoba First Nations communities, but currently First Nations are developing innovative approaches to mental health which uniquely suit their communities. There is a need for trained community workers to work within evolving First Nations approaches to mental health, but what special skills and training do these workers require? Answers to this question can be found within the knowledge of those already working in First Nations health and social services, that is, within the knowledge of those who are part of the process of developing their communities' approaches to mental health. Through open-ended interviews, people in three Manitoba reserve communities are asked the following questions: what does mental health mean; what are the problems, the causes, and the solutions to mental health problems in their communities; what training and skills do First Nations mental health workers need; what are the attributes of a good helper; and what supports do helpers require?

15. Corrado R, Cohen I. Mental Health Profiles for a Sample of British Columbia's Aboriginal Survivors of the Canadian Residential School System. The Aboriginal Healing Foundation. 2003.

16. Couture JE. Comments on Hollow Water Community Healing. Kirmayer LJ, Macdonald ME, Brass GM (editors) The Mental Health of Indigenous Peoples: Proceedings of the Advanced Study Institute. McGill Summer Program in Social & Cultural Psychiatry and the Aboriginal Mental Health Research Team, Institute of Community and Family Psychiatry, Department of Psychiatry, McGill University

17. Cox J, Bota GW, Carter M, Bretzlaff-Michaud JA, Sahai V, Rowe BH. Domestic violence. Incidence and prevalence in a northern emergency department. Can Fam Physician. (Department of Family Practice, Sudbury Regional Hospital, Ontario.)

Objective: To examine the incidence and prevalence of domestic violence (DV) against women presenting to emergency departments.

Design: Prospective cohort study to determine health status and exposure to DV.

Setting: Hospital emergency department in urban northern Canada.

Participants: Random sample of women older than 16 presenting to the emergency department for any reason.

Main Outcome Measures: Demographic variables, exposure to DV.

Results: Of 1800 potential subjects, 577 (32%) did not fit inclusion criteria. Of the remaining 1223, 983 (80%) agreed to participate. Mean age was 41, 135 of participants (14%) were aboriginal, and 546 (56%) were married. Overall, 725 (74%) had current partners. Incidence of DV resulting in emergency department presentation on the day of assessment was 2%. Of women with partners, 66 (9%) had previously been threatened or injured by those partners. Lifetime prevalence of DV was 51%; physical DV was experienced by 40%. One-year prevalence was 26%.

Conclusion: Incidence of DV was lower than expected; prevalence of DV was high.

18. Dalrymple AJ, O'Doherty JJ, Nietschei KM. Comparative analysis of Native admissions and registrations to northwestern Ontario treatment facilities: hospital and community sectors. Can J Psychiatry. 1995 Oct;40(8):467-73. (Lakehead Psychiatric Hospital, Thunder Bay, Ontario.)

    Objective: To study Native and non-Native admissions to acute psychiatric care in the northwestern region of Ontario in 1992.

    Method: To replicate a 1986 to 1987 study comparing Native to non-Native admissions to acute psychiatric care in the northwestern region of Ontario in 1992 and examine Native registrations to community mental health agencies in the first 6 months of 1993.

    Results: The comparative analysis of hospital admissions revealed that: Natives are still being admitted at 33% more than the rate expected on the basis of population; depression appears to be under diagnosed for Natives; they continue to be admitted mainly for reasons other than major psychiatric conditions; substance abuse and forensic history are commonly involved; they stay in hospital for twice as long as their non-Native control; they more often come from rural settings; and they are less likely to be followed by the outpatient service and more likely to be followed by the criminal justice system. The examination of registrations to community mental health agencies revealed that: the same over representation of Natives; mood- and thought-presenting problems of Natives in this sector were identical to non-Natives; and their length of stay was similar. The psychiatric hospital appears to be providing acute care treatment, not for the serious psychiatric illnesses for which it is mandated, but for atypical admissions that result from economic, social and cultural dislocation. There

may be under diagnosis of atypical depression in the Native hospitalized population. When asked what they are being treated for the diagnostic profile of Natives and non-Natives is identical on mood and thought dimensions.

Conclusion: No appreciable change has occurred over the 5 years in the way hospital psychiatric services are used by Natives. Cultural stereotypes may be influencing the diagnosis of Natives in inappropriate ways. Enhancing Native control of treatment programs and community development may provide a partial solution. Properly mandated and accountable community agencies (both generic- and culture-specific) will help reduce unnecessary hospitalization.

19. Daniel M, Cargo MD, Lifshay J, Green LW. Cigarette smoking, mental health and social support: data from a northwestern First Nation.Can J Public Health. 2004 Jan-Feb;95(1):45-9. (Department de medecine sociale et preventive, Universite de Montreal, succursale Centre-ville, Québec. mark.daniel@umontreal.ca)

Background: The prevalence of smoking is high in many Aboriginal Canadian communities; rates of 50% are not uncommon. Aboriginal Canadians suffer a severe burden of smoking-related disease. Research in other populations has linked depression and smoking. It is not known whether mental health or affective measures are related to smoking for any of Canada's First Nations, and this study sought to answer this question. Understanding relations between affect and smoking behaviour is requisite to mounting anti-smoking interventions.

Methods: Smoking status and psychosocial measures including depression, mastery, affect balance and social support were obtained in a community-based chronic disease survey for a rural Interior Salishan First Nation in British Columbia (Plateau area). Persons surveyed were on-reserve residents (n=187), overweight (body mass index > or = 25 kg/m2), with mean age of 44.1 years (standard deviation 15.0).

Results: The prevalence of smoking was 48.1%. Adjusted for age, sex and body mass index, smokers relative to nonsmokers had higher ($p<0.010$) depression (mean 21.3 [CI 95%, 19.1-23.4] vs. 16.1 [14.1-18.0]) and negative affect (18.6 [14.9-22.3] vs. 11.0 [7.6-14.4]), and lower mastery (36.4 [35.5-37.3] vs. 38.1 [37.2-38.9]). A positive relationship between mastery and social support was greater for nonsmokers ($p=0.046$).

Conclusion: Depression and negative affect are associated with smoking among overweight persons in a rural First Nation in British Columbia. Furthermore, smoking is inversely related to mastery, and this relation varies with social support. Longitudinal study is required to determine whether smoking influences mental health and mastery, or the reverse.

20. Daniel M, Rowley KG, Herbert CP, O'Dea K, Green LW. Lipids and psychosocial status in aboriginal persons with and at risk for Type 2 diabetes: implications for tertiary prevention. Patient Educ Couns. 2001 Apr;43(1):85-95. (Department of Health Behavior and Health Education, School of Public Health, The University of North Carolina, Chapel Hill, NC 27599-7400, USA. mdaniel@sph.unc.edu)

This study assessed psychosocial correlates of dyslipidemia, towards enabling improved tertiary prevention of macro vascular complications of diabetes mellitus (DM). We tested the hypothesis that psycho social measures are related to high-density lipoprotein cholesterol (HDL-C) and triglyceride concentrations in a rural aboriginal population in British Columbia, Canada. Persons sampled were on-reserve registered Indians (n=198) with and at risk for Type 2 DM. Relationships between HDL-C and psycho social variables were associated with glycemic status. For persons with diabetes and impaired glucose tolerance (n=44), quality of life and mastery were positively related (P<0.001), and depression inversely related (P<0.001), to HDL-C. An apparent lack of effect of behaviour suggests the influence of emotional pathways involving autonomic-neuroendocrine axes. We recommend assessing mental health, and promoting mastery and diabetes quality of life through empowerment oriented diabetes management strategies, in negotiating culturally acceptable treatment of diabetic dyslipidemia for aboriginal people.

21. Dickson G. Aboriginal grandmothers' experience with health promotion and participatory action research. Qual Health Res. 2000 Mar;10(2):188-213. (College of Nursing, University of Saskatchewan, Canada.)

This article describes a case study examining the effects of participating in a health promotion project, one aspect of which was a health assessment conducted using participatory action research. The study was carried out over 2.5 years in a project for older Aboriginal women (hereafter known as the grandmothers). Participation in the project and health assessment contributed to a number of changes in them, which were categorized as cleansing and healing, connecting with self, acquiring knowledge and skills, connecting within the group, and external exposure and engagement. This experience demonstrated an approach to health promotion programming and conducting a health assessment that was acceptable to this group of people and fostered changes congruent with empowerment.

22. Dion Stout, M. 1995. Social and Economic Factors Affecting Aboriginal Women's Mental Health: A Theoretical Perspective. Ottawa: Native Physicians of Canada.

23. Dion Stout M & Kipling GD. Aboriginal Health: Synthesis Series. Health Canada. 2002.

The Health Transition Fund (HTF), a joint effort between federal, provincial, and territorial governments, was created out of the 1997 federal budget to encourage and support evidence-based decision making in health care reform. Between 1997 and 2001, the HTF funded approximately 140 different pilot projects and/or evaluation

studies across Canada. In order to communicate research evidence from the projects to decision-makers, experts were employed to synthesize the key process and outcome learned in each of nine theme or focus areas: home care, pharmacare, primary care/primary health care, integrated service delivery, children's health, Aboriginal health, seniors' health, rural health/telehealth, and mental health. This document summarizes the key learnings from 21 projects in the Aboriginal health theme area.

24. Dion Stout M and Kipling G. Aboriginal People, Resilience and the Residential School Legacy. Aboriginal Healing Foundation. 2003

    The government of Canada established the Aboriginal Healing Foundation (AHF) in March 1998 to address the Legacy of Physical and Sexual Abuse suffered by Aboriginal people in residential schools. Since the Foundation supports research that promotes healing, a priority to study the resilience of individuals, families and communities within the context of the residential school legacy has been acknowledged. In this report, a critical analysis of the resilience literature is undertaken and is considered against the cultures, lived experiences and larger social contexts of Aboriginal Survivors of residential school. The findings [...] serve as the basis for recommended actions in the areas of planning and research, interventions and evaluation.

25. Elias B. The Influence of the Social Environment on the Health of Manitoba First Nations Communities. (Abstract Only)

26. Enns MW, Inayatulla M, Cox B, Cheyne L. Prediction of suicide intent in aboriginal and non-aboriginal adolescent inpatients: a research note. Suicide Life Threat Behav. 1997 Summer; 27(2):218-24. (Department of Psychiatry, University of Manitoba, Winnipeg, Canada.)

    The relationship among depressive symptoms, anxiety, hopelessness, and suicidal intent was explored in a group of 77 adolescents who had been hospitalized after attempting suicide. Regression analyses indicated that hopelessness was the only significant predictor of suicide intent in Caucasian patients, and depressed mood was the only significant predictor in the Aboriginal group. Clinicians should be aware that measures of hopelessness may be of limited value in assessing suicidal risk in Aboriginal adolescents.

27. Fisher DG, Pearce FW, Statz DJ, Wood MM. Employment Retention of Health Care Providers in Frontier Areas of Alaska, International Journal of Circumpolar Health 62:4 2003. 423-435

    Objectives. The objectives of this study were to: describe the length of employment of health care providers in rural Alaska; assess whether there are differences in length of employment among community health aides, medical doctors, and nurses; and determine whether provider length of employment is significantly increased following

implementation of telemedicine.

Study Design. We conducted a prospective cohort study of length of employment among health professionals in rural Alaska, and identified the cohort based on current employment status of community health aides, medical doctors, and nurses.

Methods. Employment data were collected from four Alaska Native regional health corporations. Kaplan-Meier product-limit survival analysis was used to assess employment length. The Mantel-Haenszel log-rank test was used to test the difference between retention (survival) curves among doctors, nurses, and community health aides for all four regional health corporations combined. Data included provider hire date, termination date, and position title. Fifty seven percent of the data points were right-hand censored.

Results. The community health aides (median (Mdn) = 1186 days) were retained significantly longer than either the doctors (Mdn = 596 days), or the nurses (Mdn = 408 days), who were not significantly different from each other (log-rank c2 (2, N = 996) = 68.30, p = 0.0001).

Conclusions. Our findings document that community health aides in the region retain their jobs significantly longer than doctors and nurses. Findings highlight the problem of providing an adequate health work force in rural areas.

28. Grey R. Inuit Concepts of Mental Health and Illness. Widening the Circle: Collaborative Research for Mental Health Promotion in Native Communities, Institute of Community of Family Psychiatry of the Sir Mortimer B. Davis-Jewish General Hospital. September 1998 p 42-44

    This is an opportunity to provide Inuit perspectives on mental health issues to conference participants. Mental health is a challenging area for Inuit peoples to explore and understand as it is associated with good and bad spirits. Indigenous peoples and Western scientists such as anthropologists and psychologists have different understandings of how the human mind works. The workshop will cover Inuit perspectives and theories on mental illness.

29. Hanson I, Hampton MR. Being Indian: strengths sustaining First Nations peoples in Saskatchewan residential schools. Can J Commun Ment Health. 2000 Spring;19(1):127-42. (Saskatchewan Institute of Applied Science and Technology.)

    This qualitative study asked the question: what were the strengths that contributed to the survival of First Nations peoples during their stay in residential schools? Six Elders who are survivors of residential schools in southern Saskatchewan were asked to respond in narrative form to this research question. Analysis of interviews revealed that, drawing on community-building skills of First Nations cultures, they created their own community with each other within the confines of this oppressive environment. The strengths they identified are consistent with sense of community identified in community psychological literature, yet are also unique to First Nations cultures. These strengths are: autonomy of will and spirit, sharing, respect, acceptance, a strong sense

of spirituality, humour, compassion, and cultural pride. It is suggested that community-based mental health initiatives which identify traditional sources of strengths within First Nations communities will be most effective in promoting healing from residential school trauma.

30. Health Canada. Acting on What We Know: Preventing Youth Suicide in First Nations: Report of the Advisory Group on Suicide Prevention. (circa. 2003)

    Suicide among First Nations youth has been occurring at an alarming rate in recent years. Statistics show an Aboriginal suicide rate two to three times higher than the non-Aboriginal rate for Canada, and within the youth age group the Aboriginal suicide rate is estimated to be five to six times higher than that of non-Aboriginal youth .

    In July, 2001 a Suicide Prevention Advisory Group was jointly appointed by National Chief Matthew Coon Come of the Assembly of First Nations and former Minister of Health Allan Rock. The purpose of this Advisory Group was to review the existing research and formulate a series of practical, doable recommendations to help stem the tide of youth suicides occurring in First Nations communities across Canada.

    The Advisory Group met between July 2001 and June 2002 to collaborate on this task. Through discussion, literature review and preparation of background papers, key issues were identified and recommendations generated. This report provides an examination of these issues, from basic suicide data to specific factors affecting First Nations, and based on this, presents recommendations for action.

    The recommendations listed below fall into four main themes: (1) increasing knowledge about what works in suicide prevention; (2) developing more effective and integrated health care services at national, regional and local levels; (3) supporting community-driven approaches; and (4) creating strategies for building youth identity, resilience and culture.

    No single approach is likely to be effective on its own. To reduce the risk of suicide, it is essential to make multi-level changes to systems that support youth, families and communities in crisis.

    This report sets out a concrete series of steps, some of which can be immediately initiated by government and Aboriginal organizations. It is hoped that through these recommendations a collaborative and proactive response to First Nations youth suicide prevention will emerge.

31. Health Canada. A Report on Mental Illnesses in Canada. Ottawa, Canada 2002.

    Mental illnesses touch the lives of all Canadians, exerting a major effect on relationships, education, productivity and overall quality of life. Approximately 20% of individuals will experience a mental illness during their lifetime, and the remaining 80% will be affected by an illness in family members, friends or colleagues. With sufficient attention and resources, much can be done to improve the lives of people living with

mental illness.

A Report on Mental Illnesses in Canada is designed to raise the profile of mental illness among government and non-government organizations, and the industry, education, workplace, and academic sectors. It describes major mental illnesses and outlines their incidence and prevalence, causation, impact, stigma, and prevention and treatment. Policy makers will find the information contained in this report valuable for shaping policies and services aimed at improving the quality of life of people with mental illness. Five mental illnesses and the phenomenon of suicidal behaviour have been selected for inclusion in this document by virtue of their high prevalence rates or because of the magnitude of their health, social and economic impact. Suicidal behaviour, while not in itself a mental illness, is highly correlated with mental illness and raises many similar issues. Future reports will address other mental illnesses as well as addictions.

A Report on Mental Illnesses in Canada responds to a recommendation from the Workshop on Mental Illnesses Surveillance, organized in September 1999 by the Canadian Alliance on Mental Illness and Mental Health (CAMIMH), with assistance from Health Canada. The workshop recommended the collation of existing data as the first step toward developing a surveillance system to monitor mental illnesses in Canada.

To study mental illnesses in Canada, this report uses the Canadian data that are currently available (hospitalizations in general hospitals and mortality data), as well as provincial studies. [...] Hospitalization data have limitations, however. Many factors other than the prevalence and severity of illness can influence hospital admissions and lengths of stay. Moreover, the majority of people with mental illnesses are treated in the community rather than in hospitals, and many may not be treated at all within the formal health care system. Data from provincial psychiatric hospitals would provide additional insight, but these data were unavailable by type of illness at the time of writing.

32. Health Canada. A Statistical Profile on The Health of First Nations in Canada. 2002.

This report presents a national description of the current health status and conditions of First Nations people on reserves in Canada. The statistics herein can be compared with available local health status and trends to help develop community health plans and to prioritize prevention programs, interventions and services. At regional and national levels, this information can be used to monitor trends and to detect emerging health priorities.

In keeping with the health determinants model that is complementary to Aboriginal perspectives of wellness, one that encompasses physical, social, emotional and spiritual domains—a section on some of the non-medical determinants of health has been included. That section presents information obtained from Health Canada's First Nations and Inuit Health Branch, Indian and Northern Affairs Canada and Statistics

Canada on education, employment, housing conditions, water quality and sewage

treatment.

33. Hotson KE, Macdonald SM, Martin BD. Understanding death and dying in select first nations communities in northern Manitoba: issues of culture and remote service delivery in palliative care. Int J Circumpolar Health. 2004 Mar;63(1):25-38. (Department of Family Medicine, University of Manitoba. ken_hotson@medscape.com)

Objectives: The purpose of this study was to delineate and describe the local palliative care services available to residents of remote Aboriginal communities in northern Manitoba; to identify attitudes and beliefs about death, dying and palliative care in these communities; and to explore obstacles related to palliative care service delivery from the perspectives of culture and geographic isolation.

Study Design: Forty-four in-depth semi-structured interviews were conducted with a representational sample of key informants including Aboriginal people resident in remote communities, community Elders and religious leaders, doctors, nurses and allied health care providers working in First Nations Communities, as well as specialist service providers in Winnipeg. Thematic qualitative analysis was done on the data collected. Data collected from interviews with northern physicians and nurses was coded and analyzed.

Results: Currently, many Aboriginal people living in remote communities are transported to large urban centers to die, isolated from friends, family and their culture. However, the majority of Aboriginal people and health care providers interviewed reported that Aboriginal people living in remote communities would prefer to die at home. The issues surrounding palliative care provision in remote Aboriginal communities are cultural and geographic. Culturally sensitive care requires that patients have access to family supports and traditional services if requested. Geographic isolation requires that: 1. patient-specific care plans be created for use in the remote community; 2. effective lines of communication are established between remote health care providers and urban specialists; 3. health care providers and family care-givers be properly trained to fill their respective roles; and 4. appropriate guidelines and resources be available in the community to support this type of care.

Conclusions: Providing the equipment, supports and education necessary for home-based palliative care in remote Aboriginal communities can be an effective way of addressing the medical, psycho-social, and spiritual needs of these patients.

34. Hudon F. Setup of an Integrated System For Persons Suffering From Major Psychiatric Problems. Inuulitsivik Health Centre, Puvirnituq. March 2001

35. Hunter E, Harvey D. Indigenous suicide in Australia, New Zealand, Canada, and the United States. Emerg Med (Fremantle). 2002 Mar;14(1):14-23. (North Queensland Health Equalities Promotion Unit, School of Population Health, University of Queensland, Cairns, Australia. Ernest_Hunter@health.qld.gov.au)

This paper reviews literature on self-harm and suicide among Indigenous populations

in four nations with histories of British colonization, with a more detailed exploration of patterns and primary care considerations in Australian Aboriginal and Torres Strait Islander populations. Issues of definition, under-reporting, lack of reporting, varying coronial practices and the influence of race on investigative procedures make comparisons of suicide rates among indigenous populations problematic. However, international interpretations highlight the impact of the breakdown of cultural structures and historical processes associated with colonization. Recent studies suggest that the predisposition to suicide by vulnerable young people is influenced not only by absolute living standards but also how they view their circumstances relative to those around them. The complexity of associations with mental disorder, alcohol use and 'meaning' in an indigenous context are considered. Responses in terms of prevention and treatment are presented, highlighting the importance of hospital-based practitioners as the likely first point of contact. The article concludes by outlining considerations in the primary care management of indigenous self-harm.

36. Ing R. "Dealing with shame and unresolved trauma: residential school and its impact on the 2nd and 3rd generation adults." Vancouver: University of British Columbia, 2000.

37. Iwasaki Y, Bartlett J, O'Neil J. An examination of stress among Aboriginal women and men with diabetes in Manitoba, Canada. Ethn Health. 2004 May;9(2):189-212. (Health, Leisure and Human Performance Research Institute, 102 Frank Kennedy Centre, University of Manitoba, Winnipeg, Manitoba, Canada.iwasakiy@ms.umanitoba.ca)

    In this study, a series of focus groups were conducted to gain an understanding of the nature of stress among Canadian Aboriginal women and men living with diabetes. Specifically, attention was given to the meanings Aboriginal peoples with diabetes attach to their lived experiences of stress, and the major sources or causes of stress in their lives. The key common themes identified are concerned not only with health-related issues (i.e. physical stress of managing diabetes, psychological stress of managing diabetes, fears about the future, suffering the complications of diabetes, and financial aspects of living with diabetes), but also with marginal economic conditions (e.g. poverty, unemployment); trauma and violence (e.g. abuse, murder, suicide, missing children, bereavement); and cultural, historical, and political aspects linked to the identity of being Aboriginal (e.g. 'deep-rooted racism', identity problems). These themes are, in fact, acknowledged not as mutually exclusive, but as intertwined. Furthermore, the findings suggest that it is important to give attention to diversity in the Aboriginal population. Specifically, Metis-specific stressors, as well as female-specific stressors, were identified. An understanding of stress experienced by Aboriginal women and men with diabetes has important implications for policy and programme planning to help eliminate or reduce at-risk stress factors, prevent stress-related illnesses, and enhance their health and life quality.

38. Jette M. A health profile of the Inuit of Nunavik: report of the Sante Québec Health Survey (1992). Int J Circumpolar Health. 1998;57 Suppl 1:630-5.
    This general survey of health and well-being aimed primarily to provide a comprehensive insight into the health and social situation in Nunavik, with a view to

setting up prevention and intervention programs more properly adapted to the needs of the Inuit of Nunavik. The data gathered through the use of questionnaires were combined with the anthropometric and biological readings of some 1,567 Inuit of all ages to generate the survey findings. In essence, the report demonstrated that, as the current Inuit lifestyle, save for the consumption of traditional foods, was setting the stage for the development of several types of illness previously absent from Nunavik, behavioural changes were warranted. Although the Inuit reported few problems of a physical nature, mental health issues appeared challenging. The prevalence of psychological distress, suicidal thoughts, and parasuicides was of sufficient import to justify direct, concerted, and immediate action.

39. Kaufert JM, Putsch RW, Lavallee M. Experience of aboriginal health interpreters in mediation of conflicting values in end-of-life decision making. Int J Circumpolar Health. 1998;57 Suppl 1:43-8. (Department of Community Health Sciences, Faculty of Medicine, University of Manitoba, Canada.)

    This paper examines the experience of Aboriginal medical interpreters working with terminally ill patients, family members, and care providers, and serving as mediators when cultural values and decision frameworks are in conflict. The discussion is based on a qualitative analysis of interaction in 12 patient encounters which were observed and for which transcripts were made of the discourse and interaction. Each case involved intervention by a professional interpreter. Interaction involved the signing of advance directives or other consent agreements in situations in which Aboriginal patients were terminally ill. Analysis will focus on the cultural dimension of value conflict situations, particularly in relation to issues of individual autonomy and biomedical emphasis on truth-telling in the communication of terminal prognosis.

40. Kirmayer LJ, Brass GM, Tait CÉCILE LEBLANC. The mental health of Aboriginal peoples: transformations of identity and community. Can J Psychiatry. 2000 Sep;45(7):607-16. (Division of Social and Transcultural Psychiatry, McGill University. cylk@musica.mcgill.ca)

    This paper reviews some recent research on the mental health of the First Nations, Inuit, and Métis of Canada. We summarize evidence for the social origins of mental health problems and illustrate the ongoing responses of individuals and communities to the legacy of colonization. Cultural discontinuity and oppression have been linked to high rates of depression, alcoholism, suicide, and violence in many communities, with the greatest impact on youth. Despite these challenges, many communities have done well, and research is needed to identify the factors that promote wellness. Cultural psychiatry can contribute to rethinking mental health services and health promotion for indigenous populations and communities.

41. Kirmayer LJ, Corin E, Corriveau A, Fletcher C. Culture and mental illness among the Inuit of Nunavik [Article in French] Sante Ment Que. 1993 Spring;18(1):53-70.
    While the major psychiatric disorders described in current nosology can be found among the Inuit of Northern Québec (Nunavik), there are important cultural influences on the symptomatology, social response and course of these disorders. A literature

review, consideration of experiences with psychiatric consultation among the Inuit and the preliminary results of ongoing ethnographic research underscore the importance of the study of Inuit ethno psychology and current attitudes toward the mentally ill in developing culturally sensitive psychiatric care.

42. Kirmayer LJ. Research and Clinical Perspectives on Mental Health in Native Communities. in *Widening the Circle: Collaborative Research for Mental Health Promotion in Native Communities*. Institute of Community of Family Psychiatry of the Sir Mortimer B. Davis-Jewish General Hospital. 1998.

    This presentation gives a broad overview of the mental health of First Nations and Inuit communities of Québec based on epidemiological and clinical psychiatric research. What are the types and rates of problems ranging from everyday problems in living to psychiatric disorders? What factors contribute to well being and mental health, and what are the risk and protective factors for mental illness and social suffering? What distinctive challenges are faced by Native communities compared with the rest of Canadian society? How must conventional mental health practices in treatment, prevention and health promotion be modified to fit Native realities? The presentation examines the value and limitations of existing information on these issues in order to identify priorities for future research.

43. Kirmayer LJ, Boothroyd LJ, Laliberté A, Laronde Simpson B. Suicide Prevention and Mental Health Promotion in First Nations and Inuit Communities, Culture & Mental Health Research Unit, Institute of Community & Family Psychiatry, Montreal. 1999

44. Kirmayer LJ, Gill K, Fletcher C, Ternar Y, BoothroydL, Quesney C, Smith A, Ferrara N, and Hayton B. Emerging Trends in Research on Mental Health Among Aboriginal Peoples: Culture and Mental Health Research Unit, Report No. 2. Sir Mortimer B. Davis, Jewish General Hospital, Montreal. 1994; revised

    As requested by the Royal Commission on Aboriginal Peoples, our aim in this report is to review the scientific literature on the mental health problems of Canadian Aboriginal peoples to identify emerging trends in research themes and methods. The topics to be covered include the following:

    1. an overview of epidemiological data on Aboriginal mental health in Canada;
    2. a critical review of existing literature on the topic of prevention and treatment among Aboriginal peoples in Canada;
    3. a comprehensive discussion of emerging trends in this field;
    4. guidelines for future research.

    This report is organized in accordance with these themes. We have endeavoured to include specific material on women, status and non-status Indian, Inuit and Métis peoples. Unfortunately, in most cases there is very little information available. Given that the problems we address cut across groups, we have not created separate sections for each important subgroup. The index provides a way to track down specific

mention of groups, geographical regions or other specific interests. The index can also function as a glossary since many technical terms are defined on their first occurrence.

45. Kirmayer LJ, Fletcher CM, Boothroyd LJ. Inuit attitudes toward deviant behaviour: a vignette study. J Nerv Ment Dis. 1997 Feb;185(2):78-86. (Department of Psychiatry, Sir Mortimer B. Davis-Jewish General Hospital, Montreal, QC.)

    Attitudes toward deviant behaviour that might indicate psychiatric disorder were investigated among the Inuit of Northern Québec (Nunavik). In a convenience sample of 137 Inuit adults, respondents were randomly presented with one of six different vignettes that described a man with "strange" behaviour who was either threatening or withdrawn and whose problem was labelled either "isumaluttuq" ("burdened or weighed down by thoughts"), "demon possession," or "mental illness." Respondents rated their willingness to live, work, or hunt with this person and allow him into their family on a social distance scale. Significant predictors of greater social distance were female gender, more education, less familiarity with the behaviour, and perception of the person as less likely to recover. There were no significant effects of vignette behaviour or label on social distance ratings. Rating of likelihood of recovery was influenced by the vignette label, with isumaluttuq associated with less chance of recovery. Ascribing strange behaviour to morally wrong action and to spirits or demons were highly inter-correlated and each was associated with perception of greater likelihood of recovery. Results suggest that Inuit attitudes toward deviant behaviour are influenced more by perceived familiarity and likelihood of recovery than by labels, causal attributions, or explanations. The indigenous psychological concept of isumaluttuq does not serve to reduce social stigma. Efforts to promote the community integration of psychiatric patients through education should aim to increase familiarity with the problematic behaviour and emphasize potential for recovery. Publication Types: Clinical Trial Randomized Controlled Trial

46. Kirmayer LJ, Fletcher c, Corin E, Boothroyd L. Inuit Concepts of Mental Health and Illness: An Ethnographic Study. Culture and Mental Health Research Unit, McGill University. 1994; revised 1997.

    The concepts of mental health and illness of the Inuit of Nunavik (Northern Québec) were studied through ethnographic interviews, participant observation and a questionnaire survey. The aim was to document Inuit knowledge and practices in order to inform mental health workers and planners working in Nunavik of the range of different perspectives and identified needs. The research involved the participation of the community in the selection of survey sites and the identification of appropriate problems for study. Three communities differing in their existing resources and average level of acculturation were studied.

    Three types of research interview were conducted, corresponding to distinct parts of the project: (1) problem identification interviews with Inuit health care and community workers identified the range of problems in the community and the usual terminology used to describe them, resulting in a list of specific registers of potentially problematic behaviour; (2) problem register interviews with key informants from the community

identified the perceived prevalence of problems in the community and the typical signs and symptoms associated with each type of behaviour or problem; (3) case history interviews with key informants reconstructed detailed accounts of cases with which they were personally familiar.

Major findings of the study include:

• There is no general term for mental health or illness in Inuktitut. When pressed, informants either used an English term ('mental health problem') or offered two terms with different connotations: Isumaluttuq and Isumaqanngituq. Isumaluttuq implies thinking too much while Isumaqanngituq means 'having no mind' or not thinking at all.

• According to informants, the most prevalent mental health problems were alcohol and drug abuse, family violence and abuse, and suicidal behaviour.

• Most people were not very familiar with mental health problems. Although many had heard of demon possession, only a small number of cases were actually described.

• Although some people who completed suicide were described as withdrawn, isolated, depressed, having heavy thoughts, low self-esteem or hating themselves prior to their suicide, in many cases their suicide came as a complete surprise even to close friends and relatives.

• Inuit recognized four broad types of causes of mental health problems: (1) physical and environmental; (2) psychological or emotional; (3) demon or spirit possession; and, (4) culture change and social disadvantage. In many cases, multiple causes were offered for the same problem.

• The presence of hallucinations or bizarre behaviour prompted people to think of mental illness or demon possession.

• Violence, drug abuse and suicide were all commonly attributed to abuse and neglect in childhood or to ongoing family violence.

• Inuit tended to label behaviours or states of mind rather than individuals. This left open the possibility that someone who had an affliction or troublesome behaviour could change and improve.

• People tended to be very tolerant of others' unusual behaviour. This may improve the integration and prognosis for people with psychiatric disorders. It may also, however, delay the recognition of depression, psychosis and suicidal tendencies.

• Talking with others was widely recognized as a good way to prevent and/or resolve mental health problems.

• Religious exorcism was viewed as an appropriate treatment in cases of demon possession by people who believed this was a cause of unusual behaviour or illness.

From the interviews and survey, a model of indigenous concepts of and attitudes

toward mental health and illness was developed. An Inuktitut/English lexicon of mental health related terms was also prepared. The model and lexicon can be used in future research on the prevalence, causes and consequences of specific social and psychiatric problems.

The research also has more immediate implications for the design and delivery of mental health care among the Inuit, including community education programs to improve the recognition, treatment and rehabilitation of people with major psychiatric disorders and community and professional interventions for people facing life crises.

47. Kirmayer L, Simpson C and Cargo M. Healing Traditions: Culture, community and mental health promotion with Canadian Aboriginal peoples. Australasian Psychiatry, Vol 11, Supplement, 2003) 15-23

    Objective: To identify issues and concepts to guide the development of culturally appropriate mental health promotion strategies with Aboriginal populations and communities in Canada.

    Methods: We review recent literature examining the links between the history of colonialism and government interventions (including the residential school system, out-adoption, and centralised bureaucratic control) and the mental health of Canadian Aboriginal peoples.

    Results There are high rates of social problems, demoralization, depression, substance abuse, suicide and other mental health problems in many, but not all, Aboriginal communities. Although direct causal links are difficult to demonstrate with quantitative methods, there is clear and compelling evidence that the long history of cultural oppression and marginalization has contributed to the high levels of mental health problems found in many communities. There is evidence that strengthening ethno cultural identify, community integration and political empowerment can contribute to improving mental health in this population.

    Conclusion: The social origins of mental health problems in Aboriginal communities demand social and political solutions. Research on variations in the prevalence of mental health disorders across communities may provide important information about community-level variables to supplement literature that focuses primarily on individual-level factors. Mental health promotion that emphasises youth and community empowerment is likely to have broad effects on mental health and well-being in Aboriginal communities.

48. Kristiann A. Negotiating Health: Meanings of Building a Health Community in Igloolik. Kirmayer LJ, Macdonald ME, Brass GM (editors) The Mental Health of Indigenous Peoples: Proceedings of the Advanced Study Institute. McGill Summer Program in Social & Cultural Psychiatry and the Aboriginal Mental Health Research Team, Institute of Community and Family Psychiatry, Department of Psychiatry, McGill University

49. Lane P, Bopp M, Bopp J, Norris J. Mapping the Healing Journey: The final report of a First Nation Research Project on Healing in Canadian Aboriginal Communities APC 21 CA, 2002.

50. Kelly L, Brown.JB. Listening to Native patients: Changes in physicians' understanding and behaviour. Canadian Family Physician. Vol 48: October 2002. 645- 1652

Objective: To discover how physicians develop an understanding of Native* patients and communities that enables them to communicate better with these patients.

Design: Qualitative method of in-depth interviews.

Setting: Native communities across Canada.

Participants: Ten non-Native physicians providing primary care to Native patients and communities.

Method: In-depth, semistructured interviews explored communication strategies developed by primary care physicians working with Native patients. The audio taped and transcribed interviews were analyzed by the investigators using the phenomenologic approach of immersion and crystallization.

Main Findings: Three main themes emerged. First was elements of communication: during patient-physician communication, physicians speak less, take more time with patients, and become comfortable with silence. Second was community context: patients' illnesses are not distinct from their community context; patient care and community relations, culture, and values are often inseparable. Third was the process of change in physicians: over time, participants increased understanding of Native culture, ways of communicating, and behaviour. Change comes about through long service, listening well, and participating in community events.

Conclusion: Developing cross-cultural communication was difficult and took years, if not forever. Understanding Native communities changed physicians. They described a journey of self-examination, development of personal relationships, and rewards and frustrations.

51. Lemchuk-Favel L & Jock R. Aboriginal Health Systems in Canada: Nine Case Studies. Journal of Aboriginal Health. January 2004. 28-51

This paper investigates Aboriginal health systems in Canada, in urban and rural First Nations communities, Inuit communities and Métis Settlements. A summary of the primary strengths and challenges of Aboriginally-controlled health systems is presented. Strengths include holism, synergy of western and traditional health philosophies, focus on primary care, collaboration with provincial services, integrated health service delivery, and administrative reform. Aside from the challenge of health status, Aboriginal health systems must contend with small community size, remoteness, lack of human resources including Aboriginal health professionals, a

growing and aging population, inadequacy of funding accompanied with non-sustainability of the system, and jurisdictional barriers. Through nine case studies, successful approaches are presented to providing effective, responsive and culturally-appropriate community health services. These case studies underscore the diversity in Aboriginal health systems necessary to accommodate vast differences in cultural expectations, health service needs, jurisdictional complexity, and geographic location.

52. Lester D. Aboriginal suicide in British Columbia. Percept Mot Skills. 1996 Dec;83(3 Pt 2):1202. (Psychology Program, Richard Stockton College of New Jersey, Pomona 08240-0195, USA.)

53. Malchy B, Enns MW, Young TK, Cox BJ. Suicide among Manitoba's aboriginal people, 1988 to 1994. CMAJ. 1997 Apr 15;156(8):1133-8. (Department of Psychiatry, University of Manitoba, Winnipeg.)

    Objective: To compare and contrast the characteristics of suicides among aboriginal and nonaboriginal people in Manitoba.

    Design: Retrospective review of all suicides, based on a confidential analysis of records held by the Office of the Chief Medical Examiner.

    Setting: Manitoba between 1988 and 1994.

    Outcome Measures: Standardized suicide rates, age- and sex-specific suicide rates, blood alcohol level at time of death, psychiatric help-seeking behaviour before suicide and residence on a reserve. RESULTS: Age-standardized suicide rates were 31.8 and 13.6 per 100,000 population per year among aboriginal and nonaboriginal people, respectively. The mean age of aboriginal people who committed suicide was 27.0 (standard deviation [SD] 10.8) years, compared with a mean age of 44.6 (SD 18.8) years for nonaboriginal people who committed suicide ($p < 0.001$). Blood alcohol levels at the time of death were a mean of 28 (SD 23) mmol/L among aboriginal people and 12 (SD 20) mmol/L among nonaboriginal people ($p < 0.0001$). Before their death, 21.9% of nonaboriginal suicide victims had sought psychiatric care whereas among aboriginal suicide victims 6.6% had sought care ($p < 0.0001$). Although the suicide rate was higher among aboriginal people living on reserve than among those living off reserve (52.9 v. 31.3 per 100,000 per year), both of these rates were substantially higher than the overall rates among nonaboriginal people. There were no significant differences in mean age, sex, blood alcohol level and previous psychiatric care among aboriginal people who committed suicide living on and off reserve.

    Conclusions: There was a high rate of suicide among Manitoba's aboriginal people between 1988 and 1994; this rate was comparable to earlier estimates of national suicide rates among aboriginal people. The reserve environment does not, by itself, account for the high suicide rate among Manitoba's aboriginal people. Further study of help-seeking behaviour and the association between alcohol abuse and suicide, particularly among aboriginal peoples, is indicated.

54. Maar M. Clearing the Path for Community Health Empowerment: Integrating Health Care Services at an Aboriginal Health Access Centre in Rural North Central Ontario. Noojmowin Teg Health Centre and Department of Anthropology, McMaster University. 2004

The article provides a critical examination of the rewards and challenges faced by community based Aboriginal health organizations to integrate the rapidly evolving provincially- and federally funded Aboriginal health program streams within an existing mainstream rural and federal First Nations health care system in Ontario. The shift to self-governance in health care means Aboriginal health organizations are dealing with rapid organizational changes. In addition, community health program planners at the First Nations level are faced with the challenge of developing local Aboriginal models of care and integrating these within the often-conflicting backdrop of the existing mainstream model of community health. While political leadership and health organization typically both have mandates to work towards the health and well-being in their communities, the two sectors may not always have the same expectations on how to realize these goals. While autonomy in the development of services is essential to self-determination in health, there is also a need for Aboriginal health agencies to collaborate regionally in order to improve health at the community level in the most effective and timeliest manner. Using the example of the mental health and traditional Aboriginal health services, this article provides an analysis of the role of an Aboriginal health access centre in regional community health empowerment.

55. Martin Hill D. Traditional Medicine in Contemporary Contexts: Protecting and Respecting Indigenous Knowledge and Medicine. National Aboriginal Health Organization. 2003.

56. McCormick RM. First Nations counsellor training in British Columbia: strengthening the circle. Can J Commun Ment Health. 1997 Fall-Autumn;16(2):91-9. (Mohawk Nation, University of British Columbia.)

First Nations people in British Columbia are struggling to overcome the effects of assimilationist practices and cultural loss. Many of the mental health problems facing First Nations people today can be traced to this loss. Their communities believe the best way to address this problem is by training their own people as mental health professionals who could then provide informed and culturally relevant counselling services. In the spring of 1996 a province-wide survey was conducted to determine the nature of counsellor training needed by First Nations people in the province of British Columbia. This article describes the rationale for this survey and the results.

57. Minde R, Minde K. Socio-cultural determinants of psychiatric symptomatology in James Bay Cree children and adolescents. Can J Psychiatry. 1995 Aug;40(6):304-12. (Montreal General Hospital, Québec.)

Objective: To examine the type of psychiatric disorders found in 100 Cree children living in a Native community in northern Québec.

Method: Standardized semi-structured interviews were given to all children and their caregivers, collecting 24 items of information.

Results: 51% of the children did not qualify for a DSM-III-R diagnosis but their frequently severe behavioural symptoms could be categorized by using 5 types of socio-cultural disturbances. There were also significant correlations between parental educational level, including length of time spent away from home, and the number of stress factors the children had been exposed to.

Conclusion: There is a need to develop a diagnostic classification for child psychiatric disorders for aboriginal children.

58. Mignone J, O'Neil JD, Wilkie C. Mental Health Services Review: First nations and Inuit Health Branch, Manitoba Region. Centre for Aboriginal Health, University of Manitoba. 2003.

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

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

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

59. Minore B, Boone M. Realizing potential: improving interdisciplinary professional/paraprofessional health care teams in Canada's northern aboriginal communities through education. J Interprof Care. 2002 May;16(2):139-47. (Centre for Rural and Northern Health Research, Lakehead University, Thunder Bay, Ontario, Canada.)

    To address a shortage of health professional human resources and to overcome cultural barriers, the interdisciplinary health care teams practising in most northern Canadian aboriginal communities include a number of paraprofessional recruited locally. This model has great potential to fill service gaps in many rural contexts; there are challenges, however. Drawing from an extensive program of research in

indigenous communities in the northwestern part of the Province of Ontario, we identify factors fundamental to effective team functioning: members' clarity about their own and others' roles, appreciation of their respective 'equal but different' knowledge bases, and confidence in one another's competence. We argue for an extension of the information on interdisciplinary practice included in health science education programs to address these issues, thereby enhancing the utility of paraprofessional within the health human resource mix in rural areas.

60. Mussell B, Cardiff K, White J. The Mental Health and Well-being of Aboriginal Children: Guidance for New Approaches and Services. British Columbia Ministry of Children and Family Development. 2004.

61. Oblin C. An Overview of Mental Health Challenges and Programs in Québec Aboriginal Communities. Widening the Circle: Collaborative Research for Mental Health Promotion in Native Communities, Institute of Community of Family Psychiatry of the Sir Mortimer B. Davis-Jewish General Hospital. September 1998 p 10-14

62. Paproski DL. Healing experiences of British Columbia First Nations women: moving beyond suicidal ideation and intention. Can J Commun Ment Health. 1997 Fall-Autumn;16(2):69-89. (University of British Columbia.)

    This study explores how five British Columbia First Nations women moved through suicidal ideation and intention in their youth. Much of their healing process was facilitated by a reconnection to their cultural identity and traditional native spirituality. Phenomenological research methods were used to guide the interview process, analysis, and the interpretation of unstructured interviews. Each transcribed interview was analyzed for themes and developed into a narrative. Several procedures were used to examine the validity of the analysis and interpretation, including participant review of the findings. Three of the 12 themes that emerged suggest common experiences surrounding suicide attempts or ideation. These experiences suggest that the impact of separation from family, community, and culture was significant for each of these women. Nine of the 12 major themes describe a variety of healing experiences for these five women, involving Elders or other role models, professional counsellors, family, and community. As a consequence of their healing experiences, all participants reported an increased sense of personal empowerment, a positive view of themselves, and a commitment to a positive future for themselves and other First Nations people. The significance of cultural connections and native spirituality may have important implications for the intervention and prevention of suicide in First Nations youth.

63. Peters R, Demerais L. Improving mental health services for urban First Nations: policy issues relevant to health care reform. Can J Commun Ment Health. 1997 Fall-Autumn;16(2):29-36. (Tsimshian Nation, Greater Vancouver Mental Health Service.)

    This paper discusses issues related to the development of plans to improve the effectiveness of mental health services for urban First Nations people. The discussion

focuses on emerging issues related to health care reform and regionalisation. While it is impossible to make specific recommendations without reference to local conditions, developing an awareness of the general issues involved will help in the process of identifying the principles and approaches needed to frame local solutions.

64. Poushinsky N, Taillon-Wasmund P. Foundations for Reform: Section 17 First Nations and Mental Health (Section A: Golden Lake; Section B: Akwesasne).

65. Racine, Louise, Implementing a postcolonial feminist perspective in nursing research related to non-Western populations, Nurs Inq, V 10 N 2. 2003

    Implementing a postcolonial feminist perspective in nursing research related to non-Western populations In this article, I argue that implementing a postcolonial feminist perspective in nursing research transcends the limitations of modern cultural theories in exploring the health problems of non-Western populations. Providing nursing care in pluralist countries like Canada remains a challenge for nurses. First, nurses must reflect on their ethnic background and stereotypes that may impinge on the understanding of cultural differences. Second, dominant health ideologies that underpin nurses' everyday practice and the structural barriers that may constrain the utilization of public healthcare services by non-Western populations must be further examined. Postcolonial feminism is aimed at addressing health inequities stemming from social discriminative practices. I will draw on extant literature and data of an ongoing ethnography exploring the Haitian caregivers' ways of caring for ageing relatives at home to unveil how the larger social and cultural world has an impact on caregivers' everyday lives. Marginalised locations represent privileged sites from which health problems, intersecting with power, race, gender, and social classes, can be addressed. Postcolonial feminism provides the analytic lens to look at the impact of these factors in shaping health experiences. It also suggests redirecting nursing cultural research and practice to achieve social justice in the healthcare system.

66. Regina Qu'Appelle Health Region. Improving First Nations and Métis Health Outcomes: A Call to Collaborative Action. 2000

67. Royal Commission on Aboriginal Peoples. Report of the Royal Commission on Aboriginal Peoples: Gathering Strength Vol 3, Chapter 3. 1995

68. Schmidt G. Barriers to recovery in a First Nations community. Can J Commun Ment Health. 2000 Fall;19(2):75-87. (University of Northern British Columbia.)

The practice of psychiatric rehabilitation is a concept and method that developed in urban-based settings. It has become a widely used guiding principle in mental health practice. This research examines how psychiatric rehabilitation fits within a remote First Nations community. Ten people--service providers, consumers, and family members--were interviewed to gather information about their perceptions of and experiences within the mental health system. The interview material was examined using content analysis. The results suggest that geographic and economic factors create serious barriers to application of the psychiatric rehabilitation method in a remote First Nations community.

69. Smye V, Browne AJ. 'Cultural safety' and the analysis of health policy affecting aboriginal people. Nurse Res. 2002;9(3):42-56. (University of Victoria, Canada.)

Vicki Smye and Annette Browne explore the exportability of the concept of 'cultural safety' from the healthcare literature in New Zealand to inform an analysis of mental health policy discourse affecting aboriginal communities in British Columbia, Canada. The moral issues raised are, they suggest, ones that nurses in research, policy and practice must attend to when providing health care to marginalised, disenfranchised populations.

70. Smye V & Mussell B. Aboriginal Mental Health: “What Works Best” A Discussion Paper, Mental Health Evaluation and Community Consultation Unit, July 2001

71. University of Manitoba, Northern research Unit. Canupawakpa First nations Health Survey: Final Report 1998.

72. van Uchelen CP, Davidson SF, Quressette SV, Brasfield CR, Demerais LH. What makes us strong: urban aboriginal perspectives on wellness and strength. Can J Commun Ment Health. 1997 Fall-Autumn;16(2):37-50. (University of British Columbia, Vancouver. collin@unixg.ubc.ca)

The limitations of a needs orientation for aboriginal mental health planning are evaluated in terms of the discrepancy between First Nations and western medical paradigms of health. We propose an alternative approach that focuses on how aboriginal people conceptualize wellness and describe their strengths. This provides a focus for initiatives that promote well-being by enhancing strengths rather than concentrating solely on deficits. We illustrate this approach by highlighting the indigenous knowledge of urban First Nations people in Vancouver's Downtown Eastside neighbourhood. We conclude that supporting existing strengths promotes wellness in holistic, culturally appropriate, and empowering ways.

73. Waldram JB, Wong S. Group therapy of aboriginal offenders in a Canadian forensic psychiatric facility. Am Indian Alsk Native Ment Health Res. 1995;6(2):34-56. (Department of Native Studies, University of Saskatchewan, Saskatoon, Canada.)

In recent years, the use of group therapy approaches with Aboriginal or Native

Canadians/American Indians has become widely accepted. However, many advocates of this approach rarely consider the implications of group therapy for culturally heterogeneous groups, such as when non-Aboriginal peoples are involved or when there are Aboriginal peoples from different cultures and/or with different degrees of orientation to Euro-Canadian culture. This article documents the use of one form of group therapy for Aboriginal offenders in a forensic psychiatric facility, where this degree of cultural heterogeneity exists. The article concludes that, at least within a forensic psychiatric setting, group therapies that mirror the social, cultural, racial, and class structures of Euro-Canadian society are problematic in the treatment of traditional Aboriginal offenders but much less so for acculturated Aboriginal offenders.

74. Waldram JB. But Does It Work? Traditional Healing and Issues of Efficacy and Evaluation. In Widening the Circle: Collaborative Research for Mental Health Promotion in Native Communities. Institute of Community of Family Psychiatry of the Sir Mortimer B. Davis-Jewish General Hospital. September 1998,

    The intent of this workshop is to critically examine the issue of the efficacy of traditional healing, and if/how traditional healing can be evaluated. Scientific studies of traditional healing have often yielded ambiguous results. Many questions emerge from this. Is this because the healing itself is ineffective? Or is it possible that science currently lacks the tools (and the inclination) to Asee@ traditional healing? How do healers view the issue of efficacy? What are their goals when they undertake healing, and what measures (if any) do they employ to determine success? Is efficacy as science understands it even an issue for traditional healers? Is the whole idea of questioning efficacy and developing evaluation programs even necessary? Is it possible that to undertake these we are violating the basic principles of the healing itself? Can traditional healing ever be understood by the dominant biomedical system? These questions are controversial, and lead to many more questions. This workshop will begin a dialogue that, it is hoped, will better inform those interested in developing collaborative projects with traditional healers.

75. Wardman D, Khan N, el-Guebaly N. Prescription medication use among an aboriginal population accessing addiction treatment. Can J Psychiatry. 2002 May;47(4):355-60. (Division of Medicine, Foothills Hospital, Calgary, Alberta. Dennis_Wardman@hc-sc.gc.ca)

    Objectives: Inappropriate prescription medication use can have significant consequences. Although it is suspected that Aboriginal populations within Canada have high rates of inappropriate use, published information is lacking. To better understand this issue, we studied an Aboriginal population seeking addiction treatment.

    Methods: We surveyed Aboriginal clients who accessed addiction treatment in Calgary, Alberta, for prescription medication use in the previous year, frequency of medication use, and medication source(s), if inappropriately used.

    Results: Sixty-nine percent of the clients completed the survey (n = 144). Most respondents were aged 31 to 50 years (56%), and 52% were male. Of the

respondents, 48% reported that they used prescription medication inappropriately, 8% indicated appropriate use, and the rest indicated no medication use. Sedatives or relaxants were most frequently used inappropriately. Among those who inappropriately used medication, 47% used medication more than 10 times in the previous year. Common sources for those who used medication inappropriately included medication given by a friend or a stranger (52%), medication bought on the street (45%), and medication prescribed by a physician (41%). Age greater than or equal to 30 years was associated with inappropriate use. Sex, residence, and Aboriginal status were not found to be associated with inappropriate use.

Conclusion: Inappropriate prescription medication use was a significant problem among an Aboriginal population that sought addiction treatment, and many of these individuals accessed medication from a prescribing physician.

76. Wiebe J, Huebert KM. Community mobile treatment. What it is and how it works. J Subst Abuse Treat. 1996 Jan-Feb;13(1):23-31. (Alberta Alcohol and Drug Abuse Commission, Edmonton, Canada.)

    In 1984, Paul Hanki of Prince George, British Columbia, Canada, developed community mobile treatment, an innovative approach to substance abuse treatment in Native communities. The feature that distinguishes community mobile treatment from most other forms of treatment is the strong emphasis on community involvement. Before an actual treatment program is implemented, the community must acknowledge that a substance abuse problem exists and be committed and involved in addressing the problem. Once a community is mobilized, a 21 to 28 day intensive alcohol and drug treatment program for substance abusers and their families is brought into the community. Since its inception in 1984, community mobile treatment has been implemented in approximately 17 Canadian communities. The few evaluations that have been conducted suggest that this approach holds much promise in reducing alcohol and drug-related problems. This article reviews the existing documentation and provides a comprehensive description of this unique approach.

77. Wilkie C, Macdonald S, Hildahl K. Community case study: suicide cluster in a small Manitoba community. Can J Psychiatry. 1998 Oct;43(8):823-8. (Selkirk Mental Health Centre, Manitoba. umwilki6@cc.manitoba.ca)

    Objectives: To review a cluster of suicides and suicidal ideation in a First Nations community.

    Method: The medical records and autopsy reports of the victims are reviewed. Collateral information obtained in the community is presented. A series of psychiatric assessments conducted at the local health centre in a 3-day period is outlined. The dilemma of developing appropriate treatment plans is discussed.

    Results: In the period from February 3 to May 5, 1995, an isolated northern Manitoba First Nations community had 6 suicides in a population of less than 1500. Several other suicide attempts occurred. Community resources were strained. Alcohol was a

factor in 4 of the suicides. Previous sexual assault was cited in 4 of 5 female cases presenting with suicidal ideation.

Conclusions: Cluster suicide is a shared psychiatric and public health problem of major concern. Dreams of beckoning are common following a suicide. Communities should have a prepared plan to deal with a suicide. Resources should be provided quickly in an effort to prevent a cluster of suicides from occurring. High-risk individuals must be identified. Substance abuse must be addressed. Resources to assess and treat victims of sexual abuse must be available. Publication Types: Case Reports

78. Wilson K, Rosenberg MW. Exploring the determinants of health for First Nations peoples in Canada: can existing frameworks accommodate traditional activities? Soc Sci Med. 2002 Dec;55(11):2017-31. (School of Geography and Geology, McMaster University, 1280 Main Street West, Hamilton, Ontario, Canada L8S 4K1.)

    While much research has examined First Nations peoples' health in Canada, few studies have explored the role of traditional activities in enhancing health. Using data from the 1991 Aboriginal Peoples Survey (APS), this paper incorporates a set of measures of traditional activities within a determinants of health framework for understanding First Nations peoples' health. Results from the analyses undertaken show that many of the determinants of health identified in analyses of the Canadian population in general hold for First Nations peoples. While only a few statistically significant relationships between health status and traditional activities were identified, taking into account the limitations of the APS and other conceptual issues, we argue that there is the potential to move from the analysis of traditional activities to a more nuanced analysis of cultural attachment.

79. Young LT, Hood E, Abbey SE, Malcolmson SA. Psychiatric consultation in the Eastern Arctic. II. Referral patterns, diagnoses and treatment. Canadian Journal of Psychiatry, 38. 1993. 28-31.

80. Young TK. Review of research on aboriginal populations in Canada: relevance to their health needs. BMJ Vol 327 August 2003

    Objective To determine if research has adequately examined the health needs of the aboriginal population of Canada.

    Design Review . Study selection Medline search of journal articles published during 1992-2001. The search terms used were "Canada" and various synonyms and categories for Canadian aboriginal people. Each paper was categorised according to the aboriginal group, age-sex group, comparison group, geographic location, and type of research topic (health determinant, health status, or health care).

    Results. Of 352 citations found, 254 were selected after elimination of those without abstracts, not containing data on Canada, or not focusing on health issues. The proportion of papers does not reflect the demographic composition of aboriginal people

in Canada, with severe under-representation of Métis, urban aboriginal people, and First Nations people not living on reserves and over-representation of the Inuit. Children and women received less attention proportional to their share of the population. A few prolific research groups have generated a disproportionate amount of publications from a few communities and regions. 174 papers dealt with health determinants (for example, genetics, diet, and contaminants), 173 with health status, and 75 with health care. Injuries, which account for a third of all deaths, were studied in only 8 papers. None of the health care papers examined rehabilitation.

Conclusion Researchers have not adequately examined several important health needs of the aboriginal population.

81. Zubek EM. Traditional Native healing. Alternative or adjunct to modern medicine? Can Fam Physician. 1994 Nov;40:1923-31.

Objective: To ascertain the extent to which family physicians in British Columbia agree with First Nations patients' using traditional Native medicines.

Design: Randomized cross-sectional survey.

Setting: Family medicine practices in British Columbia.

Participants: A randomized volunteer sample of 79 physicians from the registry of the BC Chapter of the College of Family Physicians of Canada. Of 125 physicians contacted, 46 did not reply.

Main Outcome Measures: Physicians' demographic variables and attitudes toward patients' use of traditional Native medicines.

Results: Respondents generally accepted the use of traditional Native medicines for health maintenance, palliative care, and the treatment of benign illness. More disagreement was found with its use for serious illnesses, both for outpatients and in hospital, and especially in intensive care. Many physicians had difficulty forming a definition of traditional Native medicine, and were unable to give an opinion on its health risks or benefits. A significant positive correlation appeared between agreement with the use of traditional Native medicines and physicians' current practice serving a large First Nations population, as well as with physicians' knowing more than five patients using traditional medicine.

Conclusions: Cooperation between traditional Native and modern health care systems requires greater awareness of different healing strategies, governmental support, and research to determine views of Native patients and healers.