Community Team Approaches to Mental Health Services and Wellness Promotion
A Report Prepared for Health Canada, First Nations and Inuit Health Branch

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This report was prepared under contract for Health Canada, First Nations and Inuit Health Branch. We were requested to review the scientific and gray literature on "community mental wellness teams." As this is a new term and covers a very broad territory, we have included literature both on mental health promotion and mental health services for Aboriginal communities in peri-urban, rural and remote geographic settings.

Many people have assisted with this review and synthesis. We would like to thank Drs. Abdel hamid Afana, Dr. Ademole Adeponle, Dr. Sudeep Chaklabanis, Tamsyn Farr, Sarah-Louise Fraser, and Megha Sedhev. At an early stage in the process, Dr. Margaret Cargo shared the preliminary methodology for her own similar review in Australia. Jocelyne Andrews and Teodora Constantinu assisted with library resources. Kay Berckmans and Antonella Clerici provided administrative and clerical support.

We hope this report is useful to all those striving to develop and support mental health promotion and mental health services for indigenous communities.

Laurence J. Kirmayer

Montreal, December 2009.

This report reviews the evidence base regarding collaborative approaches to community wellness and service provision for mental health and addictions in Aboriginal communities. This includes aspects of training, service organization, and evaluation.

We review the literature and international best practices relevant to the varied settings in which Aboriginal peoples in Canada live. We have focused on collaborative approaches in Canada, New Zealand, Australia, and the United States. We selectively reviewed the available research and reports on collaborative team approaches to mental health and addictions, regardless of context and setting and more comprehensively examined those team approaches that have been implemented in or specifically designed for Indigenous communities.

In general, mental health services are scarce for people living in remote and rural areas, with limited access to both primary care and specialized mental health service providers. This is partly a consequence of Canada's geography, especially in northern regions, but it also reflects historical, political and economic issues in the provision of health services.

Even where there are adequate primary health care services, community wellness teams operating in rural and remote areas may lack access to secondary or tertiary experts who can assist them in case management. To address this lack, innovative modes of specialist service delivery must be developed so that community wellness teams are be properly supported and integrated into the fabric of the health care system as a whole. This is essential for to ensure quality in services, maintain team morale, and provide ongoing training.

These innovative methods may include telepsychiatry and mobile consultation terms as well as regional and national networking strategies. However, all of these programs will require development of training and support services for Aboriginal and non-Aboriginal community mental health workers.

Aboriginal community wellness teams will need to take into account key cultural, historical and geographical issues to be successful, including: (i) the practical dilemmas posed by serving many small communities that are remote from urban centres; (ii) the pervasive impact of the history of collective trauma and loss; (iii) the key role of cultural identity in community revitalization and in insuring the safety and competence of health services; and (iv) the central role of community engagement, empowerment and governance in strengthening mental health and wellbeing.

Community wellness teams could play a significant and meaningful role in enhancing recovery from severe mental illness. As such, the composition of community wellness teams should pay attention to the various skills needed to enhance recovery.

To provide services for the full range of Aboriginal communities in Canada, at least three different levels of organization must be addressed: local communities, regions (defined geographically and culturally, as well as jurisdictionally), and nations. Different types of community wellness teams can be constituted at each of these levels:

(1) At the local community level, teams would consist primarily of Aboriginal mental health workers working in close collaboration with existing health and social service workers to develop and implement community-wide interventions. Local governance is important to insure engagement but external networking and supervision are essential to avoid burnout and management potential conflicts of interest or ethical issues that arise from working in small communities. The Aboriginal mental health workers would receive training through specialized programs developed for this purpose with brief residence outside the community and ongoing in-service training and supervision. At the same time, existing health care and social service workers would receive training in ways of collaborating with the community wellness team and steps taken at administrative and professional levels to insure cooperation. Ideally, the team would incorporate local NNADAP workers, community workers, educators, religious leaders, community political leadership and stakeholders to govern, advise and collaborate in the delivery of specific services.

(2) At the regional level, mobile teams based at a larger centre can visit communities and work with local teams to provide resources, training activities and back-up for challenging situations. The resources available at these regional centres (or through links to other centres) would include mental health professionals with expertise relevant to Aboriginal communities and others with expertise designing and implementing mental health promotion programs for regional Aboriginal populations. These regional centres would also have telehealth capacity so that much training as well as some assessment and intervention could be provided without travel. In some cases, these centres could be set up in association with regional residential treatment centres to capitalize on staff and increase continuity of care. However, attention must be given to the potential conflicts of interest between those focused on residential treatment and wellness approaches focused on people living in the community.

(3) At the national level, regional centres and teams need to be linked to share resources, training and models of intervention. The Native Mental Health Association, NAHO and other organizations currently provide some linkage at this level and this should be strengthened expanded to through the use of the internet, videoconferencing, as well as regional and national meetings. The national network could provide resources for training and evaluation of programs. In most cases, rigorous evaluation will be beyond the resources of communities and even regional centres. At the same time, the national network can serve as a means of recruitment and training of new mental health workers, professionals and researchers engaged in the area of community wellness. Having some staff move between centres would facilitate knowledge exchange and build a larger community of practice with expertise that can be shared across the country. It would also facilitate larger scale research in which communities or regions could implement specific programs, allowing more accurate assessment and the opportunity to identify contextual factors that may be crucial for good outcomes.

The teams at each of these three levels have specific roles to play that can complement, enable and sustain the others. The regional teams and centres can promote sharing among Aboriginal communities in the same geographic area and, through the national network, advise and assist communities in other areas in developing their own community wellness teams and programs.

This report reviews the evidence base regarding collaborative approaches to community wellness mental health promotion, and service provision for people with mental health and substance use problems. This includes aspects of training, service organization, and evaluation.

We review the literature and international best practices relevant to the varied settings in which Aboriginal peoples in Canada live. We have focused on collaborative approaches to promote mental wellness in Canada. However, we also examine relevant studies, programs and policies from Australia. New Zealand, and the United States. This allows us to assess the available research and reports on collaborative team approaches to mental health and substance use disorders, regardless of context and setting; but placing an emphasis on team approaches specifically implemented in or designed for indigenous populations and communities.

In preparing this report, we have cast a wide net to identify interventions, services and approaches that can enhance community wellness. To present the results, we have split the material into two chapters. The first chapter deals with background and contextual issues that are essential for understanding the roles, functions and potential impact of community wellness approaches and community wellness teams. This includes some discussion of psychiatric nosology, assertive community treatment teams, telepsychiatry, specific types of services, Aboriginal mental health workers, training and supervision, and program evaluation. The second chapter presents a series of promising case studies identified in the literature, which are good examples of current team approaches to community wellness.

This introductory chapter addresses some basic background issues essential for understanding the current contexts of Aboriginal communities and the key issues in the development of culturally appropriate community wellness teams.

1.1. Mental Health, Mental Illness and Community Wellness

Mental health, mental illness and community wellness are concepts reflecting different aspects of well-being. *Mental health* often refers to lay notions such as personal happiness, fulfillment in life, overall well-being and sense of accomplishment or mastery (World Health Organization, 2008).. It is sometimes referred to as Social and Emotional Well-being (SEWB), especially in Australia (Andary, Stolk, & Klimidis, 2003). *Mental illness* refers to mental problems or disorders that cause distress and limit everyday functioning. *Community wellness* refers to the general well-being of a circumscribed community. Joubert and Raeburn (1998; p.16) describe mental health as follows:

> Mental health is the capacity of each and all of us to feel, think and act in ways that enhance our ability to enjoy life and deal with the challenges we face. It is a positive sense of emotional and spiritual well-being that respects the importance of equity, social justice, interconnections and person dignity.

Indigenous notions of mental health and wellbeing additionally emphasize balance and harmony among the many dimensions of life experience. These include family and community relationships, spirituality, and connection to the land and the environment (Brant Castellano, 2006; Stout, 1994; Henderson, Robson, Cox, et al., 2007; Kirmayer, Fletcher & Watt, 2008).

Wellbeing is not simply the absence of illness. Although physical and emotional health are correlated, wellness and illness are not on a single continuum but have their own qualities and characteristics and can vary independently. There are people who have illness who nonetheless feel a sense of wellness, and people who lack a sense of wellbeing despite having no identifiable illness (Cloninger, 2004; Keyes, 2002; 2007). Reducing illness and promoting wellbeing are both important goals for mental health programs and services. Biomedicine and psychiatry have tended to focus on discrete illnesses, and have developed methods for diagnosing and treating various specific symptoms and disorders. This emphasis on illness tends to neglect positive health, wellness and resilience. The emphasis on mental health and wellness is more holistic and inclusive. However, a mental health and wellness approach risks neglecting the needs of the most vulnerable members of society, for example those who suffer from severe mental illness or those who have common mental health problems with co-occurring substance use disorder. These vulnerable groups often need specific interventions beyond those that are commonly part of wellness approaches.

Furthermore, insofar as they focus primarily on individuals rather than communities, illness and wellness approaches may ignore the ultimate determinants of health and illness, which often lie in broader social structural issues (Anderson, Baum, & Bentley 2008; King, Smith & Gacey, 2009; Wilkinson & Marmot, 2003). Hence, the most inclusive approach to community wellness should be based on considering the structural factors that promote health, and take into account the diversity of the population in terms of health status, cultural background and aspirations. In other words, the optimal approaches to community wellness will involve prevention and health promotion, as well as treatment services.

1.2. Prevention and Promotion

Public health practitioners distinguish several different types of prevention. In this section, we outline these types of prevention, paying particular attention to their relevance for mental health. The most common typology describes three different levels of prevention based on the stage of the health problem (Commission on Chronic Illness, 1957):

> *Primary prevention* or health promotion aims to prevent the occurrence of health problems.

> *Secondary prevention* involves interventions designed to identify (e.g. through screening) and treat individuals at risk for a disorder.

> *Tertiary prevention* or rehabilitation aims to promote recovery, limiting the impact, and preventing the recurrence of a condition in people who have already suffered an episode.

A complementary typology considers interventions in terms of the population or group targeted (Gordon. 1983; Rose, 1992):

> *Universal* (or population) prevention and health promotion strategies target the whole population and aim to enhance the health and wellbeing of all members of a community
>
> *Selective* prevention interventions are directed to higher-risk groups who may be particularly vulnerable for a specific disorder, for example older people or pregnant women.
>
> *Indicated* (or high-risk) prevention strategies interventions are aimed at high-risk individuals who have elevated indicators of illness (and who therefore may be in the early stages or prodrome of illness) but do not yet meet diagnostic criteria for an illness or disorder.

Within primary prevention, mental health promotion include many different types of activities which have the overall goal of improving health (Clark, 2002). These activities can occur at multiple levels in terms of the social organizations, agencies, and institutions involved (Prilleltensky & Prilleltensky, 2006; Cohen & Chehimi, 2005, p. 14). Mental health promotion activities range in scope from those that focus on individual behavior to those focusing on governmental policy. These include:

- strengthening *individual* knowledge and skills regarding health and illness. This could include school-based programs that enhance everyday coping skills and knowledge of appropriate resources for young people.
- promoting *community* education. This could include health education messages delivered via local or national media regarding signs and dangers of substance abuse.
- educating *providers*. This could involve providing regular workshops, seminars and web-based resources in order to update family physicians on innovations in psychiatry, encouraging appropriate screening and treatment.
- fostering coalitions, *networks* and collaborations. This could involve inter-sectoral work between statutory agencies and community organizations to raise awareness of mental health issues and combat associated stigma.
- changing *organizational* or institutional practices. This could involve working with employers and educational institutions to ensure occupational health measures are consistent with mental health best practices.
- influencing *governmental* policy and legislation. This could involve securing national funding for appropriate screening and preventative services, along with the necessary educational programs in mental health for medical personnel to ensure implementation.

Having a sustained impact in health promotion depends on making changes at multiple levels that reinforce each other. Hence, isolated interventions are less likely to have a long-lasting

impact. Changes in policy and practice can be mutually reinforcing and lead to changes in values that are more entrenched and self-sustaining.

1.3. The Context of Aboriginal Communities

There are distinct issues faced by Aboriginal communities that influence the design and implementation of mental health services like community wellness teams. These include issues of geographic location, cultural diversity, history and economy (Potter, 2006; Waldram, 2008). It is vitally important to understand these background factors to develop approaches to health and well-being that fit indigenous realities. This is especially so in the design and delivery of mental health services. In this section, we describe some of these important contextual factors which will have a bearing on later discussion of community wellness team approaches.

1.3.1. Geographical and Epidemiological Issues

Policies that are designed for the general population by definition have an impact on Aboriginal people. Provincial and federal funding for health services and health research all impinge on the health of Aboriginal people. So do health promotion policies endorsed and enacted by federal or provincial governments. This may especially be the case in terms of environmental health policies, which can influence factors such as access to traditional hunting grounds and fisheries (and levels of pollutants tolerated therein). Interventions at the general population level are important for Aboriginal people, however the specific health issues and needs for services of individuals and communities depend to some extent on their geographic setting or location.

In particular, Aboriginal people live in cities, peri-urban reserves, as well as rural and remote communities. These settings influence specific social determinants of health and largely determine the nature and configuration of available health and social services. In this section, we outline the main geographical settings in which Aboriginal peoples in Canada live and discuss the specific strengths and challenges associated with each setting for the promotion Aboriginal health and well-being.

1.3.1.1. Urban

Over the last 25 years, the urban Aboriginal population has been growing at an accelerating rate. This is partly due to a high fertility rate and Aboriginal outmigration from rural to urban areas. According to the 2006 census, 54% of those who identify as Aboriginal live in one of the nation's 27 urban census metropolitan areas.[1] Winnipeg and Saskatoon have the greatest proportion of Aboriginal people. Edmonton, Vancouver, Calgary and Toronto have large numbers of Aboriginal people. Other cities with significant Aboriginal populations include Regina, Ottawa-Gatineau, Montréal and Victoria (Statistics Canada, 2008).

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[1] Urban census metropolitan areas (CMA) are large urban areas with a population of at least 100,000.

Aboriginal people living in urban areas face specific challenges. In some cities, they may be concentrated in a bounded neighbourhood with low income, for example Vancouver's Downtown East Side. Problems such as homelessness, petty crime and substance abuse may be prevalent in such neighbourhoods. As a consequence, the neighbourhoods and their residents may become stigmatized and marginalized by the surrounding population. This may aggravate the lack of appropriate health and social services, and be associated with increased involvement of law enforcement agencies (Peters & Demerais,1997; Benoit, Carroll & Chaudry, 2002). Lack of opportunity and investment may further worsen problems in such neighbourhoods.

However, many urban Aboriginal people do not live concentrated in one neighbourhood. In cities such as Toronto or Montreal, Aboriginal people live dispersed throughout the city. This brings a different set of challenges (Macdonald, 2008). The sense of belonging, community and cultural continuity that is a benefit of reserve life may be lacking in some metropolitan areas. The Aboriginal population of cities is also multi-national, consisting of people from different First Nations, Inuit and Metis backgrounds with different cultures, languages and values. As a result, centralized services (e.g. Native Friendship Centers or specialized clinics and residential treatment programs) may have to deliver generic 'pan-Indian' programs that may not fit the needs of some Aboriginal people who would prefer services grounded in their own specific tradition (Brass, 2008).

Urban environments may offer some advantages in terms of general living for Aboriginal people. Cities bring economic, educational and employment opportunities which are not available in rural and remote areas. Cities also tend to have comprehensive and specialized health services, with the best teaching hospitals and medical staff available. Cities may also provide a home for those fleeing individual or collective stress on reserves (MacDonald, 2008).

1.3.1.2. Peri-urban Reserves

According to Statistics Canada (2008), about 27% of Canada's Aboriginal population lives on reserve. Many of these reserves are within a short distance of a city, and can be consider peri-urban reserves. Many such small reserves circle western cities such as Vancouver, Winnipeg and Saskatoon. Other larger well-known peri-urban reserves include the Six Nations Reserve (near Hamilton) and Kahnesatake and Kahnawake Mohawk Territories (near Montreal).

These communities usually have a significant degree of self-government, administering their own health, social, educational and law enforcement services. Decisions about these services are made within the community in Band Councils or other locally elected or traditionally recognized leadership. These communities are also important for the continuity of Aboriginal cultures, languages and spirituality (Champagne, 2007). Traditional spirituality and other communal activities may be closely related in such communities. Many communities have their own popular media, most commonly local radio stations but also TV and print publications. The organizational and geographic configuration of large peri-urban reserves may make it easier to provide mental health services through community clinics and local wellness teams. Existing community resources can provide a strong basis to initiate new interventions and activities (Wieman, 2008).

Peri-urban reserves may have some of the advantages of urban settings. The proximity of a major city may provide educational and employment opportunities within commuting distance. This means that residents do not have to move off reserve to access such opportunities, thus can maintain their link to their community. They can also access secondary and tertiary health services relatively easily.

Despite urban migration, in recent years, reserves are showing a net gain in population with significantly more people moving onto reserve than leaving, showing their continued popularity as a place to live for Aboriginal people. However, there are many challenges facing some reserves, particularly those in rural or remote locations, with large variability in the quality of services and social cohesion.

1.3.1.3. Rural and Remote Communities

Many reserves are located in rural areas. As well, according to Statistics Canada (2008), approximately 20% of Aboriginal people in Canada live in rural non-reserve areas. This includes remote and wilderness areas and agricultural lands, as well as small towns, villages and other populated places with a population of less than 1,000 and a density of less than 400 persons per square kilometer. Many of these communities are located in Canada's northern regions.

Fully 90% of Aboriginal communities across Canada consist of less than 1,000 people. These communities are often located in regions with very low population density. Some of these communities, especially arctic and northern communities, are more than 2,000 kilometres from a major city. Towns or small cities such as Yellowknife, Iqaluit or Sioux Lookout serve vast areas with many small communities. Access to many of these centres from rural and remote areas is often difficult. Few roads connect some of the smaller communities, which may be hundreds of kilometers from neighbouring communities.

Rural communities have some advantages with regard to mental health. There can be greater social cohesion, easy access to social and family support systems, a comprehensive informal helping network, and widely-shared knowledge of the community and available community resources. Rural areas may also have dense social connections where professional and personal networks are likely to overlap. This can be an advantage when immediate responses are needed to avert a crisis, but can be a disadvantage to both clinicians and clients when privacy and professional distance is desired.

A variety of forms of mental health services have been provided to Aboriginal people living in rural and remote areas, including primary care, crisis intervention, prevention and health promotion programs. However many people living in rural or remote areas do not have ready access to professional health care. Larger communities may have a primary health clinic staffed by a physician and other health professionals. Smaller communities may have a nursing station, with visits from other health professionals on a rotating basis. Specialist, secondary and tertiary services are generally not readily available in smaller rural and remote communities. As such, people with health problems, especially serious ones, may need to travel long distances at

considerable expense to consult the appropriate medical care.

This situation is compounded by common difficulties faced in the provision of mental health services in rural and remote settings. These include: (i) shortage of trained professionals or other helpers. These professionals often have to work alone with limited access to ongoing clinical supervision and continuing education; (ii) the pressure on the few workers living in a small community who may be overwhelmed; (iii) the difficulty of ensuring confidentiality in small communities; (iv) stigma associated with mental illness that is difficult to conceal in small communities. Patients may not seek services because of realistic fears about maintaining confidentiality; (v) the costs and troubles associated with transportation of providers or patients; (vi) Scarcity of resources may also contribute to less collaboration among mental health professionals as they feel pressure to function as generalists, accommodating a wide variety of clinical problems. (Nagarajan, 2004; McDonel et al., 1997).

In addition to the challenges associated with geographical remoteness, rural and remote communities face similar challenges to those faced by Aboriginal people across Canada. Many remote Aboriginal communities have social problems including housing shortages, overcrowding, poverty, unemployment and issues of substance abuse that may reduce wellbeing and increase the prevalence of mental health problems (King, Smith & Gracey, 2009; Kirmayer, Tait & Simpson, 2008). Social and health services may be underfunded. Rates of substance abuse, violence and suicide may be high (Kirmayer, Brass, Holton et al., 2007). Aboriginal language use is more common in rural and remote areas, posing an added challenge for the provision of culturally safe and competent mental health services.

In addition to the general difficulties mentioned above, there are some specific challenges associated with service delivery in many remote and rural Aboriginal communities (McCormick & Quantz, 2009). These include:

• Services are often provided only in reaction to crises, in the form of crisis intervention and fewer resources are invested in primary and secondary prevention or health promotion activities;

• Services are often fragmented and lack continuity of care over time and across sectors. The lack of temporal continuity results from staff shortages, high levels of staff turnover, and shortages of resources. Remote and rural communities often rely on locum or itinerant physicians and nurses on rotation (Armstrong, 1978; Group for the Advancement of Psychiatry, 1995). Discontinuity across sectors occurs because services are segmented in 'silos', i.e. substance use disorder services, mental health services, social services, and education are not integrated and may provide contradictory advice or interventions;

• Financial sustainability of projects is one of the main challenges to the continuity of care. Often services are provided through specific projects or initiatives. Project funding tends to be on a pilot or short-term basis, with promising and innovative health care projects are terminated just as communities are becoming more comfortable with the intervention.

Program evaluation is far less common in rural mental health than in urban settings, due to a

shortage of resources, costs of hiring outside researchers to evaluate projects and lack of trained personnel on the ground to conduct evaluation. There may also be a heightened sensitivity on the part of providers about the perceptions of urban-based outsiders that their services are of an inferior quality. The result of all this is that there is a lack of rigorously evaluated, evidence based interventions vis-à-vis promoting Aboriginal mental health and well-being in rural and remote regions. In the absence of a comprehensive service, it has been suggested that a community mental health liaison service could provide support for primary care practitioners, while also assisting family carers, though again this model has not been rigorously tested (Hazelton et al., 2004).

1.3.2. The Need to Address Social and Historical Context

Aboriginal peoples in Canada have faced distinctive forms of adversity. Their history has been marked by colonization, forced assimilation, cultural oppression and expropriation of land and resources (Brant Castellano, 2008). In recent years, this adversity has been described in terms of historical trauma, loss and grief (Brave Heart, 1993; Brave Heart & Lebruyn, 1998). There is evidence that these historical experiences have not only left their mark on communities and families but contribute in an ongoing way to individuals' sense of ill-health (Whitbeck, Adams, Hoyt, & Chen, 2004). Dixon and Iron (2006, p.1) state:

> "For many American Indians and Alaska Natives, a health history is not just the events of the past week that led them to seek health care, or even their own life story. Relevant health history goes back for generations. Many of the health problems that afflict American Indians and Alaska Natives today are the result of intergenerational trauma and historic trauma—the individual's history is inseparable from the history of the tribe."

Addressing the health impact of historical loss and trauma requires community-based approaches that re-establish or strengthen the sense of historical continuity and belonging that was undermined by the oppressive policies of the state. As yet, there are few evidence-based interventions in this area, but the rationale and needed direction for innovation are clear (Gone, 2009). In the United States, psychologists Eduardo and Bonnie Duran (1995) have developed a "postcolonial" treatment model that involves reconnecting clients with their Native American identity. This improves self-esteem and sense of identity, which are related to healthy psychosocial functioning and positive health behaviours (Adams, Fryberg, Garcia et al., 2006). An increased awareness of the role of historical factors in contributing to Aboriginal marginalization may reduce shame, guilt and internalized oppression at the individual level.

Duran and Duran note that the effects of colonization have been especially severe for American Indian men. Treatment models that address issues around the destruction of traditional economic and cultural roles, which has resulted in loss of roles and identity, may be effective in treating substance use disorders and addressing family violence (Brant Castellano, 2006). Wanganeen (2001) comments that successful healing of psychological and mental health problems associated with the historical impacts of colonization and forced assimilation should include:

- awareness of the history of colonization and its impact;
- identification and acknowledgment of historical and collective losses (e.g. of land, language etc.);
- identification and acknowledgement of emotional issues that are legacies of historical events;
- reclaiming under-recognized emotional losses by bolstering a sense of indigenous identity, power, trust, confidence, self-esteem and safety

In Australia, there is some literature describing good practice approaches to Aboriginal SEWB services, but little that refers specifically to provision of services to people affected by forcible removal practices like those associated with the residential schools. A notable exception is the Marumali Program designed by a survivor of the forced removal. This program involves one or five day workshops for survivors of forced removal. It is designed "as a healing program rather than a 'therapy' or a 'treatment'" culturally tailored to the strengths and challenges faced by Aboriginal people in Australia. According to the website, this program

> "offers a culturally appropriate and supportive forum for participants to discuss colonisation, grief, loss, identity and other issues of a sensitive nature, and allows for identity to be affirmed and strengthened. Specifically the workshop offers insight into: Common types of removal/separation & their effects on those removed, their families & communities; Silence & transgenerational effects; Outlines the stages of Marumali healing journey; Importance of identity & belonging place & spiritual dimensions of healing" (www.marumali.com.au).

The Aboriginal Healing Foundation funded similar programs in Canada (Brant Castellano, 2006). This type of intervention will take on renewed importance with the work of the Indian Residential Schools Truth and Reconciliation Committee (TRC) (Brant Castellano, 2008). The emphasis of the TRC on healing and reconciliation has a direct bearing on community wellness, mental health and SEWB. As yet, it is unclear what exactly the TRC will provide in terms of health supports and benefit to residential school survivors and other Aboriginal people. However, its activities will be a form of intervention for the general population, raising awareness and documenting issues of historical trauma. Researchers and health professionals need to work with the commission to understand and address the issues of trauma and loss (both direct and transgenerational, individual and collective) that continue to negatively impact on Aboriginal peoples in Canada. Community mental health programs that address the impact of the residential schools can build on indigenous sources of resilience (Hanson & Hampton, 2000).

1.3.3. Community-Based Resources and Traditional Healing Approaches

Aboriginal peoples have a rich heritage of healing practices and traditions (Kirmayer & Valaskakis, 2008). These healing practices convey core cultural values and perspectives and so, in addition to addressing individual symptoms and concerns, they work to strengthen collective identity and cultural continuity. Many of these traditions share an understanding of health as arising from a proper state of balance and equilibrium between the physical, the mental, the spiritual and the emotional aspects of the person (Anderson, Baum & Bentley 2007;

McCormick, 2008). This holistic, integrative view of the human condition lends itself to broad considerations of the importance of interpersonal relationships, social networks, and relationship to the environment as key sources of mental health and wellbeing. In addition to healing practices, Aboriginal communities have their own strengths and resources, which often include strong extended families and cultural, religious, and spiritual practices. These communal or collective values and practices are potential sources of strength and resilience (Kirmayer, Sedhev, Whitley, Dandeneau & Isaac, 2009). Traditional healing approaches and community-based resources can provide the basis for mental health promotion and wellness programs.

A review conducted for the Assembly of First Nations of successful Aboriginal health programs in Canada, the United States and Australia identified common strengths across the programs:

- projects tend to be tradition-based and value-based;
- interventions focus on the entire family;
- links are made between spirituality and therapy;
- there is an intimate knowledge of the tribal community and a drawing together of traditions;
- projects respond to the needs of the community;
- the community actively supported healing and recovery (Elias & Greyeyes, 1999).

The Aboriginal Healing Foundation (AHF) recently conducted a similar review of common approaches to healing practices among indigenous peoples, and attempting to distill the essential ingredients of successful programs (Brant Castellano, 2006). These include:

- learning about the history of colonization;
- having a chance to mourn the losses associated with colonization;
- reconnecting with traditional cultures, values and practices;
- using of culturally sensitive screening and assessment tools to complement holistic and relational worldviews;
- creating community-level healing interventions that are culturally appropriate and rooted in local practices, languages and traditions;
- creating specific strategies to meet the needs of Indigenous people who do not have strong cultural ties (Brant Castellano, 2006, pp. 49-51).

There is a large degree of overlap between the results of the AHF and the AFN reviews of successful programs. However, the AHF cautions against the assumption that healing programs that work well in one context can be successfully transported to another social, cultural or political milieu, even within the same or similar nations. Attention to context is paramount, and adaptation of an intervention may be necessary when exporting any intervention across Aboriginal communities (Gone, 2009).

There are specific models and modalities within conventional mental health practice that may have a better fit with traditional healing practices (Gone & Alcantara,, 2007). For example, family systems and psychoeducational approaches may fit well with Aboriginal cultures, which place a strong emphasis on the extended family or clan (Speck & Attneave, 1973). Many communities in Canada have made use of talking or healing circles to address conflict and

promote mental health. This adapts traditional Aboriginal approaches to collective decision-making, provision of support, and conflict resolution. The following five types of circles are most commonly discussed in the literature (Kirmayer, Simpson, & Cargo, 2003):

- 'sentencing circles' used to assess and reintegrate offenders who might otherwise be ostracized and handled entirely within the mainstream penal system;
- talking circles, in which people speak openly and listen to others' stories to begin to become aware of psychosocial and emotional issues afflicting the person and the community at large;
- sharing circles, in which a high degree of trust is established and people express painful emotions and are consequently supported by others in the circle;
- healing circles, where people can work through memories of painful experiences
- spiritual circles, in which people share their own experiences of spirituality as a source of comfort and guidance, which is reinforced by the perspectives and experiences of others in the circle.

Some approaches to counselling and psychotherapy may fit better with indigenous values and perspectives (Kirmayer, 2007). For example, narrative therapies elicit and rework the explanations that define life problems as well as those stories that individuals use to construct their own identities (White & Epston, 1990). Narrative therapy "starts from the premise that the job of the counsellor is to help people identify what they want in their own lives, and to reconnect with their own knowledges and strengths" (Aboriginal Health Council of South Australia (AHCSA), 1995, p. 18). The narrative approach asks questions that can raise awareness of the historical origins and context of individual and collective problems: "exploring the history of a person's ways of being and thinking creates the opportunity for that person to identify the real effects of these ways of being and thinking on their life" (AHCSA, 1995, p. 19).

The narrative approach recognizes the importance of stories for Aboriginal people, giving voice to those who have had their sense of power and agency undermined by the dominant culture (Hodge, Pasqua, Marquez & Geishirt-Cantrell, 2002; McCormick, 2008). Personal stories often embody collective history, traditional knowledge and local moral codes. Situating the person in this wider context may enhance cultural identity and give a sense of continuity and cohesion (Chandler, Lalonde, Sokol, & Hallett, 2003). Narrative therapy thus may promote links between historical and cultural identity and foster political awareness and community activism.

In addition to explicit healing interventions, the popular and fine arts provide important vehicles for transmitting cultural knowledge and practices as living traditions. There are many compelling examples of the use of the arts in mental health promotion among indigenous communities around the world (Kirmayer, Brass & Valaskakis, 2008). For example, the Taiho Theatre Company in New Zealand is a collective of Mäori women who use theatre and traditional forms to address local issues through the dramatic retelling of people's stories (Rowling & Taylor, 2005, p. 279). Telling personal and traditional stories that have been suppressed or marginalized is reaffirming of cultural identity and community. Taiho theatre performs at local community recreational and cultural events and in Mäori mental health facilities. In Canada, the performing arts, including theatre, music and dance have all been used by Aboriginal artists to explore the contemporary issues relevant to mental health promotion.

Wider systems of health services delivery and care can also reflect an Aboriginal ethos. Probably the best example of this also comes from New Zealand. Settlement of claims under the Treaty of Waitangi has allowed some tribes to provide their own social and mental health services. The National Body of Traditional Mäori Healers has been established, and traditional healing is now offered in many primary health care settings. This body recognizes regional and tribal variations in healing traditions but also works to develop a collective approach to issues such as professional standards, policy and access to funding. The Ministry of Health has published standards for traditional Mäori healing, with support from the National Body of Traditional Mäori Healers (Brant Castellano, 2006, p. 31).

In general, approaches that build on existing resources, that respect community values and that are sensitive to the Aboriginal context are more likely to be accepted by communities. At the same time, by mobilizing existing individual and communal resources, strength-based approaches can promote well-being and resilience at multiple levels.

1.4. Cultural Competence, Safety and Responsiveness

Strengthening community wellness in Aboriginal communities can make use of programs developed for the general population. However, there is general agreement that interventions developed for the general population must be adapted to be accessible and acceptable to First Nations (Dixon & Iron, 2006). Each Aboriginal community, nation or people has its own cultural knowledge, values and ethos, as well as a particular history of challenges and adversities. This local knowledge and context is relevant to any effort to develop, adapt and implement mental health promotion.

A large literature shows that cultural concepts influence basic social determinants of health including social status, employment, education, wealth and social support (Alpertsein & Raman, 2003; Wilkinson & Marmot, 2003). These social factors cannot be understood without taking culture into account (Corin, 1994; Gone & Kirmayer, 2010; Morrissey et al., 2007). For example, the meaning of poverty is different in a culture or community not centered on monetary or material wealth. Similarly, the meaning of unemployment is entirely different in a community where a valued contribution and participation in the community is unrelated to wage earning.

Contemporary anthropology emphasizes that culture is not a fixed, homogeneous, intrinsic characteristic of individuals or groups (Kuper, 1999). Instead, culture involves a flexible, ongoing process of transmitting and using knowledge that depends on dynamics both within communities and at the interface between indigenous communities and institutions of the dominant society, like the health care system. As a result, cultures are often hybrid, mixed, and undergoing constant flux and change. Nevertheless, because culture is a core element of how individuals and communities see the world and construct their hierarchies of goals and values, it is central to the ethics and pragmatics of health promotion and health delivery.

There is wide recognition that health services and mental health promotion must consider culture to be ethically sound and effective (Anderson, Scrimshaw, Fullilove et al., 2003; Brach & Fraser, 2000). In the U.S. and other countries, this has been approached in terms of the need for 'cultural

competence' in health professionals, organizations and institutions (Allan, 2008; Betancourt, Green, Carillo, Ananeh-Firempong, 2003). Cultural competence aims to make health care services more accessible and acceptable to people from diverse ethnocultural communities. Cultural competence is defined variously as:

- a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations (Cross, Bazron, Dennis, & Isaacs, 1989).
- "the ability of systems to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs" (Betancourt et al., 2003).

Several broad domains of cultural competence have been described by the U.S. Department of Health and Human Services (2007, p. 17): (i) organizational values; (ii) governance; (iii) planning and monitoring/evaluation; (iv) communication; (v) staff development; (vi) organizational infrastructure; and (vii) services and interventions. A variety of measures for these domains and related domains have also been developed (Siegel et al., 2000).

Cultural competence is increasingly recognized as a crucial skill set for all mental health professionals, especially those working in multicultural milieus or with ethnocultural minorities (Sue et al., 2009). Cultural competence can be addressed at the level of the organization of health systems and institutions, specific models of care, the training and composition of the health workforce, and the types of intervention. There is evidence that attention to cultural competence at each of these levels can reduce health disparities (Bhui et al., 2007; Brach & Fraser, 2000; Smedley et al., 2003).

Training materials and approaches have been developed to teach cultural competence to physicians, mental health practitioners and staff and there are many resources available on the Internet to address these issues (Betancourt, 2006; McPhatter, 1997; Sue & Sue, 2004; Ecklund & Johnson, 2007; Ring, Nyquist & Mitchell, 2008; Tseng & Streltzer, 2004; Warren, 2000). Though evaluations of the impact of such training is limited (Price et al., 2005). Recently, specific curriculum and materials have been developed by the Indigenous Physicians Association of Canada and the Royal College of Physicians of Canada (2009) to train medical students and psychiatric residents in cultural competence for Indigenous mental health.

Cultural competence is an important counter-balance to the movement for evidence-based mental health care, which tends to lead to a 'one-size-fits-all' approach (Whitley, 2007). However, current approaches to cultural competence have been criticized for essentializing, commodifying and appropriating culture, leading to stereotyping and further disempowerment of patients (Kleinman & Benson, 2006). Various alternative approaches to addressing cultural diversity have been proposed, including a focus on *cultural safety* (Papps & Ramsden, 1996) and *cultural humility* (Tervalon & Murray-Garcia, 1998).

The notion of cultural safety was developed in the 1980s in New Zealand in response to the Maori people's discontent with nursing care (Papps & Ramsden, 1996; Koptie, 2009). In contrast to the notion of cultural sensitivity discussed in some nursing literature, cultural safety "moves

beyond the concept of cultural sensitivity to analyzing power imbalances, institutional discrimination, colonization and colonial relationships as they apply to health care" (NAHO, p. 2008a, p. 3). Cultural safety has been recognized by the National Aboriginal Health Organization, other Aboriginal organizations and the Mental Health Commission of Canada as a preferred approach to guide efforts at improving the cultural responsiveness and appropriateness of care. Nursing educators and practitioners have led the development of the concept of cultural safety (Aboriginal Nurses Association of Canada, 2009; Stout & Downey, 2006).

> "Cultural safety is a powerful means of conveying the idea that cultural factors critically influence the relationship between carer and patient. Cultural safety focuses on the potential differences between health providers and patients that have an impact on care and aims to minimize any assault on the patient's cultural identity. Specifically, the objectives of cultural safety in nursing and midwifery training are to educate students to examine their own realities and attitudes they bring to clinical care, to educate them to be open-minded towards people who are different from themselves, to educate them not to blame the victims of historical and social processes for their current plight, and to produce a workforce of well-educated and self-aware health professionals who are culturally safe to practice as defined by the people they serve" (Crampton et al., 2003, p. 596).

Cultural safety in indigenous contexts means that professionals and institutions, whether indigenous or not, work to create a safe space for an encounter with patients that is respectful and responsive to their social, political, linguistic, economic, and spiritual realities. Culturally unsafe practices involve "any actions that diminish, demean or disempower the cultural identity and well-being of an individual" (Nursing Council of New Zealand, 2002, 7).

NAHO (2008a) has advocated principles of cultural safety that are grounded in recognizing the historical context of Aboriginal experience. This includes recognizing the diversity of populations, understanding power issues in health care worker–patient relationships, and raising awareness of cultural, social and historical issues in organizations and institutions. In the training of health care providers and professionals, cultural safety involves attention to issues of communication, power sharing and decision making, working toward understanding and addressing misunderstandings, and recognizing and respecting fundamental cultural values and commitments.

> "Cultural safety refers to what is felt or experienced by a patient when a health care provider communicates with the patient in a respectful, inclusive way, empowers the patient in decision-making and builds a health care relationship where the patient and provider work together as a team to ensure maximum effectiveness of care. Culturally safe encounters require that health care providers treat patients with the understanding that not all individuals in a group act the same way or have the same beliefs." (NAHO, 2008a, p. 19)

Cultural safety has some overlap with concepts such as 'cultural sensitivity', cultural responsiveness and 'cultural humility'—that is, with a willingness and ability to listen and learn from patients. This openness, respect and attentiveness is a pre-requisite for cultural safety but,

by itself, is not sufficient. "Sensitivity can be thought of as the first step towards learning about oneself within the context of one's interaction or relationship with people of a different culture" NAHO (2008a, p. 27).

Although there is overlap between concepts of cultural safety and cultural competence, they are not one and the same. Cultural competence has occasionally been criticized for encouraging a stereotypical approach to ethnicity, for example by teaching that African-Americans are religious, or that Latinos come from strong intense families. Cultural safety does not rely on developing 'competence' through knowledge about the cultures with which professionals are working. Instead, cultural safety emphasizes recognizing the social, historical, political and economic circumstances that create power differences and inequalities in health and the clinical encounter (Anderson et al., 2003).

The concept of cultural safety has also received some criticism. Johnstone and Kanitsaki (2007) provide a critique from an Australian perspective. Cultural safety developed in the bicultural political context of New Zealand, and it is not clear how well it applies to the multicultural context of Australia. There has been relatively little research on cultural safety and a link between cultural safety and positive outcomes (in training or practice) has not been clearly demonstrated. As a metaphor and model, cultural safety is not a transparent concept but requires unpacking and further specification in terms of its implications for training and practice. Discussions of cultural safety tend to frame the clinical encounter as one of risk and vulnerability, with all the power and potential for aggression and harm on the side of the clinician. As a result, cultural safety tends to approach culture in terms of vulnerabilities rather than strengths. By implying that the cultural 'other' is vulnerable, cultural safety may also contribute to essentializing and stereotyping ethnocultural groups.

To explore some of these criticisms, Johnstone and Kanitsaki (2007) conducted a focus group and key informant study of understandings of cultural safety among practitioners, patients, consumers and ethnic minority organizations in Australia. Their findings suggested the potential value of the concept of cultural safety. Providers interpreted cultural safety as not imposing their own cultural values on patients in areas that were vital, or to 'racial respect' and anti-racist perspectives. The key threats to cultural safety identified by patients included:

- inability to communicate with service providers;
- poor attitude and not being treated with respect by staff (including patients being treated as stupid, staff making assumptions about and stereotyping patients, language prejudice);
- not having their families present;
- not being listened to or understood;
- not knowing what is going on and not being given explanations;
- forced to comply with unfamiliar cares and treatments;
- inability to take action to help themselves or their loved ones (being powerless);
- inflexibility of the system;
- feeling isolated (i.e., not having people around who shared the same culture and language);
- not having access to safe and competent interpreting services; and
- feeling shame, embarrassment or anxiety because of having to rely on children or other "inappropriate relatives" as interpreters.

Research on cultural safety related to improving the quality of services has also been conducted with providers in the Queensland, Australia. In this study, key elements of cultural safety from the providers' perspective included (Queensland Health, 2005):

Communication: promote cultural awareness amongst colleagues; respect cultures; insure cultural sensitivity and consideration of local customs; provide a checklist for safe cultural practice; display relevant posters in common areas and staff rooms;

Staff development: provide cultural awareness training, education aimed at promoting Indigenous learning styles, and general training on health and health promotion; educate and employ more Indigenous staff; develop a resource book for staff and clients;

Resources: create culturally appropriate posters, booklets, and handouts; insure that information is readily available for staff; publish newsletters on current indigenous health issues and cultural awareness;

Health services: link with other services that provide support; increase number of Indigenous liaison officers; improve access to indigenous services; provide interpreters for Indigenous clients; insure there are Indigenous health workers in each clinical area; recruit and retain of Indigenous health workers; increase employment of Indigenous people

Engagement with local community: increase community knowledge, awareness and involvement; improve transportation to facilities; insure communities have ownership of health promotion.

Clearly, the concepts of cultural competence and cultural safety are very relevant to efforts to enhance community wellness in Canadian Aboriginal contexts. Any teams delivering care to Aboriginal communities must be trained in approaches to cultural competence and cultural safety that are consonant to local Aboriginal values. Community wellness teams will be more effective if they are thoroughly grounded in Aboriginal ways, in terms of values, orientation, and interventions. Issues of ownership and governance may be particularly important in this regard, ensuring that teams include Aboriginal members and have the oversight of Aboriginal community organizations and local professionals, helpers and healers.

While there are very good reasons, as summarized above, to adapt or transform programs or interventions to make them culturally safe and appropriate, the evidence that this actually results in improved effectiveness remains limited due to a lack of studies (O'Connell, Boat & Warner, 2009; Sue, 2009). In fact, in some instances, cultural adaptation may actually reduce the benefit of a program if essential elements are eliminated. For this reason, evaluation research on the effectiveness of culturally adapted or novel interventions is essential. At the same time, studies are needed to clarify the crucial ingredients of effective programs and the processes by which they work in order to guide the development and adaption of new interventions (Bess, King &

LeMaster, 2004). For example, understanding the relationship between an individual's sense of self-esteem and self-control and the collective sense of esteem and control, can point toward potentially effective interventions at both individual and communal levels (Tiessen, Taylor & Kirmayer, 2010). If the goals and processes of the implementation and efficacy of mental health promotion can be clearly described, they can be translated into culturally grounded local forms that are both feasible within the community setting and that serve to strengthen collective identity and commitment.

1.5. Community Engagement, Development & Empowerment

As we have noted, there is a substantial literature showing that mental health problems among Aboriginal peoples are largely determined by social, historical and cultural factors. This is consistent with studies around the world clearly showing that mental health is socially determined (Wilkinson & Marmot, 2003). The social origins of prevailing mental health problems require social solutions, and in the case of Aboriginal peoples this points to the importance of community engagement.

In the public health and community development literatures, 'community' generally refers to groups of people interconnected on the basis of identity, geography or common issues or commitments (Bauman, 2001; Baum & Palmer, 2002; Labonte, 1997; Warry, 1998). Community interventions usually involve a progression of degrees of involvement aiming at engagement, development and empowerment (Vandiver, 2009). This process may be especially critical to the success of interventions for Aboriginal communities. Community engagement and empowerment can create a sense of ownership in the local community. It can ensure local Aboriginal people can make an essential contribution to intervention development and implementation, addressing basic issues of cultural safety as well as insuring the aspirations and priorities of the community are central to any intervention (Macauley et al., 1999).

In the context of mental health promotion, *community engagement* refers to active dialogue and ongoing connections between individuals, communities and governments (or other institutions) on needs, resources, policies, programs and service delivery issues. Engagement can encompass a wide variety of interactions ranging from information sharing to community consultation, active participation in decision-making processes and the development and implementation of community-based teams and initiatives.

Two main types of outcomes can be promoted through a *community development* approach: (1) improvement in health outcomes achieved by addressing a health problem or its determinants factors; and (2) increased individual and community empowerment, which leads to health and wellbeing through more equitable power relationships (Baum & Palmer, 2002; Labonte, 1994).

In the community development context, *empowerment* has been described as a social action process that promotes participation of individuals, organizations and communities in gaining control of their lives both in their community and in the larger society (Wandersman, 2003). Empowerment can operate at the level of the individual, the organization or the community (Israel, Checkoway, Schulz et al., 1994). The community mental health movement has argued

that empowerment, through active involvement of the community and of people with lived experience of mental health problems, is central to improving the social integration people with mental health problems and creating more responsive services (Nelson, Lord & Ochocka, 2001). This work on consumer/survivor empowerment is relevant to Aboriginal communities and to the situation of Aboriginal peoples more generally, since they have experienced a prolonged process of political invalidation and disempowerment. Recognizing and respecting indigenous peoples' power and authority to direct their own lives is essential to any mental health intervention and should be integral to the organization and governance of all programs (Chino & Debruyn, 2006).

The differences between top-down, target-oriented health promotion and an empowerment approach are found at multiple levels: who makes decisions on resource allocation (professionals versus community members); the expected outcomes (improvement in health status versus social change); the process of outcome assessment (often, quantitative versus qualitative); the definition of community (as a circumscribed population at risk or an political and cultural group of inter-related people who are active agents in pursing their own individual and collective health concerns); the capacity building and educational process (unidirectional versus dialogical), the nature of leadership (individual versus collective); the documentation process (through participatory action research); and the approach to ethical issues (attention to issues of power sharing and balance individual and collective responsibility) (Perez et al., 2009).

1.6. Summary

In this introduction, we have reviewed some of the background literature important for understanding the geographic, historical and sociopolitical contexts of mental health and well-being among Aboriginal peoples in Canada. These diverse contexts are the basic realities that any approach to community wellness teams must address. Aboriginal communities have faced many challenges. Although there are common adversities that arise from the history of colonization and subsequent policies of forced assimilation and marginalization, the specific issues for each community depend on culture, history and geography. Despite the high level of adversity they have faced, Aboriginal peoples and communities have great strength and resilience. Many communities have strong community cohesion and natural support networks through family, clan and nation. Aboriginal knowledge, values and practices of health and healing resonate with the basic principles of health promotion advocated by national and international organizations across the world. Given the collective orientation to life in these communities, as well as commonly-shared grounded notions of wellness, Aboriginal communities can provide fertile soil for the growth of community wellness teams. However such teams will need to take into account key cultural, historical and geographical issues to be successful, including: (i) the practical dilemmas posed by serving many small communities that are remote from urban centres; (ii) the pervasive impact of the history of collective trauma and loss; (iii) the key role of cultural identity in community revitalization and in insuring the safety and competence of health services; and (iv) the central role of community engagement, empowerment and governance in strengthening mental health and wellbeing. Any program will have to begin with assessing the communities needs and priorities and that can also serve as a method to engage the community and build partnerships for mental health promotion (Freeman et al. 2004; Novins, et al., 2004).

In order to identify current approaches and best practices, we conducted a systematic search of the available literature. Community wellness approaches are described in several diferent literatures with different disciplinary perspectives, including: psychiatry, psychology, social work, public health, epidemiology, criminology, sociology and anthropology. Given that many community wellness approaches attempt to deal with mental health and mental illness, we first assessed common approaches in community mental health that can help in the development of community wellness approaches. Secondly, we gathered and reviewed material on community wellness approaches in general, in the context of new developments in psychiatry and public health. Thirdly, we examined secondary and background services that may be necessary or sufficient for the successful operation of community wellness teams. Lastly, we collected and reviewed available materials on the development, implementation and evaluation of community wellness teams. We reviewed journal articles, publications, books, web sites, and unpublished reports, and also consulted with researchers, clinicians and planners with expertise in this field.

As part of this process, specific programs, services or models were identified, categorized and characterized according to a list of descriptors developed from earlier work. This includes a Canada-wide scan of suicide prevention and mental health promotion programs for Aboriginal communities previously conducted by our group for Health Canada (Available at: www.namhr.ca), and work by the One Sky Centre in the U.S. (www.oneskycenter.org), and a ongoing systematic review by Dr. Margaret Cargo and colleagues in South Australia. These descriptors were used to extract information from online computerized databases, the Internet and consultation with leading experts internationally.

Bibliographic searches of available medical and psychological databases including PubMed, PsychINFO and Google Scholar were conducted in October 2008 and updated in October 2009. These searches focused on literature explicitly discussing models of community mental health services, interventions and promotion in the context of community wellness. We examined recent material applicable to the general population in order to understand general approaches to community wellness. This was augmented by a comprehensive search and review of approaches to mental health promotion Aboriginal peoples in Canada. This search was then widened to include indigenous peoples in the U.S.A (American Indians and Alaska Natives), Australian Aboriginals and Torres Strait Islanders, and New Zealand Maori who have faced many similar challenges (Durie, Milory & Hunter, 2008). This broader literature was sampled more selectively with the focus on programs that had received some form of evaluation, or were currently considered promising. Material on indigenous populations was supplemented by a more selective review of the national and international literature on current best or promising practices in the areas of community mental health services and promotion for the general population.

Assessment of the published literature was supplemented with reviews of reports on the web, unpublished documents (government, community or other reports) and other materials. These were identified by use of Internet search engines (primarily Google and Google Scholar), as well as by canvassing experts in the field of Aboriginal mental health in Canada, Australia, New Zealand, and the U.S. Individuals consulted are listed in the Appendix.

All of the reviewed models, services, programs and policies designed for the general population, non-Aboriginal communities, or Aboriginal communities outside Canada were critically assessed in terms of their potential relevance and applicability to Aboriginal people in Canada. This assessment included consideration of culture, language, political and social context, geography and environment, human and technical resources, and ethical issues. Additional material was collected on current strategies for evaluating community mental health policies, programs, services, and interventions.

The material was abstracted by research assistants, reviewed for relevance, and summarized in terms of core themes and specific elements. These summaries were used to identify material presenting promising practices for more intensive review. This material was synthesized and analyzed to extract key principles and programs that could be developed as pilot projects on community wellness in the Canadian context to meet the needs of Aboriginal communities and populations.

In conducting the review, it became apparent that there is relatively little published academic literature on community wellness teams from a mental health perspective in Aboriginal communities in Canada, as well as in New Zealand, Australia and the U.S. In a Medline search using the search term 'community wellness team*', only 23 papers were found, few of which were concerned with the Aboriginal population, or indeed at all relevant to the present report.

However, there is a substantial "grey" literature including unpublished reports, conference proceedings and websites (Henderson, Robson, Cox, et al., 2007). We have accessed this both through web searches and our international network of colleagues and collaborators. In reviewing this literature, we have tried to identify the most promising or well-developed programs and models. In what follows, Chapter 3 focuses more on background and contextual factors that are essential to understand community wellness approaches and community wellness teams. Chapter 4 focuses on case studies of programs with a community wellness team orientation, from which many lessons can be learned.

3.1. A Matrix of Focus and Setting in Mental Health Services and Promotion

Community mental health services and interventions cover a broad domain. To organize the review, we have used a matrix of types of need for service by setting or location.

Figure 1. The Matrix of Focus and Geographic Setting

Geographic Setting	Focus				
	Severe Mental Illness	**Common Mental Disorders**	**Substance Use Disorders**	**Mental Health Promotion**	**Community Wellness**
General population					
Urban					
Peri-urban reserve					
Rural and remote					

The rows reflect the previously described geographic settings in which Aboriginal peoples live, which we have roughly divide into: remote and rural communities (some of which include reserves), peri-urban reserves (located near large cities), urban centers, and regional or national populations as a whole. It is useful to distinguish these different settings because they affect the type of mental health service or intervention that may be needed, as well as what is practical or feasible given the physical, social, environmental and political context.

The columns reflect a focus on different types of mental health problems or mental health promotion. The five categories described are often the focus of specific types of policies, programs, services or interventions, including: severe mental illness (SMI; illnesses that are severely disabling and that often require hospitalization, i.e. schizophrenia, bipolar disorder, major depression, and schizoaffective disorder); common mental disorders (CMD; e.g. depression and anxiety disorders, with a wide range of severity that frequently occur in the community); substance use disorders (i.e. alcohol or drug abuse); mental health promotion, which is concerned with primary and secondary prevention often at the national, provincial or regional level; and community wellness interventions that are locally grounded and aimed at improving the socio-cultural context in which mental health problems are experienced, as well as improving the lives of all community members.

A third dimension, not depicted in this matrix but important for developing programs, concerns the clinical setting or type of service. Mental health services may be based in the general population (as in some public health or media campaigns), community (community mental health clinics, self-help groups or other institutions), primary care (nursing station or GP), specialty care (psychiatrist, psychologist, or other mental health provider) or inpatient care (general hospital or other institution).

A fourth dimension concerns the timeframe of interventions. Mental health services can include crisis intervention or emergencies, acute care, chronic care, prevention or health promotion. Prevention is future oriented, working to improve the health of vulnerable individuals or whole populations in the long term. Prevention in mental health aims to reduce the prevalence and incidence of mental health problems. Mental health promotion works to enhance the well-being of the community or population as a whole, sometimes with an additional focus on specific groups or individuals.

Different types of mental health problem present specific types of need for services or intervention. In this section, we briefly review current views of the service needs of people with severe mental illness (SMI), common mental disorders (CMD), and substance use disorders, as well as the resources needed for promotion of mental health and community wellness.

3.1.1. Severe Mental Illness (SMI)

Severe Mental Illness (SMI) is an umbrella term encompassing schizophrenia, schizoaffective disorder, bipolar disorder and major depression. These disorders are characterized by intense mental suffering, which severely affects day-to-day experience and consequent functioning. Many people with SMI are hospitalized for their illness for short periods of time (Mueser, Bond, Drake, & Resnick, 1998). People with SMI are at elevated risk of losing their jobs and their housing. They may have difficulty maintaining relationships with family and friends, especially with intimate relationships. People with SMI are at increased risk of suicide and up to 50% of people with SMI also have a co-occurring substance abuse disorder (McCormick & Quantz, 2009). Symptoms and behaviors associated with SMI increase the risk of involvement with the criminal justice system, even though people with SMI are more likely to be victims than perpetrators of crime (Teplin, McClellend, Abram & Weiner, 2005). Numerous studies have shown that treatment, social supports, and the socioeconomic and cultural context can all influence the onset and course of SMI (King, 2001; Drake, 1998; Gone & Alacantra, 2007).

Although SMI often are viewed as chronic conditions, people show varying degrees of improvement or recovery both and without treatment. In recognition of this fact and the desire to focus on quality of life, the notion of 'recovery' has become particularly important in recent years in community mental health (Anthony, 1993; Davidson, 2003; Jacobson & Greenley, 2001). The Mental Commission of Canada (2009) has recovery made recovery a key principle in its framework for reform of the mental health system in Canada. The recovery movement insists that people living with SMI can lead full and active lives in their communities, given the right resources. Recovery has been described in terms of four broad and overlapping domains: clinical; functional; existential; and social (Whitley, 2009).

Clinical recovery is based on reduction and control of symptoms, so that they do not overwhelm and incapacitate the life of the sufferer. Psychotropic medication can help control and reduce severe symptoms. Illnesses such as schizophrenia and bipolar disorder can be clinically controlled and managed through appropriate medical care (Davis, 2006). This clinical management depends on several factors. First, there needs to be well-trained and accessible physicians (either psychiatrists or general practitioners) available to make an accurate diagnosis

and prescribe the most effective medication. Secondly, the medication must be readily available, not too costly, and supervised by a pharmacist or other health professional. Thirdly, case managers (usually social workers or community nurses) need to follow-up patients to ensure they are taking their medication and not suffering undue side effects. This type of care is often delivered through Assertive Community Treatment teams (ACT Teams; described in more detail later) that visit people in the community to ensure adherence to medical recommendations (King, 2001). It should also be noted that people with SMI often have poor physical health, with many having diabetes or HIV. This leads to a significantly lower life expectancy. As such, they may require medical services for other health needs (Davidson, 2003).

Functional recovery refers to domains of everyday life that enable people to function effectively in society. The most common factors studied as part of functional recovery are employment, housing, and education. People with SMI often lose their jobs, or if the illness begins when they are young, never find a job in the first place. Vocational rehabilitation specialists or supported employment counselors can work with people with SMI to help them obtain and maintain meaningful employment (Becker & Drake, 2003). Similarly, people with SMI often live in precarious housing, or become homeless as a consequence of their illness. There are various supportive housing programs that aim to ensure people with SMI have stable housing with the right supports; these programs are often delivered by social workers and case managers (Tsemberis & Eisenberg, 2000). Education is often interrupted for people with SMI, which often affects youth or young adults of high-school or university age. Because they have suffered multiple difficulties across their lifespan, some people with SMI have low-levels of literacy and numeracy. Some programs and supports exist that attempt to help people with SMI complete appropriate educational courses (Ungar, 1998).

Existential recovery refers to factors of meaning and value that may be of prime importance for individuals with SMI. One domain commonly included under this heading is religion and spirituality (Russinova & Blanch, 2007). Many people with SMI experience their illness in moral or spiritual terms. To make sense of their illness, many people with SMI seek religious and spiritual guidance. They may come to see their recovery as depending on finding a spiritual path or reintegration into a religious or spiritual community (Fallot, 2001). Clearly, this depends on the presence of religious or spiritual practices and communities, as well as the involvement of appropriate leaders or lay people. As such, religious and spiritual leaders and healers may be important figures in assisting recovery, especially among Aboriginal people (Waldram, 1997). Other approaches to existential recovery promote a sense of self-efficacy or personal empowerment that allows people with SMI to feel more in control of their lives and less at the whim of an uncontrollable illness (Deegan & Drake, 2006). Some programs train peers to help other people with SMI feel a sense of mastery over the illness, which is part of existential recovery (Clay, Schell & Corrigan, 2005).

Social recovery refers to positive change in the social arena for people with SMI. Many people with SMI suffer stigma and social exclusion, with ruptured relationships with family, friends and significant others (Kirby, 2008). Adults with SMI may often have difficult relations with their children, who may be in statutory care. Social recovery involves reestablishing rewarding relations with family, friends and significant others. Case managers often work with patients in an attempt to help them reconnect with close and extended family. They may also help patients

try to regain access and custody to their children. Religious and spiritual communities may also help in this regard.

As can be seen, according to current community mental health practice, optimal care for people with SMI requires the participation of helpers with various skills. Psychiatrists, pharmacists, vocational rehabilitation specialists, social workers, case managers, religious leaders, peers, addiction counselors, family and friends can all contribute to recovery. A team approach and inter-sectoral collaboration is essential for good care (Manson, 2000). This may be challenging to provide in rural and remote areas but the strength of connections within small communities provides an important asset (Kane & Ennis, 1996).

Community wellness teams could play a significant and meaningful role in enhancing recovery from severe mental illness. The team could address the four domains of recovery outlined above. Each domain requires different expertise. For example, clinical recovery may be depend on some input from mental health professionals, functional recovery on vocational rehabilitation, existential recovery on spiritual leaders, and social recovery on active lay community members. As such, the composition of community wellness teams should pay attention to the various skills needed to enhance recovery. The principal public health activity targeted at this group would thus be tertiary prevention to people already diagnosed. Such teams may be more viable in urban or peri-urban areas where there may be higher concentration of Aboriginal people with SMI. In rural areas, Aboriginal paraprofessionals (for example Aboriginal Mental Health Workers) could be trained to enhance recovery and service delivery for people with SMI (Schmidt, 2000; Nagal & Thompson, 2006).

3.1.2. Common Mental Disorders (CMD)

Common Mental Disorders is an umbrella term referring to mental illnesses that commonly occur in the community, mainly depression and anxiety. These disorders are less severe than SMI, but they have a much higher prevalence within the community. SMI affects approximately 1-5% of the community during one year, whereas CMD can affect up to 15% of a community. CMD have a wide range of severity and can also be disabling with impact on many of the domains of life described above, for example job performance and social functioning (Goldberg & Huxley, 1992; Abas, Baingana, Broadhead et al., 2003).

Because CMD are common in the community, concerted efforts have been made in Canada and elsewhere to train primary health care physicians to detect and treat these problems. Research suggests that primary care delivery of such mental health services can a cost-effective strategy (WHO, 2008). Psychiatrists do not need to be involved in the treatment of most people with mild or moderate anxiety and depression. This assumes that primary care clinicians are available, well trained and able to appropriately refer more difficult cases to secondary or ancillary services. These resources are not always available in Aboriginal communities (Ward, 1991)

First-line treatments for CMD are usually divided into psychopharmacological and psychological or psychosocial ('talking therapies'). Physicians can treat CMD in the short or long term with a variety of anti-depressants or anti-anxiety medications. Studies have shown mixed results as to

the efficacy of these interventions, but they continue to be used as a first-line treatment for CMD, and are certainly of benefit to many patients (Goldberg & Huxley, 1992). People with CMD are also frequently treated with one of the many psychotherapies. The most common and best studied of these is Cognitive Behavioural Therapy (CBT). In CBT, a patient will meet with a clinical psychologist or a psychotherapist over a 10 to 12-week period in order to address the underlying symptoms and manifestations of CMD. Much literature suggests that CBT is a very effective intervention for mild and moderate CMD (Beck, Rush, Shaw et al., 1979). Behavioural treatment is also often used as a strategy to help with anxiety. Providing these treatments requires a well-trained health care workers with knowledge of the diagnosis and management of CMD. Many of the most effect treatments for CMD require well-trained psychologically oriented clinicians such as clinical psychologists, psychotherapists or social workers. These practitioners can work collaboratively with primary care clinicians to provide integrated care.

The recovery movement described previously has not been deployed in reaction to CMD. This is mainly because CMD is usually not associated with the same long-term disabling effects seen with SMI. However, some people with CMD may become functionally impaired and need some of the supports referred to in the previous section to help overcome the impact of the illness.

In many cases CMD resolve on their own or with ordinary social support. People with mild to moderate symptoms of depression and anxiety may only need help in self-management or in mobilizing their social supports (Paykel, 1994). Various forms of self-care, healing practices, and religious or spiritual practices may be effective in reducing CMD (Waldram, 1997).

There is a substantial literature on the importance of social and cultural context in the causes, course, and outcome of CMD. Much work suggests that living in a precarious socio-economic situation places people at risk for CMD (Fryer, Melzer & Jenkins 2003). Women are significantly more likely than men to have a CMD, which has been attributed to the tensions of maintaining multiple social roles and the vulnerability of women to domestic violence and other social stressors. Isolation and lack of social support has also been consistently associated with CMD (Brown & Harris, 1978). As such, social and cultural resources such as religious and spiritual groups or organizations have often been recognized as potential ways to reduce the impact of CMD. Such groups can enhance an individual's sense of belonging and diminish loneliness and isolation. Another strand of research suggests that 'fresh start experiences', such as a new job or new romantic relationships are associated with better CMD outcomes (Harris, Brown & Robinson, 1999). Again, health and other services and resources in the community can lessen the impact and intensity of CMD.

There is obviously a role for community wellness teams in terms of primary, secondary and tertiary prevention of CMD. Social activity, social support and social cohesion are associated with prevention and mitigation of CMD. Community wellness teams that take a universal approach to health promotion can help enhance the health of a community which may be protective for CMD. This could involve organizing social activities and working with community organizations to increase social capital (Hawe & Shiell, 2000; Kirmayer et al., 2009). In terms of secondary prevention, community wellness teams can target selective interventions at groups known to be vulnerable to CMD, for example women with multiple role strain. This could have an important preventative role. Community wellness teams can also help in terms of

tertiary prevention, visiting and supporting those with existing CMD. Given that CMD is known to have a strong psychosocial component, Aboriginal Mental Health Workers and local Aboriginal paraprofessionals on the team (working closely with other health professionals on the team) may be very well suited to deliver services to people with CMD. Their intimate knowledge of the local culture and the community resources, networks and protocols can be used to promote the health of those at risk for, or currently living with, CMD (Nagel & Thompson, 2006).

3.1.3. Substance Use Disorders

Substance abuse refers to the excessive use of alcohol, drugs or other chemical agents to the point where it has a deleterious effect on health, well-being and functioning. In times past, substance abuse was often considered a moral problem. However, at present, substance abuse is understood as a mental health problem. In the psychiatric diagnostic systems, substance abuse is subsumed under the generic category *substance use disorders*. The excessive or inappropriate use of substances is seen as a form of psychopathology which requires attention from health professionals (Dell & Lyons, 2007; Butler, Kane, McAlpine et al., 2008).

The concepts of dependence and addiction are important in the study of substance use disorder. These concepts assume that some individuals become pathologically (biologically, psychological and socially) dependent upon a substance for their everyday functioning. They may crave the substance, go to great lengths to obtain it, and use it in ways that impair their health, psychological adaptation and social functioning (Korhonen, 2005). Substances commonly abused that are deleterious to health include: nicotine; alcohol; 'street' or illicit drugs such as heroin, crack-cocaine, cannabis or hallucinogens; and prescription drugs such as tranquilizers or pain-killers. Solvent abuse has also been an important problem in some Aboriginal communities, mainly among young adolescents (Kirmayer et al., 2008).

Epidemiological surveys suggest that Aboriginal populations in Canada have significantly higher rates of substance use disorders than the general population (Rush, Urbanoski, Bassani et al., 2008; McCormick & Quantz, 2009). This has been attributed to lack of hope and opportunity in communities facing social problems. This is a result of ongoing marginalization as well as the legacy of the insidious and abiding psychological and social effects of colonization, residential schools, forced relocations, sedentarization and other forms of cultural oppression (Brant Castellano, Archibald & DeGagne, 2008).

Treatment of substance abuse problems usually requires prolonged intervention and intensive social support. Constraints on public mental health systems often limit the amount of work psychologists and psychiatrist can do for people with substance use disorder. As a consequence, general treatment for substance use disorder has become the domain of a specialized group of substance abuse counselors or addiction specialists. In Canadian Aboriginal communities, such substance abuse counselors come under the purview of the National Native Alcohol and Drug Abuse Program (NNADAP). These counselors undergo separate training from mental health case managers and to treat people with substance use disorders. They deploy a range of interventions and techniques to try and reduce dependence on substances and the health risk associated with substance use. These include methods such as harm reduction, behavioral therapy, and

motivational interviewing (Walls, Johnson, Whitbeck et al., 2006; One Sky Centre, 2008). Services may be delivered individually, but are also often delivered through group therapy. Specific forms of group intervention have become closely associated with treatment for substance abuse. This was pioneered by the founders of Alcoholics Anonymous who formulated the now famous 12-step program for treatment of alcoholism. Such programs have spawned similar interventions such as Narcotics Anonymous (NA). In these groups, peer support and fellowship with people who are struggling with a similar substance use disorder is considered the active ingredient. A strong ethos of anonymity, confidentiality and spirituality undergird these interventions (Emrick, Tonigan & Montgomery, 1994).

People with substance use disorders suffer many of the same forms of socioeconomic exclusion associated with severe mental illness previously mentioned. They may lose their jobs and their houses, and have fractured relationships with family and friends. As such, many of the resources deployed to assist people with SMI can also be used to assist people with substance use disorder. These include factors such as supportive housing, supported employment and community integration (Davidson, 2003).

Substance abuse disorder and severe mental illness frequently co-occur. In general, a higher proportion of people with substance use problems have other co-occurring mental health disorders than the proportion of those with mental disorders who have substance use problems (Jane-Llopis & Matysina, 2006). However, in some studies, up to 50% of the SMI population also has a co-occurring substance use disorder (McCormick & Quantz, 2009). This co-occurrence is termed 'concurrent disorders', 'co-morbidity' or 'dual diagnosis'. Despite the high degree of co-occurrence, and the fact that each problem may aggravate the other making treatment more complex, current health care systems tend to treat them separately or even as mutually exclusive (Hawkins, 2009). Some mental health and addictions clinics even refuse to treat people with dual diagnosis, recommending that individuals must resolve one or the other first before receiving treatment at the clinic. This puts many patients in an impossible situation: they must resolve one difficult problem on their own in order to get treatment for the other. Patients with mental health problems are often considered as too risky to include in substance use treatment programs; conversely, many believe that treatment of mental health problems is unlikely to be successful as long as patients are actively using substances. As a result, even in well-resourced urban settings, the care of people with concurrent mental health and substance abuse problems is often inadequate (Dell & Lyons, 2007; Duran, Oetzel, Lucero et al., 2005).

This segmentation of care may be especially challenging the case in Aboriginal communities, which are already liable to have limited and fragmented services. Many commentators have suggested that a major obstacle to tackling the challenge of dual diagnosis among Aboriginal peoples has been the 'silo approach' in which services are segregated, and do not communicate or collaborate well. Whereas NNADAP provides services for substance abuse disorders, FNIHB provides services for mental health problems. There is thus a lack of integrated treatment (Rush et al., 2008). The Native Mental Health Association recently critiqued the continued existence of such segmented services, and Health Canada (2002) has made better integration a priority.

The co-existence of substance use and other mental health problems has a profound impact on many processes and outcomes, including physical health, social relations, treatment trajectories

and others. Individuals suffering from dual diagnosis typically present greater disease symptom severity, more chronic and prolonged course of illness, elevated distress and more compromised quality of life than individuals with either type of disorder alone (Glicksman, Rylett & Douglas, 2007; Rush et al,. 2008). They are significantly more likely to experience negative consequences of their health problems, including death (by way of suicide or accidental death), legal troubles (arrest and incarceration), violent behavior and victimization, homelessness, physical health problems, elevated utilization of health care and emergency services (Duran, Oetzel, Lucero et al., 2005). Dual diagnosis are more prevalent in specific populations, including: young people, women, poor or homeless individuals, and Aboriginal populations (Hawkins, 2009). A large proportion of individuals with dual diagnosis do not access, or receive, the help they need. In the 2002 Canadian Community Health Survey (CCHS), respondents with dual diagnosis were three times as likely to report unmet treatment needs compared to those with single disorders, and they generally expressed lower satisfaction for services received (Rush et al., 2008). When receiving treatment, dual diagnosis patients typically suffer substantially worse treatment outcomes (Kranzler et al., 1996; Lasser et al., 2000; Cacciola et al., 2001).

There is now a clear consensus that integrated treatment and other services are needed to help people with dual diagnosis (Dennsion, 2005; Hawkins, 2009; Rush et al., 2008.). Provincial and territorial governments across Canada have implemented directives to health authorities and service providers to proceed with such integration. However, there is currently a widespread lack of professionals (e.g., physicians, nurses, counselors) with skills in both fields, a lack of programs dedicated to dual diagnosis, and insufficient research on the best strategies to integrate and implement treatment. Clearly, the provision of effective services and promotion of mental health in Aboriginal populations and communities cannot be addressed without an integrated approach to dual diagnosis.

Substance use disorders, and especially the treatment of individuals with dual diagnosis, require teamwork and coordination or integration of services for optimal treatment. Substance abuse has a strong social component, and is maintained through social networks of abusers (particularly among young people), who may feel they have no other avenues for social support or sense of belonging (Hawkins, 2009). Community wellness teams can tackle problems of social exclusion and youth alienation through various universal, selective and indicated interventions. Examples of potentially effective interventions include encouraging indigenous spirituality, and developing sports programs and recreational activities that promote positive engagement, enhance social competence and self esteem, and strengthen the sense of belonging among young people.

Community wellness teams may also offer a potentially effective vehicle for the successful treatment of people suffering from dual diagnosis. However, this requires that community wellness teams to include both substance use disorder specialists and mental health specialists who can work closely together in tertiary prevention activities, and in developing indicated interventions for at-risk groups (especially youth). Integrated services and wider community involvement are essential to create a supportive environment for youth at risk (Burt, Resnick & Novik, 1998). Finally, to the extent they are integral to the community and have strong links to local governance, community mental health teams can work with local authorities to establish regulations that limit the access to and use of alcohol in communities in processes of harm reduction (Gliksman, Rylett & Douglas, 2007).

3.1.4. Mental Health Promotion

Mental health promotion refers to policies, activities, and interventions that aim to promote the mental health of a whole community or population. Mental health is usually broadly defined to refer, not simply to reducing the prevalence and impact of clinically significant mental disorders—though this would usually be one objective—but more holistically as an effort to enhance overall community well-being, as well as the subjective and emotional well-being of individuals within that community (Saxena & Garrison, 2004; Vandiver, 2009).

Mental health promotion draws much of its inspiration from the principles of public health and health promotion. Public health declarations such as the Ottawa Charter and the Alma-Alta declaration ambitiously set out to promote holistic health and well-being for all through the creation of healthy societies (WHO, 1978; 2008). Indeed, mental health promotion is driven by the World Health Organization's famous declaration that "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Mental health is an integral part of this definition, seen as a state of well-being that allows individuals (and communities) to thrive and flourish, realizing their full potential and participating fully in communal life. Much theoretical work has been done to clarify the scope of mental health promotion and WHO has given the following definition:

> "Mental health promotion covers a variety of strategies, all aimed at having
> a positive impact on mental health. Like all health promotion, mental health
> promotion involves actions that create living conditions and environments
> to support mental health and allow people to adopt and maintain healthy
> lifestyles. This includes a range of actions that increase the chances of more
> people experiencing better mental health."[2]

It can be seen from this definition that living conditions, environments and 'healthy lifestyles' are all essential components of mental health promotion. This fits with work on the social determinants of health which suggests that factors such as social inequality, poverty, conflict, racism, poor housing, social exclusion and unemployment can have deleterious affects on the mental health of individuals and populations (Wilkinson & Marmot, 2003). Indeed, research on marginalized populations including as Aboriginal peoples in Canada or Australia suggests that environments and living conditions can have an enormous impact on population and individual health (Stacey, Keller, Gibson et al., 2007; Reading, 2009; Reading, Ritchie, Victor et al., 2005; Smylie, 2008; Gracey & King, 2009; King, Smith & Gracey, 2009; Reading & Wien, 2009). This has prompted calls for action at the population and community level to address these issues.

Mental health promotion is usually viewed as an activity of central or regional government (Saxena & Garrison, 2004). The WHO explicitly states that it is "working with governments to promote mental health." Government policies that reduce poverty, crime, pollution, violence and unemployment can all be considered mental health promotion interventions. For example, a law

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[2] http://www.who.int/mediacentre/factsheets/fs220/en/ (Accessed September 22, 2009).

guaranteeing a minimum wage could be considered a mental health promotion intervention. Likewise policies that increase access to housing, primary care, education and employment could all be considered mental health promotion interventions. Similarly, the provision of social housing for those on a low income could be considered a mental health intervention.

Any policy that improves well-being in the most general sense can also be considered a mental health promotion intervention. This is the case even though the policy may have been designed with completely different objectives in mind, with no reference to mental health. That said, there are health promotion policies that have been specifically designed to improve mental health.

One common mental health promotion approach involves *anti-stigma initiatives*. These initiatives encourage the general public to view mental illness in empathetic and sympathetic terms as 'just another sickness' (Grandbois, 2005). These initiatives also encourage people suffering from mental illness to access services, as well as acknowledging the role of family and social support in healing people with mental illness. More broadly, *mental health literacy* programs aim to give the public better information about mental health problems so they can recognize the signs and symptoms of illness and make appropriate use of services (Owen, Tennant, Jessie et al., 1999). Other popular initiatives that aim to promote mental health include *parenting classes* that attempt to promote positive relationships and communication between parents and their children (Hazelton, Habibis, Schneider et al., 2004). Widespread *screening* and interventions for people showing signs of emotional distress or mental illness (e.g. suicide screening in schools, or depression screening in indicated groups using primary care) that are linked with education and clinical interventions can also be considered mental health promotion activities (Kirmayer, Fraser, Fauras & Whitley, 2009).

Mental health promotion policies usually are formulated at the governmental or regional level, generally by public health authorities working in collaboration with civil officials and academic experts. Depending on the policy, mental health promotion initiatives are often executed by a mixture of statutory and non-statutory bodies. In addition to health care providers, this may include the police, educators, and community workers or activists.

Community wellness teams can implement mental health policies developed at the regional or central level. This may involve screening initiatives or universal interventions such as encouraging service utilization. They may also create their own local mental health promotion measures, for example a locally grounded anti-stigma initiative. In developing or implementing such projects, community wellness teams can use their local expertise and local Aboriginal health workers to ensure programs are appropriately tailored to local culture and circumstances.

3.1.5. Community Wellness

Community wellness has some overlap with concepts of mental health promotion, but focuses on positive mental health and wellbeing at the level of the whole community (Kral & Idlout 2008). Community wellness approaches also tend to be bottom-up rather than top-down interventions. In other words, they are often created by local communities, sometimes working in tandem with policy makers and academics (Prilleltensky & Prilleltensky, 2006; Raeburn & Rootman, 1998).

Likewise finances and resources for community wellness approaches are locally controlled, with funds available for local-initiatives. In other words, community wellness approaches are much more than the enactment of top-down legislation coming from central government. They are locally created and locally controlled, though drawing inspiration from the wider public health and health promotion movement (WHO, 1978; 2008).

Like mental health promotion, community wellness approaches tend to consider both the community and the individual as important targets of intervention (National Rural Health Alliance, 2006; New Zealand Ministry of Health, 2002). Community wellness approaches recognize that the welfare of the community is determined by factors such as living conditions, environments, social networks, health and social services, education and employment. In this sense, community wellness has some overlap with concepts of social capital. Social capital theory suggests that social resources and social connections create an atmosphere that can enhance community wellness (Mignone & O'Neil, 2005; Hawe & Shielle, 2000). Community wellness approaches assume that factors such as social resources, education, housing, policing, environmental policy and the like are all influential in determining health and well being for individuals, families and the community as a whole.

Community wellness is determined by many sectors of society. As such, partnerships, coalitions and inter-sectoral collaboration are necessary to enhance community wellness (Ovretreit, 2002; Mosher & Burti, 1994; Perkins, Roberts, Sanders et al., 2006). There are many examples where such an approach has been taken, with or without a specific focus on health. For example, a common community wellness approach deals with factors such as nutrition or physical activity (Rogers, 2001; Hamilton, Martin, Guyot et al., 2004). These are important determinants of health, and important for the prevention of common diseases. Healthy eating and physical activity are determined by both individual-level and social level factors. Community wellness approaches may create or support facilities and environments that encourage physical activity. This could include funding sports clubs or ensuring access to hunting and other land-based activities. Likewise healthy eating can be facilitated by making healthy food cheaply available or encouraging people to obtain healthy food through traditional subsistence activities. Schools can be encouraged to provide healthy school meals. Health care workers can screen for people at risk of 'lifestyle diseases' such as diabetes, cancer or cardio-vascular disease and suggest appropriate interventions to reduce risk.

The above examples illustrate the usual approach to promoting community wellness. A threat to health is identified, and a local strategy is developed to reduce or eliminate this threat. The strategy may involve various tactics, some of which are targeted at the individual level, others of which are targeted at the community level. The strategy is implemented by various professionals and lay people working in partnership. In the case of improving nutrition and activity level, this could include doctors, nurses, nutritionists, educators, youth workers, sports club leaders and even local business (e.g. who may be encouraged to stock more healthy food).

Such initiatives can also focus on mental health. There are many examples of community wellness approaches which attempt to increase overall mental health and well-being within a community or that tackle specific problems or emergencies such as a spike in suicide rates or endemic alcoholism. Again approaches are usually bottom-up and driven by the local

community. Though outside funding is often necessary for a community wellness team, a local steering committee usually manages the funds and implements key decisions on the ground.

In urban settings, community mental health teams are often responses to fragmented services and the tendency to 'silo' services. As has been mentioned, many people with mental illness have a co-occurring substance use disorder. They may also have other physical health problems such as HIV, hepatitis C, diabetes or obesity (the latter two are common side effects of long term usage of anti-psychotic medication). In many instances, the individual will have three different sets of clinicians who are treating three different sets of problems in isolation. This creates problems of poly pharmacy and also conflicting advice. This is not to mention the role of psychosocial rehabilitation services that may be attempting to help an individual obtain employment or secure housing. Community wellness teams can aspire to co-ordinate these services so that individuals receive integrated care in a supportive and humane environment.

Community wellness approaches usually rely on the involvement of many health care and non-health care personnel. Depending on the scope and funding of the approach and available resources, they may engage the range of health care professionals including physicians, nurses, dentists, nutritionists and physical therapists. Community wellness can also involve social services such as vocational specialists, social workers, teachers and the police.

Even when professionals are employed, community wellness approaches usually require that lay community members are intensively involved in the team, making key contributions to the formulation of policy and implementation of the interventions. When mental health services are part of the initiative, this lay involvement would explicitly include people living with mental illness. Where marginalized and minority communities are concerned, the team will include lay community members who can act as helpers, healers, and culture brokers and who can provide training, consultation and advice to other members of the team. Increasingly, these roles are played by paraprofessionals termed 'Aboriginal Mental Health Workers', as discussed in more detail later on in this chapter. These workers can also suggest appropriate ways to tailor interventions to the culture and context of the community.

Beyond the provision of community mental health services and health promotion, community wellness teams also may address issues of community development. A recent review of 17 published studies of community development programs found that most of these programs were initiated and facilitated by agencies outside of the community, generally in response to community members expressing concern about a particular issue (Campbell, Pyett, McCarthy et al., 2007). Several studies described a community-initiated response to a specific health issue, rather than the facilitation of a community development process by an outside agency. Most were case studies in a single setting without control groups; only two involved more systematic comparisons among several communities involved in similar interventions.

Several studies have used community development approaches to establish culturally appropriate health services for Indigenous communities (Campbell et al., 2007). For example, in Halls Creek, Australia a government department initiated a process to involve local people in decision-making about creating a sobering-up centre to address alcohol-related problems in the town (Midford et al., 1994). In another Australian example, the Tweed Valley Health Service and the local

Aboriginal and Torres Strait Islander community developed and delivered a mental health service through a partnership based on participation and empowerment (Salisbury, 1998). This process involved the health service supporting a local Indigenous health council in efforts to identify and conduct interventions to promote mental health.

Two of the studies identified by Campbell and colleagues (2007) described strategies designed to improve community health generally, rather than focusing on a specific health issue. The New South Wales Health Department implemented a novel public health program in ten disadvantaged indigenous communities from 1986 to 1990 (Lawson & Close, 1994). An Aboriginal health promotion officer was trained and a health committee established at each site to support activities aimed at improving the physical environment, promoting health, and enhancing self-esteem and pride. Finally, several interventions were more directly concerned with building capacity and promoting empowerment than with addressing health per se. For example, a number of papers were reviewed that described the use of a community development approach to support a men's group.

Many health projects and programs in Aboriginal communities often embrace more general principles of community development, participatory evaluation and collective empowerment (Advisory Group on Suicide Prevention, 2003; Gone, 2004; Kirmayer & Valaskakis, 2008). This is an optimal approach as research overwhelmingly suggests that interventions that are simply 'parachuted' in from the outside are unlikely to be accepted or used by community members. A number of general factors have been identified as critical to the success of community development and empowerment projects in Aboriginal communities (Campbell, et al., 2007; Macauley et al., 1998). Some of these are refer to the particulars of the project itself, whereas others involve pre-existing resources in and around the community. These include:

- community members own and define their problems and solutions;
- the project employs local people and trains them in community development skills and processes;
- a local committee is established and actively participates in all aspects of the community development process;
- trusting, respectful partnerships between Aboriginal community members and outside resource people, agencies and providers are developed and maintained over time;
- outside resource people are available who can provide information about health problems and possible action strategies, as well as stimulate critical reflection;
- adequate resources are available both within and outside the community;
- there is an adequate level of pre-existing community capacity and a context that supports local involvement and continuity in promoting health.

Several lessons can be drawn from the existing literature on community wellness approaches in Aboriginal communities. First, they will work best where there is a sense of local control and ownership. Secondly, they often have broader goals than simply reducing the impact of a specified health problem, sometimes with a universal or primary prevention focus. This holistic and universal outlook matches Aboriginal values of interconnection and harmony (Waldram, 2004; 2008). Thirdly, even when treating individuals, community wellness teams can approach the whole person in the context of their community, rather than focusing a specific problem or

disorder. This is especially important as many people in Aboriginal communities may suffer from co-occurring mental illness, substance use disorder and physical health problems (McCormick & Quantz, 2009). Finally, teams are often composed of health professionals and Aboriginal paraprofessionals working in close collaboration. These issues are discussed in more detail in later sections of this report.

3.2. Types of Service

Any community wellness team will exist within an overall context of health systems and services. Teams must be networked with this health system to function most effectively. They must make a complementary contribution to the mosaic of health services currently available (Lenihan & Iliffe, 2001). For reasons of efficiency, it is important that they do not replicate existing services. In this section, we outline the types of services that are commonly used to deliver health care to the population. Some of the services we discuss are applicable to the general population. Others are mainly applicable to the Aboriginal population, or to certain sections of this population, e.g. those living in rural and remote regions. In describing each service, we pay attention to implications for community wellness teams in Aboriginal communities.

3.2.1. Primary Care

Primary health care refers to first contact front-line services by providers such as family physicians and nurse practitioners. These front line services diagnose and treat common illnesses (and often manage chronic conditions) and refer more severe problems to secondary and tertiary care (Cohen, Chavez & Chemini, 2007). Primary health care systems are of critical importance in improving population health. In Canada, many cities and other areas have an excellent primary health care system. Some remote communities have basic primary care facilities, usually in the form of a nursing station, which is staffed by nurse practitioners and periodically visited by physicians and sometimes medical or mental health specialists (Nagarajan, 2004). However, many rural, remote and northern regions do not have comprehensive primary health care systems. Issues of economy, geography and population density preclude such a system. Primary health care facilities may thus be useful in the delivery of certain health services in certain regions. But in other regions alternative approaches must be considered (National Rural Health Policy Forum, & National Rural Health Alliance, 1999; Owen, Tennant, Jessie et al., 1992; Rajkuna & Hoolahen, 2004; Sheldon ,2001).

The Romanow report (2003) detailed some of the problems with primary health care in Canada. In addition to problems of access in remote and rural regions, this report noted that primary health practitioners often work in isolation from each other, resulting in a lack of mutual support and poor continuity of care for patients. The report also notes that primary health care in Canada emphasizes clinical diagnosis and treatment, to the detriment of prevention and health promotion. This situation has led Health Canada to encourage an ongoing reform of primary health care, with a team approach that allows a focus on health promotion as well as treatment. Health Canada has stated on its website that:

"The key feature of primary health care reform is a shift to teams of providers who are accountable for providing comprehensive services to their clients. There is a growing consensus that family physicians, nurses, and other professionals working as partners will result in better health, improved access to services, more efficient use of resources, and better satisfaction for both patients and providers. Such teams are well positioned to focus on health promotion and improving the management of chronic disease. This team approach, along with telephone advice lines, facilitates access to primary health care services after-hours, reducing the need for costly emergency room visits." [3]

Such collaborative approaches have been used with success among Aboriginal people within Australia. Team approaches in primary care have become the norm in certain regions of Australia. Recent studies have concluded that reform of primary care has significantly improved population health over the last forty years (Anderson, Baum, & Bentley 2007). Primary health care interventions that have shown success within Aboriginal communities have some common factors (Freemantle, Officer, McAullay et al., 2007; Fuller, Edwards, Martinez et al., 2004; Hunter, 2007). These include:

1. involvement of the local indigenous community with full community control;
2. work with different service providers promoting a collaborative approach;
3. providing primary health care for maternal and child health and disease identification, prevention and management;
4. promoting locally adapted evidence-based interventions;
5. organizing a multidisciplinary team approach including community members;
6. taking a holistic approach to health and well being;
7. ensuring respectful and trustworthy staffing.

This list of features is similar to the list of characteristics of promising community wellness approaches in the previous section. Augmented primary health care resources have been shown to positively influence some of the harmful health effects of socioeconomic disadvantage and inequality (Cohen & Chehimi, 2007). Socioeconomic disadvantage and inequity are known to be important social determinants of poor health, as well as factors that can hinder treatment and prevention of physical and mental illnesses.

Primary health care can contribute to all the types of intervention described previously. At the micro-level, it can influence changes in individual behaviour, for example, in substance abuse prevention. At the macro-level, well-funded and comprehensive primary health care services can deliver population level interventions to whole communities. Primary health care can be directly linked to post-treatment monitoring and management. Most importantly, primary care can have a major impact on conditions where morbidity and mortality can be avoided through secondary prevention, for example through early detection and management of depression (Fallon & Fadden, 1993). This role for primary care may be especially important for the prevention of depression and suicide in Aboriginal communities. Much research shows that well trained and accessible primary health care providers are critical in detecting and managing at-risk people

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[3] http://www.hc-sc.gc.ca/hcs-sss/prim/about-apropos-eng.php [Accessed September 29, 2009]

(especially youth) afflicted by depression or suicidal ideation (Advisory Group on Suicide Prevention, 2003; Pawlenko, 2005; Pauzé, Gagné & Pautler, 2005).

The primary health care approach was formally adopted by the World Health Organization (WHO) as the preferred strategy for organizing comprehensive health care after the Alma Ata Declaration in 1978 (WHO, 1978). The underlying principles of this declaration include (in addition to the provision of curative care) health promotion, illness prevention, rehabilitation and community development. This approach calls for shifting the focus of health care policies from curative care to a broader and holistic orientation that considers levels of health care promotion beyond the individual. There can be a good fit between community wellness teams and approach to primary health care that is team oriented and focused on disease prevention and health promotion, as well as diagnosis and treatment. Community wellness teams can obviously be a useful adjunct to primary health care. They can provide many of the same health promotion and disease prevention activities provided through primary health care. If accessible, they can serve rural and remote areas as a front line service, where primary health care is not available.

3.2.2. Collaborative Care

Recent mental health policy in Canada highlights the need for stronger linkages between primary health care and mental health services, as well as with the more informal sectors of health care (Pauzé, Gagné & Pautler, 2005; Pawlenko, 2005). This can improve continuity of care, and reinforce the capacity of professionals and non-professional helpers in service and community settings. The emphasis is on the development of collaborative approaches to delivering mental health care, with a central role for primary care. Primary care can be used to diagnose, treat and manage people with CMD, as well as stabilized cases of people with SMI. Secondary and tertiary mental health services can then be reserved for more severe or complex cases. Indeed, many guidelines now suggest that primary health care is the optimal arena to detect and manage CMD as well as certain problems of substance use, e.g. nicotine or moderate cases of substance use disorder (Cohen, Chavez & Chemini, 2007). Integrating mental health services in primary care has many advantages. It can make mental health services more accessible, acceptable and affordable to the community and can lessen the stigma associated with mental illness.

The overall objective of integrating mental health services into primary heath care is to create a comprehensive mental health infrastructure able to meet the needs of the population in community settings. Models for providing comprehensive management of psychiatric disorders in primary health care settings have received increasing attention from many health systems all over the world. Though mental disorders are frequent, disabling and cause significant social and economic costs, these models assume that all but the most severe disorders can be successfully managed in primary health care (Patel, 2002; WHO, 2008).

The literature describes different models of integrating psychiatric disorder into primary health care services. However, the majority of these models refer to contexts where primary health care facilities already exist and are easily accessible. There is little literature on the development and integration of services where primary health care facilities are less organized, poorly resourced, and situated in remote areas (Patel, 2002). Unfortunately, this scenario describes the situation in

many Aboriginal communities in Canada. As such, these communities face particular challenges establishing and maintaining integrated mental health services.

The 2008 WHO report "Integrating mental health into primary care," describes successful models of integration of mental health in primary care in a variety of low and middle income countries with varying levels of infrastructure development. Relevant points from the report for the Aboriginal context in Canada (especially in remote and rural regions) include:

> "Integrating mental health services into primary care is the most viable way of closing the treatment gap and ensuring that people get the mental health care they need.
>
> Certain skills and competencies are required to effectively assess, diagnose, treat, support and refer people with mental disorders; it is essential that primary care workers are adequately prepared and supported in their mental health work.
>
> There is no single best practice model that can be followed by all countries. Rather, successes have been achieved through sensible local application of broad principles.
>
> Integration is most successful when mental health is incorporated into health policy and legislative frameworks and supported by senior leadership, adequate resources, and ongoing governance.
>
> To be fully effective and efficient, primary care for mental health must be coordinated with a network of services at different levels of care and complemented by broader health system development."

Continuity of care is an essential feature of integrated services. While services at the primary health care level are the most accessible, affordable and acceptable for many communities, they must be integrated with community care and, when needed, with collaborative specialist care. By 'community care' we mean the informal, lay or popular sector of health care which constitutes a community care system including extended family, community workers, religious leaders and congregations, traditional healers, elders, teachers, police, and other community organizations (Kleinman, 1980; Waldram, 2008).

There are four broad sets of models for integrating mental health in primary care: (i) community mental health teams (CMHT); (ii) shifted outpatient clinics that locate mental health services in the primary care setting; (iii) attached mental health professionals who are associated with the primary care clinic; and (iv) outpatient consultation-liaison models (Gask, Sibbald & Creed, 1997). These have evolved into a variety of approaches termed *shared care* or *collaborative care* (Kates, 2008). The key to all of these approaches is the quality of communication between professionals with different expertise.

There is good evidence that community mental health teams can improve accessibility and acceptance of mental health treatment, reduce hospitalization and suicide (Simmonds et al.,

2001). However, involvement of community mental health teams in treatment of common mental disorders can lead to segmentation of care between primary care providers, local health authorities and mental health providers. There is little evidence that the shifted outpatient model reduces this conflict. The impact of attached mental health professionals on referral patterns also remains unclear. Collaborative care models have a number of theoretical advantages. They may improve the capacity of primary care providers to treat CMD while providing reliable backup, high quality assessment and treatment, and continuity of care for more complex cases. There is good evidence for the effectiveness of collaborative care models in improving the outcomes of major depression in primary care (Bower et al., 2006; Gilbody, 2008; Richards et al., 2008; Simon, 2009; van Orden et al., 2009). Current research focus on more rigorous clinical trials and on strategies for implementation (Fortney et al., 2009).

The Canadian Collaborative Mental Health Initiative (Kates, 2008) has provided background materials for implementation of shared care along with a toolkit for work with Aboriginal communities.[4] Collaborative care also may be provided through telepsychiatry making it feasible for rural and remote communities (Fortney et al., 2007).

Consultation-liaison models may be the most effective use of specialists in delivery of care to rural and remote communities. An example is the Medical Specialist Outreach Assistance Programme developed in South Australia (Cord-Udy, 2004). The program is based on a consultation-liaison model that provides in-depth psychiatric assessment followed by liaison with local health care providers in order to assist them in their ongoing community-based care. When working with very remotely located settings, clinicians must be flexible and aware of cultural and language limitations. The psychiatrist may need to work indirectly by undertaking case note assessments, medication reviews or consultation with family members or other persons who know the patient (community members, local clinical staff). The consultation-liaison model allows this flexibility because it requires little infrastructure and it helps to raise the skill levels of the local health indigenous workers.

The visits of consultant psychiatrist to communities may begin with planning by contacting primary care practitioners and mental health workers to establish the dates when the patients to be seen can be discussed (here videoconferencing can be useful). After the actual visit, the practitioner may make follow-up calls to the community-based practitioners, nurses and mental health workers. Although this approach maximizes the use of limited consultant time, there are a number of clinical challenges associated this model. It does not address local cultural and linguistic issues and may have only limited impact on building local capacity.

An approach that builds on the consultation-liaison model but that explicitly addresses cultural issues has been termed cultural consultation. In the cultural consultation service developed by Kirmayer and colleagues (2003) in Montreal, cases are referred for in-depth evaluation of their social and cultural aspects. This is accomplished by using interpreters and culture-brokers or other resource people able to put patients' problems in cultural context. The consultants collect the information about culture and social context through interviews with the client and family and organize the findings using a version of the cultural formulation developed for DSM-IV (Group for the Advancement of Psychiatry, 2002; Kirmayer et al., 2008; Mezzich, et al., 2009).

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[4] To access the toolkits see: www.ccmhi.ca

This type of culturally-informed consultation service can provide a useful supplement to existing primary care services. In the case of Aboriginal communities, the role of culture broker can be played by mental health workers from the community. The consultation model gives this person a clear role as a mediator, who is both an advocate for the patient and a resource and guide for the clinician. This type of collaboration can improve the cultural competence of conventional mental consultations and provide training for clinicians unfamiliar with specific cultures and communities.

3.2.3. Multidisciplinary Teams and Assertive Community Treatment

Multidisciplinary mental health teams have been defined as "[groups] of practitioners with different professional training, employed by more than one agency, who meet regularly to coordinate their work providing services to one or more clients in a defined area" (Ovretveit, 1993). Although not a recent development, multidisciplinary work has grown in importance as part of efforts to meet the needs of increasingly diverse populations (Law, 2007). Each mental health discipline brings a somewhat different perspective and set of skills to the processes of assessment and intervention (Hazelton, Habibis, & Schneider et al., 2004). This approach is also a response to the growing criticisms of the way services are separated in silos which have little communication with each other, as often seen with addictions services and mental health services.

Multidisciplinary mental health teams developed as a pragmatic response to the demand for help in areas that lie beyond the traditional competence of psychiatry, especially with regard to attaining positive vocational, housing, community integration and social role outcomes for people with severe mental illness. Addressing these needs depends on professional intervention as well as resources and dynamics within the individual's social networks or community. In relation to the evaluation of multidisciplinary mental health teams, what this means is that the extent that the team is able to achieve its goals will also depend on prevailing health, economic and social conditions in the community or catchment area.

Assertive Community Treatment teams (ACT) are the most common team approaches in contemporary psychiatry (Salyers & Tsemberis, 2007). These teams are multidisciplinary and support a caseload of individuals with severe mental illness that have a history, or are at high-risk of, hospitalization (McDonel et al., 1997). The goal of these teams is to keep the individual in the community, functioning as smoothly as possible, though improving social support and treatment delivery. Members of the ACT team typically include a psychiatrist, one or more nurses, and case managers who may be social workers or have just basic on-the-job training (Drake, 1998). ACT programs can be implemented in rural settings with mobile teams or with paraprofessionals as community case managers (Gammonley, 2006; Wagenfeld, 2008).

ACT is usually one component of a comprehensive community service model including home-treatment teams (24/7 crisis services), primary care liaison teams (acting as gatekeepers to specialist mental health services), and rehabilitation and recovery teams (focusing on the needs of those with complex long term mental health needs who do not require assertive outreach) (Wane, Owen, Sood et al., 2007). ACT may reduce hospital admissions but may not have a

significant effect on other outcomes (Commander, Sashidharan, Rana et al., 2005). ACT teams have been developed as an intervention applicable to the general population. A few attempts have been made to tailor ACT services to ethnocultural minorities, one of which is discussed in depth in the next chapter (Yang, Law, Chow, et al., 2005). An Aboriginal ACT program has been developed in Alberta.[5] At present, there are no published reports on Aboriginal ACT programs. There is certainly a need for thorough cultural adaptation to make ACT consonant with Aboriginal values (Lavallee & Poole, 2009).

One method of tailoring mental health teams such as ACT to the Aboriginal context is to employ Aboriginal Mental Health Workers (AMHW) on the team. This insures an ACT team serving Aboriginal peoples has locally-informed team members who not only bring their own professional skills to the team, but who can also act as culture brokers between the patient and the treatment team as a whole. The potential roles for AMHW are discussed in more detail in a later section.

Many lessons can be learned from the literature on ACT teams, which provides a good example of skilled and intensive support for people with SMI, but it should be clear that ACT teams are not the same as community wellness teams. ACT teams are essentially a form of tertiary prevention for high-risk individuals-aiming to prevent re-hospitalization. Community wellness approaches aim to be more holistic with broader goals of health promotion at the universal and selective level, as well as helping individuals with common mental disorders or a variety of social problems. Such a broad mandate will require different organization, resources, training, and support.

3.2.4. Family-Centered Intensive Case Management (Wraparound)

In rural and remote communities, identification of at-risk youth poses a dilemma because services either do not exist, are only available at long distances from the community, or are chronically over-stretched by the many needs within the community. Conventional mental health services outside the community may be viewed negatively because they lack cultural knowledge and respect for cultural ways (Walls et al., 2006). Many of the currently available services approaches are not culturally safe or competent and may involve removing the young person from the community for inpatient care.

Family-centered intensive case management or "wraparound" is a method of intervening for youth with severe mental health problems including substance abuse and suicidality (Burns & Goldman, 1999; Evans, Armstrong & Kuppinger, 1996). The approach involves both professionals and extended family members who work together to protect the child in crisis This approach that has good fit with Aboriginal cultural values and community contexts: 1) it emphasizes and empowers the family and recognizes the need for extended family involvement; 2) it keeps the child in the community; 3) it involves the entire community in protecting the child; 4) it is flexible and decisions are made at the community level; 5) it involves cultural ways of healing and elder oversight; and 6) there is community ownership of the intervention.

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[5] http://www.albertahealthservices.ca/services.asp?pid=service&rid=1026176

Although implementations of wraparound vary, the basic elements include: a community-based intervention with a "team-driven" process involving the family, child, natural supports, and formal services providers; families are full and active partners at every level of the process; services are individualized, strength-based and culturally competent; there is adequate flexible funding that may be used to bring in specialists (e.g., psychiatrists, psychologists, psychiatric nurse practitioners); the process is implemented on an inter-agency basis (Burchard, Bruns & Burchard 2002; VanDenBerg & Grealish, 1996).

Wraparound has been used with success in mental health and child protective settings for youth with very severe behavioral disorders (Burchard & Clarke, 1990; Clarke et al., 1992; Rosen et al., 1994). Studies have found that children in wraparound programs did as well or better than those in foster care and that wraparound was more cost effective (Clark et al., 1996; Evans et al., 1996). The wraparound approach has been particularly effective in rural and remote settings and has been adapted in Indigenous communities in Maine, Alaska, and South Dakota (Ch'eghusten, Fairbanks, AK; Nagi Kicopi, Calling the Spirit Back, Porcupine SD). These adaptations engage traditional extended family systems and include traditional cultural interventions.

3.3. Community-Based Resources, 'Natural Helpers', and Traditional Healing

Models of integrative care emphasize that the community must be engaged in order to enhance mental health, community wellness and recovery (Smye & Mussell, 2001; Davidson, Digiacomo, Abbott et al., 2008). In practice, the level of community engagement is variable, and depends on factors such as local leadership, resource allocation, and community capacity to initiate health promotion initiatives and assist people with mental health problems. Clearly, models of community based care tap into prevailing Aboriginal values of mutual support and interdependence. In all Aboriginal communities, there are many recognized and unsung community-based individuals and healers providing informal health and social services to other community members (Stout, 2003). This could include people looking after sick family members, shared child care responsibilities among women or provision of healing ceremonies and circles for those suffering from substance use disorder or emotional distress. It is essential that community wellness teams work with these local helpers and social support networks.

Family and community helpers and healers are important resources in most indigenous communities. Because they share a common worldview and set of values, they may be preferred sources of help for most common mental health problems. In the Kimberley region of Australia, Vicary and Bishop (2005) identified a number of community resources that Aboriginal people would use preferentially either prior to, or to the exclusion of, Western treatments. These included:

- support, advocacy, storytelling, and practical advice from immediate family members;
- assistance from extended family members;
- assistance from the community and Elders;
- a return to country to make a spiritual reconnection with the land;
- referral to a spiritual healer for specialist assistance (Vicary & Bishop, 2005, p. 13).

This list supports the importance of family, community, ecology and spirituality in the healing process for indigenous peoples. Community wellness teams can support and integrate these resources into their activities, ensuring that they are seen as complementary rather than in competition with local community wellness approaches.

It is now well-recognized that culturally sensitive integrated health care must extend beyond the formal professional sector of medical care to include other sources of support in the community (Betancourt, Green, & Carrillo, 2003). This is both an ethical and political issue of respecting local strengths and values, and a crucial element of intervention effectiveness, enhancing community engagement and ownership. The importance of this process is increasingly recognized even by professionals practicing conventional mental health care. For example, the Royal Australian and New Zealand College of Psychiatrists (2002) prepared a position statement which recognizes the following key principles:

- Mental illness in Aboriginal contexts is complex and responding to it requires need understanding a range of cultural, historical, family and societal issues;
- The relationship between Aboriginal mental health workers and their clients often extends outside the normal clinical experience of the patient-therapist relationship;
- The nature of the work of Aboriginal mental health workers is often demanding, being outside the normal temporal and spatial boundaries of the work of other mental health workers;
- Mature Aboriginal people with no formal educational qualifications may possess a unique knowledge and particular skill in dealing with mental health issues within their local community;
- Cultural awareness courses are a valuable tool for any service dealing with Aboriginal people, and should be credited as part of any workers' continuing education;
- Resource allocation should reflect the standards expected by other mental health workers, for example in terms of staffing levels, appropriate resources to enable them to do their work effectively, and occupational health and safety requirements (RANZCP, 2002).

This list is recognizes the unique situation faced by Aboriginal people, as well as the unique resources and knowledge within indigenous communities that can be mobilized to enhance mental health. Translating such a plan into action is challenging. There is still lack of information best practice models in the Aboriginal context, and training and quality assurance measures aimed to improve service delivery in Aboriginal contexts are not sufficiently developed or applied.

3.4. Aboriginal Mental Health Workers and Aboriginal Paraprofessionals

Aboriginal mental health worker (AMHW) is a term used to describe the paraprofessional role of Aboriginal people who have received a short amount of formal or on-the-job training in mental health care, who usually work as part of a mental health team (Giblin, 1989; Harris & Robinson 2007; Nagel & Thompson 2006). Their training is usually similar to the training for mental health case managers in urban mental health services across North America. The term AMHW can also be used (though less frequently) to refer to especially wise, insightful and mature

Aboriginal people with no formal training in mental health, who work as auxiliaries, aids or culture brokers in mental health teams (Robinson & Harris, 2005).

Much of the literature on AMHWs comes from Australia, where there has been formal recognition of their role and an effort to develop such workers. In Australia, AMHWs are usually integrated into larger treatment teams. The team may involve primary care physicians, mental health nurses and psychiatrists. These teams either serve Aboriginal communities of around 1,000 people, or a series of smaller communities dispersed over a wide geographic area (National Rural Health Alliance, 2006). The AMHW is considered a vital member of the team for various reasons. As an Aboriginal person, the worker has first-hand insights into Aboriginal culture, often hailing from the same community they serve. They may intimately know local resources and the local language. As such they can be a bridge between the community and the mental health team. They can ensure bi-directional knowledge transfer or exchange between the mental health treatment team and the patient or community. The AMHW may also be an appropriate response to the manifold workforce issues plaguing rural and remote areas (National Rural Health Policy Sub-Committee & National Rural Health Alliance, 2002; New Zealand Ministry of Health, 2005). As stated previously, rural and remote areas have great difficulties recruiting and retaining health care staff. Using locally recruited AMHWs can be an effective way to overcome this problem.

There are many examples from Australia of the usefulness of AMHWs in mental health teams. One case study comes from the area around Darwin in Australia's Northern Territory, where 30% of the population is Aboriginal. This region suffers from a thin distribution of health services and a lack of family physicians. There is a high rate of psychiatric hospitalization of Aboriginal people in the area. This has been attributed, in part, to Aboriginal people being unable or unwilling to access primary mental health care during the early stages of first episodes of psychosis. AMHWs have been integrated into wider treatment teams in this setting in order to perform various tasks. Their tasks are described by Robinson and Harris (2005) as follows:

> "The AMHWs are engaged in a range of activities in all communities. They have taken on a role in primary health care, assisting GPs and RNs with management and treatment of clients, and engaging in follow-up of clients due for medications. The mix of duties and activities varies from community to community. In some, they are frequently involved in crisis situations, responding to attempted suicides, acute episodes involving threatened violence or other manifestations of distress. In some cases they are engaged in advocacy on behalf of the client, undertaking measures to assist with client welfare, including liaison with courts, prison, community services, providing assistance with food and clothing, or with accommodation and travel following hospitalisation in Darwin. AMHWs also carry out counselling of clients with a range of difficulties, relating to substance misuse or to marital violence and relationship difficulties, and have variously participated in community health promotion and education activities, in the areas of general wellbeing, men's and women's health, youth issues, alcohol abuse, and domestic violence. There is no single model for the community roles of the AMHWs."

Interestingly, the AMHWs in the setting described above are employed by the local community council, rather than the health care authority, even though they work primarily out of the local health center. This arrangement has practical and political benefits. The AMHW is clearly employed by the local community to serve communal interests and this improves local control and accessibility as well as strengthening the community's sense of ownership and engagement with mental health issues. However, researchers conducting an evaluation of this program note that the integration of AMHW in mental health teams may be problematic owing to ambiguities about their roles and responsibilities (Harris & Robinson, 2007). The roles of AMHW need to be carefully thought out to provide appropriate levels of training, autonomy and support.

The concept of AMHWs is attractive to those grappling with the challenges posed by inequities in Aboriginal Mental Health Care. Using AMHWs as an intervention is also in alignment with national and international guidelines about community participation in the delivery of health care. However, to date, there have been no scientific studies of their efficacy. To address this lack of evidence, the implementation of AMHWs should be accompanied by rigorous evaluation of outcomes. These outcomes could include rates of service utilization and rehospitalization as well as the satisfaction of patients, families, and care providers.

Aboriginal mental health workers face many of the same challenges as other mental health workers working with Aboriginal people. As such, any attempt to utilize AMHWs must be accompanied by appropriate training and ongoing support. AMHWs should also be compensated in the same manner as other health professionals and not exploited as "cheap labour." Below are some of the specific challenges faced by AMHWs identified in the Australian literature (Robinson & Harris, 2005; Harris & Robinson 2007; Nagle & Thompson, 2006):

- AMHWs face enormous demands for urgent, high intensity, and stressful tasks including crisis intervention, responding to suicide attempts, advocacy, liaison with courts and other community services, domestic violence and relationship difficulties. Not only does this raise practical difficulties, it also can take its toll on the psychological well-being of AMHWs;
- Although the rhetoric associated with AMHWs may pay homage to ideas of prevention and health promotion, their training and day-to-day practice tends to be solely focused on tertiary prevention, especially case management and crisis intervention activities with indicated or diagnosed individuals;
- Despite their responsibilities for case management or crisis intervention, AMHWs are expected to participate in community education and promotion as well as providing advice on cultural issues or acting as culture brokers for other health professionals.
- There are usually limited opportunities for AMHWs to receive professional supervision, managerial support, follow-up and continuing education and training;
- In many settings, GPs cannot provide proper mentoring because of their own heavy workloads and limited resources, and they lack training in how to work in multidisciplinary teams. Because of the focus on pathology in medicine and their training in the medical model, GPs may misunderstand the psychosocial and cultural dimensions and focus on wellness or social and emotional issues associated with some AMHW programs;
- There is no clear career structure and professional affiliation for AMHWs. Workers may be unclear who they are or to what group they belong. Like any bridge, they connect two distinct terrains, but are not technically fully embedded in either. This may be a strength in

some cases, but in other instances they may be treated with suspicion from both camps, and suffer demoralization as a result;

- The basic issues of sustainability needed to make it feasible for individuals to train for and take on the role of AMHW as a long-term commitment or "career" often has not been addressed.

In Canada, there is little literature on AMHWs. Developing criteria, training materials and programs, and national networking strategies for AMHWs would be a crucial step in building capacity in communities. At present, some colleges and universities offer certificate or degree programs for Aboriginal mental health workers. For example, in Ontario there are several two-year degree programs that focus on counselling skills needed to promote Aboriginal community and individual health and well-being.[6] Many of the programs combine addiction counselling with mental health training. Laurentian University also offers a 4-year program in Native Human Services, leading to a Bachelor of Social Work degree.

There have been some efforts to outline Aboriginal mental health provider roles and career paths.[7] However, the development of theory and practice in community mental health has occurred mainly in urban milieus with little consideration of Aboriginal contexts and cultures (Goldenberg, 2001; Gone, 2004; 2008; Gone & Alcantara, 2007). Developing appropriate programs requires new initiatives. Both new and existing programs need systematic evaluation to establish efficacy and effectiveness as well as to examine their social and political implications both in the community and in the wider domain of mental health systems and services.

3.5. Telepsychiatry and Tele-Mental Health

Telepsychiatry refers to the use of telephone, interactive video, electronic medical records, and the internet to allow communication between doctors, patients and other health care personnel for the assessment, treatment or prevention of mental health problems. Telepsychiatry is a particularly important strategy for providing specific mental health services and reducing health disparities for people in remote areas where specialist providers are not available (Hilty et al., 2009). Telepsychiatry can reduce the need for lengthy, expensive and arduous trips for patients or health care personnel to and from urban centers. Telepsychiatry is also consistent with the ongoing movement for community care and community involvement in service delivery.

Faced with a challenge similar to that in Canada of serving a geographically dispersed population, the Royal Australian and New Zealand College of Psychiatrists (1999) took an early lead in promoting telepsychiatry and videoconferencing and published guidelines on implementation. More recently, the American Academy of Child and Adolescent Psychiatry has published guidelines for the use of telepsychiatry (Myers & Cain, 2008).

There is increasing evidence that telepsychiatry can be an effective method to deliver mental health services for both children and adults. It can be used to training, supervision, team

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[6] http://www.workinginmentalhealth.ca/Forms/education.aspx#section7
[7] http://www.workinginmentalhealth.ca/forms/career.aspx.
 http://www.naho.ca/firstnations/english/public_mentalHealth.php

building, assessment and intervention. Telepsychiatry can be a reliable method of assessing psychiatric disorders (Manguno et al., 2007; Shore et al., 2007) and a cost-effective method of assessing suicidal patients (Jong, 2004). Several studies have found that videoconferencing and face-to-face meetings have comparable effectiveness for diagnostic and therapeutic intervention (Elford, White , Bowering, et al., 2000; O'Relly et al., 2007). Telepsychiatry also can work well for providing specialized services in child and adolescent mental health (Myers, Valentine & Meltzer, 2007; Paing et al., 2009). One study actually indicated better results among children who had depression and were treated through videoconferences compared to those treated by face-to-face meetings (Nelson, Barnard, Cain, 2003).

Patients and clinicians, both in the general population and in indigenous communities, generally report high levels of satisfaction with telepsychiatry services (Alexander & Latanzio, 2009; Greenberg, Boydell & Volpe, 2006; Hilty et al., 2009). Both mental health providers and patients tend to be comfortable with this method, in part because it allows them to avoid lengthy and costly travel and stay in their work setting or community while giving (or receiving) consultation (Kennedy & Yellowlees, 2000; Hilty, Yellowlees, Nesbitt et al., 2006).

Although many people express skepticism when first presented with the idea of telepsychiatry, most quickly adapt to the situation. In a study with rural American Indian youth, patients expressed some concern at the beginning of videoconferencing about "talking to a box" (Savin, Garry, Zuccaro et al. 2006). However, knowing that the session was conducted by an expert, and having their own local clinician present in the room, helped them become comfortable with the process. Clinicians sitting-in with the patient at the teleconference reported that the sessions acted as training experiences, increasing their knowledge and skills as clinicians. They also reported feeling less professionally isolated and appreciated the regular contact that the teleconferences allowed as a better format for learning than irregular and infrequent visits to the city. Consultants did express apprehension about the potential for decreased rapport with the patients seen only by teleconference, and the challenge of collecting all the needed information for clinical assessment through teleconference. However, these concerns subsided with increased familiarity with telepsychiatry.

There are several different models of telepsychiatry based on the available resources at each end of the link (Janca, 2000). The community primary care clinic may have general practitioners, nurse practitioners, social workers or Aboriginal community mental health workers with varying level of training. The outside consultant may be a psychiatrist, psychologist, psychiatric nurse or social worker, or a multidisciplinary team consisting of some or all of these types of practitioners.

Telepsychiatry can facilitate communication between a centrally located mental health care team (generally consultant psychiatrists in urban centres) and scattered primary care providers practicing in geographically remote locations (Hilty, Yellowlees, Nesbitt et al., 2006). A collaborative care model can be implemented for remote rural areas through telepsychiatry (Fortney, Pyne, Edlund et al., 2006; 2007). Telepsychiatry can be used to build a mental health team (Cornish et al., 2003). Community wellness teams operating in rural and remote areas can use telepsychiatry for staff training, supervision and support, for clients experiencing difficulties, or simply for routine follow-up appointments.

To work effectively, mental health professionals and mental health workers on both ends of the line must be trained in the use of telepsychiatry (Szeftel et al., 2008). Outside professional consultants should have expertise in working with multidisciplinary teams and knowledge of the Aboriginal communities where the patients involved live. In some circumstances, the outside consultant may be chosen for their specific expertise in Aboriginal mental health; this might include Aboriginal mental health workers from one community or organization consulting with another community where such expertise is not available.

Telepsychiatry may be an especially effective intervention when used in conjunction with AMHWs. As discussed in an earlier section, AMHWs can provide support on the ground for people with mental health problems under the supervision of psychiatrists based elsewhere. The development and implementation of a system that incorporates and values AMHWs involves specific challenges, mainly in the provision of adequate training and supervision. Telepsychiatry can be used to deliver training programs, case supervision and case-conferences as part of the development and continuing education of a cadre of community-based AMHWs. Telepsychiatry also can provide essential back-up for the assessment and management of challenging cases. Without adequate training and supervision, however, telepsychiatry may be ineffective (Bartik, et al., 2007; Crowe, Deane, Oades et al., 2006; McBride & Gregory, 2005).

In 2003, there were nine telepsychiatry services in Canada (Urnesss, Weisser, Campbell et al., 2003). Some of these have paid particular attention to the needs of First Nations communities. The Province of Ontario Telepsychiatry Delivery System is an instructive example of telepsychiatry in action (Urness et al., 2003). This system began in 1997 as small pilot projects developing in relative isolation from each other. For example, psychiatry departments at Ontario's major universities (Toronto, McMaster, Western Ontario and Ottawa) created links with 20 remote and underserved municipal sites and 20 First Nation communities. This mostly consisted of general psychiatric consultation, but gradually added specialty services within psychiatry. The Ontario provincial government eventually endorsed telepsychiatry as an intervention, and with the aim of better integration between the various projects. Urness and colleagues (2003) report some of the lessons learned from the Ontario Telepsychiatry Delivery System. These include:

- Telepsychiatry can be as effective as an adjunct to existing services.
- The service proved cost-effective, with a 60% reduction in costs associated with face-to-face visits.
- Early intervention leads to improved adherence and outcomes. This can lead to a decrease in waiting lists and prevention of hospitalization.
- Medical management of a remote or distant clinic is done best with a multidisciplinary team, with the clinic affiliated with a local family physician and pharmacist.
- Medical record keeping is best done at both sites. Electronic psychiatric records obviously enhance the ability for dual maintenance of records.

Many of the original Ontario pilot projects involved isolated First Nation communities. More recently, the Ontario government has stated that telepsychiatry should take specific account of

issues pertinent to First Nations. This includes suggestions that traditional Aboriginal healers be integrated into the telepsychiatry team of consultants as appropriate.

There are also some concerns about the deployment of telepsychiatry in Ontario (Urness et al., 2003). Some community leaders have expressed concern that provincial style of management of telepsychiatry could be an overly technocratic approach, disrupting traditional referral patterns. Others have worried that the availability of telepsychiatry may be used to justify fewer visits from psychiatrists to rural and remote communities, which allow beneficial face-to-face meetings not only with patients and their families but with other community members and leaders important for improving the delivery of mental health services and mental health promotion.

Major challenges for telepsychiatry are sustainable funding and the provision of local services to collaborate with the teleconferencing consultant and insure adequate support and follow through (Hilty et al., 2008). First Nations communities in remote areas face technological challenges in obtaining the necessary bandwidth for telepsychiatry. In Ontario, the government and private enterprise have taken steps to ensure such bandwidth is available to remote and rural regions, which also allows the delivery of other specialized services such as education and other non-psychiatric health issues.

One final challenge for telepsychiatry is that patients and providers often have concerns about confidentiality when using telecommunications, and some perceive telepsychiatry as impersonal (Paing et al, 2009; Rohland et al., 2000). Provider concerns may stem from real worries in the early days of telepsychiatry about the security of systems used in providing telepsychiatry. Improvements in the security of telecommunications have assuaged many of these concerns. Patient concerns over impersonality can be diminished if the family physician or AMHW sits in on consults and ensures the patient that such consults are in everyone's best interest.

Given the increasing use of internet communications, familiarity with and acceptance of the technology is likely to grow over time. Nevertheless, many patients do prefer face-to-face mental health assessment. Beyond preferences, it is important recognize that being present in a community allows a consultant to gain a much greater appreciation of social context and environment and may allow various forms of networking, mobilizing and negotiating with others that can lead to new clinical solutions.

The internet and electronic media can be used on other ways to deliver educational health promotion and training materials. There is evidence that internet programs are well-received and may be especially appealing to youth who make use of such technologies for social networking (Di Noia et al., 2003). Such communications technology can provide a way to disseminate and share resources to be used by individuals on their own in self-management of mental health problems or as an adjunct to other forms of mental health promotion (Griffiths & Christensen, 2007).

There is evidence that, with proper attention to local protocols, tele-mental health can be used effectively in Aboriginal communities (Muttitt, Vigneault & Loewen, 2004; Shore, Savin, Novins & Manson, 2006). To be most effective, teleconferencing should be a complement to, not a replacement for, face-to-face services.

3.6. Recruitment and Training Issues

There is wide recognition that there is a lack of qualified health professionals from an Aboriginal background in all medical professions (nursing, medicine, social work etc.), as well as paraprofessionals or trained lay people who can function as Aboriginal Mental Health Workers (AMHWs). This lack of trained mental health workers is an issue both in urban centres and in remote, rural or northern settings (Berntson, Goldner, Leverette et al 2005; Boone, Minore, Katt et al 1997; Cord-Udy 2006). Aboriginal organizations and institutions in Canada have discussed strategies for building capacity in health and human resources in Aboriginal populations, with the aim of increasing the number of licensed and non-licensed workers (McBride & Gregory, 2005). This process can involve guiding and supporting young people to pursue training in mental health as well as reaching out to community-based helpers and care givers interested in contributing their skills and talents to mental health promotion activities.

Expanding the pool of qualified workers must be a priority if community wellness teams are to be developed and implemented. This should involve a concerted effort to recruit and train Aboriginal people. This should go beyond some existing models where Aboriginal people are employed as low-paid 'cultural link workers'. The assumption in such models is often that AMHW are inherently culturally skilled. As such, they usually receive no formal assistance in developing their skills and knowledge. However, this tends to reinforce their auxiliary status within the medical system and prevents capacity building. Both Aboriginal and non-Aboriginal health workers can benefit from training programs in cultural psychiatry (Dixon & Iron, 2006).

In addition to recruiting mental health workers with Aboriginal background, it is crucial that all mental health professionals receive specific training in working with Aboriginal communities. Although most would agree that cultural competence and cultural safety are essential components of professional and organizational effectiveness, many communities or health care organizations have not developed comprehensive cultural training programs. The reasons cited for the difficulty developing such programs include: insufficient time, staff or funds; a view that it is a low priority in the face of other pressing problems; and lack of knowledge about how to develop such a program (Dixon & Iron, 2006, p. 3). These issues and are important obstacles to the development of community wellness teams serving Aboriginal communities, in that such teams must be culturally competent and confident in being able to work within Aboriginal settings (Inuit Tapirisat of Canada, 2001; National Aboriginal Health Organization 2008c).

Aboriginal communities themselves have a key role to play in the development of a culturally competent work force. Dixon and Iron (2006) identified innovative programs aimed to develop cultural competency in health care for American Indian communities. Programs were identified through a telephone survey of a national sample of tribes from the 12 Indian Health Service Areas, with oversampling in California. Of the 52 tribes surveyed nationally, only 16 had cultural training programs and only 5 of those considered that their program was a good model. In California, where state mental health policies have specifically targeted the issue of cultural competence, a higher proportion of tribes had programs in this area: 15 of 25 had such programs and more than half considered they had model programs. This indicates the importance of local mandating of training programs accompanied by appropriate funding. Larger tribes were also

more likely to have model programs, pointing to the importance of scale and resources

Dixon and Iron describe 6 programs in detail: (i) the Arctic Slope Native Association at Samuel Simmons Memorial Hospital; (ii) United Indian Health Services (UHS) of Potawot Health Village; (iii) a history course developed by the Cherokee Nation; (iv) the American Indian Health and Family Services of Southeastern Michigan *Minobinmaadziwin*; (v) cultural training for the California Smokers Helpline developed by the California Rural Indian Health Board; and (vi) the Puyallup Tribal Health Authority. The programs most directly related to community mental health were *Minobinmaadziwin* and the Puyallup. The methods used to enhance cultural competence included: (i) developing formal courses with an established curriculum for health care staff; (ii) in-service training with guest presenters; (iii) encouraging health providers to experience tribal culture in community settings; (iv) creating a "culturally expressive" environment within the health care facility; (v) integrating traditional healers; and (vi) providing explicit criteria for cultural competence and assessing it as part of employee evaluations.

Another interesting training model comes from Australia. The Djirruwang Program at Charles Stuart University delivers a Bachelor of Health Science (Mental Health) degree, with exit points at Degree, Diploma and Certificate levels (Brideson & Lanowksi, 2004). The program is restricted to Aboriginal people and was initially developed in a collaborative process between mental health services and Aboriginal people. This involved a National Reference Group consisting of representative stakeholders from mental health, Aboriginal community sector and education sectors. The course is delivered by Aboriginal and non-Aboriginal mental health professionals as well as university lecturers. The Djirruwang Program has strived to align itself with broader developments in the Aboriginal mental health arena, while remaining consistent with relevant mental health policies and initiatives. Brideson and Lanowski comment that:

> If the Aboriginal mental health workforce is allowed to grow into a valued, respected and essential component of the workplace those people occupying the professional positions will provide the cultural context to the workplace. The inclusion of the National Practice Standards into the program has provided a vehicle to establish equivalence as professionals in their own right (Brideson & Kanowski, 2004, p. 7).

Another source of training in Australia developed in relation to the national Indigenous Social and Emotional Well-Being (SEWB) initiative is a certificate in community care included within the Health Training Package recently endorsed by the National Quality Council (Fletcher, 2007; Garvey, 2008). This stream includes an orientation to mental health work. A number of electives also cover issues relating to Indigenous SEWB, including "The Provision of Non-clinical Services for People with Mental Health Issues." The Health Training Package also includes a community stream of the Diploma in Aboriginal and Torres Strait Islander Health Care.

Clearly, training and recruitment issues must be addressed if community wellness teams are to be widely deployed and sustained over the long term. There is a need to develop a larger pool of competent and well-trained Aboriginal and non-Aboriginal health care professionals committed to working in Aboriginal communities. Ongoing training and support must be provided to ensure staff retention and continuing education. This requires changes in policy, education and

accreditation that go beyond the design of specific community wellness teams. That said, teams can create their own in-service training programs, based on some of the ideas discussed in this section. Where possible, internal training should be augmented by external training provided by community organizations or professional bodies.

Community mental health teams face many difficult situations with significant emotional impact on team members. Intimate partner violence, child abuse and suicide all pose challenges to mental health workers no matter what their training and background (Linke, Wojciak & Day, 2002). This challenge is even greater in situations where team members must work with clients who are relatives or with whom they closely identify because of shared backgrounds or life situations. For this reason, community wellness teams need ongoing supervision and support.

A final training issue of special relevance to the creation of community wellness teams concerns the need to become comfortable working in multidisciplinary and interdisciplinary teams. The ability to collaborate effectively can be fostered by training experiences that bring together students from different disciplines for both didactic and experiential learning. This can include a specific focus on indigenous issues of concern to all the professions (Horsbaugh & Lamden, 2004). Models of interdisciplinary cooperation must be made explicit since professional boundaries and hierarchies sometimes hamper open dialogue. Working with large multidisciplinary teams with complex interventions can overload organizations and so requires careful priority setting (MacLean et al., 2007).

3.6. Summary

Mental health services are scarce for people living in remote and rural areas, in part because of limited access to both primary care and specialized mental health service providers. This is partly a consequence of Canada's geography, especially in northern regions, but also reflects historical and political issues in the provision of health services.

Even where there are adequate primary health care services, community wellness teams operating in rural and remote areas may lack access to secondary or tertiary experts who can assist them in case management. As such, innovative modes of specialist service delivery need to be developed if community wellness teams are to be properly supported and integrated into the fabric of the health care system as a whole. This is essential for both appropriate management of patients, team morale and ongoing training.

These innovative methods may include telepsychiatry and mobile consultation terms as well as regional and national networking strategies. However, all of these programs will require development of training and support services for Aboriginal and non-Aboriginal community mental health workers.

Our search of the available literature suggested that team approaches to mental health are becoming more common. Governments and health authorities are advocating team approaches to mental health, mindful of the limitations of conventional models of mental health care (Anderson, Anderson, Smylie, et al., 2006; Black, 2007; Burns, 2004). These conventional models often lack integration of key players, leading to the well-known silo effect. Common team approaches include Assertive Community Treatment for people with severe mental illness, and multidisciplinary teams for treatment of people with a co-occurring substance use and mental health disorder.

Our review of the literature suggests that while these team approaches are widely endorsed, they are often quite limited in scope when applied to mental health. For example ACT teams are solely concerned with tertiary prevention for people with severe mental illness, and do little in terms of promoting community wellness or subjective and emotional well-being at a population level (Drake, 1998). The same criticism could be leveled at integrated treatment for co-occurring mental health and substance use disorders. Indeed many team approaches in mental health have traditionally been concerned solely with tertiary prevention. This situation is slowly changing, partly in response to the recovery movement in mental health. The rethinking of mental health team approaches is also a result of wider shifts towards health promotion and public health— shifts that have been embraced by both federal and provincial governments (Health Canada, 2006). Still it remains that most current team approaches in mental health are focused at the individual level and on aspects of tertiary prevention. Community wellness teams therefore could be a vehicle to advance desirable changes in the focus of services towards mental health promotion and community wellness.

One problem with the existing evidence-base is that much of the material relevant to community wellness teams is published in the grey literature. This mainly consists of non-peer-reviewed reports of programs which have shown promise. However, these programs have rarely undergone rigorous evaluation involving careful measurement by independent researchers of exposures, interventions, and outcomes. As such, the scientific evidence for the efficacy and effectiveness of these teams is very limited. Indeed, our search of the academic literature identified few rigorous peer-reviewed evaluations of community wellness teams. This result in itself is revealing. It implies a need for systematic and rigorous evaluation studies of existing and new community wellness teams. These evaluations should follow certain standards and guidelines regarding their proper conduct, described in detail in the next chapter.

In this section, we present case studies of some promising community wellness approaches. We start by giving examples of community wellness teams that have been developed in Aboriginal communities in Canada. We then give examples from community wellness team approaches with other Aboriginal communities in Australia. Finally, we present examples from non-Aboriginal communities in Canada. In the conclusion to this chapter, we distill and discuss what appear to be some of the critical ingredients from the examples given, making recommendations for the design and implementation of successful Aboriginal community wellness teams.

4.1 Aboriginal Communities in Canada

4.1.1. A Provincial Approach: The Ontario Aboriginal Healing and Wellness Strategy

In the 1990s, Aboriginal people and government agencies in Ontario came together to develop the Aboriginal Healing and Wellness Strategy (AHWS) in response to the growing crisis in Aboriginal health and well-being. This strategy serves as both a policy and a service initiative. The approach was based on Aboriginal theories of health, which emphasize the close connection between physical, emotional, mental and spiritual dimensions of human experience. The strategy now funds various community-based projects. These include Aboriginal Health Access Centres, treatment centres, shelters, healing lodges, and other community based programs (described in more detail below). The projects are community designed and delivered. Elders, traditional healers and traditional practices are often integrated into treatment and the healing process. As described on its website,

> [the] AHWS fosters and promotes integration of traditional and culturally appropriate approaches to healing and wellness in Aboriginal communities with contemporary strategies, while supporting better access to the type of care and services for Aboriginal People that most other Ontarians take for granted. As a result of the efforts of the Strategy's participants, more and more Aboriginal people are receiving the kinds of holistic health and healing services health they have sought for many years and are enjoying an improvement in the quality of care they receive. Other benefits derived from the implementation of the Aboriginal Healing and Wellness Strategy include the creation of more than 650 jobs in the Aboriginal community, construction of facilities and the development of management and program planning capacity. An important feature of the Strategy is that programs and services are Aboriginal designed, delivered and managed. Empowerment is a key aspect in promoting wellness in Aboriginal communities striving for self-reliance by using traditional and cultural teachings and values that kept them strong in the past.[8]

The strategy is highly structured around a community team approach, although this phrase is not explicitly utilized, and the approach is not highlighted. Perhaps reflects an Aboriginal orientation in which community team approaches are expected, and not considered out of the ordinary or worthy of special note. Similarly, there is no separation between mental and physical health in many of the programs, again reflecting the holistic notions of health found among many Aboriginal cultures. The overall AHWS and the types of projects it funds are governed by committees made up of Aboriginal people and government agencies working on the principal of consensus. As such, there is a strong sense of First Nations ownership and control.

In terms of specific team approaches within the strategy, many examples could be given. Aboriginal Health Access Centers are similar to Community Health Centers, where teams of

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[8] http://www.ahwsontario.ca/about/strategy.html

health professionals work together to provide holistic care. This health team can include primary care physicians, nutritionists, counselors, mid-wives, and nurse practitioners.

The mental health program of the AHWS consists of specialized multi-disciplinary teams working together to provide services to (i) people at risk (especially high risk) of developing mental disorders and their families by providing appropriate indicated interventions; and (ii) people currently living with mental illness in the community and their families by providing tertiary prevention services. Services are designed to be culturally safe and competent and encompass aspects of traditional Aboriginal healing. These services include early intervention, crisis intervention, peer counseling and specialized case management. These services are provided by both conventional health care professionals and traditional healers. Most of these services are delivered by 'community wellness workers', many of whom are from an Aboriginal background.

These workers provide individual-level case management and support services to patients with existing and emerging issues of health and wellness. They also operate at the community level, working to enhance community health and wellness by conducting primary and secondary prevention activities. For example, they may organize and facilitate community events including health and wellness fairs, health education initiatives, illness prevention strategies and crisis intervention workshops. They may also identify sub-populations at particular risk and develop selective and indicated interventions accordingly. These workers are augmented by specialized 'crisis intervention workers' whose remit is to be proactive in preventing and intervening in cases of suicidality and family violence. These workers are mostly employed in rural and remote regions of Ontario. Both these cadres of workers are networked into the macro-level health system. They liaise closely with the Aboriginal Health Access Centers and other healing places developed as part of the strategy including shelters, a maternal and child health center, outpatient lodges and healing lodges. These healing places are located throughout Ontario.

The strategy has also funded specialized workers in urban areas known as 'health outreach workers'. These workers proactively engage at-risk and ill Aboriginal clients with SMI or substance use disorders, providing support and making frequent home visits to ensure health and wellness. They may help patients link with Aboriginal cultural resources and appropriate health service providers or agencies. These workers also organize and facilitate health promotion, illness prevention and family violence workshops and seminars. Aboriginal cultural approaches to healing are employed in day-to-day work.

The Ontario AHWS has been recently evaluated through longitudinal study of outcomes among people involved in its programs.[9] The analysis suggested the approach is having a positive impact on Aboriginal health. Given the involvement of Aboriginal people in the governance of the strategy, and in the front line delivery of services, there was a reported sense of ownership and empowerment associated with the strategy. Frontline workers benefit from a range of associated (and relatively local) secondary and tertiary services with an Aboriginal ethos to which patients can be referred. This may be essential for the success of community wellness team approaches. Teams can deal with many issues on the ground, but both they and patients will need meaningful back-up services for triage and further referral. Otherwise teams may become

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[9] http://www.ahwsontario.ca/publications/AHWS_Longitudinal_Study2009.pdf

alienated and overworked, employing 'band-aid' medicine that does not attack the root of a problem.

The evaluation identified several gaps and directions for future development: (i) develop Aboriginal cultural indicators that can be used to study the links between the process of cultural revitalization, which was an essential intermediate outcome of the strategy, and individual and population-level mental health outcomes; (ii) streamline the governance of the AHWS which was found to be cumbersome; (iii) strive for budgetary equity with similar mainstream government funded programs; (iv) more services to address family violence and programs to promote family healing; (v) development of human resources, the terms of Aboriginal health care professionals, and engagement with traditional healers; (vi) the need for specific programs for men, children, youth and elders (e.g. an apprenticeship program that brings together youth and elders to promote cultural transmission; anger management and shelters for men; grief counselors for elders dealing with the aftermath of residential school experiences).

4.1.2. Community Wellness in Remote and Rural Communities: Northwest Ontario

There are about 30 Ojibway and Cree communities located across the expanse of northwestern Ontario. Most are only accessible by air, with only a few being accessible by road. Some communities have around 100 inhabitants, while others have over 1000. As there are only a total 17,000 inhabitants, population density is extremely low. Like other Aboriginal communities, this region is faced with elevated rates of many health problems, including suicide, intentional injury (to self and others), substance abuse, mental illness and physical health problems such as type 2 diabetes and tuberculosis.

Most communities have a nursing station, which may have from one to three nurses depending on the size of the community. Because of high staff turnover and hiring problems, many stations have less than an optimal complement of nurses at any one time. Nurses are often assisted by locally-recruited Aboriginal paraprofessionals, often known as community health representatives, who have some training in health-care. Some have received on-site training while others have attended certificate level training courses lasting up to 10 months at local colleges. These courses focus on essential clinical and counseling skills, as well as health promotion and education. These paraprofessionals are sometimes the only health-care personnel in a community, running the nursing station on a day-to-day basis. However, most often they work as adjuncts to nurses. In this role, they often act as culture-brokers or as interpreters, as well as providing basic health care. They also sometimes initiate and carry out health promotion and primary prevention activities in their communities.

These nursing stations are visited regularly (usually at least once a month) by a host of health care professionals. These include family physicians, psychiatrists, dentists, ophthalmologists and other specialty staff. Mental health workers will often visit to offer care to individuals and families, as will National Native Alcohol and Addiction Program (NNADAP) workers to give counsel to people with substance use disorders and sub-clinical substance abuse problems. These personnel are generally based in the town of Sioux Lookout. This is the largest town in the region and also the location of the regional hospital.

The approach to community wellness in this region is one of the few to have undergone formal evaluation by academic researchers. In a qualitative study, Minore and Boone (2002) conducted interviews with staff and residents in these communities over an extended period of time. They also observed the settings in which professionals operate. The model of health care delivery was similar to others that take a community wellness orientation. Trained health care professionals work together with Aboriginal paraprofessionals on a day-to-day basis. These are supplemented by regular visits from specialists. According to the authors of the evaluation, the "model holds the potential to be inclusive, responsive and flexible." However they identified specific areas for improvement. The main issue was the relationship between Aboriginal paraprofessional community health representatives and non-Aboriginal health care workers. They found that the Aboriginal workers were often under-utilized, spending most of their time doing language interpreting and other non-health related activities. The knowledge, skills and judgment of Aboriginal community health representatives was undervalued by professional health care staff. The authors recommended educational interventions to ensure that health care staff work productively and respectfully with Aboriginal paraprofessional community health representatives. These paraprofessionals should be considered a dual resource, having expertise in health care, as well as in the culture and community being served.

Minore and Boone (2002) found several factors that seemed essential to smooth team functioning, including: (i) shared purpose; (ii) creative problem solving, (iii) mutual respect among team members for each other's knowledge; and (iv) acceptance and utilization of overlaps in their respective domains of practice. They also emphasize that the structure of an interdisciplinary team should be flexible and nonhierarchical. Team members should participate or take leadership based on their specific expertise or their relationship to a client, rather than the professional position they hold. These factors are potentially relevant for all community and institutional settings, but may be especially important for rural or remote places, where diverse professionals and lay helpers must work together closely.

4.1.3. Community Wellness on a Small Reserve: Little Shuswap Lake

Little Shuswap Indian Band (Skwlax) is a small First Nations community of around 300 people in central interior British Columbia.[10] It faces many of the challenges common among small First Nations reserves, including outmigration and decline in traditional customs such as language use. Approximately half of the population lives off-reserve. This reserve has developed a Community Wellness Department which covers health, education, social development and day-care.

For the Little Shuswap Lake First Nation, community wellness is defined by well-being in various different life domains. Community wellness is explicitly facilitated by a team approach. Staff in the department work as a community wellness team, attending to issues of individual and community-level health. In line with their holistic philosophy, all staff in the team learn about the programs throughout the department, regardless of their specialization, so that they are readily able to answer relevant questions from community members about service provision.

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[10] http://www.littleshuswaplake.com/

This also enhances sense of belonging and teamwork among staff. Most services are delivered from a devoted 'wellness center', though many services involve home-visits as well.

The team itself comprises various health professionals. These include a public health nurse-practitioner who conducts primary prevention activities such as immunization and screening for chronic and infectious diseases. At the community level, the nurse conducts education and community awareness programs. The nurse also liaises with local secondary and tertiary services, making the appropriate referrals where necessary. Other health professionals in the community wellness department include an addictions counselor, a dental hygienist and an oral health promoter. Other workers whose activities have a direct bearing on health and well-being include a social worker, a youth and family worker, and personal care aides, all overseen by a health care coordinator. All these health professionals take a holistic approach to health, conducting activities that enhance the health of specific individuals in the community, as well as conducting public health and health promotion activities at the community level. The activities of the team are facilitated by a community health representative whose job is to be a bridge between health professionals and the community. For example, this person assists the nurse in delivering services such as immunizations and health promotion programs. The community health representative may also coordinate and organize community wellness events and workshops. The team is completed by a day care coordinator and an education coordinator.

This community wellness approach has not been scientifically evaluated. However it still serves as an interesting model, especially for small First Nations communities desirous of implementing a holistic, self-governed community wellness team that can serve the everyday health and wellness needs of a small community. As previously mentioned, such local services may only be successful in responding to the range of mental health services needs in the community if backed-up by appropriate and culturally informed secondary and tertiary services at the regional level.

4.1.4. The Yukon Community Wellness Courts and Teams

Community wellness approaches can also be applied to the legal system in efforts to improve individual and collective outcomes. Aboriginal people are over-represented in prisons and Analysis of data from 1989-2003 indicates that up to 86% of offenders appearing before Yukon courts have substance abuse problems, and the rate of mental illness is three times higher than that of a comparable non-corrections population. This situation is compounded by socioeconomic issues; about 70% of offenders do not work and 30% do not have stable housing. Fully 70% of offenders before Yukon courts belong to a First Nation (Four Worlds Centre for Developmental Learning, 2003)

In response to this situation, in 2007, the Yukon Community Wellness Court was established as an innovative attempt to work therapeutically with criminal offenders who also have substance use or mental health problems, in a holistic and culturally-relevant manner.[11] The objective of the court is to address the root causes of offenders' problems through the deployment of various health and criminal justice professionals. This approach aims to help individual rehabilitation

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[11] http://www.yukoncourts.ca/courts/territorial/cwc.html

and prevent recidivism. It is also considered an opportunity to enhance community wellness in that it contributes to the safety and integrity of Yukon communities.

The Community Wellness Court is a collaboration between seven partners, including local legal entities such as the Yukon Department of Justice, federal entities such as the Public Prosecution Service of Canada, Aboriginal entities such as the Council of Yukon First Nations, law enforcement agencies such as the RCMP, and health agencies such as the Yukon Department of Health and Social Service. Participation in the Community Wellness Court is voluntary and open to people with non-serious criminal charges whose criminal conduct was influenced by (i) an addiction to alcohol or drugs; (ii) a mental health problem; and/or (iii) an intellectual disability, including fetal alcohol spectrum disorder. Participants must show meaningful motivation to change and be willing to work with professionals on the Community Wellness Team.

In order to participate in the program, individuals must plead guilty to the charges against them in the Community Wellness Court. In response, the Court issues detailed bail conditions. This includes a demand that offenders work with a primary case manager to develop an individually tailored wellness plan (termed their 'wellness journey'). This plan is implemented over 12-18 months through a program of intensive supervision, treatment and support delivered through appropriate members of the Community Wellness Team. Some services are provided through agencies outside of the Community Wellness Team. This includes services provided by the Territorial government or other community agencies.

The Community Wellness Team consists of core members, and others who are deployed on a case-by-case basis. Core team members include the Primary Case Manager, the Community Wellness Court Physician, and the Community Wellness Court Support Worker. Others involved in the team include addictions counselors, mental health nurses and a social worker. The client can identify their own support persons to be members of the team; this will often include family members or friends, but can also include Elders or other First Nations representatives (for example traditional healers). With the client's permission, an employer can be invited to be a formal member of the wellness team. The team members work closely with each other and with the client to ensure the Wellness Journey enhances individual rehabilitation and community wellness. The involvement of First Nations representatives aims to insure that First Nations perspectives on healing are incorporated into the therapeutic plan. Education and employment are often considered key components of rehabilitation. As such, the primary case manager and the community wellness court support worker will work with the client in the pursuance of educational and employment goals. They can be assisted in this regard by various programs run by local community agencies or the territorial (and federal) government.

The Community Wellness Team has responsibility for frontline treatment and day-to-day care of the client, including meeting basic needs. The medical focus of the team includes the appropriate provision of substance abuse counseling, detoxification, mental health assessment and treatment and medical assessment and treatment. The socioeconomic focus includes dealing with issues of housing, social welfare assistance and assistance with the provision of other basic needs (e.g. food and clothing). The team is supported by a wide range of secondary and tertiary services elsewhere in the territory. Referral can be made to a variety of other services on a case-by-case basis. This may include a local wellness center (Kwanlin Dun), the principal community hospital

(Whitehorse General Hospital) or to community groups such as alcoholics anonymous or a local parenting group.

The Yukon Community Wellness Court and the associated team are innovative interventions that attempt to address the needs of individuals and communities negatively affected by problems of crime, mental illness and substance use disorder. The approach recognizes that individual and community wellness are closely intertwined. The multidisciplinary team is mobilized in order to address both the causes and consequences of problems. The broad approach addresses not only at medical and psychiatric symptoms, but also issues of housing, employment and education. Though the target group for the wellness team are individuals with existing health problems (i.e. tertiary prevention), the emphasis on rehabilitation and social inclusion can benefit the whole community.

4.1.5. Community Wellness in Urban Areas: Vancouver Coastal Authority Aboriginal Wellness Program

The premise of the Vancouver Coastal Authority Aboriginal Wellness Program (AWP) is that Aboriginal people experience elevated mental health and substance use problems due to ongoing and historic marginalization. Addressing the root causes and consequences of this marginalization is considered essential to enhancing wellness. The mission of the AWP is to provide "culturally safe mental wellness and addiction programs that promote health, wellness and healing."[12]

The clients of the AWP are Aboriginal people living in Vancouver (many of whom are in the Downtown Eastside: DTES) struggling with issues of substance abuse, victimization, homelessness and other social and mental health problems. The aim of the program is to help clients set and achieve wellness goals, improving their psychosocial functioning in a positive and healthy manner. The AWP principal office is located in the DTES, though they have a satellite office elsewhere. Thus, clients have some choice regarding where to meet and receive treatment.

This program is urban in focus, designed to address problems of access and continuity of care for Vancouver's Aboriginal population. The program attempts to address issues of mental health, addiction and victimization simultaneously in one comprehensive package. Services are individually tailored to each client's needs, specific situation and overarching worldview. Western and Aboriginal notions of healing propel the approach, with each being deployed appropriately (or simultaneously) depending on the client's desires.

A team approach is taken to address issues and assist clients. There are two clinical supervisors on the team, one who specializes in addictions, the other in mental health. Additionally, there are up to three generic therapists, two support workers (similar in function to case managers), two Aboriginal women's victims assistance workers, and a cultural support worker. Traditional healers and Elders are often brought into the team to work with specific clients or in specific groups. Clients can also be referred to a consultant psychiatrist who works outside the team.

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[12] http://aboriginalhealth.vch.ca/wellness.htm

Any Aboriginal adult living in Vancouver (and their family members) is eligible for services. In addition to individual therapy, many group sessions are conducted, including couple and family therapy. Wellness circles and counseling circles also occur regularly, with separate sessions for men and women. These can include story telling, drumming, singing and other culturally specific activities that can promote wellness and recovery. Staff members also work as advocates with clients, helping them navigate the health and social care system, as well as helping them achieve employment and educational goals.

The AWP conducted an internal evaluation in 2006. This indicated that the program helped clients achieve their wellness goals and improved their psychosocial functioning. Clients particularly valued the culturally specific services and the fact that staff encourages an ethic of self-help. As such, clients reported a sense of empowerment and an abiding trust in staff.

Similar team approaches to urban Aboriginal populations have been developed in other cities; for example, the Toronto Aboriginal Care Team provides coordinated substance abuse and mental health case management to Aboriginal people, with care being grounded in Aboriginal values and notions of harmony and healing. [13]

4.2. Indigenous Communities Elsewhere

Below, we present two case studies of promising programs in Australia and a planning initiative in the U.S. Because Aboriginal peoples have endured a similar history of colonization and marginalization and face similar geographic challenges for service delivery, these programs have implications for the development of community wellness teams in Canada.

Australia has done much work to develop Social and Emotional Well-being programs. These have worked collaboratively with communities using community engagement and development approaches. Two landmark reports, 'Deaths in Custody' and 'Stolen Generation' in early 80's and mid 90's underscored beyond doubt the importance of social and political determinants of health in Indigenous peoples lives. This paved way for various structural and systemic "social and emotional wellbeing" (SEWB) policies and programs to be implemented out in Indigenous settings. However, the distinction between the domains of SEWB and mental health have been unclear in terms of basic definitions, policies, training, research and outcomes. In practice, the focus of Mental Health programs has been on mental illness and hence clinical service delivery and quantitative research have largely dominated the field. The focus of SEWB has been on community development and group empowerment. Both SEWB and MH have had some integration in mental health promotion, prevention and early intervention philosophies or programs. However, these are poorly articulated and still tend to sit in silos. The multifactorial contributors to SEWB have led to a complex system, in which many different disciplines and paradigms collide.

Indigenous understanding of the causes and cures for adequate or inadequate SEWB is different in its language, meaning and outcome when compared to the mainstream SEWB discourse. For example, "belonging to country" (connection to the land) is a key theme for Indigenous

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[13] http://torontocareteam.org/about.html

wellbeing whereas homeownership is critical for middle class Australians as an adequate SEWB measure. Clearly, belonging to country and owning a home are quite different, even diametrically opposed, concepts and measures of SEWB.

The Social Justice report by Tom Calma (2007) is one of the key policy documents from the Australian government that emphasizes SEWB components beyond health equity. This document highlights 'collective health determinants' such as racism towards ATSI people in society; collective ability (or lack of it) of ATSI people to control their lives; control over their physical environment, of dignity, of community self esteem, and of justice (as a health indicator); discrimination in health services (as reported in relation to secondary and tertiary cardiovascular disease interventions) What is clear is that the strategies, solutions and vision for addressing SEWB issues requires and will require broader social and political will and action far beyond the health sector

In Australia, various practice guidelines have been developed which are of relevance to Aboriginal community wellness teams. These include:

- National Strategic Framework for Aboriginal and Torres Strait Islander Health (NSFATSIH) 2003-2013 (Australian Health Ministers' Conference 2003)
- National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Wellbeing 2004-2009 (Social Health Reference Group 2004)
- National Practice Standards for the Mental Health Workforce (Department of Health and Ageing 2002)
- Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004-2009 (Australian Health Minister's Advisory Council on Aboriginal and Torres Strait Islander Health Working Party 2004)
- RANZCP Position Statement #50, Aboriginal and Torres Strait Islander Mental Health Workers (Royal Australian and New Zealand College of Psychiatrists 2002).

These correspond to key strategic directions of the Australian Social and Emotional Wellbeing (SEWB) Framework, which includes a comprehensive list of goals and potential interventions (Department of Health and Aging, 2004).

The National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Wellbeing 2004-2009 gives the following examples of initiatives:

Victoria Health developed a community leadership program for emotional and spiritual well being promotion in Koori communities. The program draws on the knowledge and experience of older people and recognizes that the extended family as the basis of community. Under this initiative, five community leadership programs were funded reflecting the themes of strengthening culture, community and family.

Leave No Footprints is a Central Australian Remote Mental Health Team that consists of twelve members from a range of government and non-government services. Most team members belong to local clans and language districts, bringing representing great cultural diversity and geographical distances. They aim to provide culturally sensitive treatment and support and encourage community connections. One team member is a psychiatrist who provides clinical supervision to mental health workers. The treatment models may incorporate traditional healing.

An Aboriginal Health Impact Statement was developed by New South Wales Health and the Aboriginal Health and Medical Research Council to assure that Indigenous people health needs and interests (which include appropriate consultation and negotiation) are taken into consideration while developing and implementing the mainstream health policies.

Indigenous Psychological Services, a private company led by Tracy Westermann, a clinical psychologist of Aboriginal background, has developed training workshops including: "Working with Suicidal and Depressed Aboriginal Clients" and "Psychological Assessment of Aboriginal Clients." These workshops cover the complexities of conducting psychological assessments and the importance to provide practical and theory driven strategies to reduce the biases that can occur in clinical assessments of Aboriginal clients.

Central Sydney Area Health Service and Aboriginal Medical Service Redfern developed a partnership through the hiring of experienced Aboriginal Clinical Nurse Consultant by CSAHS, who is able to provide advocacy for patients and the community in the mainstream service. This The Consultant is supported by the multi-skilled team and Regional SEWB Centre staff to support mental health workers in culturally appropriate service delivery.

Djirruwang Aboriginal and Torres Strait Islander Mental Health Program is a tertiary level course specifically designed for Indigenous mental health practitioners to meet the needs of their own communities across Australia. Graduates of the Djirruwang program have secured work within mainstream mental health, community mental health services, Aboriginal organizations and Aboriginal community run health services.

The Public Health Department in Queensland, Australia has developed materials to facilitate community health forums (Queensland Health, 2005).[14] The aim of the printed manual and accompanying videos and CD-ROM is to assist community workers and health promoters to engage community members in identifying their health needs and priorities and promote knowledge exchange about existing health services. The assumption is that community engagement can improve the quality and accountability of health services. Tools include checklist and templates for: overcoming barriers to meetings; terms of reference for local health

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[14] Available online at: http://www.crcah.org.au/communication/downloads/OneTalk.pdf

forums; mapping local organisations; community profiles; local health plan; developing protocols for communication and consultation with the local community; developing cultural safety strategies; developing local protocols for research, ownership and use of data; example of a project plan; engaging with communities; strengths and limitations of consultation tools; dealing with difficult situations in the consultation process; assisting people through change management process; business case; project management; and barriers and strategies for indigenous people in making complaints.

4.2.1. Murray Bridge: An Aboriginal Health and Well-being Team

The Australian National Mental Health Plan 2003-2008 promoted new models of service delivery.[15] It suggested an integrated team approach to mental illness that covers the public health principles of the Declaration of Alma-Ata, the Ottawa Charter and Jakarta Declaration. The plan recommended that the following four services be delivered by mental health teams throughout Australia: (i) cognitive behavioural therapy; (ii) narrative therapy; (iii) crisis, trauma, sexual abuse and solution focused counselling; and (iv) psychiatric nursing and system therapy (Fairlamb & Muir-Cochrane, 2007)

At the same time as the National Mental Health Plan was being formulated, a Primary Health Care Policy Statement was released by the South Australian Territorial Government that recommended (i) the reorientation and development of innovative health care services; (ii) an approach that recognizes and addresses social and structural determinants of health; (iii) the development and maintenance of collaborative care; and (iv) support in workforce planning lead by primary health care services.[16]

Policies from the National and Territorial governments were the driving force behind a new community wellness team approach developed by the Murray Mallee Community Health Service (MMCHS). This is located in the region of Murray Bridge, serving a population of about 30,000 people. This population is overwhelmingly of Ngarrindjeri indigenous heritage.

The community health service specializes in the provision of the following specialized services: Indigenous health; care for elderly; nursing for local communities; care in diabetic disease; dietetic programs; home care; mental health care; sessions of occupational therapy; palliative care; physiotherapeutic care; podiatry; speech specialists; women's health care; social work; community nursing; and allied health. These services are provided by various health professionals including general practitioners, nurses, social workers, a visiting consultant psychiatrist, and various other allied health professionals. The service has collaborative liaisons with the local hospital via a registered nurse who works closely with the wellness team members.

Many of the services are delivered by a dedicated Health and Well-being team. This team has responsibility for: (i) mental health services; (ii) Aboriginal health services; (iii) women's health services; and (iv) social work services. A holistic approach is taken to health and well-being,

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[15] http://www.health.gov.au/internet/main/Publishing.nsf/Content/mental-pubs-n-plan03
[16] http://www.publications.health.sa.gov.au/phc/5/

with no sharp distinction made between mental health problems, psychosocial problems and other issues affecting well-being. This team is described as such on its own website:

> The Health & Wellbeing team within MMCHS aim to support and contribute to the development of strong, enriched, healthy, Murray Mallee communities, by the promotion of interconnectedness, resilience and participation, including all cultures and lifestyles within the region. The Health & Wellbeing team operates within Primary Health Care principles, Social Justice and Health Promotion principles. This is reflected in the way we work with people. Our work is also influenced by narrative therapy ideas and feminist principles.[17]

The team does not conduct psychiatric assessment or diagnosis; this is left to the consultant psychiatrist. Instead, the team accepts patients referred to them by psychiatric institutions, general practitioners and other different agencies. In terms of mental health, the purpose of the team is to focus on lessening psychological distress among users and increasing functioning. Patients can receive support from any member of the team.

The team consists of a project leader, numerous AMHWs, social workers, mental health nurses, mental health workers (case managers), women's support workers, an activities coordinator, a speech pathologist and supporting administrative staff. As such, the community wellness team includes AMHWs as well as university trained mental health professionals. Some professionals have expressed worry that AMHW team members would miss important acute psychiatric conditions that need hospitalization, as they do not have the appropriate medical training. This could also be compounded by the fact that the model used is based on risk level and not diagnosis. However, the AMHWs work in partnership with specialized mental health professionals, and consult with them regarding difficult cases. Being a part of the consultation process, over time the AMHWs gain the specific knowledge that helps them to better refer acute cases when needed.

The team focuses most of its work on individuals and their families with mental illness or other psychosocial health issues. This involves one-to-one counselling focusing on emotional, physical and spiritual issues. Other services include a Well Women's Service that focuses on factors such as breast cancer, domestic violence, reproductive health and perinatal health. In all its work, the team operates on a strengths-based model, trying to mobilize the psychosocial resources of individuals and their families. This may involve close attention to issues of culture.

The MMCHS conducts numerous training activities for all its health care professionals to build capacity and knowledge in the area of Aboriginal mental health and community wellness. Two important areas for training are cultural issues and violence awareness. A three-leveled training course is provided spanning several days that includes in-depth discussion of issues such as Aboriginal culture, history and racism. A violence awareness program includes discussion about domestic violence and links with the WHO's Violence Prevention Alliance.

To summarize, this team shares many of the features of other community wellness teams. Team members consist of professionals and AMHWs working in collaboration to meet goals.

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[17] http://mbsmh.sa.gov.au/article/view/277/ [Retrieved October 10, 2009.]

Disciplinary and specialty boundaries often drawn in medical settings are bridged in this model of community wellness, where psychosocial, mental health, physical health, spiritual and overall well-being issues are considered as inter-related manifestations of problems that require integrated treatment. Unlike some of the other models, this model focuses on individuals and families, and places less emphasis on primary prevention or health promotion approaches. Instead, the focus is on tertiary prevention and selective and indicated interventions.

4.2.2. The Tiwi Islands Mental Health Service

The Tiwi Islands are located 80 km north of Darwin and are part of Australia's Northern Territory. Over 90% of the 2500 inhabitants of these islands are Tiwi; an indigenous people culturally and linguistically distinct from other Aboriginal communities in Australia. Most community members still speak the Tiwi language. In common with other indigenous communities in Australia, the Tiwi people suffer from elevated rates of mental health problems, and face challenges accessing conventional mental health services due to the geographic the remoteness of the islands and the low population density.

Until recently, frontline care for mental illness on the islands was provided by a psychiatric nurse operating from the Royal Darwin Hospital who would visit the islands periodically. The hospital also provided inpatient and specialist care. In the late 1990s, it was recognized that this model was not adequately meeting the mental health services needs of islanders. A new approach was taken with the creation of the Tiwi Island Mental Health Service. This consists of a team comprising of one psychiatric nurse and five Aboriginal Mental Health Workers (AMHWs). The Tiwi Islands Mental Health Service is well-described in the academic literature, and has received preliminary evaluation (Norris, Parker, Beaver et al., 2007; Parker & Ben-Tovin, 2002).

The mission of the team is summarized in the following broad objectives, which were established after a 2002 mental health needs assessment:

- to respond to the mental health needs of the populace;
- to demystify mental disorder;
- to promote Aboriginal responses to mental ill health;
- to improve psychological and social well-being;
- to utilize community resources;
- to challenge attitudes and behaviors so the risk factors are minimized and incidence and prevalence of disease and injury are reduced;
- to create a mental health care network.

The AMHWs employed by the team do not have formal qualifications in mental health, but are recruited for their cultural expertise, local knowledge and empathy with those who are suffering. These workers are usually senior community Elders. They receive training from mental health professionals who come into visit the Island, in particular from health and social welfare experts. Training courses are also provided by the Batchelor College in the Northern Territory. Once recruited and trained, AMHWs are encouraged to attend appropriate conferences and workshops and even present academic papers. In turn, AMHWs also become trainers for the professional

staff who come to work on the Islands. The AMHWs train these professionals on local culture and on holistic approaches to health commonly embraced by local people.

AMHWs are seen as an essential bridge between the community and the health care system. Their strengths include having already established relationships with key resource people and institutions in the community, for example the police and community elders. They have a good knowledge of community issues. They often know intimately the personal history of individual cases and have an in-depth understanding of the complexities of local social and cultural issues.

Of course, there also are some difficulties associated with the AMHW being a part of the same community where they provide their services. In small communities, AMHWs will be part of many intricate cultural webs and social networks and will often end up working with people they went to school with, or are closely related to, including their own family members. This raises issues of confidentiality and privacy, which may not be so prominent (or take different form) for workers from outside the community.

The team undertakes psychiatric assessment of individuals, and subsequently provides basic mental health services and support. The AMHWs act as case managers to people suffering from mental illness or substance abuse problems. Services may also be provided to those with severe psychosocial problems. The team encourages family members to support patients in their everyday lives. In this sense, family members are considered unofficial members of the team, acting as joint case managers.

The approach taken by the Tiwi Island Mental Health Service uses various aspects of prevention (primary, secondary and tertiary) and combines individual and a population level approaches. This can be seen in an intervention somewhat unique to the islands, involving 'Strong Men' and 'Strong Women' groups. These are monthly meetings that provide an opportunity for Elders to assemble and note areas or individuals of concern, coming up with appropriate action plans to solve problems. Areas of concern frequently noted are suicidality, self-harm, substance abuse and domestic violence. Young community members are also encouraged to attend these groups. This approach draws on the traditional wisdom of the Elders as well as taking a communal approach to problems.

Like all Aboriginal communities, Elders play a very important role in Tiwi Islander life, often being a first-line of referral for mental health problems in younger people. As such Elders are closely involved in the day-to-day working of the Tiwi Island Mental Health Service, both formally and informally. As part of the program, governing council members and recognized traditional Elders are provided with up to date information on mental health issues and service development, which they can use in their interactions with younger people. As such, Elders could also be considered members of the loosely defined community wellness team.

In addition to the groups described above, the mental health team carries out more focused interventions and programs. The following specific initiatives have been developed and implemented to improve mental health and enhance psycho-social well-being at the individual-level: case management for people with a mental health disorder; social care program for persons with a mental health issue who are assessed as at risk; prisoner support program (for prisoners

and ex-prisoners in rehabilitation); and court reports and support for those charged with an offense who have a mental health problem.

Programs have also been developed to support the operations of the Tiwi Mental Health Service. These include a comprehensive training program for all team members, and enhanced collaboration and linkage between the mental health service and tertiary services such as the Royal Darwin Hospital. These linkages have also been extended to local agencies such as the police, schools, correctional services, and aged care to ensure a holistic approach to mental health across the Islands.

In the Tiwi mental health team approach, the AMHWs aim to promote community mental health, rather than providing help only for those suffering from mental illness. Much of their work focuses on combating general stigma towards the mentally ill, as well as reducing social exclusion and addressing psychosocial issues for everyone in the community. As such, a distinction between those with or without mental illness is not part of the underlying philosophy of the team. This inclusive approach has been a source of some friction with the local health authority, which has sought to have services limited to those with a confirmed psychiatric disorder. Since this comprehensive approach has been taken, however, numerous improvements in care and mental health status mental health indicators have improved on the Islands. These include:

- There has been a decrease in the number of suicides from 10 in 2001 to 3 in 2003;
- At one count, 52 people known to suffer from mental health disorders were receiving treatment and support including case management, medication, counseling, accommodation and meals;
- Acute cases are supervised by the community based teams available 24/7;
- As a result of training programs held, local mental health workers have greater competence in dealing with case histories and current mental health assessment with less need to refer to psychiatrists;
- There is increased inter-sectoral communication and collaboration, between the Tiwi mental health team, Darwin inpatient psychiatric facility, police, correctional services, health centre, schools, youth group, aged care and Red Cross;
- Clients who are at risk of offending have received training sessions held by Tiwi Island police workers;
- Cases of domestic violence are referred by the Tiwi Police to mental health teams.

The local AMHWs and the professional mental health staff often work well together, bringing their different perspectives to bear on individual (and communal) distress and suffering. However, there is a high turnover of professional mental health staff on the Tiwi Island Mental Health team. This has been attributed to a 'culture clash', in which university-trained staff have difficulty accepting the more community-grounded notions of health, well-being and appropriate intervention strategies held by the AMHWs. As a result, a lot of time and effort is spent training new staff members in local concepts of health and well-being.

A basic problem faced by the Tiwi island team is the complexity and continuity of funding. Team members receive funding from several different sources, each with their own agendas. The

psychiatric nurse receives funding from the government, while eight different external funding sources (including government and non-government agencies) support the salaries of other team members. As a result, the objectives of the local mental health teams are often changed to be in concordance with requirements of the funding organizations. As well, the funding from these sources is often short-term, creating instability and shifting goals as time progresses. This can be demoralizing for team members and undermines the principles of local control and empowerment.

4.2.3. The Circles of Care Initiative

In the U.S., the Federal Center for Mental Health Services (part of the Substance Abuse and Mental Health Services Administration, or SAMHSA) funded the Circles of Care initiative to support the planning, design, and feasibility assessments of implementing culturally appropriate mental health service models for American Indian/Alaska Native children with serious emotional or behavioral disturbances and their families (Freeman, Iron Cloud-Two Dogs, Novins & LeMaster, 2004). The focus of the program was on children with severe mental health problems. These conditions are often associated with social stigma and so the language used to label or describe them is important (Talley 2006). The process involved 6 steps: (1) assessing community service needs (Novins, LeMaster, Jumper-Thurman, & Plested, 2004); (2) finding a locally relevant definition of serious emotional disturbance (Simmons, Novins, & Allen, 2004). The local definitions aimed to minimize stigmatization and promote a strengths-based conceptualization of need. Each community's specific concept and labeling of the childhood problems also had implications for the design of a system of care; for example, a more broadly conceived definition required consideration of a broader array of services; (3) evaluating current local service systems (Allen, LeMaster, & Deters, 2004); (4) developing a plan for measuring outcomes (Novins, King & Stone, 2004); (5) a feasibility assessment (Coll, Mohatt & LeMaster, 2004); and (6) process evaluation (Bess, King & LeMaster, 2004).

The core values and guiding principles in the development of the CoC models were:

Core Values
1. The system of care should be child-centered and family focused, with the needs of the child and family dictating the types and mix of services provided.
2. The system of care should be community based, with the locus of services as well as management and decision-making responsibility resting at the community level.
3. The system of care should be culturally competent, with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve.

Guiding principles
1. Children with emotional disturbances should have access to a comprehensive array of services that address the child's physical, emotional, social and educational needs.
2. Children with emotional disturbances should receive individualized services in

accordance with the unique needs and potentials of each child and guided by an individualized service plan.

3. Children with emotional disturbances should receive services within the least restrictive, most normative environment that is clinically appropriate.

4. The families and surrogate families of children with emotional disturbances should be full participants in all aspects of the planning and delivery of services

5. Children with emotional disturbances should receive services that are integrated, with linkages between child-serving agencies and programs and mechanisms for planning, developing, and coordinating services.

6. Children with emotional disturbances should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner and that they can move through the system of services in accordance with their changing needs.

7. Early identification and intervention for children with emotional disturbances should be promoted by the system of care in order to enhance the likelihood of positive outcomes.

Much can be learned from this development process, which addressed some of the communities' disaffection with existing services and the lack of attention at various levels of government by beginning a process of dialogue and working together. The CoC program evaluation documented the usefulness of a cyclical process of evaluation which began with understanding the local history and context relevant to participants, the definition and development of the evaluation effort, the transformation of data collection into policy and planning recommendations, and a final transition from planning to implementation (Bess, Allen, & Deters, 2004). Nine communities participated in the CoC initiative, which produced positive outcomes in terms of some new services or changes in existing services and successful applications for funding for programs (Duclos, Phillips, & LeMaster, 2004). To date, however, in-depth descriptions or systematic evaluations of actually implemented programs have not been published.

4.3. Non-Aboriginal Examples

4.3.1 The Canadian Forces Health Services: Psychosocial and Spiritual Wellness

The Canadian Forces Health Service exists to promote, protect, and restore the health of Regular and full-time Reserve Canadian Forces members. This is done through the deployment of various health professionals including physicians, pharmacists, nurses, dentists and medical assistants. These are backed up by appropriate health service administrators and other ancillary staff.

The Canadian Forces Health Services has specific teams devoted to fostering what they call 'psychosocial and spiritual wellness'. These teams consist of psychiatrists, psychologists, social workers, addictions counsellors and mental health nurses, directly supported by medical officers, nurses and chaplains. This team is further integrated into the Canadian Forces Primary health care system, and other components of that system which deal with health promotion and illness

prevention. The psychosocial and spiritual wellness teams are propelled by an overarching philosophy of holistic care, as stated by the Canadian Forces:

> "The Canadian Forces leadership recognizes that the psychological fitness of its members is an essential component of operational effectiveness and that psychosocial and spiritual wellness care is part of its fundamental obligation to promote the well-being of its members."[18]

In terms of actual services delivered, individuals are screened for mental health problems before and after operational deployment. The team provides basic and continuing education on aspects of mental wellness, including a focus on operational stress injuries (that is, any persistent psychological difficulty resulting from military service). Teams are located on Canadian Forces Bases. For those suffering from severe problems, advanced psychosocial and spiritual wellness teams operate from select specialized centres located across the country referred to as Operational Trauma and Stress Support Centres. In other words, front-line teams are supported by specialist teams to whom serious cases can be referred. In order to ensure continuity of care and equitable service provision, these centers are also open to veterans, as are many of the programs offered by the psychosocial and spiritual wellness teams.

Several collaborative initiatives have been implemented by the psychosocial and spiritual wellness teams to enhance mental health among Canadian Forces personnel and their families. These include new interventions that are emerging as popular and effective in mainstream mental health care. One of these is known as Operational Stress Injury Social Support (OSISS). This is a peer support network of people who have recovered from Operational Stress Injury (OSI). They provide support to CF members needing help for mental health problems. As well as providing support to individuals with OSI, this network is trying to effect institutional cultural change so as to lessen stigma associated with mental health problems in the Forces. These dual interventions, providing peer support and combating stigma, are now being acknowledged as essential to the promotion of individual and community mental health in any specified community. Other innovative interventions include the psychosocial and spiritual wellness team working in collaboration with military family resource centers to provide appropriate information, support and programs to military families.

This example is relevant to the Aboriginal situation in several ways. It illustrates how a comprehensive top-down organizational structure can be implemented to provide comprehensive mental health and wellness services. The services integrate spiritual and psychosocial well-being and takes a multidisciplinary approach to mental health. The wellness team is an integral part of the community being served, rather than a separate organization with a distinct cultural ethos or cultural practices. Finally, the team has embraced innovative interventions such as peer support and anti-stigma initiatives, which have a strong recovery and public health focus.

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[18] http://www.forces.gc.ca/health-sante/pub/fs-fd/psw-sps-eng.asp

4.3.2. Assertive Community Treatment for Ethnic Minorities in Toronto

Assertive Community Treatment teams (ACT) are multidisciplinary teams that support a caseload of individuals with severe mental illness in an effort to promote recovery, improve quality of life and reduce hospitalization (McDonel, Bond, Salyers et al., 1997). ACT programs have been implemented in rural settings with mobile teams or with non-professionals as community case managers (Gammonley, 2006; Wagenfeld, 2008). ACT is usually one component of a comprehensive community service model including home-treatment teams and crisis services, primary care liaison teams which act as gatekeepers to specialist mental health services, and rehabilitation and recovery teams that focus on the needs of those with complex long term mental health needs who do not require assertive outreach.

ACT teams are usually designed to cover a specific geographical area. They rarely have been employed as interventions with specific cultural groups in mind. A well-documented exception is the ACT team developed in Toronto, funded by the Ontario Ministry of Health (Yang, Law, Chow et al., 2005). The Hong Fook Mental Health Association (a community agency) worked with Mount Sinai Hospital to develop a team and adapt the core ACT model to meet the needs of diverse cultural and ethnic minority groups in Toronto. Local research suggested that the groups in most need of culturally tailored ACT were people from South and East Asia, the Caribbean, Africa, and Aboriginal populations. The team made a point of recruiting staff that were bilingual and shared some of the ethnocultural characteristics of the key groups of people to be served.

The team conducts all the regular activities of the ACT model, but have created additional components to better serve the ethnocultural groups with which they work. In order to engage patients, the team tailored their services so that culturally meaningfully activities and programs were readily available for patients. This included cookery classes where the ethnic cuisine of the group in question was prepared, and culturally appropriate activities such as yoga. Given the importance of the family unit in many of the cultures being served, family psychoeducation was made available at weekends in families' mother tongues. This followed a well-established model of family psychoeducation (McFarlane, 1996). Different seasonal and religious festivals are incorporated into the rhythm of the team to ensure patients understand that their cultural and religious beliefs are recognized and respected. Cultural issues are always brought to the fore during regular team meetings. All team members are trained in and expected to help with social, economic and legal matters such as immigration, refugee and social assistance issues.

The team has been evaluated positively by mental health researchers in a retrospective before and after design (Yang, Law, Chow et al., 2005). In a comparison of hospitalizations before and after the implementation of the team, it was found that there were significantly fewer hospitalizations in the sample after implementation. There was also a significant reduction in symptom severity. Over 60% of clients were matched with workers who spoke their language and were of the same or similar ethnicity.

The model adopted by this group gives many lessons for those interested in community wellness teams. Taking account of the social, cultural and religious foundations of community life is important to provide culturally safe and competent care. Employment of staff who are representative of the ethnocultural background of the clientele, especially those who speak community languages, appears to be a critical variable. Mental health care needs to be

considered and provided holistically, and should not stop at simple symptom reduction. Other key elements include working in partnership with the community from the start and employing a model that recognizes the central importance of culture, religion and politics. The approach to adapting the ACT model to a cultural diverse community could readily be extended to other forms of mental health services and promotion strategies.

4.4. Critical ingredients and analysis

There is much commonality across the teams discussed above, although there are also important differences in orientation and composition. This is to be expected, because they come from a variety of sources and serve very different types of communities or populations. Some work in urban settings where there are various resources available; relatively few are designing specifically for rural or remote communities or for indigenous populations specifically.

Some of the teams focus their activity on providing care for high-risk individuals such as people with severe mental illness or substance use disorders. This in itself is a contribution to community wellness because the suffering and impairment of functioning associated with these severe disorders can have a deleterious effects not only on individuals, but on families and the whole community. The development of multidisciplinary teams is especially important given that people who have both severe mental illness and substance use disorder have had great difficulty accessing integrated services. People with such co-occurring disorders are often shunned both by clinics providing treatment for substance use disorders and by mental health services, which do not have the training or desire to work with dually diagnosed patients.

Other teams provide services for the groups described above, but also attend to individuals with problems that are not strictly considered mental health issues. These teams aim to reduce distress and suffering in individuals regardless of its source or manifestation. Their activities may include helping people involved with the criminal justice system, social welfare, domestic abuse, or with employment or housing. Services may include shelters and supports for people suffering domestic abuse or help navigating the criminal justice and welfare systems.

Many teams go beyond a focus on high-risk and suffering individuals, to provide health promotion and public health activities. This may include primary prevention activities such as organizing health fairs or promoting healthy eating and exercise. They may also encourage secondary prevention activities such as screening and immunization. In the area of mental health, these activities may include stigma-reduction activities, suicide awareness programs, and educational interventions to improve mental health literacy and appropriate use of mental health services. These interventions may be delivered through schools, churches, community centres, and local radio, TV or other media.

Community-level approaches to mental health promotion should be central, if community wellness teams are to live up to their name. The models reviewed and other literature also suggests that to be effective, teams must pay close attention to many Aboriginal specific issues at the population and individual levels. This starts with building strong partnerships with the local communities so that the teams are well-connected to the community and there is a sense of trust

and ownership of the team, based on local involvement in governance and control. Engagement of the community in building a wellness team is, in itself, a basic intervention.

There is evidence that cultural continuity is associated with mental health in Aboriginal communities (Chandler & Lalonde, 1998; Chandler, Lalonde, Sokol et al., 2003). Community wellness teams may thus work to enhance cultural continuity and bolster identity and esteem. The team may also attend to experience of historical loss, grief and trauma, which are pervasive issues many Aboriginal individuals and communities (Whitbeck, Adams, Hoyt & Chen, 2004). For example, many of the teams operating in Australia work to support collective identity and esteem among Aboriginal communities. They do this through both social and psychological interventions, for example facilitating land- and community-based activities and the transmission of traditional culture and values through groups and other programs (Tsey et al., 2007).

In terms of team composition, again there is variation, but the core members of the team usually include mental health workers, mental health nurses, addictions counselors and Aboriginal Mental Health Workers. The AMHWs are essential because their intimate knowledge of the culture and community gives the team the basic understanding of context and values needed for its work. However, the use of AMHWs must go beyond tokenism. Some reports find that Aboriginal paraprofessionals are used primarily as interpreters. A more engaged role is essential.

Other community resource people often included in the team include Elders, spiritual leaders, and traditional healers. Their presence can be essential for community engagement, mobilizing resources, and the development of grounded health promotion interventions. Other figures sometimes found in a community wellness team include psychiatrists, pharmacists, primary care physicians and other medically qualified personnel. However, these professionals are often in the background, consulted only when necessary. One problem facing people in community wellness teams is 'burn out' due to the constant demand for their time and expertise. This can be countered by ongoing training and support programs, as well as by giving appropriate compensation for services rendered (Edwards, Burnard, Coyle et al., 2000; Chur-Hansen, Todd & Koopowitz, 2004).

Community wellness teams appear to function best where there are comprehensive and easily accessible background services that enable the team to work collaboratively. These background services include: (i) organizational administrative, and logistical support; (ii) appropriate physical space and material resources to deliver services; (iii) adequate initial and ongoing culturally informed mental health training for team members; and (iv) comprehensive secondary and tertiary care services for consultation, training and support as well as referral of more challenging cases.

Optimal team functioning and sustainability depend on sound and secure financing. Many promising teams in Australia have had to be wound down due to lack of funding (National Rural Health Alliance, 2006). A team which is insecurely funded is likely to be demoralized and have high levels of staff turnover; this is obviously not an optimal situation. Administrative support both at the team level and within community and regional organizations committed to mental health services and promotion must work together with FNIHB or other responsible government agencies to ensure this ongoing funding.

In terms of administrative support, most teams have a project manager or an administrator who deals with the day-to-day logistics of the team. This individual may also be important in terms of factors such as updating medical records and keeping the office supplied with essential equipment.

In terms of space and accommodation, it is important that the team operates from a place that is hospitable and easily accessible to both staff and community members (Wieman, 2008). Rooms should be provided for private consultations as well as group meetings. Although having a dedicated centre can serve an important symbolic functioning, improving the visibility of wellness services, confidentiality issues should also be considered.

A critical factor affecting the performance of community wellness teams is the nature and quality of training and continuing education for staff (Bartik, Dixon & Dart, 2007). Training in team work is important, as well as in the mental health issues commonly faced by the team (DeBruyn, Hymbaugh & Valdez, 1988; Dell & Lyons 2007; Falloon & Fadden, 1993). Aboriginal mental health workers may need training in health, medical and counseling issues. This can be provided on and off site, or remotely through tele-education. Health professionals also need supplementary training in mental health promotion (since their education is usually focused on the assessment and treatment of psychopathology). They also need to acquire knowledge of Aboriginal cultures, history and social contexts essential for ethical, and respectful collaborative work. The curriculum developed by the Indigenous Physicians Association of Canada (2009) provides a good framework that can be adapted to the specifics of local culture, traditions and current concerns by working closely with community members, Elders and leaders.

In the community wellness teams discussed in this document, professionals often have to work in ways that challenge or extend conventional roles and boundaries both because of cultural issues but especially because of the small size of communities (Savin & Martinez, 2006; Simon & Williams, 1999). Minore and Boone (2002) note that prevailing professional attitudes tend to bring discipline specific approaches and discipline-centric training. Innovative training programs are needed to go beyond these rigid models and provide a basis for collaboration in what Ermine (2007) has called "ethical space." Team members can act as educators to each other, in a process that can also contribute to team building. Links with higher education institutions that provide accredited training in various domains relevant to the work of community wellness teams can be useful and contribute to the recognition and support of AMHW and other community helpers.

Another key factor in the effectiveness of Community Wellness Teams a success is the ready availability of secondary and tertiary services for those people suffering from problems which cannot be managed by the team itself. Teams in remote and northern regions can refer difficult cases to psychiatrists who can provide their services via telepsychiatry. If team members sit in on telepsychiatry consults, this can also play a vital educational role in helping them learn more about psychiatric diagnosis and treatment. Visiting clinicians can play a similar role and work closely with Community Wellness Teams to develop treatment plans and mental health promotion interventions tailored for specific individuals or groups in the community.

Most of the Community Wellness Teams we have described spend much of their time assisting people with substance use disorders and severe mental illness. These problems are important but many people in Aboriginal communities have other types of problems including suicidality, domestic abuse and physical health problems. As such, teams should have adequate secondary and tertiary services available to assist in severe or acute cases. Our review indicates that this is sometimes not the case. Community Wellness Teams will be most effective where there is a range of culturally appropriate and expert services to which people can be easily referred. To make efficient use of these resources, teams need to be trained to understand their own limitations, and to make appropriate referrals of severe cases.

Most of the initiatives involving "community wellness" do not address common mental disorders (e.g. mild or moderate depression or anxiety disorders). And, despite their name, most of these teams work with individuals rather than the community as a whole. Community wellness teams have also tended to shy away from political advocacy and community development, focusing on working through existing resources to help individuals and communities promote health.

Our review suggests that community wellness teams can operate successfully in all of the geographical settings outlined at the beginning of this document. We have assessed community wellness teams working in urban areas, remote and northern areas, as well as on reserves. All teams must be tailored to the specifics of the community and geographical configuration of the people being served.

It is also vitally important for teams tailor their services to the cultural values and contexts of the communities they serve. Every team discussed in this report that works with Indigenous peoples has tired in some way to adapt, transform or augment the 'western' biomedical model. Of course the integration of Aboriginal Mental Health Workers and Elders into the team can greatly contribute to adaptation and transformation, but it is not sufficient. Ongoing training of non-aboriginal workers is also important in this regard. In the Medicine Wheel approach to health common among Aboriginal groups, well-being is considered a consequence of harmony among the physical, emotional, intellectual and spiritual dimensions of experience but hr precise form this takes will vary with culture, community, and individual (Bartlett, 2005). Likewise harmony and balance at the community level is considered essential for health and well-being at the individual level (Stewart, 2008). Such an approach must be recognized and incorporated into the work of the team. This requires a critical rethinking of conventional approaches to health promotion to seriously engage Aboriginal ways of life and aspirations.

Issues of ownership and governance may be paramount in determining community engagement and project success vis-à-vis community wellness teams (Chandler & Lalonde, 1998; Macauley, Commanda, Gibson et al., 1999; Voyle & Simmons, 1999). Many of the models discussed were managed by a board or oversight committee that included a substantial number of Aboriginal members. These governing bodies made key decisions on the form, content, and delivery of the service model. They also made key decisions regarding hiring and other staff issues. In other words, the team was not simply parachuted in from the outside, and was not governed by distance bureaucrats following centralized diktats. A strong form of community ownership and accountability to the people being served is ethically sound and probably essential to ensuring team success.

As has been noted throughout this report, very few community wellness teams have undergone systematic evaluation. In fact, most of the case studies and promising programs we present have been subject to only an internal evaluation or produced a "progress report" as required by funding agencies. This is not surprising, given that community wellness teams are a relatively new approach to health services and promotion in Canada and elsewhere. Evaluation is critical for new and emerging programs where there is a limited evidence base. As such, it is vitally important that the implementation of any community wellness team initiative is accompanied by appropriate evaluation. In this chapter, we describe approaches to evaluation that can be used to assess the impact of community wellness teams.

Evaluation of policies, programs and interventions is crucial to confirm their effectiveness and identify factors related to successful implementation and outcome (Vandiver, 2009). Evaluation is conducted to determine if health interventions perform as planned, whether they have achieved their intended goals and objectives, and whether the program is justified in economic terms. Evaluations can be *formative* (concerned with improving the ongoing operation of a program), or *summative* (conducted at end of a program to elicit 'lessons learned' and thus benefit the same and similar programs in the future) (Raskin, Novacek, Bahlinger et al., 1996).

There is no gold standard to the evaluation of bundled psychosocial community interventions, especially those conducted with Aboriginal people (Thomas & Bellefeuille, 2006). Various approaches can be taken, and various processes and outcomes can be measured to assess ongoing performance and overall impact. In this section, we describe a variety of evaluation strategies that can be used to assess community wellness teams. Evaluation is best seen as an ongoing process involving an iterative loop, in which repeated measurements lead to better program planning and implementation.

5.1. Domains of evaluation

Evaluation of an intervention involves assessing program performance in various domains. Many of these domains are common across all evaluations, but others may be specific to a particular type of intervention. In general, a rigorous evaluation requires specifying the program objectives (goals), intended users of the evaluation, and the political context of the evaluation. The evaluation then consists of determining how the program's objectives have been (or are being) achieved in terms of several basic questions. Systematic evaluations are usually conducted by outside researchers, either consultants or university-based academics. This is considered optimal because such evaluators are independent and, ideally, unbiased in their assessment. However, increasingly, there is recognition of the importance of close collaboration and the value of collaborative evaluations that are built into programs through the methods of community-based participatory action research. These collaborative, partnership approaches to evaluation respect community values and protocols. The results they produce may be more valid reflections of local realities and more likely to be integrated into future practice (Macauley et al., 1999; Minore et al., 2004).

Below, we list common domains that are assessed during a health care evaluation, and some questions that can be asked to explore the performance of community wellness teams:

Relevance: Does the program meet essential needs, in terms of social and health policies and priorities? For example, is a community wellness team addressing issues of absolute concern to the community, for example youth suicidality?

Progress and implementation: Were the planned activities carried out in a timely manner? For example, is a community wellness team being formulated and implemented according to schedule?

Efficacy: Does the program work? For example, under ideal circumstances, does a community wellness team have a positive impact on key variables related to the desired outcomes?

Effectiveness: Does the program do what it is intended to do in actual practice, in terms of specific outcomes? For example, has a community wellness team contributed to better mental health outcomes among indicated groups and individuals?

Efficiency: Is the program cost-effective? For example does it deliver value for money?

Quality: What is the level of program performance in terms of: i) *structure*, that is the setting in which care occurs, which may involve material resources (facilities, equipments, finances), human resources (staff number and qualifications) and organizational structure; ii) *process*: what the program actually does, i.e., specific services it delivers, to whom, and to what extent; and iii) *outcome*: the effects on the health status of the population served.

Coverage: What proportion of the target population is reached? This reflects issues of accessibility, availability and acceptability. For example, does a community wellness team have a broad reach and penetration, including those in geographically isolated communities?

Impact: What is the overall effect on health status of the population, or in an even broader sense, on equity, social justice, and economic development? For example, is a community better off in health and well-being outcomes after a community wellness team has been implemented?

Conducting a full evaluation using all the above domains and asking all the above questions would be time-consuming and costly. Real-world evaluations of community wellness teams could focus the most salient domains for evaluation in relationship to the specific program objectives. Often, evaluators choose questions which can be most easily answered through routinely collected statistics and data. This can be done in collaboration between professional evaluators and community members to ensure community-relevant questions are asked during the evaluation.

5.2. Common Models of Health Services Evaluation

In the field of health services research, three overlapping models of evaluation are commonly used, often in combination (Young, 1998):

1. *Clinical audit*: This involves comparing clinical procedures for individual patients against normative standards (such as treatment guidelines, or peer review). When focused on consecutive cases involving the same clinical problems, a clinical audit closely approximates a research project, the distinction being that comparison is made against the guidelines, not against a control group. In the case of community wellness teams, this would mean comparing care received by patients on the team with official clinical guidelines regarding best practice for the population under study. Since these do not exist at present, establishing such guidelines would be an important task for future ongoing evaluation of programs.

2. *Monitoring*: This involves routine or special collection of data that can subsequently be used as part of comparative hypothesis testing. Such databases can be used as sampling frames for clinical audits or more focused research. Databases include traditional medical records, linked records systems, and health information systems. Individuals or communities being serviced by community wellness teams can be monitored in this manner to build up information for evaluation. This can be part of quality assurance and program development.

3. *Focused research*: This may be quantitative, qualitative, or a mix of the two:

   Quantitative methods include the *randomized controlled trial* (RCT), *quasi-experimental study*, *cross-sectional* analytic study, *case-control study*, the *cohort study* and *pre-post study*. According to most regulatory bodies, the RCT offers the highest level of evidence, and is considered the gold standard measurement of efficacy. However, RCTs are very difficult (both practically and ethically) to conduct with bundled psychosocial community interventions such as community wellness teams. A quasi-experimental study involves comparing various interventions to which people have not been randomly assigned. The case-control study is versatile and especially suitable to evaluating programs whose intended impact is on outcomes with a low prevalence (e.g. suicide). Case-control studies are widely used in evaluation studies. Cross-sectional studies are conducted at one point in time with a group of people selected for a specific purpose in order to examine an association between an exposure and an outcome (e.g. smoking and lung cancer). Cohort studies follow a group of people over time and allow for multiple outcomes and can help address questions of causation, but are expensive and time-consuming. A pre-post study examines the same outcomes in a group of people who have not been randomly assigned to an intervention before and after receipt of the intervention. A *meta-analysis* pools the results of several independent studies, and generates a numerical summary (such as odds ratio) to demonstrate a significant effect for an intervention. A simple quantitative evaluation can also be conducted using frequency counts of key outcomes, for example the number/proportion of people using a service. This is usually related to a benchmark figure from the existing literature, or historical records of previous service use.

Qualitative methods emphasize understanding social phenomena in their natural settings, giving due emphasis to the meanings, experiences and views of participants. The methods include *participant observation*, *interviews* (semi-structured, in-depth, key-informant, ethnographic), the use of *focus groups*, use of *archival materials*, *participatory action research, case studies* and use of *expert opinion* panels (e.g, the Delphi method). Qualitative methods can be used during and/or after the implementation of an intervention to learn about various dynamics and perspectives on the intervention. Qualitative research may be especially suitable to Aboriginal communities as it collects knowledge and experience in the form of narratives, and is not associated with past colonial practices of enumeration for the sake of government and bureaucratic control.

Mixed methods studies refer to research that combines both qualitative and quantitative methods. This is becoming a very common form of service evaluation as it gives two perspectives on the issue under study. Qualitative results can illuminate quantitative results, and vice versa.

In terms of evaluating community wellness team approaches, all of the above described approaches can shed light on performance. Pre-post designs with some auxiliary qualitative research may be most applicable given the current, limited state of the literature. Qualitative ethnographic methods can investigate the process of implementation, identify potential mechanisms of action, and can be used to generate ideas for outcomes to be studied in a subsequent pre-post quantitative study (Aronson, Wallace, O'Campo et al., 2007). Patient outcomes such as symptom severity could be measured before and after their care has been assigned to community wellness teams. Additionally outcomes important to the community (e.g. social integration) could also be measured to assess impact of the intervention.

Although evaluation research may be conducted purely for purposes of quality assurance and fulfilling the reporting requirements of a granting agency, with any new intervention there is an ethical imperative to determine what works and what is potentially ineffective or even harmful. At the same time, evaluation research must be conducted in a manner that is ethically sound and that respects Aboriginal values and protocols. The CIHR (2007) has set out ethical guidelines for research in Aboriginal communities.

It is essential that communities be actively engaged in any process of evaluation for ethical reasons as well as to improve its validity and increase the knowledge translation of uptake of any findings. There are a variety of strategies for engaging and mobilizing the community based on work in developing mental health services in indigenous communities (e.g. Eley et al., 2006; Novins et al., 2004; Queensland Health, 2005).

Community-based participatory research is particularly consonant with Aboriginal values and can contribute to an evaluation process that insures that local voices and perspectives are heard and that protects collective well-being and strengthens community autonomy (Fletcher, 2003; Macauley et al., 1999; Potvin, et al., 2003). CPAR involves researchers (usually from the university sector) working closely with community members to plan, carry out, analyze and disseminate the results of a research project such as a program evaluation.

CPAR engages community researchers at every stage of the evaluation study beginning with the definition of goals and the design of the study. Community partners have a sense of what outcomes are important from the local perspective. For example, Aboriginal communities may be interested in how community wellness teams enhance social harmony. CPAR has been used as a way to give voice to clients in mental health services research, ensuring that these voices are heard by policy makers, planners and service providers. Community members are well placed to understand issues of implementation, acceptance and barriers to utilization. The CPAR partnership can also provide appropriate community forums, media and avenues for dissemination of health promotion materials and evaluation result (Macauley, Commanda, Gibson et al. 1999; Tsey, Wilson, Haswell-Elkins et al., 2007).

5.3. Important Steps in Program Evaluation

In evaluation of a mental health intervention such as a community wellness team, the first step is to identify the purpose of the intervention. This leads directly to listing the primary goals of the service. A next step is to decide on whether the intervention as a whole, or some of its specific components directed to particular goals will be evaluated. Such decisions depend on stakeholder priorities and the state of existing knowledge (which determines what is an open question that needs more evidence), but must also consider pragmatic constraints including available resources, time and cost, as well as existing methodological tools and benchmarks.

Mental health care goals can be general or more specific operational goals. General goals that are often measured when evaluating a mental health intervention may include the following (Wiley-Exley, 2006; Wing, 1996; Knudsen & Thornicroft, 1996):

(i) reduction and containment of psychological and physical impairment associated with psychiatric illness;
(ii) effective treatment of mental illness in which patients recover more rapidly and completely than they would without treatment. Recovery encompasses the clinical, functional, existential and social factors previously listed. Specifically, these often include symptom reduction; prevention of disabilities; improved work and social roles functioning; and improved quality of life (QoL) for patients, family and caregivers;
(iii) prevention of the incidence or recurrence of specific mental health problems;
(iv) promotion of community and individual wellness and capabilities.

Specific goals are usually worked out on the ground by the project team. These may include numbers of people served, staff turnover, outreach to marginalized or minority groups, and the like. Murphy (1992) introduced a further category of "*visionary goal*s," rooted in social ethics. For example, a visionary goal of a progressive mental health service might be to enable individual to have fulfilling lives, by promoting and providing for basic needs of life, including home, employment, relationships, and recognition of individuals' rights as citizens. The idea of visionary goals fits with Aboriginal notions of holistic health and may be important to measure in studies of community wellness teams.

Many of these visionary goals have been taken up by the recovery movement in mental health. Recovery is increasingly recognized as the goal of a transformed, contemporary mental health system (Ralph & Corrigan, 2005). Indeed, the Mental Health Commission of Canada (2009) has adopted *recovery* as a key principle of its framework for a mental health strategy. The development of measures assessing the recovery-orientation of mental health services is still at an early stage, but some emphasis is put on the existence and implementation of psychosocial interventions such as supported employment or supportive housing that allows people to live in dependent lifestyles. These could be expanded to include Aboriginal values about communal living and integrated into an evaluation that included visionary goals.

Once the key goals and objectives have been specified, the next step is choosing appropriate level of analysis and corresponding indicator measures of outcome. This goes hand-in-hand with choices about the design of the evaluation and plan for analysis of the data. Measures can be directed to the level of the individual, the health service system or the community as a whole (Knudsen & Thornicroft, 1996). Each level raises specific measurement and logistical issues.

Evaluation can occur at the level of the individual, the health service system or the community as a whole. In the following sections, we discuss each in turn.

5.4. Individual-level Outcome Measures

Measuring individual-level outcomes is important as any intervention ultimately aims to enhance health and reduce suffering and distress in individuals. In conventional psychiatric research, a distinction is often made between 'hard' and 'soft' outcomes (Thornicroft, Brewin & Wing 1992). Hard outcomes include factors such as hospitalization, symptom severity, medication adherence, service utilization, self-harm/suicide attempts and the like. These outcomes can usually be enumerated by observers with high levels of inter-rater reliability. These measures are usually deemed most important by policy makers, health economists, and health services researchers. Soft outcomes include factors such as quality of life, community integration, spirituality, empowerment, social support and the like. These outcomes are more difficult to define and measure and are avoided by some mental health researchers.. However, these softer outcomes are often critically important domains of interest from the point of view of the community under study (Tsey, Wilson, Haswell-Elkins et al., 2007). This may especially be the case in Aboriginal communities, where the ethos is generally more holistic and spiritually oriented than that of the contexts in which most health services research occurs. Given the prominence of the new recovery paradigm in mental health, new outcomes that move beyond the soft/hard dichotomy are emerging. These includes obtaining and maintaining secure housing, obtaining and retaining gainful employment, and factors related to spirituality, social life, and other existential domains of experience.

To chose appropriate outcomes for evaluating wellness teams in researchers can work in partnership with community members to identify which life domains are important to change in order to enhance individual and community health (Macauley, Commanda, Gibson et al., 1999). The Medicine Wheel domains of physical, emotional, mental, and spiritual provide a way to organize and explore more specific facets, as do the four domains of clinical, functional,

existential, and social discussed in the recovery literature. These domains can be applied to the life contexts of people with or without mental illness, to understand the dimensions of individual mental health and assess the impact of interventions on a community or population.

There are literally hundreds of instruments designed to measure various aspects of individual-level outcomes related to mental health, well-being and other similar constructs. However, very few have been validated in Aboriginal contexts. Evaluators should choose reliable measures that have been used in diverse settings and devote some effort to local validation. Below we list some of the common measures at the individual level used to assess various aspects of mental health and related constructs. This gives an example of the type of measures that can be used in any evaluation of the impact of community wellness teams on individuals:

1. *Symptoms of distress*: A wide variety of measures of symptoms of distress are available, which tap general distress or aim to identify specific dimensions of mood or bodily symptoms. These may be self-report or rated by clinicians. The General Health Questionnaire (GHQ; Goldberg, 1978), the Center for Epidemiologic Studies Depression Scale (CES-D; Somervell et al., 1992; 1993), or the K-6 (Furukawa et al., 2003) are examples of self-report measures frequently used in community samples. Such measures can be used to assess a very broad range of common emotional, psychological and bodily symptoms that are usually nonspecific and associated with many different sorts of problems. These include anxiety, depression or life difficulties that may or may not reach a threshold requiring mental health services. Scores from individuals can be aggregated to the community level to give a rough assessment of community wellness. Scales measuring more specific types of symptoms, developed for clinical populations may be useful for assessing the outcome of specific clinical interventions. However, outcomes should be measured across multiple dimensions since interventions may have broad effects or cause improvement in some symptoms and worsening of others.

2. *Psychopathology*: Psychiatric disorders go beyond symptom measures because they involve particular configurations of symptoms and behaviours that co-occur in a predictable way with specific prognosis and response to treatment. Diagnostic interviews administered by clinically trained personnel, such as the Structured Clinical Interview for Diagnosis (SCID; First, 1997) or the Schedule for Clinical Assessment in Neuropsychiatry (SCAN; Wing, Babor, Brugha, 1990) are common instruments for assessing psychopathology. There are also highly structured interview protocols that can be administered by trained lay people, like the Composite International Diagnostic Interview (CIDI; Wittchen, 1994). These are structured methods for determining the presence of symptoms indicating a specific psychiatric disorder according to conventional diagnostic criteria (e.g. DSM-IV-TR and ICD-10). Such instruments may be more useful for identifying needs for specific types of services and measuring the outcome of indicated interventions.

3. *Level of functioning or disability*: This domain describes functional impairment and disability in individuals within a community. Functional impairment is both a cause and a consequence of mental illness. As stated, the recovery movement emphasizes functional recovery as one of the key domains for people with severe mental illness. Common instruments used to measure functioning include the activities of daily living scale (ADL;

Nouri & Lincoln, 1987), the SF-36 (Ware & Sherbourne, 1992) and the global assessment of functioning scale (GAF; Jones, Thornicroft, Coffey et al., 1995). Because they reflect actual impairment or functioning, these measures are closer to identifying need for services and are more useful for evaluation of service outcomes. Impairments in functioning have important individual and social costs, hence the social and economic impact of intervention can be indirectly assessed through these measures.

4. *Quality of life or Wellbeing*: These are multidimensional measures that aim to assess the individual's wellbeing in a holistic way. Dimensions commonly include physical wellbeing, psychological wellbeing, social support, community integration, social relationships, and spirituality. These tap into the aspects of existential and social recovery spoken of previously in this report. Many of these concepts will resonate with Aboriginal communities. One example of a widely used scale in this regard is the World Health Organization Quality Of Life Scale (WHOQOL, 1998). The WHOQOL was explicitly developed as a measure that would recognize cultural values as a central aspect of quality of life (Skevington et al., 2004; WHOQOL Group, 2006). There is no well-established, valid and reliable measure of wellbeing specifically for Aboriginal populations **(**Henderson, Robson, Cox, et al., 2007; Kowal, Gunthorpe & Bailie, 2007).

The dilemma with all of these standard measures is that few have been validated with indigenous populations. Without such adaptation and calibration, there is a risk that measures will significantly over- or under-estimate the prevalence or seriousness of particular problems, giving a distorted and incomplete picture of needs, strengths and outcomes (Beals, Manson, Mitchell & Spicer, 2003; Haswell-Elkins, Sebasio, Hunter & Mar, 2007). Qualitative research can provide accurate description of local realities but may be difficult to generalize. Developing local culturally valid quantitative measures requires a large investment of time and resources and may still not allow comparison with other communities (De Jong & van Ommeren, 2002; Canino, Lewis-Fernandez & Bravo, 1997). The solution is to use a combination of measures standardized on the general population with locally devised or adapted measures that capture modes of expression of distress and dimensions of outcome of crucial importance to the community. This allows both comparison across settings and identification of unique issues for the community.

5.5. Service System Evaluation

At the service system level, various domains of interest can be measured. Again, the choice of measures should be governed by the objectives of the program and the evaluation. Resources will influence the scope of the evaluation. The design is best done in collaboration with service providers, users and community members. Below we list some commonly measured domains and some of the modes of accompanying investigation:

1. *Comprehensiveness of care*: This maps the extent to which mental health needs in the population are covered by the system. It must be measured against current standards for a comparable population and/or systematic assessment of unmet needs. One potential task for community wellness teams is to address the lack of comprehensive care for Aboriginal people in rural and remote areas. Assessing the extent to which such teams

meet this need for services (or enable existing services to function better) is critical to achieve community wellness in ways that are inclusive of the most vulnerable individuals in the community.

2. *Continuity of care*: This refers to the degree to which the service system links care in a seamless whole so that clients receive appropriate follow-up and continuity across different parts of the service system. Again providing integrated services would be an aim of any community wellness team.

3. *Client satisfaction*: This is obtained through surveys or qualitative research and may be targeted to specific aspects of care. Simple questions can be used to assess consumers' specific needs and experiences concerning mental health services (Blankert & Hazem, 2002).

4. *Volume of service utilization*: This could include factors such as days of hospitalization or number of outpatient visits or numbers of people receiving a prevention or promotion program. This reflects the productivity of the system and is important to assess overall efficiency.

5. *Rate of re-hospitalization*: This is a specific measure important for severe mental illnesses in which hospitalization may occur. For remote communities, avoiding hospitalization or transportation outside the community for other specialized services through local interventions may be a useful outcome measure provided there is assurance that people are receiving a comparable alternative form of care.

Systematic evaluation of mental health services requires record linkage to track individuals across different services and sectors. Focused evaluation of a specific program or intervention is possible without record linkage, but evaluation of a whole mental health service system will be limited or misleading without record linkage. Evaluation of a whole mental health service system is best done using a psychiatric case register, or at the least, linked uniform reporting systems, in which the entire spectrum of care for a cohort of individuals is assessed, even if this does not cover the whole population. In the case of rural or remote Aboriginal communities, this type of assessment may be easier insofar as individuals receive most or all of their care within the community. However, the segmentation of care that often results in social service or community worker records separate from nursing station or medical records may impede getting a complete picture of service use. Clinical records also do not generally record the use of informal, lay, or religious sources of help and healing that may be crucial resources for many individuals.

Evaluation of the impact of community wellness teams on the health system should consider at least two sets of basic goals: (i) the primary prevention of mental illness and promotion of mental health assigned to such teams; and (ii) the role of the team in meeting the mental health service needs of the community. Prevention and promotion might eventually lead to lower rates of service utilization but their initial impact is likely to be an increase in service needs as individuals become aware of the potential value of mental health interventions.

5.6. Community Evaluation

One way of measuring community wellness is to aggregate individual-level data to produce an average indicative of wellness at the community level. Aggregating individual-level data collected through existing systems is low-cost way to assess community wellness. Potential indicators of community wellness include: (i) economic level and activity; (ii) health status; (iii) educational attainment or school retention; (iv) family wellbeing; and (v) measures of social cohesion, support, and connectedness, often termed *social capital* (Kirmayer, Sedhev, Whitley, et al., 2009; Mignone & O'Neil, 2005).

Economic indicators that can be utilized in this way include factors such as the proportion of able-bodied adults employed, average household income or levels of home ownership. However, this approach ignores the economic structure of reserves and remote communities, as well as the importance of unpaid activities (e.g. hunting, fishing, trapping, ceremonial activities, care giving) and activities related to spirituality, which may be central to community wellness.

In terms of health, psychiatric epidemiological methods may be used to measure the extent of a mental health problem, for example substance abuse or depression, in the community. Both physical health and mortality may also be indirect measures of community wellness, although it is clear that wellbeing is more than the absence of ill health.

Educational indicators of community wellness might school retention rates or the percentage of students graduating from high school. Other measures could include percentage of individuals entering higher education or completing college degrees. Academic performance has been viewed as a measure of resilience among Aboriginal youth but may be associated with trade-offs in other domains of social functioning (Burack, Blidner, Flores & Fitch, 2007: Iarocci, Root, & Burack, 2008). A focus on formal schooling, rather than on education in its broadest sense, does not capture the range of learning experiences important in Aboriginal communities. For example, some Aboriginal communities place great value on education by participation in traditional subsistence activities, which includes family-centred activities and opportunities for learning from Elders through storytelling, modeling and mentoring.

Social and familial indicators can also be used to measure for community wellness. This may include such factors as the divorce rate, the number of single-parent families, rates of domestic abuse or of children under supervision of child welfare authorities. However, the significance of these indicators depends crucially on social, cultural and political factors. Configurations of the family in Aboriginal communities may differ from Euro-Canadian notions of the nuclear family. Cohabitation, custom adoption and extended families are common in many communities. As well, the involvement of outside agencies, like child protection authorities, is complicated by these differences in norms and values (Lavergne et al., 2008). Crime statistics can also be used as proxies for community wellness but face similar dilemmas in terms of the interaction of outside agencies and the judicial system with Aboriginal communities.

In terms of social capital, many indicators may be viewed as proxies for community wellness. including levels of trust, participation in community activities, social support, and social networks. These indicators can be collected through self-report measures (Von Kemenede,

2003b). Some of these indicators, however, do not fit the contexts of Aboriginal communities and need to be adapted considering issues of culture, geography and social structure (Mignone & O'Neil, 2005). One instrument currently applied to First Nations across Canada is the First Nations Community Well-Being (CWB) index (McHardy & O'Sullivan, 2004). Developed by Indian and Northern Affairs Canada (INAC), the CWB index uses information on education, labour force participation and employment, income, and housing from the Canadian Census to derive a single indicator. Although it only reflects part of what contributes to well-being in Aboriginal communities, the CWB does provide a baseline measure for comparing the impact of wellness teams on Aboriginal communities over time.

Chandler and Lalonde (1998, 2008; Chandler et al., 2003) identified indicators of "cultural continuity" that may be related to community wellness, either as mediators or as valued outcomes in their own right. Most of these relate to the degree of control people exert over their civic lives, including: 1) positive engagement in securing legal title to traditional land; 2) effective self-government; 3) local control of social services, including education, police, fire and health facilities; 4) community programs to preserve and promote traditional practices; 5) the level of traditional language use in the community 6) involving women in local governance; and 7) taking control of child and family services. These indicators can be assessed by simple questions to local administrators or by consulting existing databases. The specific indicators need to be adapted to the social and political situation of Aboriginal peoples in different geographic regions (Kirmayer, Sedhev, Whitley et al., 2009).

The impact of community-based programs themselves should be assessed from the point of view of multiple stakeholders. Community members may have quite different perspectives on the value of interventions that those who are directly involved with implementation (Lempa et al., 2008; Santhanam et al., 2006, 2009). Community members are more likely to emphasize the importance of recognition, engagement, dialogue, and power-sharing or transfer.

5.7. Economic Evaluation

All programs and practices need to be evaluated for their economic efficiency. Economic appraisal involves the comparative analysis of alternative courses of action in terms of costs and consequences. Costs refer to the economic resources consumed or expended by the program (i.e, inputs) and consequences to health and other psychosocial outcomes (i.e. outputs). Costs are usually expressed in units of currency. There are three types of consequences commonly measured, which distinguish three basic types of economic appraisal:

1. Cost-effectiveness analysis (CEA): costs are compared to health effects, in units of mortality, morbidity, or some health status measure.
2. Cost-benefit analysis (CBA): consequences are expressed as economic benefits, in units of currency, which can then be directly compared to costs.
3. Cost-utility analysis (CUA): utility is the preference for or desirability of a specific outcome. In the health context, it is the value or worth assigned to a level of health by an individual or a community

CBA allows comparison of totally different fields of activity, e.g. building schools versus clinics, CEA and CUA tend to be used to evaluate different strategies within the same sector, e.g. providing medications or psychosocial interventions for common mental disorders.

5.8. Summary

The limited level of community participation in previous evaluation studies has made communities less supportive of evaluation research because they lacked a sense of ownership and were not motivated to engage these programs (Reading et al., 2005). Most of the services reviewed were based on needs defined by professionals and planners from the perspective of current mental health theory and practice and not the needs expressed by communities (Clellan et al., 2007). A community-based participatory action approach to program implementation and evaluation can increase the prospects for meaningful outcomes.

The basic steps in evaluating community wellness teams can follow the established frameworks for public health programs (Perales, 2007): (i) engage stakeholders (in this case, including team members, other health practitioners, community workers, clients and families as well as policy makers and planners); (ii) develop a detailed description of the program as it is actually functioning (this includes the processes of staffing, training, implementation, and service delivery); (iii) focus the evaluation on key elements chosen on the basis of their relevance to stakeholder priorities and to filling the gaps in existing evidence; (iv) gather evidence in a rigorous way, using external evaluation and triangulation with multiple methods; (v) interpret the evidence systematically to establish empirically justified conclusions; and (vi) insure knowledge transfer to community stakeholders and others through the use of varied, culturally appropriate methods.

Evaluation of community mental health programs most commonly involves assessing the impact of an educational intervention with a pre- and post-training evaluation. Studies often show some increase in the participants' knowledge and confidence in using knowledge; skills and confidence in communication among participants; confidence to discuss issues related to their training. With the exception of some work on suicide prevention, no real longitudinal or follow up outcome studies have been conducted in indigenous communities. Research is needed on the process of implementation, on the mechanisms or effectiveness, and on a wide range of relevant outcomes.

In this concluding chapter, we discuss the key findings of the literature review and analysis. We begin with the basic issues of equity and access to care and then outline recommended programs and priorities based on the material presented in the previous chapters of this report.

6.1. Mental Health and Human Rights

Mental health can be viewed as a human rights issue (Herrman, Saxena & Moodie, 2005). This is especially clear for indigenous peoples for whom many current problems can be traced to the impact of colonization, forced assimilation, residential schools and other state practices that would now be understood as clear violations of the principles of dignity, safety and freedom that underlie human rights principles and legislation (Hunter, Milroy, Brown et al., in press). Human rights extend beyond the basic protections of individuals and equity in access to services and opportunities, to include the possibility of maintaining one's cultural traditions and community identity (Niezen, 2003).

Community wellness teams are well placed to ensure aspects of cultural traditions and community identity are incorporated into health care delivery, and thus could be considered part of broader trends to respect human rights and ensure equity and justice in health care for Aboriginal people. Of course, effective mental health services depend on recognizing the cultural and social contexts of wellbeing for individuals and communities (Gone & Kirmayer, 2010; Kirmayer, in press). Both to insure an effective response to health care needs and to support the recognition of collective identity and maintenance of values and traditions, mental health services must take culture and history carefully into consideration. Community wellness teams, appropriately tailored to context can play a key role in this response.

In a just society, Aboriginal peoples would have equal access to mental health services and enjoy health and wellbeing comparable to the rest of Canadians. However, there continue to be substantial disparities in the health of the Aboriginal population compared to the general population (Adelson, 2005; King Smith & Gracey, 2009; Waldram, Herring & Young, 2006; Reading, 2009). Although this reflects issues that go well beyond mental health, there are significant gaps in the availability of mental health services for much of the population. The delivery of care is affected by a series of problems specific to Aboriginal peoples:

(1) complex jurisdictional arrangements that result in significant gaps in coverage and ambiguities or conflicts about responsibility;

(2) the diversity of Aboriginal communities in terms of culture, language, geography, lifestyle and the scale and configuration of communities;

(3) the elevated prevalence of specific types of problems, like suicide or substance abuse;

(4) the link between mental health problems and the history of historical trauma stemming from the impact of colonization, sedentarization, forced assimilation and residential schools; and

(5) the central importance for communities of maintaining their identity, values and traditions and directing their own lives.

It is evident that community wellness teams could be well-placed to address some of the above problems, as well as harness the strengths of Aboriginal communities. They can be tailored to the culture, language and history of the people being served. They can help transcend service seams and gaps (for example between addictions and mental health services). They can target their activities at the prevention and treatment of the most severe problems (e.g. suicidality or substance abuse). Through narrative and community empowerment approaches, they can address issues of identity, culture and historicity.

Community mental health received much attention in the 1960s and 70s during the era of psychiatric deinstitutionalization (Essock, Drake & Burns, 1998). Interest waned in the 1980s and 90s in the wake of economic pressures and the increasing focus on biological research and treatments in psychiatry. Community approaches in psychiatry have often been limited to specialized services like assertive community treatment teams for people with SMI and school-based programs for children and adolescents. However, community approaches have continued to be central to public health and primary prevention of specific problems like violence, substance abuse, or suicide. The rising costs of tertiary care, the limited effectiveness of biomedical approaches to mental health problems, and the need to address the roots of mental health problems have all encouraged serious reconsideration of the role of community mental health and mental health promotion across the world (Mrazek & Haggerty, 1994).

A community approach to prevention also fits well with the growing recognition of the importance of social determinants of mental health (Wilkinson & Marmot, 2003: Mignone & O'Neill, 2005; Anderson, Baum & Bentley, 2007). In particular, the fact that social and economic inequalities in society are associated with poor health points to the need to address community-level issues that contribute to the significant health disparities between Aboriginal peoples and the general population (Adelson, 2005; Smylie, 2008; King, Smith & Gracey, 2009). Community wellness teams that take an active approach to primary and universal intervention may be most successful in helping address these issues. It should be noted that many of the community wellness teams discussed devote much of their activity to tertiary prevention or treatment, even when their philosophy or mission statements emphasize primary and secondary prevention. Resources must be allocated and systems developed to insure adequate basic mental health services to allow community wellness teams to engage in primary and secondary prevention through community development and cultural activities.

A wide variety of services have been offered as part of indigenous community mental health programs, including: direct clinical counseling services; peer support groups; conducting public health interventions aimed at improving mental health literacy; follow-up of discharged patients; and continuing care (McCormick, 2008; NAHO, 2008b; Novins, Fleming, Beals et al., 2000). Some of these programs target specific groups such as youth, elderly, people in rural/remote

areas, people bereaved by suicide and people with mental disorders. Other programs target domains such as deliberate self-harm; problem solving; suicide prevention and behavioral strategies to deal with violence and adolescents. Community wellness teams are well placed to address many of these issues. If adequately trained and supported, they can provide case management, counseling, and other rehabilitative programs for people with SMI or substance use disorder. They could also provide socially oriented services for people with CMD or other troubled groups such as at risk youth. These can be tailored to the specifics of the community under study. A great strength of community wellness teams is that they are flexible in terms of composition and deployment. They can involve a variety of professionals, community workers and trained lay people. They can be located in communities or regionally and deployed in response to individual or community crises. They can also work proactively to promote and enhance community health.

6.2. General Principles Underlying Community Wellness Teams

Based on the preceding literature review and analysis, in this section we outline some general principles relevant to the design, composition, implementation and governance of community wellness teams.

1. *Accessibility*. Aboriginal peoples should have access to comprehensive mental health services comparable to the rest of the Canadian population, wherever they live. At present, many Aboriginal people in rural and remote areas do not have adequate access to mental health services. Community wellness teams could well meet some of the mental health needs of this population, especially in conjunction with other interventions such as telepsychiatry and visiting or liaison consultation services. Community wellness teams in major urban centres are also needed to ensure that Aboriginal people living in urban settings do not get lost in jurisdictional ambiguities and disputes, and receive appropriate services.

2. *Cultural Safety*. The literature on good practice indicates that it is critically important for mental health services to be provided to Aboriginal people in a culturally safe and appropriate manner, both through supporting the use of traditional healing approaches and ensuring that mainstream mental health services are delivered in a culturally safe and competent manner. Specific issues reflecting each community's social, cultural and historical context must be addressed. The integration of Aboriginal mental health workers into the team is necessary but not sufficient to ensure that these contextual issues are addressed. All members of the team need training in the ethical, conceptual and pragmatic issues of integrating culture into mental health services and interventions.

3. *Community Engagement*. Programs work better when individuals and communities choose them and contribute directly to their development. As such, community wellness teams should not be imposed on communities from outside with no local partnership and consultation. The most effective teams will result from intense community collaboration and involvement in terms of team governance, composition, activities and goals.

4. *Diversity.* Because of the diversity of cultures, communities, populations, settings and individual needs, one model or approach will not suffice. As such, community wellness teams should be tailored to the specific diversity of the communities they serve. This can best be done through the involvement of Aboriginal mental health workers and community members in team governance. Communities can be presented with a range of options, organized according to major goals (with several alternatives within each category) so that they can choose the approaches that fit best with their needs, goals, and resources. This should also allow a place to identify new, emergent or specific local needs not already included in the options.

5. *Evidence-Based.* Effective community wellness interventions must be based on the best available evidence. This means involving academic and professional experts in the process of team design, implementation and ongoing evaluation. Clinicians and researchers with experience working for Aboriginal communities can be engaged as consultants and evaluators on projects. Research and knowledge exchange should be supported on basic mental health and community issues needed to develop approaches that are culturally appropriate and effective.

6. *Training, Recruitment and Retention.* Recruiting and retaining qualified professionals and Aboriginal mental health workers are key issues for the success of the team. Every effort should be made to recruit Aboriginal professionals and community workers. This involves building capacity through new training programs, continuing education and support for community mental health workers. Retention of trained workers in remote and rural settings can be improved both by appropriate training settings (located in or near communities) and by building regional and national peer and professional networks that provide support and opportunities for continued learning.

7. *Responsiveness.* The orientation and activities of the community wellness team should be responsive to changing circumstances in the community. Needs assessments can be conducted before a team is implemented and its goals and interventions tailored to meet local needs. Understanding the context and conducting service mapping to avoid duplication are important parts of such needs assessment. Ongoing needs assessments can identify changing circumstances and allow re-orientation of wellness teams in response to emerging needs.

8. *Sustainability* must be addressed from the start. Pilot projects developed with no prospect of continuing if they are successful may cause harm by raising expectations or leaving individuals in mid-stream. This is a common failing of projects in Aboriginal mental health. If community wellness teams are to meet their full potential, sustainability will be essential.

9. *Collaboration.* Partnerships with other agencies, institutions, and programs are essential to build strength, consensus, synergies, and sustainability and to insure integration and continuity of care of individuals across services and programs. Community wellness teams must be meaningfully networked into primary, secondary and tertiary care networks. These should also be a backdrop of supportive services (for example telepsychiatry and continuing education) that ensures teams are appropriately supported.

10. *Evaluation* is crucial for all programs to learn about effectiveness, as well as to identify issues of development, implementation and maintenance. While employed external evaluators to reduce bias, these evaluations can best take the form of community-based participatory action research, so that community members and academics work as partners to ensure a methodologically and ethically sound evaluation.

6.3 Areas of Focus for Community Mental Health Teams and Wellness Promotion

There are several recent reviews and compendia of mental health promotion programs that summarize promising programs that have some evidence base (Cohen, Chavez & Chemimi, 2007; 2007; Herrman, Saxena & Moodie, 2005; Lightburn & Sessions, 2006; O'Connell, Boat & Warner, 2009). Mental health promotion can target the whole population, vulnerable or at risk groups, or individuals already dealing with mental health problems. The main sites for mental health promotion programs are home, school, workplace, primary health care and the community as a whole (Barry & Jenkins, 2007). Examples of individual-level mental health promotion activities with some evidence-base include: the Illness Management and Recovery Program (Gingerich & Mueser, 2005, p. 397-398); Wellness Recovery Action Plan (WRAP); manualized self-management (Copeland, 2002)[19]; and integrated treatment of substance use with motivational interviewing (Miller & Rollnick, 2002; Masotti, et al. 2006). At the interpersonal level, programs include: various forms of peer and family support (Clay, 2005; www.nami.org) and family psychoeducation (Lukens & MacFarlane, 2004). At the community level, mental health promotion and prevention programs include: supported employment; workplace health promotion; and media advocacy and stigma reduction campaigns (Johnson, Grossman & Cassidy, 1996; Vandiver, 2009). These require varying levels of expertise from basic (e.g. self-management and peer support) to highly skilled (e.g. motivational interviewing).

Few of these programs directly address indigenous peoples but many can be adapted for use in Aboriginal communities by wellness teams with proper resourcing and academic support. The most common wellness focused health promotion programs for individuals include: client and family education; targeted behaviour change (e.g. smoking cessation); wellness and lifestyle programs (exercise, diet, social activities); medical and psychological self-care; and workplace-related activities (Vandiver, 2009, p. 39). Mental health promotion at the level of systems and communities includes: programs to increase participation in community activities; to strengthen collective empowerment through insuring the political voice of the community; integrating primary and mental health care; integration primary and mental health care; and intersectoral and interagency collaboration. With appropriate cultural adaptation, these are all applicable to indigenous peoples in urban settings, but they may require additional rethinking to fit the contexts of life in rural and remote communities. For Aboriginal communities, there are specific demographic, social and political realities that are relevant for the organization and goals of mental health teams; these include: the youthfulness of the population; the importance of local control; and the centrality of cultural identity and continuity to collective wellbeing.

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[19] Copeland, M.E. *Developing a recovery and wellness lifestyle: A self-help guide*. [Available from: www.mentalhealth.samhsa.gov]

Table 1 summarizes the broad areas of focus for community mental health teams. These include: a focus on children, young people, families and communities; developing Aboriginal-controlled community mental health services; improving access and the cultural safety and responsiveness of mental health services; and coordinating programs, services and resources.

6.3.1. Focus on children, young people, families and communities

Many community wellness interventions target specific sub-groups within a community. The rapid growth of Aboriginal communities in recent years has resulted in a large cohort of young people who face specific challenges. Programs targeted to youth and their families are therefore particularly relevant to most communities.

There are a wide variety of low-cost interventions that can have demonstrable positive effects on family wellbeing and on the development of young children and adolescents (L'Abate, 2007; Barry & Jenkins, 2007; O'Connell et al., 2009). Programs that strengthen maternal and child health services are common and should be further encouraged. Within the Aboriginal context, these can focus on culturally appropriate family and parenting skills. Most communities have a high proportion of children and youth, and this age group is particularly at risk for serious mental health problems including substance abuse and suicidality. Programs that aim to improve community wellness should ensure age-appropriate assessment and intervention strategies are available for children and young people at risk of mental health and related problems. As well, issues of social and culture change have often undermined traditional roles for men as providers and this has contributed to the high levels of substance abuse and suicide among young males in many communities. To counter-act these effects, interventions that address male identity, re-establishing and strengthening a sense of meaningful role, cultural continuity and communal value are particularly important.

Community development programs should build on the capacity of local communities in an attempt to promote positive mental health and wellbeing. This often involves harnessing the skills of Elders and other pre-existing cultural resources. Community Wellness teams should ensure that these resources are utilized in their response to the needs of local children. These may include harnessing educational, recreational and cultural resources to develop appropriate programs targeting youth that focus on the healthy development of individuals through their teenage years into adulthood. Some of these successful programs attempt to reinforce cultural identity, especially among young men who are most at risk of suicide, substance abuse and other negative outcomes. This approach is an example of many that attempt to improve and expand prevention, early intervention and rehabilitation programs that break cycles of substance abuse and other risky health behaviors.

6.3.2 Developing Aboriginal Community Controlled Health Services

Much of the suffering in Aboriginal communities reflects a long history of collective disempowerment, interventions must strength local control and power. To the extent that culture itself is a potential ingredient in restoring a sense of individual and collective well-being, mental

health programs should work in tandem with processes of cultural revitalization and community development.

Community wellness teams and approaches may best succeed when under Aboriginal control. They will also be more competent if Aboriginal people are included in the team itself. For this to happen, there is a need to build a skilled and confident workforce able to provide mental health and social and emotional well being services that includes Aboriginal people. Aboriginal control and the inclusion of Aboriginal people on the team would ensure that needs based care incorporates traditional and more culturally appropriate approaches to healing. Such an approach can be augmented by a strategy that attempts to develop, implement and monitor efforts to recruit, retain and support Aboriginal workers in the mental health and social and emotional well being field.

6.3.3. Improving Access and Responsiveness of Mental Health Care

Access to specialized mental health services is essential for individuals with more severe mental health problems. For more common mental health problems and social predicaments self-care and family and community supports may provide the firstline of intervention. But when those prove insufficient, additional services should be available. Beyond insuring access, even conventional services need to be culturally safe. Cultural safety is fundamentally an issue of power and so it can be achieved only by supplementing education and awareness with structural and organization change to make certain that Aboriginal people have a meaningful role in governing their own services.

Mental health promotion aims to reach the whole community without requiring that individuals identify themselves as having a problem or seeking help. Community mental wellness teams can achieve this by supporting processes of community development. Looking at the community through the eyes of people of different ages, gender and social position can identify the areas that need strengthening to foster resilience and wellbeing for each segment of the community. This in turn will benefit the community as whole.

6.3.4. Coordinating Programs, Services, Initiatives and Planning

A concerted effort to address mental health services needs and promote wellbeing requires the participation of many people both within and outside the communities. The creation of multidisciplinary or interdisciplinary teams requires a spirit of collaboration that sets aside the protectionism and self-interest sometimes found in professional associations as well as the arbitrary divisions of services. Strategies for building community collaboration are discussed by Barry and Jenkins (2007, p. 95ff)

To provide services for the full range of Aboriginal communities in Canada, at least three different levels of organization must be addressed: local communities, regions (defined geographically and culturally, as well as jurisdictionally), and nations. Different types of community wellness teams can be constituted at each of these levels.

(1) At the local community level, teams would consist primarily of Aboriginal mental health workers working in close collaboration with existing health and social service workers to develop and implement community-wide interventions. Local governance is important to insure engagement but external networking and supervision is essential to avoid burnout and management potential conflicts of interest or ethical issues that arise from working in small communities. The Aboriginal mental health workers would receive training through specialized programs developed for this purpose with brief residence outside the community and ongoing in-service training and supervision. At the same time, existing health care and social service workers would receive training in ways of collaborating with the community wellness team and appropriate steps taken at administrative and professional levels to insure cooperation. Ideally, the team would incorporate local NNADAP workers, community workers, educators, religious leaders, leadership and stakeholders at the level of governance and as collaborators on specific projects.

(2) At the regional level, mobile teams based at a larger centre can visit communities and work with local teams to provide resources, training activities and back-up for challenging situations. The resources available at these regional centres (or through links to other centres) would include of mental health professionals with expertise relevant to Aboriginal communities and people knowledgeable about designing and implementing mental health promotion programs for regional Aboriginal populations. These would also be centres with telehealth capacity so that much training as well as some assessments and interventions could be provided without travel. In some cases, these centres could be set up in association with regional residential treatment centres to capitalize on staff and increase continuity of care. However, attention must be given to the potential conflict of interest between those focused on residential treatment and wellness approaches focus on people living in the community.

(3) At the national level, regional centres and teams need to be linked to share resources, training and models of intervention. The Native Mental Health Association, NAHO and other organizations currently provide some linkage at this level and this should be strengthened expanded to through the use of the internet, videoconferencing, as well as regional and national meetings. The national network could provide resources for training and evaluation of programs. In most cases, rigorous evaluation will be beyond the resources of communities and even regional centres. At the same time, the national network can serve as a means of recruitment and training of new mental health workers, professionals and researchers engaged in the area of community wellness. Having some staff move between centres would facilitate knowledge exchange and build a larger community of practice with expertise that can be shared across the country. It would also facilitate larger scale research in which communities or regions could implement specific programs allowing more accurate assessment and some opportunity to identify contextual factors crucial for good outcomes.

The teams at each of these three levels have specific roles to play that complement, enables and sustain the others. The regional teams and centres can promote sharing among Aboriginal communities in the same geographic area and, through the national network, advise and assist communities in other areas in developing their own community wellness teams and programs.

Table 1. Areas of Focus for Community Mental Health Teams and Wellness Promotion

1. Focus on children, young people, families and communities

- Develop and implement programs that strengthen maternal and child health programs, with a focus on culturally appropriate family and parenting skills.

- Disseminate age-appropriate assessment and intervention strategies children and young people at risk of mental health and related problems.

- Support community development programs that build on the capacity of local communities to respond to the needs of children. These may include educational, recreational and cultural programs targeting youth that focus on the healthy development of individuals through their teenage years into adulthood.

- Develop programs to strengthen male cultural identity, through links between Elders, adults and youth.

- Provide effective programs to reduce the risk of violent behaviour and self-harm, to break the cycles of violence, abuse and substance misuse. This includes community supported programs for alcohol harm reduction.

- Implement culturally appropriate programs and interventions to help people with their healing process from cumulative experiences of grief, loss trauma, and anger.

2. Develop Aboriginal Community Controlled Health Services

- Build a skilled group of mental health workers able to provide mental health and social and emotional well being services within the Aboriginal community controlled health services.

- Provide optimal resources to community mental health centres and teams to deliver flexible social and emotional wellness programs and needs based care that incorporate traditional and more culturally appropriate approaches to healing.

- Develop, implement and monitor strategies to recruit, retain and support Aboriginal workers, organizers and administrators in the promotion of mental health and social and emotional well-being.

- Develop regional centres that can deliver support and in-service training to counsellors and other workers in the area of mental health and wellbeing, and ensure that training opportunities are available to meet community identified needs. The same centres can provide ongoing support, networking, and backup for local teams.

3. Improve access and responsiveness of mental health care

- Identify, monitor and disseminate information about effective models of services and partnership that improve service responsiveness to Aboriginal peoples in partnership with NAHO and other organizations.

- Support training at universities and professional programs for all health and social service professionals on Aboriginal mental health issues.

- Provide training for primary care clinicians in Aboriginal mental health issues.

- Provide in-service training for all non-Indigenous mental health workers in the knowledge, skills and attitudes required to meet the needs of Aboriginal patients and their families.

- Provide cultural safety training for administrators and planners, so they, in turn, can build this into organizational and institutional practice.

- Develop strategies to encourage psychiatrists, psychologists and other mental health professionals to work in Aboriginal communities.

- Increase the numbers of Aboriginal mental health worker positions and provide appropriate on the job support and supervision.

4. Coordination of resources, programs, initiatives and planning

- Improve linkages across all services and sectors to ensure collaborative responses and needs-based mental health care.

- Provide funding that enables Aboriginal community controlled health services to more flexibly deliver mental health and social emotional well being programs.

- Increase funding to Aboriginal community controlled health services to operate mental health and wellbeing programs.

- Develop strategies to improve the accountability of mainstream services for the delivery of culturally safe and competent mental health services for Aboriginal peoples.

- Improve coordination, planning and monitoring mechanisms.

- Form regional/local level implementation groups between service providers to coordinate service delivery across mental health, Aboriginal community health Services, substance use, and primary care services.

6.4 Summary and Conclusion

The situation for mental health services in Aboriginal communities across Canada demands concerted attention. In most communities, only limited mental health services are available, and few of these incorporate indigenous perspectives and approaches. The gap in basic mental health services is most severe in rural and remote communities, but urban services often lack any Aboriginal orientation. Telepsychiatry or mental health services are not readily available in many regions.

Although current best practices in community mental health are relevant to the design of Aboriginal community wellness teams, there are distinctive features of Aboriginal communities and populations that require adaptation of prevention strategies and interventions. These include: the scale and location of communities; the lack of existing mental health services; the small numbers of trained Aboriginal mental health professionals; the potential role conflicts and difficulties of maintaining confidentiality associated with working in small communities; and the cultural and linguistic diversity of Aboriginal peoples.

A community wellness promotion strategy should consider the following general guidelines for mental health promotion:

1) Programs should be locally initiated, owned and accountable, embodying the norms and values of Aboriginal culture. To facilitate this, FNIHB can work with NAHO and other Aboriginal agencies to provide a range of models and resources for selection, adaptation and implementation. Communities should be able to choose from a palette of comparably effective programs and interventions or have materials and resources to develop their own model incorporating components from established models and integrating local perspectives consistent with the relevant principles of mental health promotion.

2) Mental health promotion is the responsibility of the entire community, and requires mobilizing support and solidarity from family, religious, political or other groups. This means there must be close collaboration between health, education, other community services and local government.

3) Prevention begins with early child development. A focus on children, youth and young adults is crucial, but this implies involvement of the family and the community. Strong parental support and a positive home environment through early development is one the most powerful ways to improve both individual and communal wellbeing. Mental health promotion should therefore include culturally consonant family life education and support.

4) Aboriginal people everywhere should have access to the range of essential mental health services, both for crisis intervention and for longer-term counseling, individual and family intervention as needed. This will require the use of telepsychiatry, training

of community mental health workers in individual and family counselling (particularly for grief), and culturally appropriate social interventions and community development. Mental health interventions must be in harmony with local traditions of conflict resolution, healing, and family life.

5) Evaluation of the impact of prevention and mental health promotion strategies is essential. As this review has shown, there is a real paucity of evidence on what works in mental health promotion and community mental health in general for indigenous peoples. Programs developed in urban settings make many assumptions about culture and social context that may not fit Aboriginal communities. Although existing "best practice" provides a place to start, further refinement and confidence in programs and interventions will depend on careful evaluation.

Action on these issues demands cooperation and collaboration across many different organizations at national, provincial and regional levels both within government and in Aboriginal communities. This means taking down some of the barriers — of jurisdictional disputes, disciplinary boundaries, professional protectionism and bureaucratic red tape — that separate people with common interests and concerns. The rewards for cooperation will be creative dialogue and, ultimately, concerted action that leads toward an inclusive mental health system that incorporates indigenous values and, by placing communities themselves at the centre of mental health promotion, makes a meaningful contribution to the health and wellbeing of Aboriginal peoples in Canada.

AHW   Aboriginal Health Worker

AMHW   Aboriginal Mental Health Worker

Anxiety Disorder   A clinical disorder commonly occurring in populations marked by symptoms of intense anxiety often accompanied by somatic complaints such as sleep problems and inability to concentrate.

CAMHW   Child and Adolescent Mental Health Service Workers.

CBT   Cognitive behavioural therapy, a type of psychotherapy effective for many CMD and as an adjunct in the treatment of SMI.

CMD   Common mental disorders. An umbrella term for disorders commonly occurring in community settings, namely depression and anxiety.

Community Wellness Community wellness refers to the general well-being of a circumscribed community.

Depression   A clinical disorder commonly occurring in the community characterized by low mood as well as accompanying somatic complaints such as low appetite and sleep problems.

DSM   *Diagnostic and Statistical Manual* of the American Psychiatric Association. The diagnostic scheme in common use across Canada used by mental health professionals to make a diagnosis.

Efficacy   Refers to whether a treatment has been shown to work in a rigorous controlled trail (i.e. under ideal circumstances).

Effectiveness   Refers to whether a treatment actually works in a routine community setting.

Evaluation   Refers to a process of assessing the influence, inplementation and impact of a specified intervention or program.

Formative Evaluation Refers to an evaluation that occurs while the intervention is in progress that informs program development.

Summative Evaluation Refers to an evaluation that occurs after an intervention has been fully delivered to inform future programs and progress.

FNIHB	First Nations Inuit Health Branch of Health Canada.
Mental Health	Mental health is not simply the absence of mental illness. It is a positive sense of emotional and spiritual well-being that respects the importance of equity, social justice, interconnections and person dignity It is often used to refer to lay notions such as personal happiness, fulfillment in life, overall well-being and sense of accomplishment or mastery.
Mental Illness	Mental illness is a professional term referring to discrete mental disorders found in DSM-IV or ICD-10 which cause distress and limit everyday functioning.
Peri-urban Reserve	An Aboriginal reserve in proximity to an urban centre
PHC	Primary health care
Recovery	A notion referring to the process whereby people with severe mental illness or substance abuse make progress from the disabling and debilitating aspects of their disorder.
Remote	Refers to regions of Canada that are sparsely populated and at a very long distance from any type of urban center. This refers to huge swathes of Land in Canada's North and East.
Rural	Refers to regions of Canada consisting of medium or thin population density and characterized by wilderness or agriculture.
SEWB	*Social and emotional wellbeing*: a concept developed in Australia that refers to well-being and wellness in individuals living in community settings.
SMI	Severe mental illness; refers to mental disorders such as schizophrenia, bi-polar disorder, schizoaffective disorder and major depression which are seriously debilitating and often lead to hospitalization.
Prevention	refers to public health interventions aimed to prevent the occurrence of a health problem or its consequences.

Primary prevention or health promotion aims to prevent the occurrence of mental health problems.

Secondary prevention involves interventions designed to identify (e.g. through screening) and treat individuals at risk for a disorder.

Tertiary prevention or rehabilitation aims to promote recovery, limiting the impact, and preventing the recurrence of a condition in people who have already suffered an episode.

Indicated prevention strategies interventions are aimed at high-risk individuals who have elevated indicators of illness but do not yet meet diagnostic criteria for a disorder.

Selective prevention interventions are directed to higher-risk groups.

Universal prevention and health promotion strategies target the whole population and aim to enhance the emotional health and wellbeing of participants.

Substance abuse	commonly refers to the excessive use of alcohol, drugs or other chemical agents to the point where it has a deleterious effect on health, well-being and functioning.
Substance use disorder	Refers to a clinical disorder that is characterized by debilitating substance abuse.

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Appendix C. Selected Community Wellness Programs and Services

Name (Source)	**The Social and Emotional Well-being Team, Durri Aboriginal Corporation Medical Service (ACMS) (**Cleworth, Smith, & Sealey, 2006)
Objectives	To provide culturally appropriate mental health services to Aboriginal and Torres Strait Islanders in Kempsey, Australia.
Key Components	The pilot project described placed a psychiatric registrar with community-controlled Aboriginal medical service providing mental health care through its Social and Emotional Well-being team.
Setting	*Rural/Remote:* Kempsey, New South Wales, Australia. Aboriginal/Torres Strait Islander population of approximately 2,300 – the largest outside of Sydney. Kempsey's total population is roughly 26,000.
Target Population or Groups	The program targets Aboriginal and Torres Strait Islanders in the Kempsey community
Problem Focus	*SMD; CMD; Promotion; Substance; Suicide* The Social and Emotional Well-being Team saw patients presenting with a broad range of diagnoses. Common diagnoses included dual diagnosis involving alcohol and substance abuse and PTSD (often related to domestic violence, sexual abuse, and accidents) with comorbid depressive disorders.
Approach	The heart of the article discusses ten points particularly relevant to the cultural context: - Flexible (and often informal) referrals - Flexible assessment settings (park, community centre, patient's home) - Appointment system used flexibly and only when required. - Attention to comorbid physical and mental health problems - Challenging "boundary issues" where Aboriginal staff often seeking treatment for mental health problems from co-workers - Consideration to grief due to high community death rates of staff and patients - Special attention to the mental health of youth - Reciprocal disclosure where expected and appropriate
Cultural Adaptation	- Acknowledgement (implicit or explicit) of patient spiritual and cultural beliefs - Use of cultural consultants
Resources	One psychiatry registrar and two Aboriginal Mental Health Workers (one male, one female), working in collaboration with ACMS staff, including GPs, a psychologist, and a drug and alcohol service. The team also collaborated with Kempsey Mental Health Service staff.
Training	
Evaluation	The pilot program allowed staff to expand mental health services available to the Indigenous Australian community in Kempsey and to examine some of the factors particular to mental health service delivery in this context. Although no formal evaluation was conducted, the article highlights the enthusiastic welcome of the project by Durri ACMS, as well as the substantial use of services and the quality of relationships developed as indicators of the project's success.

Name (Source)	**Murray Mallee Community Health Service, Health and Wellbeing Team** (Fairlamb & Muir-Cochrane, 2007)
Objectives	• To provide specialist mental health support within a comprehensive primary health care framework. • To support and contribute to the development of strong communities, by the promotion of interconnectedness, resilience and participation, including all cultures and lifestyles within the region.
Setting	The Murray Mallee region has a population of 30,000. The main town of Murray Bridge, where Murray Mallee Community Health Service (MMCHS) is based, has a population of 17,000.
Target Population or Groups	*(Gender) (Ethnicity) (Age) (Setting) (Children/youth; adults; elders; families; community)* While MMCHS services are available to all, the article specifies that, "The region has a rich Ngarrindjeri culture, the Aboriginal nation who are the traditional custodians of the area, and many ethnic groups contributing to its identity (3)"
Problem Focus	The program's emphasis is on distress over categories of illness, so no specific diagnostic targets are mentioned.
Key Components	• *Private counseling services.* Individual therapies may include: cognitive behavioral therapy, narrative therapy, psychiatric nursing, crisis and trauma counseling, sexual abuse counseling, solution focused counseling, systems therapy. • *Group formation.* Common problems: domestic violence, sexual assault, depression, anger management. • Consumers may be trained as peer workers.
Approach	Population health, primary health care, holistic health, social determinants of health. Aboriginal focus on social and emotional wellbeing: "recognizes and affirms the community development approach." More traditional case management approaches described as stressful, unsustainable, and discouraging self-management. Aim is to maintain service users' power: • Collaborative, comprehensive assessment form – allows consumer to describe symptoms on own terms, follow own progress, develop crisis and prevention plan to be shared • Special attention to women and the role of "power and control in relationships" • emphasis on distress over illness, supportive context not dependent on diagnosis, which is envisioned as a step toward destigmatization.
Cultural Adaptation	Aboriginal focus on social and emotional wellbeing
Resources	According to website, team consists of 20 members. Team members have close "working partnerships", allowing for frequent communication and consultation about urgent and difficult problems (e.g. acute distress, suicidality, psychosis, dissociation). Disciplines incorporated include social work, counseling, mental health nursing, nursing, community development, Aboriginal social and emotional health and wellbeing, Aboriginal health, Aboriginal women's health, occupational therapy and speech pathology.
Training	Team receives cultural awareness training.
Evaluation	On data collection and evaluation: the authors argue that the current systems cater more to the medical diagnosis/treatment approach, which does not

	adapt well to the primary care promotion/prevention model. Accordingly, the authors suggest, "Systems that measure service users' models of recovery would encourage self management as well as provide meaningful data to a developing evidence base around recovery." Plans for future evaluation include an analysis of information from focus groups with both service users and providers.

Name (Source)	**Aboriginal Mental Health Worker Program** (Harris & Robinson, 2007)
Objectives	To "fund the placement of Aboriginal Mental Health Workers (AMHWs) in remote community health centres, to work under the clinical leadership of General Practitioners and to contribute to development of a culturally appropriate community based mental health care service of Indigenous people." (1)
Setting	Eight remote communities in Top End, Northern Australia.
Target Population or Groups	*(Gender) (Ethnicity) (Age) (Setting) (Children/youth; adults; elders; families; community)* While MMCHS services are available to all, the article specifies that, "The region has a rich Ngarrindjeri culture, the Aboriginal nation who are the traditional custodians of the area, and many ethnic groups contributing to its identity (3)"
Problem Focus	*(SMD; CMD; Promotion; Substance; Suicide)*
Key Components	*Clinical work* • Monitoring medications, assistance in consultations • Case conferences, monitoring and follow-up, first point of contact • Mental health promotion • Working with clients, GPs, nurses, other clinic staff and visiting health care professionals *"Wellbeing work" outside the clinic* • Culturally informed counseling • Community mental health promotion, alcohol, marijuana, violence, self-harm • Work with women, youth families • Community initiatives and visiting professionals.
Approach	From the outset, the role of the AMHWs was not well-defined. While some saw the AMHWs as having a more formal clinical role, others emphasized more general mental health promotion objectives.
Cultural Adaptation	
Resources	• Between one and two Aboriginal Mental Health Workers (AMHWs) were placed in 8 remote community health centres. • Employed by local community councils as opposed to local health service • "By mid 2004, ten AMHWs were employed under the program. At the time, this more than doubled the number of community-based AMHWs working in the Top End and provided the basis for the development of a dedicated mental health service in communities in which none at all had previously existed." • Partnership Agreement identifies four actors: Top End Division of General Practice (TEDGP) (managing body); Batchelor Institute for Indigenous Tertiary Training (certificate-level training to AMHWs); Top End Mental Health Services (gov agency responsible or visiting services

	provision to remote communities); Charles Darwin University (Evaluators)
Training	• Certificate level training provided to AMHWs by the Batchelor Institute for Indigenous Tertiary Education. In theory, GPs were to provide further on-the-job mentoring and support, but this concept failed due to: High GP turnover; High workload; and view that the role of the AMHW was in mental "wellness" promotion "and therefore not to be overshadowed by the medical paradigm represented by the GP." • "Additional supervisory support and limited training was provided in the form of visits by two experienced AMHWs who were located in remote centres, who provided local training to the community-based AMHWs and helped them to access special events and training at Batchelor Institute."(5) • "these arrangements were relatively weak, in that once funding was granted, the process of integration of the AMHWs and determination of their role and workload was largely determined by the pre-existing preferences and resources of the local health centres." (5)
Evaluation	Independent evaluation conducted by Charles Darwin University. Partnership agreement was designed to be flexible, but in so doing lacked clear objectives and timelines – the role of the AMHW was ambiguous (particularly whether they were to be involved primarily in clinical or wellness promotion work).

Name (Source)	**Magna Barndi mental health service** (Laugharne, Glennen, & Austin, 2002)
Objectives	"The objective of the project was to improve the mental health of the 6000 strong Aboriginal community in Geraldton, the Midwest and the Murchison through clinical service delivery, education of health workers and service development." (14)
Setting	Geraldton, Western Australia. Patients were served through three points of delivery: • The Geraldton Regional Aboriginal Medical Service (GRAMS) • The Regional Prison • Visits to a variety of regional centres
Target Population or Groups	The program targeted Aboriginal individuals suffering from mental health problems in Geraldton and the surrounding areas. Within Geraldton, 36 patients were male and 49 patients were female out of a total caseload of 85 patients. The mean age for Aboriginal patients was 21 years (compared to 37 years for non-Aboriginal patients).
Problem Focus	The program provided services for a full range of mental health problems, including SMD, CMD, and substance abuse. Primary substance abuse was present in 44% (57% Aboriginal; 31% non-Aboriginal) of patients whose primary diagnosis was not substance-related.
Resources	The team consisted of a psychiatrist, a trainee Aboriginal mental health worker, and a community mental health nurse (the latter appointed four months into the project).
Key Components	Over the course of the two-year pilot program, three mental health professionals were appointed to provide psychiatric services, including the following components:

	Clinical Service Delivery. • 61 Aboriginal patients within Geraldton, 22 through regional centres, 52 at the Regional Prison *Educational Program.* Training about basic mental health issues provided to: • General nurses in country hospitals • Aboriginal health workers at GRAMS and Wiluna Medical Service • Aboriginal Visitors Scheme workers (Aboriginal counselors part of a prison visiting service) *Forensic Work* • Psychiatrist as consultant at local prison, where 70% of inmates are of Aboriginal descent, providing weekly clinic and regular liaison with prison psychologist
Approach	The team used a flexible assertive community management approach. Service was introduced to regional health workers and Aboriginal community elders through two visits. The first established contact, introducing the service and assessing the needs of the surrounding communities. The second conducted more in-depth assessments, meeting with referred patients and further gauging the needs of local professionals, as well as conducting workshops. • Following first visits and assessments of regional communities, the team established whether any individual community would require 1) regular 6-weekly visits, 2) clinical input and telephone consultations as required. • The team accepted self-referrals, as well as those from health workers, GPs, and relatives. Initial assessments were conducted at first presentation, which helped engage the patient and discouraged future missed appointments. • Patients were encouraged to "drop in" to the clinic as needed • The Community Mental Health Nurse and/or trainee Aboriginal Mental Health Worker conducted follow-up home visits. • Program delivered through well-trusted, community-controlled Aboriginal medical service • Involved Aboriginal health workers (both on-team trainee Aboriginal health worker and in collaboration with Geraldton Regional Aboriginal Medical Service (GRAMS) staff). • Non-Aboriginal team members demonstrated flexibility and adaptability. • Patients were treated in the community setting and families engaged as active support structures whenever possible. • Team worked to ensure that patients interested could access traditional healing in addition to the psychiatric services provided.
Cultural Adaptation	
Training	• The trainee Aboriginal health worker took a course in Aboriginal Mental Health at Curtin University in Perth. • The psychiatrist and community mental health nurse did not receive any formal cultural awareness training, but were personally motivated and interested to learn about both traditional and contemporary Aboriginal culture, beliefs and values.
Evaluation	• At the end of the two-year period, 85 patients were on file within

Geraldton, of which 61 were Aboriginal.
- Over the course of one year, contact during an attempted home visit increased from approximately 20% to 60%.
- By the second year of the program, patient episodes and bed days declined by 58% and 52% respectively from the previous year's total
- "The total number of admissions of Aboriginal people with psychiatric diagnoses to Geraldton Regional Hospital was reduced by 58% in the second year of the project."
- Educational sessions were well-received and improved the number and quality of referrals.

Name (Source)	**Far West Area Health Service Mental Health Integration Project** (Perkins, Roberts, Sanders, & Rosen, 2006)
Objectives	- To provide access to comprehensive mental health services - To encourage multi-professional collaboration and coordination - To increase the focus on prevention and promotion - To enable consumer participation - To provide education and support for mental health workers and primary health professionals.
Setting	*(Rural/Remote)* Far West Area Health Service (FWAHS), Far West Area, New South Wales, Australia. Regional population of 50,000; 13% Aboriginal. Area with the highest level of socioeconomic disadvantage in Australia.
Target Population or Groups	Rural/remote population
Problem Focus	*(SMD; CMD; Substance)* 12% of local population suffer affective disorders, personality disorders, psychoses or cognitive impairment and are usually treated by public mental health services. 20% suffer affective disorders, anxiety disorders, and substance abuse treated by private mental health practitioners.
Key Components	"Primary mental health services are provided by local generalist staff supported by specialists from hubs and visiting psychiatrists from metropolitan centres" (107) "Hub structure: CMHT's support general health staff and provide specialist services to patients".
Approach	The decision to institute program was based on findings and recommendations of the 1998 Second National Mental Health Plan, particularly perceived failings to integrate private and public mental health care services. - Population health approach to planning - Primary health care model of service delivery - No direct referrals to visiting psychiatrists – referrals made to the CMHT who refer to the visiting psychiatrists.
Cultural Adaptation	
Resources	The network of clinical staff supported by the program include: - Visiting psychiatrists from metropolitan areas - Community mental health teams

	• General practitioners • Generalist health staff • Aboriginal medical service staff The CMHT leader serves as the local manager.
Training	
Evaluation	• Increased access to visiting psychiatrists. Residents of the Far West Area outside of the town of Broken Hill had previously never had regular access to a psychiatrist. Between January 2002 and June 2003, visiting psychiatrists received a total of 380 new referrals. • Increased access to community mental health teams: Total new referrals seen by CMHTs (July 2000 – December 2003): 3908 • Support activities • Collaboration with GPs

National Network for Aboriginal Mental Health Research
NAMHR maintains an online searchable database of Aboriginal mental health promotion and suicide prevention programs and initiatives in Canada. It also has a resource centre for supporting Aboriginal mental health research including materials on ethics, methodology.
www.namhr.ca

National Aboriginal Health Organization
www.naho.ca
NAHO is the central Aboriginal organization for gathering and disseminating health, healing and wellness information.

AHRNET
www.ahrnets.ca
The Aboriginal Health Research Networks (AHRNet) Secretariat is the coordinating body for the nine Network Environments for Aboriginal Health Research centres located across Canada (including NAMHR). The site provides links to the other sites and information on research and training activities.

One Sky Center
A U.S. National Resource Center for American Indians and Alaska Natives, One Sky Center has links to evidence-based resources for prevention and treatment of substance abuse and mental health problems.
www.oneskycenter.org

Guide to Community Preventive Services
USA Centers for Disease Control and Prevention
www.thecommunityguide.org

National Registry of Effective Prevention Programmes (NREPP)
USA Substance Abuse and Mental Health Services Administration (SAMHSA)
http://www.nrepp.samhsa.gov/

National Guideline Clearinghouse (NGC)
This is a U.S. source for evidence-based clinical practice guidelines
www.guidelines.gov

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