# DEVELOPMENT OF A MENTAL HEALTH SERVICE ORGANIZATION MODEL AMONG THE FIRST NATIONS OF QUEBEC

Research report prepared for the
First Nations of Quebec and Labrador
Health and Social Services Commission

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A French version is available.

In case there are discrepancies between the French and English versions, the text of the English version prevails.

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An electronic version of this document is available at the following address: www.cssspnql.com

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"We have to understand that issues of mental health and dependency are the residual effects of the same collective history of many First Nations people. *They are really the same condition.* ***They co-exist in our people as two related effects from the same set of causes***. The high rates of comorbidity, in excess of 80%, prove this.

All of these symptoms, including the violent behaviours and abuse, are related symptoms of what many people suffered as a result of colonialism and the residential school experience.

We have to stop treating these as two 'program' areas and see and deal with them as one set of interrelated outcomes from the same root causes. We need to take a more client-centered, integrated approach."

Robin Decontie
Director – Health & Social Services
*Kitigan Zibi Algonquin First Nation*

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# SUMMARY

Within the framework of the recommendations made in the 2005-2015 Blueprint on Aboriginal Health and the First Nations and Inuit Mental Wellness Strategic Action Plan, this research project, funded through the Aboriginal Health Transition Fund (AHTF), targets the development of a mental health services organization model for the First Nations of Quebec. Its goal will be to increase the access and continuity of the services available to all of members of these communities.

This research report presents the results of the data collection processes that were carried out to survey the mental health services available to First Nations, both inside and outside the communities, identify the success factors and barriers linked to the development of mental health services and address the shortcomings so that each community member can access a continuum of services that is equivalent to that of other Quebecers.

The first data collection process aimed to perform a survey of the existing mental health services in the Quebec system. This step allowed for the development of a list of mental health services in the Quebec system, more specifically those provided in the regions to which the First Nations of Quebec are affiliated and develop a directory of resources for each region.

The second data collection process was conducted to inventory the mental health services offered in the communities. This collection also included the perceptions of the interveners from each community with respect to the mental health issues of their members, services provided, best practices developed and shortcomings observed.

The third data collection process sought to foster consultations among First Nations stakeholders and members. These consultations were held with the stakeholders from eleven communities (isolated/semi-isolated/urban) to get an appreciation for the facilitating factors and barriers that influence the development of mental health resources as well as possible solutions.

This research sheds light on the fact that it is impossible to offer, within the current service delivery context, a range of mental health services similar to those provided to other Quebecers in all First Nations of Quebec. In this regard, the development of a mental health service organization model that is well-structured, adapted to the needs of the communities and focused on the most significant problems is vital to achieving major, sustainable and accessible results in all First Nations of Quebec.

Given the results of the three data collection processes, a few observations can be made regarding this research:

- Although several mental health problems were raised, substance abuse with or without comorbidity seems to be a major issue for First Nations stakeholders and members. Participants stressed the fact that this problem not only affects individuals but the entire community and should therefore be made a priority in order to improve the mental wellness of individuals and the smooth running of communities.

- Many mental health services implemented in the communities were reported by participants. Generally speaking, these services address common and varied health and social problems and are offered close to where the people live. The results of this research demonstrate the will of First Nations stakeholders and members to ensure that these services are developed and offered directly in the communities. A mental health service organization model could therefore be based on the mental health best practices that are already established in certain communities, while proposing various possibilities that have been less frequently implemented until now (mental health team, responding psychiatrist, crisis interventions), in order to ensure that all First Nations members have access to common mental health services in their communities.

- In a general sense, this research demonstrated that few specialized services are currently available in the communities, particularly services intended for those with the most severe symptoms whose conditions require hospitalization or those with acute issues. Given that it seems unrealistic to propose that these types of services be developed in each community, respondents suggested possibilities that would enable First Nations members to have a more fluid access to the resources in the Quebec health system, for example, the drafting of clear agreements between the communities and CSSS responsible for them, the training of CSSS stakeholders regarding First Nations realities, the sensitization among stakeholders working in the communities regarding the organizational structure of the Quebec health system and the development of services for First Nations within this system.

# RESEARCH CONTEXT AND SPECIFICATIONS

The situation of the First Nations is critical. The scope of the mental health problems, as well as related issues such as suicide, substance abuse and violence, calls for an immediate, concerted and structured intervention. As specified in the mandate of the First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC), initiatives must be undertaken to improve the physical, mental, emotional and spiritual well-being of First Nations and Inuit individuals, families and communities while respecting their culture and local autonomy.

This research is controlled by the FNQLHSSC and funded as part of the Aboriginal Health Transition Fund (AHTF). It targets the development of a mental health service organization model for First Nations of Quebec and serves to increase the accessibility and continuity of the first, second, and third-line mental health services available to their members.

"First-line services are universally accessible services that seek to promote health, prevent diseases and offer diagnostic, curative and rehabilitation services to the entire population. These responses seek to address common and varied health problems as well as social issues and must be offered close to where the people live.

Second-line services involve specialized expertise. These services are meant to support first-line teams and provide treatment to those who cannot be adequately treated at the first-line level.

Third-line services support the first and second levels. These services are intended for individuals with very complex and low prevalence health problems for which the level of complexity requires a level of expertise that cannot be provided by second-line services."

*Plan d'action en santé mentale*, MSSS, 2005-1010, pp. 24-25.

The project objective is in keeping with the vision of the Blueprint on Aboriginal Health (2005-2015), which seeks to significantly reduce the disparities between the health outcomes of the general Canadian population and those of Aboriginal people" (Health Canada, 2005, p. 1).

The **specific objectives** of this project, which stem from the First Nations and Inuit Mental Wellness Strategic Action Plan (First Nations and Inuit Mental Wellness Advisory Committee, 2008) are to:

- Support the development of a concerted continuum of mental health services including traditional, cultural and current approaches;
- Clarify and consolidate the collaborative relationships between the federal and provincial governments and the organizations of the First Nations communities;
- Document and shed light on the mental health practices developed by certain communities;
- Recognize and value the importance of community members as change agents;
- Utilize cutting edge technologies, such as Telehealth, to foster collaboration with remote communities;
- Increase the skills and knowledge of the mental health stakeholders working among First Nations, thereby fostering better stakeholder recruitment and retention processes.

This project is also in keeping with the recommendations made in the 2005-2015 Blueprint on Aboriginal Health (Health Canada, 2005), the First Nations and Inuit Mental Wellness Strategic Action Plan (First Nations and Inuit Mental Wellness Advisory Committee, 2008) and the *Plan d'action en santé mentale 2005-2010* (MSSS, 2005). In accordance with the recommendations made in these plans, this project seeks to act as a driving force for change that will allow for the establishment of a current portrait of the mental health services offer for First Nations, the identification of the shortcomings and the development, validation and testing of an organization model that would offer a solution for the shortcomings identified. More specifically, this project will allow for the redefinition of the various service corridors for each community, thereby ensuring the implementation of one of the provincial reform's objectives in terms of mental health: "To clearly define the roles, responsibilities and connections between the first, second and third lines, the community-based organizations and the intersectorial partners within agreements reached between the players of the local network and, as needed, their regional and supra-regional collaborators" (MSSS, 2005, p. 74).

The project adopts the guiding principles of the MSSS's provincial mental health action plan regarding the fact that Quebec must endow itself with "an efficient mental health system recognizing the roles of the users and offering access to treatment and support services for children, youth and adults of all ages with mental disorders, as well as people who present a suicide risk" (MSSS, 2005, p. 12), such as:

- **The power to act**: First Nations people are known to be able to make choices and participate in the decisions that concern them.
- **Recovery**: The model targets the improvement of the health condition of First Nations members, and assumes that their conditions can indeed be improved.

- **Accessibility**: At the heart of this project is the objective for each First Nations person to have access to a continuum of services to address their mental health needs.
- **The continuity**: The various service corridors will be reviewed in order to ensure a more flexible and effective journey through the various levels of the first, second and third-line services.
- **The partnership**: Many partners were called upon to contribute to the project, including governmental authorities, Aboriginal organizations, health centres and hospitals, school boards, shelters for women who are victims of domestic violence, the *Centres d'aide et de lutte contre les agressions à caractère sexuel* (CALACS), help groups for men and addiction treatment centres.
- **Efficiency**: The model being developed seeks optimal performance among the existing resources.

This project targets the First Nations communities of Quebec, which will allow for the establishment of a portrait on both the provincial and regional fronts. The process takes into consideration the great diversity of these communities by lending each of them a voice to relate their realities. Thus, this project recognizes the great disparity existing between the various communities in terms of their needs and existing resources, and it is therefore expected that the recommendations that will be made to address the shortcomings in terms of service continuum may vary from one community to the next.

More specifically, this project is based on the following foundations:

- The needs of the communities and clienteles are the primary determining factors in the development of the organization model for the services to be developed, validated and tested;
- The quality of the services must be the same for all targeted communities;
- The service organization model must take into consideration:
    - The culture of First Nations, therefore directly involving community representatives in terms of development (the local organizations, the Elders, etc.);
    - The promising approaches that have already been developed by the communities: traditional and cultural prevention, promotion, training, treatment and follow-up approaches;
    - The importance of being informed regarding the service avenues provided to all Quebecers and ensuring that the existing and accessible provincial resources are integrated into the model;
    - The main issues of concern retained by First Nations communities: suicide, substance abuse, sexual assault and conjugal violence;
    - The languages used in the communities.

The research team is composed of a professor-researcher (Delphine Collin-Vézina), a graduate student (Mireille de la Sablonnière-Griffin) and an undergraduate student (Chantal Dutrisac) – all three of whom are affiliated to the School of Social Work at McGill University. This team worked in close collaboration with Ms. Audrey Vézina (mental health clinical advisor) and Mr. Richard Gray (Social Services Manager) at the FNQLHSSC. A steering committee composed of mental health experts was also consulted throughout the research process.

The research report presents the results of the three data collection processes carried out to perform a survey of the mental health services available both inside and outside of the First Nations communities, identify the success factors and barriers linked to the development of mental health services and target the issues to be addressed so that each community member has access to a continuum of services that is equivalent to that of a Quebecer. Table 1 summarizes the collection processes carried out as well as the related activities. The following chapters present each of the three collection processes in a separate manner followed by a pooling of data collections 2 and 3. Finally, the main observations made based on the entire research process are discussed.

Table 1: Summary of the Research Activities

| Collection Processes | Activities |
|---|---|
| 1- Survey of the existing mental health services in the Quebec system | Establish a list of the mental health services in the Quebec system and, more specifically, those provided in the regions to which the First Nations of Quebec are affiliated and develop a directory of resources for each region |
| 2- Inventory of the mental health services provided in the communities | Document the perceptions of stakeholders from each community with respect to the mental health issues of their members, the services provided, the best practices developed and the shortcomings observed |
| 3- Consultations with First Nations stakeholders and members. | Hold consultations with stakeholders from at least 10 communities (rural/semi-rural/urban) to get an appreciation for the barriers, the solutions and the elements which facilitate and influence the mental health resources development |

The following section presents the conclusions drawn by Mr. Willy Fournier who, as facilitator during the consultation session held in Québec on January 18th and 19th, 2011, summarized the comments, suggestions and proposals made by the First Nations members present (see list of participants). Finally, the continuity of mental health services approach for the First Nations communities of Quebec, developed according to the results of the research and consultation among members, is presented in graphic form.

# COLLECTION PROCESS 1 : OFF-COMMUNITY RESOURCE DIRECTORY

## Methodology

The first data collection process, which took place between May and September 2009, was meant to survey the mental health services of the Quebec provincial health and social services network in the socio-sanitary regions to which the 27 First Nations of Quebec are affiliated. The resource directory resulting from this process will serve as a reference tool for community stakeholders to guide them when the services offered in their respective communities cannot address the needs of their clientele.

To that end, the socio-sanitary regions affiliated with each community targeted by this project were identified. The **public and community-based resources** serving the regions affiliated with the communities were surveyed at the local, regional and provincial levels. The team of consultants conducted the survey by referring to the various websites available. The public resources targeted were the *Ministère de la santé et des services sociaux* (MSSS), the *Réseaux universitaires intégrés de santé* (RUIS), the *Agences de la santé et des services sociaux*, the *Centres de santé et de services sociaux* (CSSS), the *Centres de réadaptation en dépendances*, the *Centres jeunesses*, the school boards, all the regional services stemming from the regional *Agences* providing mental health services that are unavailable on the territory of the CSSS affiliated with a community and the provincial assistance lines and services. The community resources surveyed had to offer services that were related to mental health or wellness, suicide, substance abuse, gambling, violence or sexual assault.

To ratify the information collected through this survey process, 69 **key informers** were contacted. The *Agences, Centres de réadaptation, Centres jeunesse* and CSSS were all contacted. Generally speaking, at least one key informer from each organization was identified but between one and six key informers was selected per organization.

A descriptive record template was developed to compile the information required for the directory in an orderly and systematic fashion. All in all, the information collected in these records included the contact information of the resources and, depending on the organization's mandate, the liaison agents, the languages spoken, the targeted clientele, the services provided and the accessibility of these services. Records were filled out for each region in light of the information obtained through the websites and following the consultation process with the key informers. The content of the records were, when possible, confirmed by at least two data sources and periodically revalidated during the developmental period.

It is important to keep in mind a few challenges related to the completion of the directory that must be considered during its use. Special attention was paid to the transcription of the contact information and other data related to the resources; however, certain transcription errors may have occurred. Furthermore, it is possible that certain organizations are not included in the directory because of their absence on the consulted websites, the lack of specifications regarding their mental health services or the fact that

the information became available only after the data collection process. Moreover, certain services or organizations included may no longer be available since the data collection process.

## Results

The results of this first data collection process are available in the document entitled "Mental Health Service Directory" available on the FNQLHSSC website.. http://www.cssspnql.com/eng/s-sociaux/s-mentale.htm

This document provides a regional list of the community and public mental health services and public resources. For the regional public resources, the directory specifies whether or not a First Nations liaison agent is available and the objective of the position, if applicable. For the CSSS, you will find notes pertaining to the accessibility of the services and whether or not these services are adapted to First Nations populations.

Globally speaking, this data collection process allowed to conclude that the public services being delivered are accessible to community members and that certain communities rely on the services provided by the network quite frequently. The level of adaptation of the services to the needs of community members varies significantly depending on the region and the type of service. We often see a more in-depth adaptation in the CSSS or regions in which members use the services more frequently.

That said this access is being compromised in certain regions by one or more of the following factors:

- A lack of understanding and knowledge of the services provided in the communities and the responsibilities of the provincial network with respect to First Nations;
- The distance between the communities and services;
- The absence of roads linking communities with the service location;
- The use of a different language.

# COLLECTION PROCESS 2 : INVENTORY OF SERVICES WITHIN THE COMMUNITIES

## Methodology

The second data collection process, which took place between November 2009 and December 2010, was meant to establish the portrait of (1) the perceptions of stakeholders regarding the various mental health problems experienced in the communities, (2) the services provided in the communities and (3) the relationships with provincial network resources.

To that effect, a questionnaire intended for stakeholders of all communities targeted by the project was developed by the team of consultants, in collaboration with the FNQLHSSC and the steering committee. In addition to elements of a socio-demographic nature, this questionnaire contains four distinct sections.

In the **first section**, the respondents used a 5-point scale (from "Not important at all" to "Extremely important") to evaluate the importance of certain situations related to mental wellness in their respective communities.

The **second section** contains six charts. The first five asked respondents to identify the professionals and other stakeholders present in their communities, the services they provide, the issues targeted by their interventions and their target population by employment sector (health and social services, schools and early childhood centres, police, community resources and informal assistance networks). The sixth table asked them to identify the existing protocols between the various intervention sectors of their communities.

The **third section** is intended for respondents who perform referrals towards the provincial network. These individuals were encouraged to evaluate the ease of the process (from "Completely agree" to "Completely disagree"), client response to referrals and client satisfaction regarding referrals based on a five-point scale (from "Almost always" to "Almost never"). All respondents were asked to indicate the elements that foster or limit referrals towards the provincial network as well as things that may enhance coordination between the community services and those of the provincial network.

Finally, the **fourth section** is reserved for respondents in communities with a service agreement or memorandum of understanding with one or more resources of the provincial network. The respondents identified the organization(s) concerned and, based on a five-point scale, evaluated their satisfaction level regarding the services provided by the organization and the agreement (from "Completely satisfied" to "Completely unsatisfied") and the adaptation of the services to First Nations realities. An open section allowed participants to formulate comments regarding the agreement.

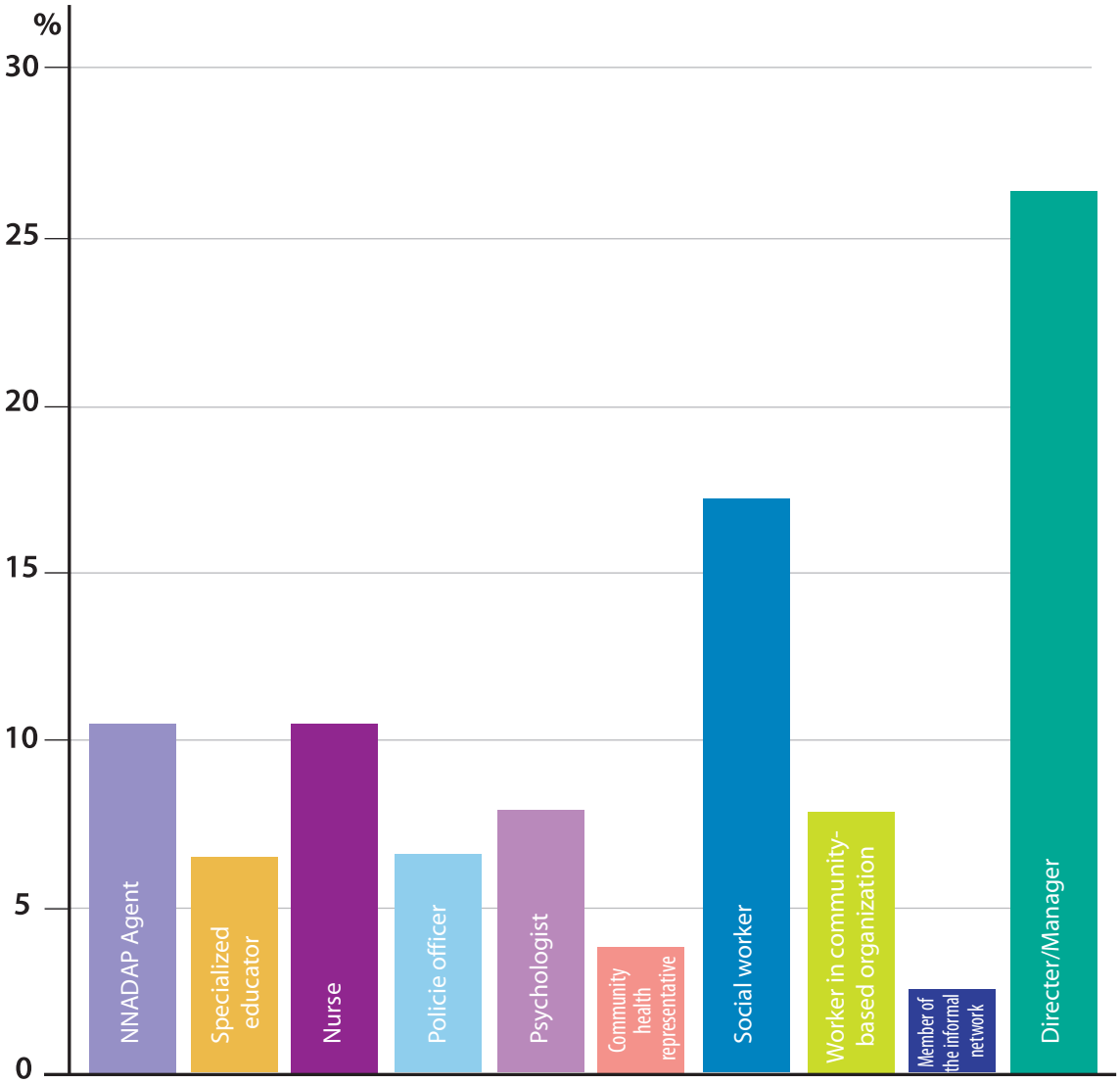
With the intention of facilitating access and use, an electronic version of this questionnaire was developed and made available online. Following the November 2009 forwarding of a letter of introduction and invitation to the health and social services directors of the targeted communities, each community included in the project was asked to identify at least one respondent for the questionnaire. This person had to be a stakeholder or manager and could come from the various intervention sectors present in the community. The communities were also encouraged to submit the names of other respondents if they deemed it relevant. Over the course of the period between January and June 2010, identified respondents who had not submitted their questionnaires were contacted by phone and the directors who had not provided the name of a respondent were contacted by email. Hard copy versions of the questionnaire were sent out to certain respondents who preferred this method of responding. Furthermore, over the course of the steps required for the third collection process, the team of consultants and the FNQLHSSC invited those participating in the data collection process to fill out the questionnaire if they had not already done so. Hard copies were also sent to those who asked for them. In August 2010, a minimum of one questionnaire had been received for 17 out of the 29 communities (59%). The health and social services directors in the communities that had yet to respond were contacted by phone between September and December of 2010 to obtain the highest possible response rate. In February 2011, upon submitting this report, the final response rate is 86% (or 25 communities).

The questionnaire data was compiled using the SPSS 18 software. For respondents who filled out the questionnaire online, the data was automatically imported into the database. Data stemming from hard copy questionnaires was entered manually and revalidated by a member of the team of consultants.

It is important to take into consideration the various challenges that the team of consultants and the FNQLHSSC were faced with during this second data collection process. First of all, despite the desire to make the questionnaire more accessible by putting it online, it turned out that most of the respondents much preferred filling out the hard copy. Certain directors provided a high number of potential respondents but few of them actually filled out the questionnaire. The phone calls made revealed that the tables in the second section were too complex and therefore discouraged certain respondents from filling out the questionnaire. Furthermore, a limited number (n=8) of questionnaires were filled out online without being sent to the database. This problem was caused by a programming error made while the questionnaire was being made accessible online. That said half (n=4) of these respondents filled out the questionnaire a second time. Moreover, there was another issue related to the duration of the collection process - the data was in fact collected over the course of an entire year. Since much of the data concerns attitudes and perceptions, it is possible that various actions taken over the course of this period may have had an impact on the answers to certain elements. That said the themes covered are complex and it is very unlikely that drastic changes took place over this period of time. Finally, since random selection was not possible, the data was collected using a convenient sampling process. The results must therefore be analyzed while taking into consideration the fact that they cannot be applied to all community stakeholders and managers. The data is limited in that it reflects opinions rather than objective observations of the situation.

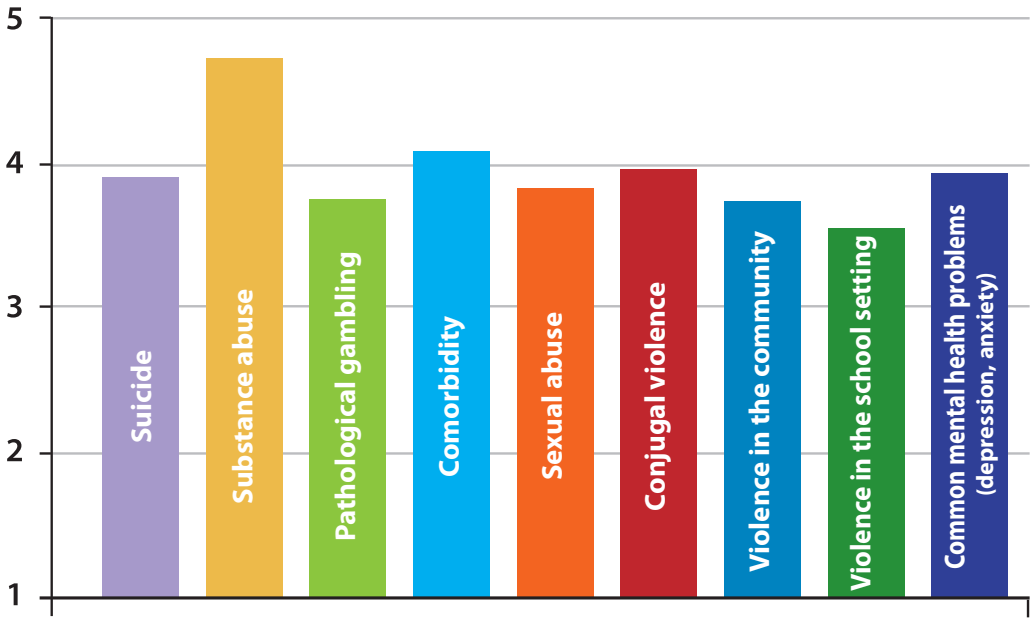
## Results

Upon drafting this report (February 2011), 76 participants from 25 communities had completed the questionnaire. About three quarters of the respondents were women (72.4%) and more than two thirds were between 35 and 54 years of age (60.0%). More than two thirds were Aboriginal people (60.5%). More than 60% of participants had been working in a First Nations community for the past five years or more. They occupied a wide range of jobs, of which the most commonly cited were director/manager (26.3%), social worker (17.1%), NNADAP agent (10.5%) and nurse (10.5%).



Regarding the severity of the mental health problems in the communities, the 76 respondents indicated that, on average, all of the problems were very significant at the very least. One of these problems, substance abuse, was particularly significant given that participants deemed it to be extremely problematic.

FIGURE 1: SEVERITY OF MENTAL HEALTH PROBLEMS




1 = Not important at all, while 5 = extremely important

As for services provided in the communities and identified by participants within the framework of this questionnaire, we noticed that the services especially target common mental health disorders, suicide and substance abuse. Interventions for sexual abuse and conjugal violence were also frequently cited. A lower percentage of interventions seem to focus on gambling problems and comorbidity.

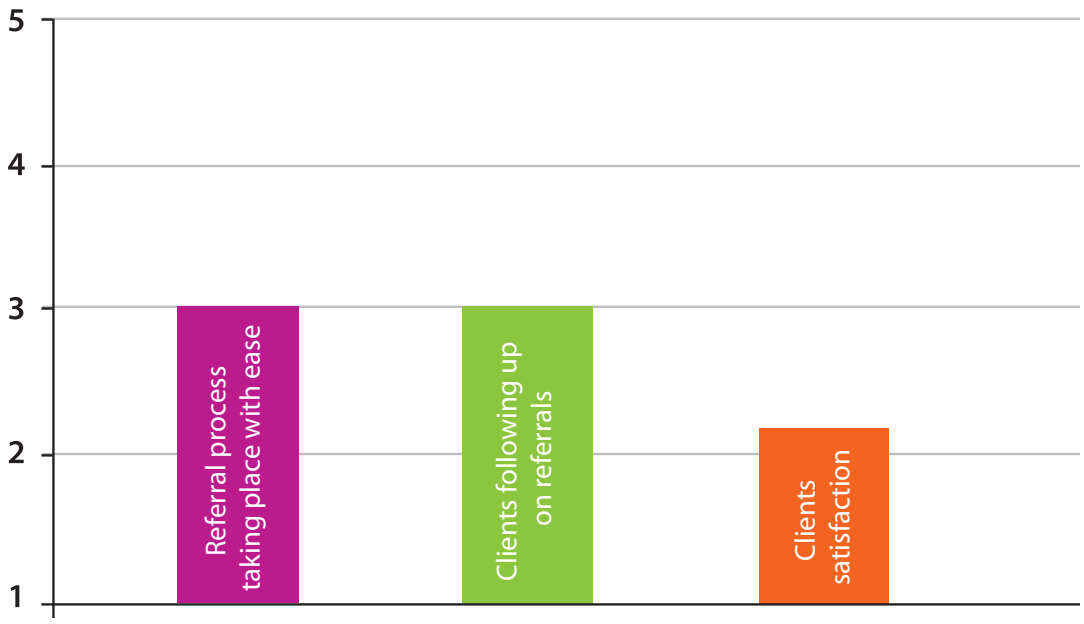
| Targeted Issue | Health and Social Services (n=307) | School and ECC (n=152) | Public Safety (n=60) | Community Resources (n=212) | Informal Network (n=154) |
|---|---|---|---|---|---|
| Mental health | 61% | 55% | 65% | 21% | 39% |
| Suicide | 56% | 51% | 82% | 20% | 47% |
| Substance abuse | 61% | 48% | 85% | 32% | 53% |
| Pathological gambling | 34% | 25% | 22% | 14% | 28% |
| Comorbidity | 42% | 34% | 42% | 17% | 26% |
| Sexual abuse | 48% | 44% | 72% | 19% | 30% |
| Conjugal violence | 50% | 45% | 92% | 23% | 36% |
| Community violence | 36% | 36% | 88% | 17% | 38% |
| Violence at school | 32% | 61% | 68% | 10% | 22% |

As for the clienteles targeted by these services, respondents reported fewer services for Elders than for other age groups. Moreover, few services are specifically designed for parents.

| Targeted Population | Health and Social Services (n=307) | School and ECC (n=152) | Public Safety (n=60) | Community Resources (n=212) | Informal Network (n=154) |
|---|---|---|---|---|---|
| Child | 70% | 88% | 87% | 49% | 45% |
| Woman | 73% | - | 93% | 50% | 75% |
| Man | 74% | - | 93% | 39% | 75% |
| Elder | 60% | - | 80% | 37% | 68% |
| Parents | - | 61% | - | - | - |

More than 86% of respondents (66) filled out the section focusing on referrals made towards services in the Quebec health network. The responses demonstrated a mitigated perception of the referral system towards the Quebec health system. Respondents reported that the referral process is relatively simple, that clients are only moderately satisfied with the referrals and that they follow-up on referrals only half the time.

FIGURE 2: REFERRALS TO THE PROVINCIAL NETWORK




1 = Not important at all, 5 = extremely important

Respondents then mentioned the factors they believe facilitate the referral process. Two facilitating factors were mentioned by a significant number of participants with respect to this process: the fact that the services are not available in the community (27.6%) and the implementation of formal or informal collaboration mechanisms (22.7%).

Factors that facilitate referrals to the provincial network

| Themes | # of respondents who mentioned the theme | % of respondents who mentioned the theme |
|---|---|---|
| When the services are not available in the community | 21 | 27.6% |
| When there are formal or informal collaboration mechanisms or when there are good lines of communication | 17 | 22.4% |
| Access to care and material in English or French depending on what language the person speaks | 8 | 10.5% |
| Good knowledge of the network | 8 | 10.5% |
| When the service addresses the needs | 7 | 9.2% |
| Participation of the patient or family | 6 | 7.9% |
| Medical emergency | 6 | 7.9% |
| To ensure the patient's confidentiality | 4 | 5.3% |
| Good transportation network for the patient | 1 | 1.3% |
| When the intervener accompanies the patient | 1 | 1.3% |
| Proximity of resources | 1 | 1.3% |

As for the factors limiting referrals to the provincial network, two of them were more significant for participants: the lack of cultural adaptation (including language barriers) and the lack of availability and knowledge of the provincial network.

Factors that limit referrals to the provincial network

| Themes | # of respondents who mentioned the theme | % of respondents who mentioned the theme |
|---|---|---|
| Lack of cultural adaptation, lack of knowledge of the community's resources and their limits, language barriers (English and Aboriginal languages) | 35 | 46.1% |
| Lack of availability, waiting list, lack of knowledge of the network | 22 | 28.9% |
| Inaccessibility of the resources – distance, absence of road networks, transportation costs, logistical needs | 15 | 19.7% |
| Lack of patient collaboration, refusal or lack of interest for non-Aboriginal services | 9 | 11.8% |
| Difficulties linked to jurisdictional battles (Quebec, Ontario, Canada) | 8 | 10.5% |
| Prejudices, lack of respect and subjectivity | 8 | 10.5% |
| None | 4 | 5.3% |
| Deficient communications, structures that are too cumbersome | 3 | 3.9% |

Three factors that could potentially contribute to enhanced collaboration were frequently mentioned by participants: the implementation of structured collaboration structures (46.0%), the signing of formal agreements (21.1%) and the reorganization of resources in the communities (18.4%).

Factors that contribute, or could potentially contribute, to better collaboration

| Themes | # of respondents who mentioned the theme | % of respondents who mentioned the theme |
|---|---|---|
| Structured mechanisms for collaboration and communication such as regular meetings, follow-up forms, reduced prejudices and ignorance and continuous training | 35 | 46% |
| Formal and signed agreements | 16 | 21.1% |
| Development and reorganization of resources in the communities | 14 | 18.4% |
| More English resources in the network or access to services in the adjacent provinces | 11 | 14.5% |
| More network resources such as shelters near care facilities | 5 | 6.6% |
| Involvement of community representatives in the network's decision-making process | 2 | 2.6% |

# COLLECTION PROCESS 3 : CONSULTATIONS AMONG THE COMMUNITIES

## Methodology

The third data collection process, which was held between February and November 2010, was meant to gather the perceptions of community stakeholders and managers with respect to facilitating factors and barriers that influence the development of mental health resources as well as possible solutions.

For this collection process, group consultations (focus groups) were held among stakeholders and managers from eleven communities targeted by the project. First, a semi-structured interview table was developed by the team of consultants and the FNQLHSSC. This table established a favoured order for addressing the various themes while not including any specific questions or excluding the possibility of amending the themes if appropriate.

The themes addressed in the framework of the consultations were:

- The high rate of mental health problems in the communities;
- Mental health initiatives and programs in the communities;
- Methods used by community members for mental health situations;
- Elements that limit the service offer and access in the communities and elements that foster a better service offer;
- The collaborative process with the Quebec network;
- Elements that foster or limit access to the resources of the Quebec network;
- Suggestions for enhanced collaboration between the two service providers;
- The community's strong points.

In accordance with the qualitative nature of the objective of this collection process, a convenient sampling process was used in the eleven communities. Through this sampling, the team of consultants and the FNQLSHSC tried to obtain a detailed description of the realities in a variety of conditions. The following selection factors were used to develop the sampling: geographic situation (degree of remoteness), nation and language spoken. Once the communities were selected, the FNQLHSSC contacted a resource person in the community in order to select a date on which to hold the consultation and, if necessary, collect the names of potential participants. The participants could come from various settings: health sector, social

services, education, early childhood centres, police, community resources or informal network, and could be managers or field stakeholders with various levels of experience. An invitational email was sent to the identified participants as well as a reminder a few days prior to the day on which the consultation was to take place.

Although the collected information was not sensitive in nature, it nonetheless required informed consent from participants. Therefore, after having received an explanation of the project and the goals of the consultation process, the participants all received a consent form that was read to them. The questions of the participants were answered before they signed the form. Once the consent form was signed, the data collection process officially began.

The consent form specified that the consultations were being recorded. A verbatim transcription of the consultation sessions was drafted based on these recordings. In order to ensure the validity of this transcription process, a member of the team performed a verification of the transcriptions while checking the recordings. The transcriptions were electronically imported with the NVIVO 8 qualitative analysis software. The transcription analysis goal was to identify the themes raised by participants.

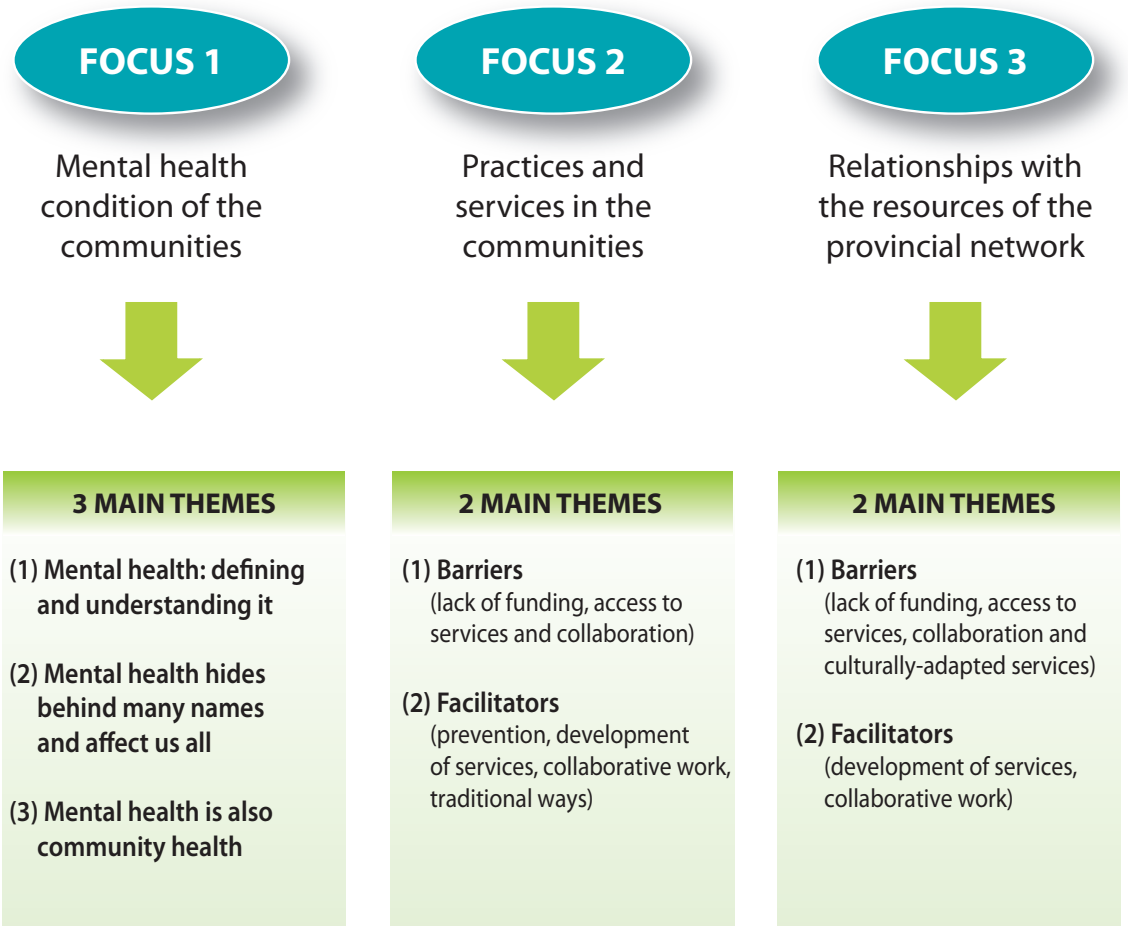
A validation analysis focusing on the themes was carried out in the fall of 2010 by an undergraduate student studying social work. This student was supervised by a project consultant. Four of the consultations were coded independently from the main process with the NVIVO 8 qualitative analysis assistance software. The choice of the four consultations was made in such a way as to ensure diversity in factors related to language and geographic distance. The goal of this complementary analysis was to confirm the themes identified by the main analysis and perfect their organization. In light of this exterior perspective, the results of the main analysis were updated.

One of the main challenges of this data collection process was the spreading out of consultations over a ten-month period (including a three-month break over the summer), given the complexity behind the coordination and mobilization of the consultations. Considering the themes being addressed and the subjective nature of the data, it is possible that the content of certain consultations was affected by changes that may have occurred during the collection period. The fact remains that the themes are complex in nature and that there is a low level of probability in terms of significant changes. Finally, the data was collected using a convenient sampling process. Despite efforts made to recruit participants from various settings, the health and social services sectors were solicited the most. Therefore, the results, which are of a qualitative nature and represent the opinions of the participants in the consultation sessions, must be interpreted as such and cannot be considered as being representative of all stakeholders and managers among the communities targeted by the project.

## Results

The following eleven communities were consulted: Akwesasne, Gesgapegiag, Kahnawake, Kitigan Zibi, Listuguj, Mashteuiatsh, Nutashkuan, Obedjiwan, Pakua Shipi, Unamen Shipu and Wendake. The number of participants per consultation session varied between 5 and 12, for a total of **89 participants**. Of this number, 52.8% were health and social services stakeholders, 25.8% were coordinators, supervisors or managers, 10.1% were non-stakeholder workers related to the health and social services field, 5.6% were from the education sector, 3.4% were from the public safety sector and 2.3% were community members involved in the mental wellness of the members of their respective communities.

The results of this data collection process are sorted into three broad focus areas: the mental health condition of the communities, the practices and services in the communities and the relationships with the resources of the provincial network. The following chart summarizes the themes linked to each focus areas, while the subsequent sections describe them in detail.



# FOCUS AREA 1
# MENTAL HEALTH CONDITION

First of all, the consultations allowed for the collection of the perceptions of the participants regarding the mental health condition of respective communities.

Three broad themes were identified:

(1) The definition and understanding of mental health
**(Mental health: defining and understanding it)**;

(2) The mental health problems and concerns
**(Mental health hides behind many names and affects us all)**;

(3) The socio-economic elements perceived as playing a direct or indirect role in the mental health condition of the community
**(Mental health is also community health)**.

The elements presented in the tables of the subsequent sections were mentioned in the majority of the consultation sessions.

## Theme 1
## Mental health: Defining and understanding it

The consultations shed light on the uncommon use of the expression "mental health", both among community members and the participants in the consultation sessions. This expression evokes uneasiness or misunderstanding, which impedes the mobilization of community members around this issue. Other than these common elements, the participants of certain consultation sessions mentioned that mental health involves an emergency to take action, that there were certain prejudices against those affected by mental health disorders and that these people were being stigmatized. Certain stakeholders stated that they did not feel that they had the tools required to intervene in matters related to mental health disorders.

| Table 2: Mental health: defining and understanding it |
|---|
| The expression "mental health" is seldom used by community members |
| Stakeholders rarely use the expression "mental health" in their discourse |
| The mobilization of community members around mental health is difficult since the notion of mental health evokes a sense of uneasiness (mental disease, craziness, taboo) or misunderstanding |
| The discourse regarding mobilization around mental health problems is often focused on the emotions and behaviours that can be linked to mental wellness or mental health disorders |
| The participants associate the expression "mental health" with specific disorders that can be diagnosed but also psychological, emotional or spiritual turmoil |

## Theme 2
## Mental health hides behind many names and affects us all

In a recurring fashion, participants identified substance abuse or comorbidity (concurrence of substance abuse with a mental health disorder) as being one of the major mental health problems in their respective communities. They also perceived this comorbidity as increasing. Participants were very concerned for the youth, who are at risk of developing mental health disorders because of their substance abuse. This situation was perceived to be deteriorating and participants were becoming increasingly concerned with it. Generally speaking, receiving services for substance abuse was perceived as a positive process. According to participants, severe diagnosed mental disorders without comorbidity were not particularly common; however, they noted that it is difficult to access diagnostic services. Finally, the transitional disorders and psychosocial risk factors linked to mental disorders are rather common but were not generally perceived as being major concerns for mental health.

| Table 3: Mental health hides behind many names and affects us all |
|---|
| The participants identified substance abuse, either alone or in comorbidity with a mental health disorder, as being one of the most visible mental health problems |
| Comorbidity (concurrence between a mental health disorder and substance abuse) is increasing |
| Youth are at risk because of their substance abuse issues |
| Substance abuse patterns are increasingly harmful (starting earlier, increasingly toxic substances, accumulation of addictions and increased accessibility of substances) |
| Getting help for a substance abuse problem is perceived positively |
| Diagnosed severe mental disorders are uncommon |
| Getting access to diagnostic services is difficult |
| Transitional mental disorders (such as depression) are the most common mental health problems, regardless of whether or not they are diagnosed. |
| Psychosocial risk factors (low self-esteem, suicidal ideation) are average to very common in the communities |

Some elements that are more specific to certain communities were raised in relation to this theme. Some participants reported a lack of services for people suffering from severe mental disorders or experiencing a situation of comorbidity, diagnosed or not, as well as problems created by the high level of demand on the existing services that these people can cause at certain times, especially those suffering from personality disorders. Furthermore, a few participants stated the possibility that a certain number of community members may be suffering from severe mental disorders that have yet to be diagnosed. The trivialization of polyaddiction and the direct link between substance abuse and the increase in suicide attempts and completions were raised. Some noted an increase in cases of Alzheimer's disease and dementia in accordance with an aging population, while others mentioned the significance of developmental problems and question the link between substance abuse and these disorders. In a few communities, participants believed that the acknowledgement of transitional disorders and risk factors was more significant and less stigmatizing than the presence of a severe mental disorder. Participants in certain consultations mentioned prescribed drug use problems, including abusive or recreational use, or misuse. They also mentioned that the population did not acknowledge these drug use problems given the medical nature of the drugs. Finally, substance abuse problems have sometimes been linked to a form of self-medication for underlying mental health problems.

## Theme 3
## Mental health is also community health

We noticed that concerns related to substance abuse issues are resurfacing in accordance with related violence issues. Participants were concerned with the lack of communication and discussion between Elders and youth in addition to the lack of parenting skills impeding the optimal development of youth. Participants also mentioned that certain community members were often committing indiscretions and not minding their own business, and that the presence of disparagement and rumours between various community factions was quite significant. Finally, in a unanimous fashion, housing-related shortages were identified as being problems affecting mental health, either because of the remoteness of communities or overcrowding.

| Table 4: Mental health is also community health |
|---|
| An increase in substance abuse engenders an increase in community violence |
| Disconnection between generations (youth and Elders) |
| The lack of parenting skills has a negative impact on youth development |
| Indiscretions and disparagement between community members |
| Housing shortages |

During the consultations, the following negative factors were also identified, although in a more sporadic fashion: the trivialization of child abuse situations and the intergenerational traumatic transmission, especially in terms of residential schools; the presence of the physical and financial abuse of Elders; the loss of identity and culture; the poor local economy and the high poverty rate; the lack of accountability from community members; the remoteness factor resulting in high living costs, a lack of resources and isolation; the frequency of the elections involving frequent changes in band councils that can have an impact on projects under way; and difficulties integrating into the regional context when the language of choice is different (English in a French-speaking context). That said, numerous aspects promoting community health were mentioned, such as job access; a strong economy; the motivation of members; community organization; the availability of professional services; the family network; strong parenting skills; mutual help and support; appreciation for cultural components, including language; adaptation and openness skills; and whistleblowing activities against problems affecting the communities, especially in terms of drug trafficking.

# FOCUS AREA 2
# PRACTICES AND SERVICES IN THE COMMUNITIES

The second focus point in terms of data is related to the services and practices that are implemented or should be implemented in the communities (those under federal jurisdiction). Two general themes were evident - the **existing barriers** to a good service offer and the **best practices and success factors**. These themes were divided into subcategories. The existing barriers are elements impeding the implementation of services or practices deemed necessary or desirable, limiting accessibility to resources or limiting the availability of optimal services for clients. On the other hand, success factors are those perceived as fostering the deployment of best mental health practices. These have already been used in the past or were suggested by participants as new avenues to be explored.

The following are existing barriers: (1) lack of funding; (2) difficulties related to service accessibility; and (3) lack of collaboration, communication and mobilization.

Best practices and success factors consist of (1) prevention and sensitization related to mental health problems; (2) the development of community services; (3) collaborative work; and (4) the use of traditional healing methods.

## Theme 1
## Existing barriers

**(1) Lack of funding**

Participants identified lack of funding as being the main factor affecting the development of services provided in the communities. Stakeholders must dedicate much of their time to resolving crisis situations or situations that are at a high risk of complications, since these must be prioritized and their volume is such that stakeholders in place, for the most part, can only focus on the highest priority files. This personnel shortage in many communities is due to a lack of available positions for additional stakeholders, which is directly related to the lack of funding. In other communities, this shortage is actually linked to a high rate of staff turnover leading to a workforce shortage. The lack of financial resources, and therefore personnel, impedes the emission of tasks for secondary or tertiary prevention. The lack of funding also prevents access to continuous training and the development of the mental health service offer for youth, beyond those provided to the youth who receive services from the *Centres jeunesse*. Finally, the lack of funding entails reduced resources for the NIHB Program, and it is important to keep in mind that this program does not cover long-term psychological follow-up.

| Table 5: Lack of funding |
|---|
| A lot of intervention time is dedicated to crisis situations or situations that are at a high risk of complications |
| Few opportunities for carrying out secondary and tertiary prevention |
| Lack of access to continuous training |
| Little or no mental health services for youth who do not receive services from the *Centres jeunesse* |
| The Non-Insured Health Benefits (NIHB) Program is not sufficient for long-term follow-up |

Issues related to the lack of funding that were only mentioned in certain communities were the absence of youth centres; the limited amount of youth activities organized; the resource shortages in schools; the lack of infrastructures for community care or well-being (community centre, intergenerational home); the very limited amount of resources for the rehabilitation of youth with substance abuse problems; the absence of a 24/7 crisis centre; the lack of a cultural stakeholder position or use of cultural approaches; the non-existent or limited number of services for Elders, particularly in terms of mental health services; the lack of comorbidity-related services; concerns related to the termination of the support that was being received through the Aboriginal Healing Foundation; the lack of funds allocated by Health Canada to the services compared to those allocated to the administration and other activities and the lack of service agreement discounts for services underfunded by Health Canada.

**2) Difficulties related to service accessibility**

The criteria in Health Canada's program are considered too inflexible and prevent all needs from being addressed. Furthermore, participants identified the existence of waiting lists and the lack of confidentiality as being significant barriers.

| Table 6: Difficulties related to service accessibility |
|---|
| Health Canada's programs are too limited and inflexible. They do not cover all of needs, particularly those related to treatment |
| Significant waiting lists for accessing services |
| Lack of confidentiality: Possible identification of those who access the health and social services because the locations where these services are provided are very visible in the community |

In certain communities, the fact that access to psychologists takes place in the framework of the NIHB Program is a limiting factor since this program's structure is too cumbersome for the people to deal with to obtain access to professional help. Furthermore, the absence of the resources required regionally and in the language of choice tends to decrease access to these resources. Finally, the versatility of stakeholders can lead to confusion and limit voluntary access to the services, as community members are unsure of the mandates

of these stakeholders (if they are working for youth protection or not).

**3) Lack of collaboration, communication and mobilization**

Table 7 indicates the elements that were mentioned in a few communities and that are related to the lack of cohesiveness between services or between the services and the community.

| Table 7: Lack of collaboration, communication, and mobilization |
|---|
| Working in silos |
| Deficient collaboration between the health and social services sectors and the school |
| Lack of clear identification in terms of who pays for what with respect to evacuations (health or social services) |
| INAC is responsible for managing goods in cases of public curatorship but does not offer any management |
| Community members generally only mobilize when the needs are pressing and become disengaged when the situation diminishes. |
| Elders only rarely participate in the activities organized for them if they are not provided with a reminder on the days on which these activities are held |

## Theme 2
## Best practices and success factors

**1) Prevention and awareness**

Generally speaking, primary prevention is very present and successful. It takes place in various forms, but during numerous consultation sessions, participants wanted to see more primary prevention or improvements to better address the problems present in the communities as noted in Table 1. Furthermore, in certain communities, participants mentioned that initiatives fostering an active cultural and traditional life were an effective way to promote good mental health. Sensitization to burnouts and vicarious traumas was discussed during a few consultations.

| Table 8: Prevention and awareness |
|---|
| Primary prevention initiatives are varied and generally effective |
| Inclusion of primary prevention related to mental health during other interventions when the context is conducive to it |
| Popular education initiatives such as radio programs, capsules or newsletters |
| Sensitization of the population as to mental health |

**2) Development of community services**

In order to develop mental health services in the communities, respondents proposed that the following factors be considered: banking on versatility, clinical expertise and support between stakeholders, fostering community control over services related to youth protection, setting up crisis services and collaborative agreements between sectors, increasing the number of stakeholder positions, implementing continuous training for stakeholders and offering more youth services and improving Health Canada's service offer, especially in terms of treatment services.

| Table 9: Development of community services |
|---|
| Versatility, clinical expertise and support between interveners |
| Control over certain aspects or all of services related to youth protection |
| Crisis intervention with the on-call system and collaborative agreements between sectors |
| Higher number of stakeholder positions |
| Improved access to continuous training |
| Increase in youth services |
| Improvement of Health Canada's service offer: Offering treatment services |

Here are some other suggestions mentioned in a limited number of communities: the creation of resources to respond to more specific needs of members affected by severe disorders; the implementation of activities for people diagnosed with a mental disorder to give them an opportunity to get out of their homes and provide the families with respite; the establishment of a mental health team to develop expertise and skills and ensure service consistency for the benefit of the clients; the existence of a centre for Elders or the organization of activities fostering gatherings for Elders on a regular basis; prevention and relations among citizens for public safety; the existence or setting up of a shelter for women experiencing difficulties and their children; extended interventions by the shelters to address the various needs of the community in general if the services are not available elsewhere; the presence of versatile stakeholders in schools; psychoeducation services to improve parenting skills; implementation of a family home, community centre and any other resource that increases the number of gateways to the services; development of family services separately from youth protection to restore trust; promote the training of a Native succession; and the establishment of a local justice system. Finally, certain communities indicated that they wanted to develop improved follow-up for those affected with mental health disorders.

### 3) Collaborative work

There are only a few points in common among the majority of the consultation sessions pertaining to collaborative work, as illustrated in Table 10; however, several communities adopt their own successful mechanisms. Among these initiatives are the grouping of services under a same roof to facilitate collaboration and the recognition of interaction between intervention sectors; the implementation of a committee or working group to improve collaboration between sectors; collaboration with the pharmacies of the sector or the community regarding access to medication (regulating medication and preventing abuse); active networking; the implementation of Telehealth services; and the creation of working committees at the band council or in an informal manner to foster community wellness. Furthermore, a few communities suggested that rallying community members around a common goal could foster overall collaboration.

| Table 10: Collaborative work |
|---|
| Joint or concerted intervention with police services |
| Good relationships with NNADAP treatment centres |

### 4) Use of traditional methods

In most consultations, it was obvious that traditional practices, whether linked to mental health services or present in a general fashion in the community, are linked to greater success and an improved mental health condition. Certain communities, not having formal services connected with these services, suggested implementing a stakeholder to foster the development of these approaches. Note that certain participants mentioned that not all community members are comfortable with these practices. Consequently, they suggest not imposing these services or approaches on all clients.

| Table 11: Use of traditional healing methods |
|---|
| Access to traditional or cultural services |
| Support towards the development of traditional practices related to mental health |
| Traditional activities in the community such as pow-wows and drum groups, hunting and fishing on the land and arts and crafts |
| Creation of a cultural stakeholder position |

# FOCUS AREA 3
# RELATIONSHIPS WITH THE RESOURCES OF THE PROVINCIAL NETWORK

The third and last category of the variables collected focuses on the relationships established between the communities and the resources of the provincial network provided outside the communities. As for the previous section, two broad themes were obvious – the **existing barriers** to a good service offer and the **best practices and success factors**. Moreover, these were divided into subcategories.

The following existing barriers were noted: (1) the difficulties linked to service accessibility; (2) the lack of collaboration and communication; (3) funding shortages; and (4) services that are not culturally adapted.

Best practices and success factors include: (1) the collaborative work and (2) the development of services for the benefit of the First Nations population.

## Theme 1
## Existing barriers

**(1) Service accessibility**

In the majority of communities, participants noted five factors limiting access to mental health care in the provincial network as presented in Table 12. They mentioned the complex organization and ignorance of the services as playing a significant role. Two other elements mentioned were the long delays and the difficulty in obtaining psychiatric consultation for a non-urgent need such as diagnosis. Finally, jurisdictional battles (federal and provincial) sometimes limit the services that can be obtained from the provincial network.

| Table 12: Difficulties linked to service accessibility |
|---|
| Service organization in the provincial network is complex |
| Ignorance of the existing resources on both sides |
| Difficulty in obtaining a consultation with a psychiatrist outside of emergency situations or to obtain a diagnosis |
| Waiting delays |
| Problems establishing responsibility for the financial coverage of services |

For certain communities, other factors come into play such as prejudices, the lack of respect and racism experienced by community members when accessing the services of the provincial network, refusal to provide services to people living in the community; the distance or absence of roads, which can limit access to crisis services when they are needed; a geographic distance that is too great thereby preventing the use of certain services; and the inexistence of services required in the local, regional or provincial resources. For some participants, there is no limit for their community, other than those inherent to Quebec's system.

**(2) Lack of collaboration**

Most respondents mentioned that the lack of communication between the services of the Quebec systems and the resources that ensure follow-up in the community has a negative impact on the deployment of services.

| Table 13: Lack of collaboration and communication |
|---|
| The lack of follow-up among resources following a hospital stay or other services requiring follow-up |

Certain communities reported other barriers such as the fact that they are not invited to training sessions offered in the network; the exaggerated number of authorizations required to access certain services, particularly second-line services; the communications between the resources of the communities and those of the network that are often deficient and involve several (too many) players; the subjective interpretation of the right to access services (knowledge regarding access to provincial services for Aboriginals varies); the ill-founded view of the CSSS that community services fall under its responsibility and are not independent; and the skills of community stakeholders, which is not always recognized.

**(3) Lack of funding**

Two barriers were identified as being directly related to the lack of funding in the provincial network. Participants perceived that the lack of funding affects the duration of hospital stays or emergency services, which causes people to be discharged prematurely, and also perceive the lack of specialists in the network, especially psychiatrists and child psychiatrists.

| Table 14: Lack of funding |
|---|
| The premature discharge of clients staying in hospitals or benefitting from emergency services |
| Lack of specialists |

**(4) Services that are not culturall adapted**

Table 15 regroups elements that were only mentioned in a few communities but that nonetheless constituted very significant barriers for them.

| Table 15: Services that are not culturall adapted |
|---|
| Certain services are only provided in French thereby preventing members from certain communities from accessing them |
| Access to psychiatric services in English in certain regions is either limited or non-existent and prevents people from obtaining care and diagnostics |
| Access to English services varies depending on the time and the day of the week |
| The fact that it is not possible to access services offered in adjacent provinces |
| The lack of adaptation of the services to the realities of the communities and the importance of the cultural aspect |

## Theme 2
## Best practices and success factors

**(1) Collaborative work**

A good collaborative relationship between the Quebec health and social services system and the communities was identified by most communities as being a success factor.

| Table 16: Collaborative work |
|---|
| In crisis situations, services offered to community members must be provided at the time and place required |
| Drafting of clear agreements between community services and the CSSS in charge, which include financial responsibilities if necessary |
| Creation of mutual trust and recognition of the skills between services |
| Sensitization regarding the organizational structure of services in such a way as to reduce overall prejudices |
| Following of training with the CSSS |

Several other existing elements were only mentioned in a few communities. These elements include collaborations with community-based organizations carried out in an egalitarian basis with no financial responsibility issues; agreement terms with the *Centres jeunesse* that ensure that services provided are also appreciated (agreements on the financial aspects and services to be received); good communication vectors facilitating communications; collaborations with community-based organizations facilitated by simpler management structures; the launching of activities containing two components and valuing both participants (community services and network services); meetings among partners, both with management

and stakeholders; and community organization tours in the community to better grasp their context. Here are some suggestions made in a few communities: implementing clear communication vectors such as liaison agents or a designated stakeholder and limiting the number of players involved in the decision-making processes to access services, particularly second-line services.

**(2) Development of services for First Nations**

In this category, no exemplary practices already in place were mentioned; however, suggestions were made in this area during some consultation sessions.

| Table 17: Development of services for the First Nations population |
|---|
| Orientation of services towards a holistic approach |
| Increased resources in remote areas |
| Shelters for patients and their families near the resources if the distance between the community and the care location is significant |
| Improved English language service offer |
| Increased access (as before) to services offered in adjacent provinces |

# POOLING OF DATA FROM COLLECTIONS 2 AND 3: SERVICES IN THE COMMUNITIES

## Results

In order to report on the mental health services genuinely offered in the communities in an accurate manner, the data stemming from collection processes two and three was used. The survey (collection 2) allowed us to inventory the positions filled by professionals working in the area of mental health, while the consultations that held among community members (collection 3) allowed us to better assess the actual service offer of these professionals.

The data being discussed here stems from nine (9) communities that answered the survey (services section) and provided information on their services during the consultations: Kahnawake, Kitigan Zibi, Listuguj, Mashteuiatsh, Nutashquan, Obedjiwan, Pakua Shipi, Unamen Shipu (La Romaine) and Wendake.

**Health services and social services**

For the health services and social services, we asked whether or not there were positions for the nine (9) following professionals in the communities: social worker, psychologist, psychoeducator, specialized educator, mental health nurse, NNADAP agent, general practitioner, psychiatrist and social or mental health stakeholder (other than a social worker or educator).

Based on the results of the survey, the breakdown among the nine communities is as follows: NNADAP agents (100%), social workers (88.9%), special educators (77.8%), general practitioners (77.8%), psychologists (66.7%), mental health nurses (55.6%), social stakeholders (55.6%), psychoeducators (44.4%) and psychiatrists (22.2%).

That said the consultations allowed for the establishment of a more nuanced perspective in terms of the actual service offer in the communities. First of all, the social workers were identified as stakeholders responsible for youth protection services and, when available, psychosocial stakeholders for general social services. Moreover, some had the official social worker title while others had another employment title such as a psychosocial stakeholder or a human relations agent. If the social work and social stakeholder positions were to be considered jointly, all communities would have at least one stakeholder in this particular field of expertise. For these stakeholders, they may be called to deal with mental health problems in the framework of their duties (i.e. substance abuse, violence) but it is rare for their main roles to be specifically related to mental health. Furthermore, these are stakeholders who often deal with emergency or critical situations and so can rarely offer long-term services.

As for **psychologists**, it was usually a matter of professionals offering services in the framework of Health Canada's Non-Insured Health Benefits Program. In a few cases, their services were being covered through other temporary envelopes or by the band council. Nonetheless, in almost all communities, the professionals were only periodically visiting the communities and were not employed on a permanent basis. These professionals therefore could not offer continuity in terms of care and were often overloaded.

Even though five (5) communities stated that they had nurses specialized in mental health, only two of them actually had a nurse or nurses strictly devoted to mental health and this title was not always official. There were nurses in all communities who were intervening in various situations, including those related to mental health. That said these nurses were rarely trained specifically in mental health intervention.

All communities mentioned having a **NNADAP agent**, which was confirmed during the consultations.

While the results of the survey seem to demonstrate a strong presence of **general practitioners** in the communities, consultation participants mentioned the fact that, in the vast majority of cases, the physicians serving their communities are not present on a permanent basis and are instead affiliated with a CSSS. Their role was perceived as being rather limited in nature. The consultations validated the fact that they are important allies, particularly in terms of transitional problems, but that they tend to play a prescribing role more than anything else.

As for **psychiatrists**, even though survey responses indicated their presence in two communities, the consultation sessions showed that no community had a psychiatrist working in the community. Collaboration has taken place with the CSSS and it is the members who must travel to see the psychiatrist.

The presence and roles of the **psychoeducators** and **special educators** were rarely addressed during the consultation sessions and therefore cannot be analyzed in a more in-depth fashion.

**Schools and early childhood centres**

As for services provided in schools and early childhood centres, the breakdown of professionals in all nine communities according to survey responses is as follows: special educators (66.7%), social workers, psychologists, psychoeducators and stakeholders (55.6% for each position).

During the consultations, few representatives from this sector were present and discussions rarely allowed for the evaluation of the presence of stakeholders working in the communities. During the few consultations dealing with the subject, educators were the most commonly confirmed positions. Psychologist services to which participants referred also based on visits rather than permanent positions; these were sometimes the same services being used for health services and social services. The interventions made by these professions were generally indentified as being related to school violence.

**Public safety**

Regarding public safety, both the survey responses and consultations confirmed the presence of police forces in all communities. Most communities have a local police force; however, some are covered by the Sûreté du Québec (SQ) while others receive support from the SQ if necessary. Even though the most common types of interventions are patrols, emergency calls and complaints processing, there are also a lot of joint interventions and police escort services. This was confirmed by consultation participants. They stressed the good collaborative relationship maintained with police officers during joint interventions and crisis situations as well as the importance of adequately identifying the roles and responsibilities of each partner. Police involvement in the communities such as through relationship-building activities with the community and work on-site and prevention/promotion were also frequently mentioned in the surveys and seen in a very positive light by consultation participants.

**Community resources**

The portrait tends to vary greatly in terms of community resources. According to survey responses, the breakdown is as follows: youth centres (66.7%), leisure centres (55.6%), community centres, support groups and family centres (44.4% for each type of organization), shelters for women experiencing difficulties, mental health organizations, centres for Elders and telephone help or referral lines (33.3% each) and resource centres for men (11.1%). No community results revealed a women's shelter. On a "by community" basis, results varied from one resource to nine, from a list of eleven choices.

The consultations stressed the fact that youth centres, even though they constitute the most commonly found resource, are sometimes being shut down in certain communities for various reasons that are often financial in nature. A single support group was identified during the consultations (an Alcoholics Anonymous group) even though survey results indicate that this type of resource was the most commonly provided. Family centres were confirmed in most cases even though they are not always fully operational. The consultations also stressed the fact that their interventions were especially related to maternal and child health, child development and parenting skills. The three communities that identified a shelter also did so during the consultation. According to the survey, they were offering services related to conjugal violence, sexual abuse, substance abuse and comorbidity. Survey results demonstrate that centres for Elders were seldom intervening with regards to the targeted issues. As for community and leisure centres, they were rarely mentioned during the consultations. In the survey responses, respondents did not often link these resources with mental health interventions. Regarding mental health organizations and help or referral hotlines, the consultations did not allow for clear identification as to which organization or hotlines respondents were referring to during the survey.

**Informal network**

Finally, all communities identified at least one informal network resource, while some selected all options proposed. Thus, according to survey results, the Elders and sharing circles are mental health resources that were present in 88.8% of these communities, informal caregivers and informal groups were present in 66.7% of these communities and healers were present in 22.2% of the consulted communities. Generally speaking, the consultations highlighted the presence and importance of Elders. The presence of informal caregivers, informal groups and sharing circles was also generally confirmed. As for healers, the consultations led to the identification of twice as many healers as those present in the survey results.

# OBSERVATIONS FROM RESEARCH DATA

This research project highlights the fact that it is impossible to offer, within the current service delivery context, a range of mental health services similar to what is being offered to other Quebecers in all First Nations communities of Quebec.

In this regard, the development of a mental health service organization model that is well-structured, adapted to the needs of the communities and focused on the most significant problems is vital to target major, sustainable and accessible results for all First Nations communities of Quebec.

Based on the results of the three data collection processes, a few suggestions will be presented here and referred to for reflection purposes by those who will be participating in the validation session to take place on January 18-19, 2011.

**Targeted issues and populations**

Even though many mental health problems were raised, **substance abuse**, with or without comorbidity, appears to be most critical for First Nations interveners and people. Participants stressed the fact that this problem not only affects individuals but all communities as well and should therefore be made a priority to improve both the mental wellness of individuals and the smooth running of communities. If priorities in addressing this issue had to be identified, a mental health service organization model could be a good place to start. Participants also seemed concerned by the situations of the youth and Elders; the model could thus propose special actions to be carried out among these populations.

**Common services (first line)**

Numerous mental health best practices that have been implemented in the communities were reported. Generally speaking, these are considered first-line services, or services that target common and varied health and social problems and are offered close to where the people live. Research results highlight the will of stakeholders and First Nations to see these services developed and offered directly in communities. A mental health service organization model could therefore aim to ensure that all common mental health services, the first-line services, are provided in each community.

Participants mentioned success factors (related to the success) that should be considered in the development of this model:

- **Prevention**: Primary prevention is very present and perceived as being very successful. It takes place in various forms, but in numerous consultations, participants wanted to see increased or improved primary prevention.

- **Intervention**: The development of services should focus on versatility, clinical expertise and support between stakeholders, foster community control over youth protection services and establish a crisis service and collaborative agreements between the sectors. The implementation or improvement of

traditional practices is an avenue to be considered, particularly traditional community activities such as pow-wows and drum groups, hunting and fishing on the land and arts and crafts. Participants also suggested creating a cultural stakeholder position in each community.

- **Collaboration**: The partnership work could draw inspiration from initiatives implemented in the communities such as the grouping of services under one roof to facilitate collaboration, the establishment of a committee or working group to improve intersectoral collaboration, collaboration with the pharmacies of the sector or community regarding access to medication (regulating of medication and abuse prevention), the implementation of Telehealth services and creation of working committees at the band council or in an informal fashion to foster the well-being of the community.

In this context, participants raised the need for Health Canada to make resources available to communities. This will allow them to increase the number of **stakeholder positions**, implement **continuous training** for stakeholders and improve the **treatment service offer**.

Despite a significant number of best practices that have been implemented in the communities, many shortcomings are still present in the struggle to offer services that are coherent with the objectives of the *Plan d'action en santé mentale* (free translation: mental health action plan) (MSSS, 2005-1010), which stipulate that the development of first-line services that are quickly accessible to the entire population is a priority. Among the practices suggested by the Plan but seldom implemented in communities are the mental health first-line teams, responding psychiatrist and crisis services.

First of all, the implementation of **mental health first-line teams** could be considered in the development of a mental health service model. A project that is also funded by Health Canada is currently under way to implement and evaluate the establishment of such a team in certain communities in Quebec (Implementation Project for a Mental Wellness Team in First Nations Communities – Quebec Region). This process will allow for the documentation of short-term outcomes of these teams on the mental wellness of First Nations communities in Quebec.

"The CSSS mental health first-line team is anchored within a territory. Its goal is situated in continuity with the existing first-line services and targets those with mental disorders that cannot be treated at this level, those who do not have a general practitioner or a paediatrician and those with severe but stable mental disorders. The mental health first-line team is the entry point of choice for the second and third-line services.

Its goals consist in participating in mental health information, promotion and prevention activities, treating certain individuals who are referred to the team, contributing to the training of its territory's first-line resources and thereby facilitating the pursuit of their treatment; ensuring social integration services that are intended for those with severe but stable mental disorders."

*Plan d'action en santé mentale*, MSSS, 2005-1010, pp. 23.

Then, the Plan proposes that a **responding psychiatrist** of a local territory be the contact person of choice for the first-line stakeholders who need a professional opinion. Based on this research, this option has rarely been implemented as of yet but could be considered in the model to be developed.

Finally, the first-line service organization, according to the Plan, must ensure access to a range of integrated **crisis services** such as telephone intervention services (a 24 hour, 7 day a week access number), "face-to-face" mobile crisis intervention services and places in a crisis centre. Currently, the implementation of these types of services seems to vary greatly from one community to the next.

**Specialized services (second and third-line)**

The second and third-line services should, according to the Plan, be accessible to those with the most severe symptoms who are in a state requiring hospitalization and those with acute problems. The specialized services also support the first-line services and ensure treatment for those whose problems were not resolved through these services.

Generally speaking, this research was able to demonstrate that few specialized services are currently available in the communities. Because of the shortage of specialized stakeholders in the Quebec health system and the rather low population of certain communities, it does not seem realistic to propose that these types of services be developed in each community. Instead, respondents made suggestions that would allow First Nations members to have easier access to the resources of the Quebec health system:

- **Collaboration**: Good collaborative relationships between the Quebec health and social services system and the communities were identified as success factors by most communities. This refers to the drafting of clear agreements between the communities and the CSSS in charge with respect to First Nations realities and sensitization among community stakeholders regarding the service organization structure in the Quebec health system.

- **Development of services for First Nations**: Participants want specialized services for First Nations members to be integrated into the Quebec health system, the English language service offer to be improved for English-speaking communities, the development of services to be based on a holistic approach and accommodation solutions to be found for family and friends accompanying First Nations people for the duration of their stay to receive care outside the community.

# VALIDATION SESSION

## List of participants

| Given Name | Name | Community/Affiliation |
|---|---|---|
| Maggie | Terrance | Akwesasne |
| Robyn | Mitchell | Akwesasne |
| Louise | Généreux | Wapan Centre |
| David | McLaren | Eagle Village |
| Virginia | McMartin | Eagle Village |
| Eleanor | Pollock | Gesgapegiag |
| Joanna | Martin | Gesgapegiag |
| Vicky | Coury Jocks | Kahnawake |
| Stacey | Ross | Kahnawake |
| Gloria | Nelson | Kanesatake |
| Kelly | Gabriel | Kanesatake |
| Glenda | Sandy | Kawawachikamach |
| Sandra-Lynn | Leclaire | Kawawachikamach |
| Michel | Penosway | Kitcisakik |
| Robin | Decontie | Kitigan Zibi |
| Martine | Mathias | Long Point First Nation |
| Gildor | Echaquan | Manawan |
| Maxime | Ottawa | Manawan |
| Alain | Boisvert | Manawan |
| Jeannine | Bellefleur | Mingan |
| Nathalie | Lapierre | Natashquan |
| Lucie | Wapistan | Natashquan |
| Claudette | Mandeville | Lac Simon |
| Serge | Awashish | Opitciwan |
| Geneviève | Riverin | Opitciwan |
| Jacqueline | Lavoie | Opitciwan |
| Louise | Rock | Pessamit |
| Marie-Claude | Hervieux | Pessamit |
| Josianne | Mapachee | Pikogan |
| Marie-Luce | Jourdain | Uashat mak Mani-Utenam |
| Jean-Claude | Therrien-Pinette | Uashat mak Mani-Utenam |
| Denis | Vachon | Uashat mak Mani-Utenam |
| Marie-Marthe | Mark | Unamen Shipu |

| Given Name | Name | Community/Affiliation |
|---|---|---|
| Jeannot | Mullen | Unamen Shipu |
| Delphine | Collin-Vézina | McGill University |
| Mireille | De La Sablonnière-Griffin | McGill University |
| Chantal | Dutrisac | McGill University |
| Pierre | Saint-Arnaud | Nutashquan |
| Marie-Hélène | Drapeau | ASSS Côte-Nord (Havre St-Pierre) |
| Agathe | Connely | Wemotaci |
| Isabelle | Wood | Wemotaci |
| Milaine | Perron | Wendake |
| Sonia | Young | Wolf Lake |
| Miriam | Alonso | UQAC |
| Réjean | Vallières | UQAC |
| Johanne | Rhainds | MSSS |
| André | Delorme | MSSS |
| Valérie | Boudreault | MSSS |
| Marie-Ève | Cournoyer | Health Canada |
| Isabelle | Alary | Health Canada |
| Audrey | Vézina | FNQLHSSC |
| Carl | Thibodeau | FNQLHSSC |
| Barbara | Bouchard | FNQLHSSC |
| Annie | Hervieux | FNQLHSSC |
| Edith | Picard | FNQLHSSC |
| Patricia | Montambault | FNQLHSSC |
| Richard | Gray | FNQLHSSC |
| Pascal | Plamondon Gomez | FNQLHSSC |

# Summary of the Validation Session

## CONFERENCE OBJECTIVES

In her welcome and opening remarks, Audrey Vézina, Mental Health clinical advisor for the FNQLHSSC and conference organizer, stated that there were two (2) conference objectives.

1. **Inform everyone on the latest developments affecting the delivery of mental health services to First Nations communities in Quebec;**

   This included the presentation and validation of a recent study assessing the status and understanding of mental health within First Nation communities in Quebec, and an assessment of delivery options. The study was commissioned by the FNQLHSSC and conducted by a team from McGill University's School of Social Work.

2. **Establish a framework or plan to guide First Nations communities in the development and implementation of quality and accessible mental health services for their members.**

## Day 1

Day one was devoted to updating participants on the most significant recent developments affecting the delivery of health services in First Nation communities.

1. **Overview of the mental health superstructure**
   **Richard Gray, Social Services Manager (FNQLHSSC)**

   Overview of the various First Nations, government and non-government organizations and stakeholder groups in Quebec, Canada, and the international community, that are contributing to the debate and development of understanding and solutions towards mental health.

   Participants were impressed with the extent of activities currently undertaken at various levels of stakeholder partnerships. These activities will all hopefully soon translate into a better understanding of mental health, and more readily available services and access to First Nations people.

## Question asked

a. Where are the seven (7) pilot projects dealing with a better dispensing of prescription drugs?

**2. Recent developments in Quebec's delivery of mental health services**
**Presented by Dr. André Delorme, Psychiatrist, Director of the Mental Health Unit, MSSS**

Most agreed with the types of initiatives being taken to make mental health services more accessible to more people on a timely basis, as well as the better use of other medical expertise to relieve the bottleneck currently created by having to go through a family doctor.

Most also agreed that everyone should work together to try to achieve the new service guidelines outlined by Dr. Delorme.

## Comments & questions asked

a. Is the MSSS open to greater flexibility in providing English services in order to better meet the needs of First Nations people in some areas in which French is not understood?

- The MSSS is bound by Quebec's language laws. The posting of language skills for personnel in all CSSS's is governed by these requirements. It is not clear how much flexibility is available. It would be preferable to ask someone who is more familiar with the language laws to see what options could be explored.

b. It was suggested that there is a need for greater flexibility in funding agreements to meet the care standards of care to which First Nations people have a legal right and address the great diversity of service delivery environments affecting various First Nations communities.

c. What can we do to address the situation of many young people, 12 years and younger, who do not realize they have a problem and do not come forward to ask for help?

- As our understanding of mental health evolves, we tend to be able to provide more appropriate services. This continues to evolve and awareness of the situation can foster better acceptance and a greater willingness to seek help. That said in some cases, as a last resort, we know that we must occasionally seek legal avenues to prevent people from harming themselves or others.

d. How can we provide better services to the more remote communities?

- This remains a major challenge, and not only for servicing First Nations communities. The best approach is to be proactive and try to identify and address cases at a very early stage when they are more manageable, but yes, this also takes good resources. We also need to look at better ways to share existing resources and to better inform and educate people. Dr. Delorme was very encouraged by the negotiation of two (2) recent *Memorandums of Understanding* for service delivery to Manawan and Opiticiwan (See Appendix 1 & 2).

e. Is the MSSS looking at ways to advance the use of Telehealth services?

- Yes, this is especially useful for the transfer of expertise/knowledge. It requires a considerable investment in infrastructure. Some pilot projects are already under way (Québec – Sept-Îles).

f. Are the guidelines for establishing the minimum number of fulltime equivalent mental health personnel in the CSSS also flexible in terms of the differing incidence of some problems in some areas, e.g. the higher incidence of dependency and mental health issues among First Nations people vs. the general population?

- Yes, the frequency of use or demand for services is taken into account when staffing local CSSS services.

**3. Presentation of the McGill University study: Development of a Mental Health Framework for Quebec First Nations.**
**Presented by Dr. Delphine Collin-Vézina, Mireille de la Sablonnière-Griffin, and Chantale Dutrisac (McGill University School of Social Work)**

Participants generally agreed with the study results, as presented. Given that it was the first time many had actually seen the full report, participants were asked to make comments and identify concerns on Day TWO.

Specifically, they were asked to consider the following questions:

I Are your current situations reflected in the study?
II Is the portrait / profile it describes consistent with your realities?
III Are there any major omissions in the study?

No comments or concerns were raised with regards to the study. The discussions and recommendations developed on Day TWO tended to confirm the major findings and recommendations of the study.

**4. Presentation of two (2) recent *Memorandums of Understanding***
**Presented by Maxime Ottawa (Manawan), and Serge Awashish (Opitciwan)**

The presenters outlined the partnership service agreements between First Nations communities in Quebec and their regional 2nd-line service providers. The presenters commented on the positive rapport that has developed between the communities and 2nd-line service providers. They also emphasized the importance of having a good action plan for the Partnership Coordinating Committee, and a regular follow-up. Both documents can be found in Appendix 1 and 2.

## Comments & questions asked

a. Did any major adjustments have to be made after reaching the MOU's?
   - Not really. The biggest changes were better coordination and follow-up.

b. Question to the MSSS representative: If we are dealing with more than one CSSS and get better service from one in particular, can we negotiate an MOU with that specific CSSS, even if it is not the one located in our area.
   - No. Quebec organizes its services by region and it is preferable to come to a good working agreement with the CSSS in your region. We try to be flexible, within reason and whenever necessary but we prefer to try to operate within the existing structures.

c. With the experience so far, has the MOU put any significant new pressure on the CSSS?
   - No, not really. It seems that better coordination helps make better use of existing resources.

d. Would it be useful to incorporate some of the major objectives from the action plan of the joint Partnership Coordinating Committee into the MOU?
   - Maybe but not right now because the current arrangement is working well.

**5. Pilot project for a Mobile Mental Health Team**
**Presented by Barbara Bouchard (FNQLHSSC) and Michel Penoshay (Kitcisakik)**

This presentation described the background and start-up process for a pilot project that established a Mobile Mental Health Team as the service provider for the two (2) participating communities (Lac Simon and Kitcisakik). The presentation took place on the morning of Day TWO.

## Comments & questions asked

a. How does the "dependency" component reflect itself in the pilot project?

- The focus is really on mental health, though the two issues are aligned at the local level depending on how each community prefers to deal with them.

b. **Comment**: This is a lingering problem with the way Health Canada's programs are organized. We all know that dependency and mental health issues are really manifestations of the same historical conditions, namely colonialism and the residential school experience. The comorbidity rates that we have assessed are at about 85%. We need to move beyond programming for the sake of program integrity towards an integrated "wellness" approach centered on the client dealing with these inter-related issues. We are currently creating our own confusion with the client and hampering the best healing conditions. Others agreed with this comment and strongly suggested a need for better understanding of the reality and a more integrated approach in dealing with wellness issues.

c. How does the Mobile Mental Health Team divide its time between the two (2) communities?

- We are still figuring this out; however, the goal is to have the communities clearly indicate their preferences based on their needs and try to have the Mobile Team work out something. This will not be easy.

d. Are there any positive developments stemming from the cooperation between the two (2) communities?

- There is a long history between the two (2) communities and we were able to quickly establish who would be responsible for what. That said it is still too early in the process to see what the results will be in terms of better cooperation.

As a general comment, participants expressed their appreciation for the presentations.
They felt they had learned a lot from sharing these important recent developments.

## Day 2

The focus on Day TWO was to get the input from participants on the development of a framework for the delivery of mental health services.

The goal is to provide mental health services with the same quality and accessibility standards as those provided to other Quebecers, as is the legal right of every First Nations person.

Participants were divided into smaller discussion groups based on linguistic practices and the size and location of the community they represented, i.e. small and isolated communities versus larger semi-urban and urban communities.

## QUESTION #1

Participants were asked to address the following question:
*Within this general 3 – tiered framework for the delivery of mental health services, and* ***considering the most important mental health challenges or problems affecting your community****…*

***What are the most important or beneficial improvements that you want to bring about to your community over the next 1 – 3 years?***

Here is a summary of the responses from the various groups.

**I 1st-line services (within communities)**
***Strengthen and integrate community services***

1. **Demystify mental health issues at the local level**
   a. Create a better understanding of the situation, services and legal aspects;
   b. Foster family and community involvement.

2. **Establish better interdisciplinary cooperation (an *integrated* approach that reflects the common history of First Nations people and the high levels of comorbidity)**
   a. Understand integration: client focused (not program focused);
   b. Clarify roles and responsibilities;
   c. More structured processes, including better case management;
   d. Improve protocol / processes for crisis management;
   e. Significantly improve follow-up;
   f. Obtain meaningful support from Canada and Quebec for an integrated approach.

**3. Bring integrated treatment programs into the communities**

a. We need to develop and implement treatment programs that can be delivered within our communities. This will provide better service and help keep youth within our communities in many cases.

**4. Establish better intersectoral cooperation, including community organizations**

In addition to the improved interdisciplinary approaches described above, we need to make better use of the other community organizations. To do this, we also need to…

a. Clarify roles and responsibilities;
b. Do some joint planning to support each other;
c. Use more structured collaboration processes;
d. Do much better follow-up.

**5. Improve community resources**

a. Personnel (provide more continuous training, cultural training and support)
b. Develop and implement better tools to enable 1st-line services to provide better services, e.g. screening tools to better assess the condition and needs of clients;
c. Adequate funding to support these improvements.

## II 2nd-line services: Partnerships for better specialized services

***Strengthen the service partnerships / network***

It was understood that there is often an overlap between 2nd and 3rd-line services, at the community level.

**1. Establish and support clear and effective service partnerships**

a. Negotiate protocols / agreements with 2nd-line service providers that fully recognize and respect the rights of First Nations people to access quality services on a timely basis;
b. Establish effective / responsive processes, including effective "access corridors" to improve access;
c. Include 2nd-line partners in community planning and case management;
d. Establish a joint action plan and ensure ongoing follow-up;
e. Train non-Native personnel, especially regarding cultural and community realities;
f. Address language issues (typically this means more English services, but it also means providing some form of translation, especially when dealing with Elders);

g. Help train / support FN personnel, and hire FN personnel within the 2nd-line service organizations;
h. Hire a FN liaison person to help improve communications and coordination.

2. **Access: Rethink / Reorganize some services (along the lines described by Dr. Delorme) to improve access**
   a. Make better use of other medical professionals like mental health nurses and pharmacists;
   b. Increase the number of other mental health professionals;
   c. Address language issues.

3. **Include medical approaches in dealing with addictions**

**III 3rd-line services: Highly-specialized**

***Negotiate timely access to highly-specialized services***

1. **Improve access to highly-specialized services** (Each community needs to identify and establish the list of highly-specialized services that it will most likely need, based on its experience and knowledge of the community.)

2. **Much better follow-up when the person is released**
   This was seen by many as a major deficiency in the current practices; people are released from a treatment situation with little or no communication about community resources available to help him/her, and often without a recovery plan. It was agreed that *all* parties must work to improve follow-up.
   a. Consider "transition homes" in some cases where a move directly back to the community would require too much of a transition for the person.
   b. Make more / better use of telemedicine and telenetworking to communicate between the treating institution and local 1st-line services within the community.

3. **Address language issues**

## Question #2

Participants were asked to address the following question while looking at each level of service delivery, i.e. 1st line, 2nd line and 3rd line:

***Looking at each potential partner, what do you most need from each of them to help you make good progress on your top priorities, especially in the next 12 months?***

Three (3) overriding considerations were identified by participants:

I The community is the best place in which to deal with mental health issues, and we must strive to strengthen capacity and resources at the community level. This includes the development of both internal and external partnership agreements and practices & more flexibility in national programs.

II We must work towards an *integrated*, *client-based* "wellness" approach, i.e. not segregate clients as though dependency and mental health were two distinct conditions.

III All approaches must be designed to ensure that the individual takes *personal responsibility for her/his recovery*. Our role is to guide, assist, & support.

## 1st-line services: PRIORITIES

***The focus of services must be in the communities***

Implement and foster an integrated approach to wellness at the community level

1. **Engaged, informed and supportive families and communities**
    a. De-mystify the whole mental health and wellness issue, including the local services and the legal context in which we must operate.
    b. Develop full support from the political and administrative leadership.
    c. With the agreement of the individual, involve the family in all aspects of the approach and get their full support.
    d. Get full involvement and support from the Elders.
    e. Make better use of the local radio in communicating and educating.
    f. Use consultations to involve the community directly in the development of better approaches and the establishment of priorities.

2. **Assess and optimize use of existing resources; improve existing facilities**
    a. Assess existing services against this framework and identify any service gaps that need to be addressed within the next 1 – 3 years.
    b. It is generally agreed that the structured development of interdisciplinary approaches within the community will help us make better use of our existing resources.
    c. A similar benefit will come from developing partnerships for 2nd-line services.
    d. Assess and improve local facilities, including meeting rooms for sessions with clients, and meeting facilities for case management teams, improved communications technology, etc.

3. **Capable personnel, with continuous training and support, and supervision**

    Develop and implement a local Personnel Development Plan to identify and address the need for quality 1st-line services.

4. **Effective community tools and training, including**
    a. Screening tools;
    b. The development and implementation of community-based treatment programs that keep our people, especially the Youth, in the communities.

5. **Improve effective interdisciplinary mechanisms and protocols (case management)**
    a. Develop and implement a structured protocol supported by joint planning, best practices and rigorous follow-up.
    b. This includes the need to break down the walls and 'attitudes' existing between the services within our own local administrations (break down the "silos").
    c. This requires all staff to be open to new approaches and to agree to act on them.

6. **Develop and implement effective intersectoral mechanisms / protocols**

7. **Develop and implement structured client-based follow-up**
    a. It was generally agreed that we need to do a much better job at following up on individuals, especially as we begin to use interdisciplinary approaches.
    b. Establish and implement follow-up protocols with 2nd and 3rd-line service providers.

## 2nd-line services: PRIORITIES

***Strengthen the service partnerships / network***

The main focus here is to develop and implement structured partnership agreements with 2nd-line service providers.

1. **Establish and support client-driven service support partnerships and agreements that commit the partners to address the following**
    a. Full recognition and respect of First Nations' rights to access quality services on a timely basis;
    b. Effective / responsive processes / services, and timely access;
    c. The availability of qualified personnel at all levels, i.e. 1st and 2nd line;
    d. Joint action planning and structured follow-up mechanisms / practices;
    e. Provisions for training non-Native personnel regarding the community's cultural heritage and its current realities;
    f. Address language issues (mostly access to English services and translation services for the Elders);
    g. Help train / support FN personnel within both the 1st and 2nd-line services;
    h. Hire a FN liaison person to facilitate communication and coordination between the parties and community;
    i. A self-evaluation / improvement process within the agreement so that the parties can conduct periodic (annual) evaluations and implement the required improvements;
    j. Adequate funding to support the agreements.

2. **Where possible, these agreements / MOU's should include clear objectives, timeframes and measurables**

## 3rd-line services: PRIORITIES

***Access to highly-specialized services***

1. **A regional agreement that provides access to highly-specialized services (a priority list will be provided by the FNQLHSSC)**

   Address language requirements.

2. **Established follow-up processes with 3rd-line services**

   There is an urgent need to establish much better follow-up procedures between the treating institution and 1st-line personnel at the community level.

3. **A Telehealth network**

   Implement a Telehealth infrastructure and skills on a priority basis.

**The FNQLHSSC**

***Education, coordination, advocacy***

There was no time to try to prioritize any of the following, all of which were offered as suggestions that the Commission should include in the framework.

a. Launch an information campaign in the media, affirming the rights of First Nations people to equal services and access, under the Law.
b. Organize, facilitate and foster good exchanges of information and expertise among First Nation communities.
c. Organize and coordinate regular (annual) such conferences to enable First Nations personnel and government representatives to share the most recent developments and best practices.
d. Hire a psychiatrist or psychologist as an in-house resource or consultant to guide First Nations community services in their dealings with 2nd and 3rd-line services.
e. Develop customized training and education programs for First Nations personnel.
f. Take a proactive role in exploring a better use of technologies, including Telehealth.
g. Play a watchdog role to ensure all parties are following up on their commitments and agreements.
h. Liaise on wellness issues with the Assembly of Chiefs.

**Addiction treatment centres**
***Update programs, more diversity & more access***

a. Offer more diversified programs.
b. Help develop and implement community-based treatment programs.
c. More beds and more access on a timely basis.
d. Work with communities in assessing and implementing new approaches (e.g. harms reduction, medical based approaches to addictions, etc.).

**FIRST NATION COMMUNITY NETWORKING**
***Let's help each other***

a. Better networking and partnering of services between First Nations communities.
b. More exchange on what is working and best practices.
c. Share some of the senior resources and experts with other communities, even if it is just to help them get better organized.

**MSSS**
***Education, coordination, advocacy***

a. Address language issues.
b. Commit to addressing the requirements for qualified personnel (1st and 2nd-line services), including the required training of existing personnel.
c. A regional agreement that provides access to highly-specialized services (a priority list of needs could be developed).
d. Create a First Nations Director's seat on the Board of Directors of local hospitals that have MOU's for 2nd-line services with First Nations communities.
e. Address Bill P38 (not sure what was intended here but it has something to do with Policing).
f. Hire more First Nations personnel within the MSSS, including at the local level (2nd line).

**HEALTH CANADA**
**Resources & support for an integrated approach**

There was a general request for adequate funding to support the proper level of mental health services at the community level, including the support of the local partnerships for 2nd-line services.

There was also a general request that Health Canada move beyond its "program rigidity" and work towards a more "community-based, integrated wellness" structure. It needs to find ways to further adapt to regional and local needs.

a. Better, more stable funding to support the types of changes that will be required over the next 1 - 3 years to implement this framework.
b. Help facilitate information sharing.

NB: It was also suggested that the MSSS and Health Canada talk to each other to better support the efforts and commitments regarding First Nations wellness.

**THE JUDICIAL SYSTEM**
***Better understanding of First Nations realities and a supportive role***

The judicial system, including the courts, need to develop a better understanding of First Nations realities, and be more understanding in developing legal responses to issues they are confronted with.

The Commission could play a major role in this process.

**OTHER: MINISTRY OF EDUCATION**
***Better understanding of First Nations realities***
***Include "prevention" as a focus in the curriculum***

We should work with the Ministry of Education to develop and implement more preventive, healthy lifestyle options in the regular curriculum, starting at a very young age.

# DEVELOPMENT OF A MENTAL HEALTH SERVICES ORGANIZATION MODEL AMONG THE FIRST NATIONS OF QUEBEC COMMUNITIES

## Key players' main responsibilities

**First Nations Communities:**
***Assistance, collaboration, involvement***

**Health Canada:**
***Subsidize resources and support for an integrated approach***

**FNQLHSSC, MSSS:**
***Education, coordination, advocacy***

**Addictions Treatment Centres:**
***Diversity and access to services***

### Services within the communities

Under the federal government`s responsibility for non-convention communities

*COMMON MENTAL HEALTH SERVICES*

Strengthen and integrate common mental health services (1st line) in partnership with communities:

- Prevention program
- Screening tools
- Community resources
- Collaboration between sectors and among profesionals
- Integrated treatment approaches (e.g. comorbidity addiction and mental health problems)

Rational: Services that aim to address common problems should be offered in proximity to the life settings of the people.

### Collaboration

Implementation of:

- Memorandum of Understanding
- Protocols for accessing services
- Coordination plans after discharge

By the following means and structures:

- Mobile Mental Health Team
- Responding Psychiatrist
- Technological means (Tele Health)

### Services outside the communities

Under the provincial government`s responsibility

*SPECIALIZED MENTAL HEALTH SERVICES*

Strengthen the service partnerships and network for specialized services (2nd and 3rd lines):

- Training of non-Aboriginal personel
- Translation and cultural consultation services
- Hirings of liaison agents

Rational: Providing easy access to specialized mental health resources that are adapted to First Nations realities is required.

# APPENDIX 1: COOPERATION AGREEMENT BETWEEN THE ATIKAMEKW NATION COUNCIL AND THE MANAWAN ATIKAMEKW COUNCIL AND THE CENTRE DE SANTÉ ET DES SERVICES SOCIAUX DU NORD DE LANAUDIÈRE

**"Memorandum of Understanding Regarding the Trajectory of Mental Health Care"**

**February 2010**

## COOPERATION AGREEMENT

### IDENTIFICATION OF PARTIES TO THE AGREEMENT

The **Atikamekw Nation Council (ANC)**, whose head office is located at 290 Saint-Joseph, La Tuque, Province of Québec, G9X 3P6,
Legally represented by Director General Thérèse Niquay
Hereinafter referred to as "ANC"

**AND**

The **Manawan Atikamekw Council (MAC)**, whose head office is located at 135 Kicik Street, Manawan, Province of Québec, J0K 1M0,
Legally represented by Director General Gaétan Flamand
Hereinafter referred to as "MAC"

**AND**

The **Centre de santé et des services sociaux du Nord de Lanaudière**, whose head office is located at 1000 Ste-Anne Boulevard, Saint-Charles Borromée, Québec, J6E 6J2,
Legally represented by Director General Marie Beauchamp
Hereinafter referred to as "CSSSNL"

## PREAMBLE

WHEREAS any person is entitled to receive adequate mental health services and social services in accordance with Section 5 of the *Act respecting health services and social services;*

WHEREAS any establishment shall ensure the provision of accessible health and social services in respect of the rights and spiritual needs of individuals and with the purpose of diminishing or resolving the health and welfare problems of segments of the population and meeting their needs in accordance to Section 100 of the *Act respecting health services and social services*;

WHEREAS the establishment of the CSSSNL required the reconfiguration of care and services trajectories;

WHEREAS the ANC, including the MAC, adopted a social contract with the purpose of becoming actively involved in specific areas such as mental health care and suicide among the Atikamekw;

WHEREAS the ANC and the MAC wish to ensure and maintain quality mental health services;

WHEREAS the ANC and the MAC wish to ensure effective liaison and monitoring of the Atikamekw clientele referred to mental health services provided by the CSSSNL and partner organizations in order to benefit from a functional continuum of mental health care and services;

WHEREAS the Parties therefore wish to improve and consolidate the mental health services provided to the Atikamekw clientele in a networking context and agree to cooperate towards achieving the purposes sought herein;

## PURPOSE OF THE AGREEMENT

**NOW, THEREFORE, THE PARTIES HERETO AGREE AS FOLLOWS:**

1. Introductory Provisions

    1.1 The preamble is part and parcel of this Agreement and shall govern its interpretation.

    1.2 This Agreement concerns the provision of adapted services to the Atikamekw mainly living in Manawan.

2. Responsibilities of the Manawan Mental Health Team

    2.1 The Manawan Mental Health Team comprising *Manawan Atikamekw Council Health Services* resources provide assistance, assessment, guidance and follow-up services.

2.2 Generally speaking, the regular and/or crisis intervention clientele are Manawan Atikamekw Band members.

2.3 An on-call care service is ensured by the Manawan Mental Health Team outside regular hours.

2.4 The adult clientele is referred to CSSSNL psychiatric services and/or residential care at the Lanaudière Crisis Centre based on their service accessibility criteria and through the access mechanism.

2.5 The 0-18 year-old clientele is referred to the CSSSNL child and adolescent psychiatric services and/or to residential care based on the accessibility criteria of the access mechanism of the Youth Centre residential care component.

2.6 Individual service plans are adopted for each client and harmonized with appropriate intervention care provided by CSSSNL and Youth Centre resources.

2.7 Manawan Health Services ensure evacuation and transportation between the community and one of the CSSSNL points of service.

2.8 The Mental Health Team of the Manawan Health Centre ensures liaison with the CSSSNL and Manawan Health Services.

2.9 The Manawan Health Services ensure the availability of professional resources and natural caregivers of the community to support not only prevention, but also certain crisis interventions, on a case-by-case basis.

2.10 The Manawan Health Services ensure the power of Manawan Mental Health Team members to provide services.

## 3. Responsibilities of the CSSSNL Mental Health Services

3.1 First-line mental health services in support of the Manawan Mental Health Team and second-line emergency psychiatric and child and adolescent psychiatric services are provided at the CSSSNL.

3.2 Liaison is ensured for all clientele referred by the Manawan Health Centre, including clientele directed to the Lanaudière Crisis Centre.

3.3 The clientele is greeted, re-assessed, placed under observation and, depending on the case, admitted to the hospital.

3.4 The clientele may be referred to the appropriate network services jointly with the Manawan Mental Health Team.

3.5 Transfers between hospitals and within the network are ensured by the CSSSNL during hospitalization, depending on the care needed.

3.6 Upon request, the CSSSNL agrees to assist in crisis situations by assigning network professional resources to support the Mental Health Team, the Manawan Health Services and the ANC Social Services.

3.7 The CSSSNL supports the contribution of mental health services and organizations within its territory to allow the clientele referred by the Manawan community to access such services, depending on the case.

## COMMITMENT OF THE PARTIES TO THE AGREEMENT

4. Joint Commitment

4.1 The Parties hereby agree to foster the sharing of information with respect to the consents obtained in order to ensure that optimum service is provided to each client.

4.2 The Parties hereby agree to maintain the liaison committee to support the provision of services and, where applicable, to establish ad hoc committees in support of the development of services.

4.3 Staff members requiring services are hereby responsible for coordinating interventions through means such as the individual service plan and contacts with key health care staff members.

4.4 The CSSSNL hereby agrees to offer clinical training opportunities to Mental Health Team members; unless otherwise stated, training costs are the responsibility of the Atikamekw party.

4.5 The Atikamekw party hereby agrees to offer from time to time an awareness-raising training session on Atikamekw culture and services provided to CSSSNL staff members and other partners; additional fees usually incurred are the responsibility of the establishment hosting the training session.

4.6 The Parties hereby agree to update their expertise in mental health prevention, promotion and intervention.

## COMMITMENT TO THE PRIVACY AND PROTECTION OF PERSONAL INFORMATION AND OBTAINING OF CONSENT

As part of this Agreement, any information on clients shall remain private under the *Act respecting health services and social services*. Information on clients shared between the Parties shall be made with the informed and voluntary consent of clients, whether written or verbal, using the form appended in ANNEX 1.

The Organization herein acknowledges as private information any personal information or document to be reviewed by staff as part of their work, particularly any information contained in clients' files under Section 19 of the *Act respecting health services and social services* (R.S.Q., c. S-4.2). Therefore, the Organization hereby agrees and is bound on behalf of its professionals, staff and all health care attendants for the entire duration of this Cooperation Agreement to provide collaboration and at any time thereafter to the following:

(a) Safeguarding and maintaining the private and confidential nature of personal information and not allowing the use of such information for purposes other than that required in the operation of this Agreement;

(b) Disclosing personal information only to staff members who need it in the operation of this Agreement;

(c) Taking the measures required to prevent the disclosure or communication of personal information to third Parties, particularly by establishing privacy rules and policies and ensuring their application,

including the rules and policies, arising from the Information Access Commission jurisdiction, with the purpose of preventing any unauthorized use or reproduction of personal information and its unauthorized access;

(d) Reporting to the other party at the earliest opportunity any incident likely to adversely affect the protection of private and confidential personal information;

(e) Immediately notifying the CSSSNL in the event that the Organization hears or has reason to believe that an unauthorized person has had access to personal information or in any way infringed this commitment to privacy.

Without limiting the foregoing, the Organization acknowledges that the personal information it holds on individuals allowing for their identification is governed by provisions of the *Act Respecting the Protection of Personal Information in the Private Sector* (R.S.Q., c. P-39.1).

## DURATION OF THE AGREEMENT AND FOLLOW-UP

5. Duration of the Agreement

5.1 The duration of this Agreement is three (3) years from the date of signing. The said Agreement will be renewed for a minimum period of three (3) years, unless otherwise stated in writing by either one of the Parties within thirty (30) days prior to the expiry date of this Agreement.

6. Follow-up Committee

6.1 The Mental Health Committee shall serve as Follow-up Committee to ensure the implementation of this Agreement. The said committee shall ensure the sound management of the clinical, professional and community aspects of interventions.

6.2 The Liaison Committee is made up of at least three CSSSNL representatives and three Manawan Mental Health Team representatives, from the following:

- The CSSSNL Mental Health Program Director
- The CSSSNL Adult Mental Health Program Coordinator
- The CSSSNL Clinical Mental Health Coordinator
- The ANC Mental Health Counsellor
- The Head of Manawan Social Services
- The Manawan Mental Health Coordinator

6.3 The Committee will meet at least twice a year.

6.4 Reports will be provided by the party hosting the meeting.

6.5 A periodical assessment shall be conducted based on the parameters identified by the Liaison Committee.

6.6 The Parties shall take joint action, when needed, to obtain funding for the development, research and carrying out of assessments.

7. General Provisions

Any dispute, disagreement or interpretation of this Agreement shall be submitted to the Follow-up Committee to identify a suitable solution in order not to compromise service access and provision.

This Agreement is governed by the laws and regulations in effect in the Province of Québec and shall be interpreted accordingly (*Band and ANC regulations and/or resolutions*).

## AGREEMENT REVIEW OR AMENDMENT

By mutual agreement, the Parties may agree to amend this Agreement. Any amendments shall be signed by both Parties and appended to this Agreement.

In the event that parameters of this Agreement should require amending, the Follow-up Committee shall send a recommendation to the director generals for the Agreement to be reviewed.

Failure to proceed according to the manner prescribed, any amendments shall be deemed forever barred.

## TERMINATION

By mutual agreement, the Parties may agree to terminate this Agreement. A thirty (30) day notice shall be given to the other party to prevent potential inconveniences to clients. In addition, either party may request termination of this Agreement based on failure by the other party to meet its obligations.

## SIGNATURE OF THE PARTIES

The Parties concerned herein acknowledge that they have read and accepted this Memorandum of Agreement Regarding the Trajectory of Mental Health Care and that they are satisfied with the contents herein.

In witness whereof, the Parties have signed and initialized each page of this Agreement on this _____ day of _____ , 2010.

**"The ANC"**

_____

Ms. Thérèse Niquay — Date
Director General
Atikamekw Nation Council

**"The MAC"**

_____

Mr. Gaétant Flamand — Date
Director General
Manawan Atikamekw Council

**"The CSSSNL"**

_____

Ms. Marie Beauchamp — Date
Director General
Centre de santé et services sociaux
du Nord de Lanaudière

# APPENDIX 2: COOPERATION AGREEMENT BETWEEN THE THE OPITCIWAN ATIKAMEKW COUNCIL AND THE THE CENTRE DE SANTÉ ET DES SERVICES SOCIAUX DU DOMAINE-DU-ROY

**"Memorandum of Understanding Regarding the Trajectory of Mental Health Care"**

**July 2010**

## COOPERATION AGREEMENT

### IDENTIFICATION OF PARTIES TO THE AGREEMENT

The **Opitciwan Atikamewk Council (OAC)**, whose head office is located at 135 Kicik Street, Opitciwan, Province of Québec, J0K 1M0,
Legally represented by the Director General
Hereinafter referred to as "OAC"

**AND**

The **Centre de santé et des services sociaux du Domaine-du-Roy**, a legal person established in the public interest under the *Act respecting health services and social services* (AHSSS) (R.S.Q., c.S-4.2), whose head office is located at 450 Brassard Street, Roberval, Québec, G8H 1B9,
Legally represented by Director General Jacques Dubois
Hereinafter referred to as "CSSSDDR"

## PREAMBLE

his Agreement constitutes an administrative mechanism shared by the two aforementioned organizations and entered into to formalize their respective commitment with respect to the mental health care and services provided to the population of the health and social service region of the Opitciwan community and the implementation of coordination and communication mechanisms. Hence, the purpose of this memorandum is to identify elements to guide the implementation and organization of a continuum of services for a clientele with mental health problems and requiring the services provided within this territory.

WHEREAS any person is entitled to receive adequate mental health services and social services in accordance with Section 5 of the *Act respecting health services and social services;*

WHEREAS any establishment shall ensure the provision of accessible health and social services in respect of the rights and spiritual needs of individuals and with the purpose of diminishing of resolving the health and welfare problems of segments of the population and meeting their needs in accordance to the Section 100 of the Act respecting health services and social services;

WHEREAS the establishment of the CSSSDDR required the reconfiguration of care and services trajectories;

WHEREAS the CNA, including the OAC, adopted a social contract with the purpose of becoming actively involved in specific areas such as mental health care and suicide among the Atikamekw;

WHEREAS the CNA and the OAC wish to ensure and maintain quality mental health services;

WHEREAS the CNA and the OAC wish to ensure effective liaison and monitoring of the Atikamekw clientele referred to mental health services provided by the CSSSDDR and partner organizations in order to benefit from a functional continuum of mental health care and services.

WHEREAS the Parties therefore wish to improve and consolidate the mental health services provided to the Atikamekw clientele in a networking context and agree to cooperate towards achieving the purposes sought herein;

WHEREAS the CSSS du Domaine-du-Roy is, historically, the channel of services for the population of the Opitciwan community;

## PURPOSE OF THE AGREEMENT

**NOW, THEREFORE, THE PARTIES HERETO AGREE AS FOLLOWS:**

1. Introductory Provisions

1.1 The preamble is part and parcel of this Agreement and shall govern its interpretation.

1.2 This Agreement concerns the services provided by the Opitciwan Atikamekw Council and the CSSS and the cooperation between the two Parties referred herein with a view to ensure the continuity of mental health services provided to a common clientele with respect of the specific mission of each establishment concerned.

2. Responsibilities of the Opitciwan Mental Health Team

2.1 The Opitciwan Mental Health team comprising *Opitciwan Atikamekw Council Health Services* resources provide assistance, assessment, guidance and follow-up services.

2.2 Generally speaking, the regular and/or crisis intervention clientele are Opitciwan Atikamekw Band members.

2.3 An on-call care service is ensured by the Opitciwan mental health team outside regular hours.

2.4 The adult clientele is referred to CSSSDDR psychiatric services and/or residential care at the ... Crisis Centre based on their service accessibility criteria and through the access mechanism.

2.5 The 0-18 year-old clientele is referred to the CSSSDDR child and adolescent psychiatric services and/or residential care based on the accessibility criteria of the access mechanism of the Youth Centre residential care component.

2.6 Individual service plans are adopted for each client and harmonized with appropriate intervention care provided by CSSSDDR resources.

2.7 Opitciwan Health Services ensure evacuation and transportation between the community and one of the CSSSDDR points of service.

2.8 The mental health team of Opitciwan Health Centre ensures liaison with the CSSSDDR and Opitciwan Health Services.

2.9 Opitciwan Health Services ensure the avaibility of professional resources and natural caregivers of the community to support not only prevention, but also certain crisis interventions, on a case-by-case basis.

2.10 Opitciwan Health Services ensure the power of Opitciwan Mental Health Team members to provide services.

The Opitciwan Atikamekw Council agrees to:

2.11 Judiciously direct its clientele to the CSSS du Domaine-du-Roy in accordance with the trajectory of established services.

2.12 Manage all the first-line mental health services (to be defined) after assessment or a stay at the CSSS du Domaine-du-Roy.

2.13 Contact the CSSS du Domaine-du-Roy through the mental health nurse for information on each client's situation to establish liaison between the two treatment teams and ensure the treatment plan is followed.

3. Responsibilities of the CSSSDDR Mental Health Services

3.1 First-line mental health services in support of the Opitciwan Mental Health Team and second-line emergency psychiatric and child and adolescent psychiatric services are provided at the CSSSDDR.

3.2 Liaison is ensured for all clientele referred by the Opitciwan Health Centre, including clientele directed to the ... Crisis Centre.

3.3 The clientele is greeted, re-assessed, placed under observation and, depending of the case, admitted to the hospital.

3.4 The clientele may be referred to the appropriate network services jointly with the Opitciwan Mental Health Team.

3.5 Transfers between hospitals and within the network are ensured by the CSSSDDR during hospitalization, depending on the care needed.

3.6 Upon request, the CSSSDDR agrees to assist in crisis situations by assigning network professional resources to support the Opitciwan Mental Health Team and Health Services and the OAC Social Services, depending of resources available.

3.7 The CSSSDDR supports the contribution of mental health services and organizations within its territory to allow the clientele referred by the Opitciwan community to access such services, depending on the case.

3.8 he CSSSDDR agrees to accept the transfer of Opitciwan community clients, depending on their clinical needs.

3.9 The CSSSDDR shall provide to clients the services they need in terms of specialized individual mental health services.

3.10 The CSSSDDR shall consider the clientele directed by the Opitciwan community with the same regard as its own, concerning the provision of mental health services in cases where clients are moved to CSSS du Domaine-du-Roy facilities.

3.11 The CSSSDDR shall send a hospitalization summary and the notes and assessment relevant to a client's file to the Opitciwan Health Services after authorization by the client and in accordance with standards in effect in their establishments.

3.12 The CSSSDDR shall inform the Opitciwan Health Services about the services provided and the trajectory of access to the said services.

## COMMITMENT OF THE PARTIES TO THE AGREEMENT

4. Joint Commitment

4.1 The Parties hereby agree to foster the sharing of information with respect to the consents obtained in order to ensure that optimum service is provided to each client.

4.2 The Parties hereby agree to maintain the liaison committee to support the provision of services and, where applicable, to establish ad hoc committees in support of the development of services.

4.3 Staff members requiring services are hereby responsible for coordinating interventions through means such as the individual service plan and contacts with key health care staff members.

4.4 The CSSSDDR hereby agrees to offer clinical training opportunities to mental health team members; unless otherwise stated, training costs are the responsability of the Atikamekw party.

4.5 The Atikamekw party hereby agrees to offer awareness-raising training opportunities on Atikamekw culture and services provided to CSSSDDR staff members and others partners; additionnal fees usually incurred are the responsability of the establishment hosting the training session.

4.6 The Parties hereby agree to update their expertise in mental health prevention, promotion and intervention.

4.7 It is hereunder agreed to implement effective communication mechanisms and to promote them among the professionals concerned.

4.8 Each party hereby agrees to work in a spirit of cooperation and consensus.

5. Clientele Served

5.1 Clientele Served

The clientele served includes children, youths and adults from the Opitciwan Atikamekw community, more specifically as follows:

- Child and youth clientele: Internal services are provided by the CSSS of Chicoutimi through the CSSS du Domaine-du-Roy in compliance with the channel of services established between the Parties.
- Adult clientele: Services are provided by the CSSS du Domaine-du-Roy.

## COMMITMENT TO THE PRIVACY AND PROTECTION OF PERSONAL INFORMATION AND OBTAINING OF CONSENT

As part of this Agreement, any information on clients shall remain private under the *Act respecting health services and social services*. Information on clients shared between the Parties shall be made with the informed, voluntary written consent of clients using the form appended in ANNEX 1.

The Parties herein acknowledge as private information any personal information or document to be reviewed by staff as part of their work, particularly any information contained in client's files under Section 19 of the *Act respecting health services and social services* (R.S.Q., c. S-4.2). Therefore, the Parties hereby agree and are bound on behalf of their professionals, staff and all health care attendants for the entire duration of the Cooperation Agreement to provide collaboration and at any time thereafter to the following:

(a) Safeguarding and maintaining the private and confidential nature of personal information and not allowing the use of such information for purposes other than that required in the operation of this Agreement;

(b) Disclosing personal information only to staff members who need it in the operation of this Agreement;

(c) Taking the measures required to prevent the disclosure or communication of personal information to third Parties, particularly by establishing privacy rules and policies and ensuring their application, including the rules and policies, arising from the Information Access Commission jurisdiction, with the purpose of preventing any unauthorized use or reproduction of personal information and its unauthorized access;

(d) Reporting to the other party at the earliest opportunity any incident likely to adversely affect the protection of private and confidential personal information;

(e) Immediately notifying the other party in the event that an unauthorized person has had access to personal information or in any way infringed this commitment to privacy.

Without limiting the foregoing, the Parties acknowledge that the personal information they hold on individuals allowing for their indentification is governed by provisions for the *Act Respecting the Protection of Personal Information in the Private Sector* (R.S.Q., c. P-39.1).

## DURATION OF THE AGREEMENT AND FOLLOW-UP

### 6. Duration of the Agreement

6.1 The duration of this Agreement is three (3) years from the date of signing. The said Agreement will be renewed for a minimum period of three (3) years, unless otherwise stated in writing by either one of the Parties within thirty (30) days prior to expiry date of this Agreement.

7. Follow-up Committee

7.1 The Mental Health Committee shall serve as Follow-up Committee to ensure the implementation of this Agreement. The said committee shall ensure the sound management of the clinical, professional and community aspects of interventions.

7.2 The Liaison Committee is made up of a least three CSSSDDR representatives and three Opitciwan Mental Health Team representatives, from the following:

- The CSSSDDR Mental Health Program Director
- The CSSSDDR Adult Mental Health Program Coordinator
- The CSSSDDR Clinical Mental Health Coordinator
- The OAC Mental Health Counsellor
- The Head of Opitciwan Social Services
- The Opitciwan Mental Health Coordinator

7.3 The Committee will meet at least twice a year.

7.4 Reports will be provided by the party hosting the meeting.

7.5 A periodical assessment shall be conducted based on the parameters identified by the Liaison Committee.

7.6 The Parties shall take joint action, when needed, to obtain funding for the development, research and carrying out of assessments.

8. General Provisions

Any dispute, disagreement or interpretation of this Agreement shall be submitted to the follow-up committee to indentify a suitable solution in order not to compromise service access and provision.

This Agreement is governed by the laws and regulations in effect in the Province of Québec and shall be interpreted accordingly *(Band and OAC regulations and/or resolutions)*.

## AGREEMENT REVIEW OR AMENDMENT

By mutual Agreement, the Parties may agree to amend this Agreement. Any amendment shall be signed by both Parties and appended to this Agreement.

In the event that parameters of this Agreement should require amending, the follow-up committee shall send a recommendation to the director generals for the Agreement to be reviewed.

Failure to proceed according to the manner prescribed, any amendments shall be deemed forever barred.

## TERMINATION

By mutual agreement, the Parties may agree to terminate this Agreement. A thirty (30) day notice shall be given to the other party to prevent potential inconveniences to clients. In addition, either party may request termination of this Agreement based on failure by the other party to meet its obligations.

## SIGNATURE OF THE PARTIES

The Parties concerned herein acknowledge that they have read and accepted this Memorandum of Agreement Regarding the Trajectory of Mental Health Care and that they are satisfied with the contents herein.

In witness whereof, the Parties have signed and initialized each page of this Agreement on this _____ day of _____ , 2010.

**"The OAC"**

_____ _____

Mr. Christian Awashish
Director General
Opitciwan Atikamekw Council

Date

**"The MAC"**

_____ _____

Mr. Jacques Dubois
Director General
Centre de santé et services sociaux du Domaine-du-Roy

Date

www.cssspnql.com