Final Evaluation Report

Mental Wellness Team pilot project 2009-2013

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AANDC: Aboriginal Affairs and Northern Development Canada

AHF: Aboriginal Healing Foundation

CAAVD: *Centre d'amitié autochtone de Val-d'Or*

CJAT: *Centre jeunesse de l'Abitibi-Témiscamingue*

CMHA: Canadian Mental Health Association

CSSSVO: *Centre de santé et de services sociaux de la Vallée-de-l'Or*

FNCFS: First Nations Child and Family Services

FNIHB: First Nations and Inuit Health Branch

FNQLHSSC: First Nations of Quebec and Labrador Health and Social Services Commission

HRO: Human Resources Officer

INSPQ: *Institut national de santé publique du Québec*

MIH: Maternal and Infant Health

MSSS: *ministère de la Santé et des Services sociaux du Québec*

MWT: Mental Wellness Team

NNADAP: National Native Alcohol and Drug Abuse Program

RMC: Regional county municipality

SUMMARY

This report presents the research-evaluation[1] findings on the planning and implementation of a Mental Wellness Team Pilot Project using the community development approach in two Quebec First Nation communities. Four community development strategies served to steer the project: community mobilization (structures and population), intersectoral coordination, involvement of local and political leaders, and empowerment.

This project set out to explore the effectiveness of the Mental Wellness Team model and was funded under the National Anti-Drug Strategy. The search for sustainable and locally adapted solutions to the dual problem of mental health and addictions in First Nation communities lay at the core of this initiative. It was to be assessed whether a multidisciplinary team combining clinical and cultural methods with mental wellness and using bottom-up logic would better meet local mental health support needs. In Quebec, the Pilot Project ran from 2009 to 2013 and comprised three phases: planning (2009–2010), implementation of the Mental Wellness Team and services delivery (2010–2012) and comprehensive evaluation (2012–2013). Though the last of these three phases consisted of a comprehensive project evaluation, the first two phases were continuously being evaluated. The decision was made to adopt a participatory approach and the use of case studies, for which intra-community rather than inter-community data was compared and analyzed.

The research-evaluation findings show that different contextual factors affect how such a Pilot Project is implemented in First Nation communities. Some factors were enabling, such as the partners' willingness to jointly search for solutions to the chronic difficulties encountered, while others, such as the turnover on the mobile MWT, on local teams or at the FNQLHSSC, were a hindrance. It proved hard to find mental health professionals familiar with First Nation communities who were culturally sensitive and open to working with First Nations. Integrating cultural, community and clinical approaches was also a challenge for this project. Mental health services had been available in communities for a long time, though in the standard clinical office model. A public consultation on mental health (and the dual issue of mental health and addictions) was held for the first time in the communities under the Mental Wellness Team Pilot Project. The changes directly effected in each community as a result of this Pilot Project include demystifying mental illness, improving networking, strengthening lines of communication and making outside mental health services more accessible.

A long-term view that goes beyond this Pilot Project must be adopted. Cooperation between

[1] The Working Group chose the term research-evaluation (see methodology section). This process uses research methods and produces knowledge within an evaluative framework that reflects local concerns and context, with the ultimate goal of helping communities.

communities and the Quebec's health and social services system, in partnership with the FNIHB and FNQLHSSC, must continue. Other initiatives in this area are needed and should specifically retain the bottom-up logic used for this project.

INTRODUCTION

In 2007, the National Anti-Drug Strategy committed to improving the quality, accessibility and effectiveness of addiction services for First Nations and Inuit across the country. The funding included an amount for forming Mental Wellness Teams. The Strategic action plan (2007), which was drawn up by the First Nations and Inuit Mental Wellness Advisory Committee,[2] focused on the dual issue of mental health and addictions as a priority for action. Across Canada, eight pilot projects[3] were launched with this funding. The proposed model calls for multidisciplinary Mental Wellness Teams to use community, collaborative and cultural approaches to boost the communities' capacity to address mental health and addiction problems in a manner appropriate to each community (FNIHB, 2009).

This report details how the Mental Wellness Team Pilot Project was implemented using the community development approach in two Quebec First Nation communities. The findings presented cover the period from October 2009 to June 2012, that is, the first two Pilot Project phases (planning and implementation). The third phase (July 2012 to March 2013) consists of a comprehensive evaluation of the project and recommendations. A short section at the end of the report describes the status of the Mental Wellness Team at the end of the project, in March 2013.

The challenge of this report is to fairly present the local benefits of this Pilot Project, given the significant challenges encountered throughout the Project and complexity of each community's context. The report begins by describing the context and conditions in each of the communities prior to the Pilot Project. Local dynamics and some social issues are described, but more emphasis is placed on the strengths of each community and the four selected action strategies of the community development approach. The context overview also includes a brief description of the process for selecting the participating communities, the various regional partners involved, the initial objectives and expectations for the Mental Wellness Team, the objective for each phase of the Pilot Project, the main concepts associated with the community development approach and the four action strategies for implementing the Pilot Project.

[2] "In 2005, Health Canada created the First Nations and Inuit Mental Wellness Advisory Committee, which was co-chaired by the Assembly of First Nations and the Inuit Tapiriit Kanatami. The Mental Health Advisory Committee is comprised of federal, provincial, territorial and non-governmental representatives, as well as by Inuit and First Nation mental health and addictions specialists" (van Gaalen et al., 2009: 14).

[3] MWT Pilot Projects have been launched in the following provinces: Newfoundland and Labrador, Nova Scotia, New Brunswick, Quebec, Ontario, Manitoba, Saskatchewan and British Columbia.

The methodology is then outlined, followed by the findings. These are listed for each phase of the Pilot Project: planning, implementation (further divided between forming the mobile Mental Wellness Team and implementing services and activities) and the comprehensive evaluation of the entire Project.

BACKGROUND

In 2008-2009, the First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC) and the First Nations and Inuit Health Branch (FNIHB)-Quebec Region worked together to obtain national funding to form a mobile Mental Wellness Team (MWT) in two First Nation communities in remote areas of Quebec. When the funding was granted, both organizations agreed that the FNQLHSSC social services sector would be responsible for coordinating and supporting the implementation of the Pilot Project in the First Nation communities, while the FNQLHSSC research sector would evaluate the Project implementation. It was further understood that FNIHB-Quebec Region would remain an active partner in the project.

Selecting communities

In June 2009, a Selection Committee comprised of partners from FNIHB-Quebec Region and FNQLHSSC met to choose communities to participate in the Mental Wellness Team Pilot Project. Based on selection criteria,[4] an assessment grid and available statistical records, two Algonquin communities in the Abitibi-Témiscamingue administrative region were picked: Lac-Simon and Kitcisakik. Though the context in each community is distinct, both are grappling with serious psychosocial issues and facing challenges in organizing their mental health services. In October 2009, they agreed to participate in this Project and in the associated evaluation.

Partner involvement

From the outset, this project involved a First Nation organization (FNQLHSSC) and a federal agency (FNIHB-Quebec Region), which formed a regional committee named the Steering and Oversight Committee. It was clear that the ministère de la Santé et des Services sociaux du Québec (MSSS) needed to be involved, so MSSS representatives joined the Committee in October 2009. The Committee was made up of the manager of the FNQLHSSC social services sector, the FNQLHSSC clinical advisor assigned to the Mental Wellness Team Pilot Project, the FNQLHSSC research officer assigned to evaluate the project, the community program coordinator from FNIHB-Quebec Region, a nurse clinician specializing in mental health from FNIHB-Quebec Region and representatives from three MSSS directorates: Mental Health; Development of Individuals and Social Environment; and Aboriginal, Ethno-Cultural and Northern Affairs. A consultant on community development approaches was invited to observe Committee meetings. In addition to his mandate as a member of the Committee, the consultant also assisted the FNQLHSSC clinical

[4] Seven selection criteria were applied when choosing the communities for this Pilot Project: 1- Geographical distance between the paired communities; 2- Implementation of first-line social services (underway); 3- Level of governance (trusteeship); 4- Community remoteness; 5- Number of suicides; 6- Number of homicides; and 7- Child placement rate (FNQLHSSC, 2009).

advisor in developing and delivering training on the community development approach for local partners in Lac-Simon and Kitcisakik.

The Committee's mandate was to steer the implementation of the Pilot Project and monitor the implementation and evaluation process in the selected communities. The main objectives of the Committee meetings (about four a year) were to inform regional partners of the project's local progress and carry out research-evaluation activities. The meetings also allowed regional partners to discuss challenges and project-related issues and identify the best strategies to adopt. Where necessary, the FNQLHSSC clinical advisor and partners consulted each other between meetings on administrative, organizational or clinical matters.

Committee members accompanied with influential actors from the Quebec's health and social services network also travelled to the participating communities to gain a better understanding of the local context, to meet with key local actors (band council members, directors, coordinators and teams) and to jointly establish how their respective organizations could better assist communities in organizing their mental health and addiction services. This was the first time a delegation comprising FNQLHSSC, federal government and provincial government representatives had travelled to communities in connection with a pilot project. Community leaders greatly appreciated this visit and seized the opportunity to raise the issues they face.

1.1. INITIAL OBJECTIVES AND EXPECTATIONS

The MWT model, developed by the FNIHB, combines psychosocial and cultural approaches and was implemented in Quebec by using the community development approach.

One of the objectives of the Pilot Project was to see whether such a team (multidisciplinary and striving for cultural safety)[5] would be better adapted to meet the needs of First Nation communities facing the dual issue of mental health and addictions. Another objective was to verify if using the community development approach (bottom-up logic), getting actors to mobilize around a single issue, promoting intersectoral collaboration, empowering local and political leaders and encouraging these leaders to be involved would be more conducive to effecting change than the top-down logic[6] customarily applied when implementing programs in First Nation communities.

The primary mandates of the MWT were to build the capacity of local actors and network with Quebec's health and social services network partners and community organizations with a view to addressing the dual issue of mental health and addictions.

[5] Cultural safety is based on an understanding of "the unequal power relationship inherent in the delivery of health services and the move to correct this imbalance through educational initiatives" [unofficial translation] (Spence 2001 cited in *L'Association des infirmières et des infirmiers autochtones du Canada*, 2009: 2). See the glossary for a full definition.

[6] See the glossary at the end of this report for a definition.

The original model established that the MWT would be interdisciplinary. Depending on the needs reported by the various partners in each community during the consultation in the planning phase, the MWT should comprise:

- one clinical advisor[7]
- one mental health nurse
- one social worker
- one cultural and community worker

Initially, the pilot communities focused on hiring a psychologist as clinical advisor. It was expected that this person would evaluate, consult and treat individuals, families and groups; ensure clinical coordination among MWT members; and provide clinical support to local personnel in association with internal supervisory resources.[8]

It was expected that the clinical advisor would be hired at the outset of the project and would carry out consultations (with the population, the two communities' intervention teams and outside partners) before proceeding with the second phase with the rest of the MWT. He would then share with his colleagues the knowledge gained in the planning phase. By this point, he would have had a sufficient grasp of the project and its objectives to explain them fully to the other MWT members and provide the required guidance. Developing a certain bond of trust with local and network partners would have made it easier for the rest of the MWT to integrate locally.

The communities also wanted the MWT to include a mental health nurse. The nurses working in the communities are overworked, have multiple duties and provide physical and mental health care to every clientele: children, elders, etc. It was therefore hoped that a specialized mental health nurse would assist the local nurses and conduct bio-psychosocial assessments and develop nursing care plans adapted to the needs of each patient. In addition to monitoring medication, supporting families and raising community awareness in these matters, the mental health nurse would serve as a resource person and consultant to the rest of the MWT for complex mental health cases and/or those involving a variety of bio-psychosocial factors. Lastly, the mental health nurse would serve as liaison between the first- and second-lines of mental health care with the Quebec's health and social services network, with the help of the MWT and local resources.

The cultural and community worker was at first referred to as a "traditional healer," a term found in the literature. However, this term made no sense to the community partners. In their

[7] The masculine has been used when referring to the MWT positions to simplify the text and is in no way discriminatory.
[8] The description of each position's duties was taken from a June 2010 job posting and has been synthesized here.

view, no such resource existed in either Lac-Simon or Kitcisakik. Instead, the local partners preferred the term "cultural and community worker."[9]

Contextual factors beyond the control of local actors meant that the MWT would not have its full complement of members as originally intended. The community development approach on which the project was based led all actors (local, regional and funding agencies) to reassess matters, make adjustments and find new strategies to adapt the composition of the MWT accordingly.

1.2. PILOT PROJECT PHASES

The MWT Pilot Project, based on the community development approach, was carried out in two main phases: planning and implementation. Both phases were continuously evaluated. The actors involved in the Project were systematically interviewed to document and understand the manner and the context in which they worked together. The third phase of the Project comprised a comprehensive evaluation from which recommendations were drawn. The following are the specific objectives for each phase.

i. **Planning** (October 2009 to October 2010): the main objective of this phase for the participating communities was to consult their population and workers, as well as their Quebec's health and social services network and community network partners. The purpose of these consultations was to identify local mental wellness needs and strengths (mental health and addictions). A concerted action plan based on these consultations was subsequently developed and served as the starting point for the professional requirements initially established for each MWT member;

ii. **Implementation** (November 2010 to June 2012) served to integrate the MWT into the communities and begin delivering services and offering activities;

iii. **Comprehensive evaluation** (July 2012 to March 2013) served to verify whether the initial objectives were met, identify the benefits directly attributable to the project and compile the lessons learned.

The recommendations drawn from this learning process could then be applied when implementing similar projects in other First Nation communities.

[9] Each MWT position is described more fully under section 3.2.1.

1.3. CHOICE OF APPROACH

The community development approach was chosen by the FNQLHSSC and FNIHB-Quebec Region because of the advantages it affords in terms of strengthening leadership and capacity building, the ultimate objective being community self-determination. The community development approach is particularly relevant to First Nation communities, given their history of dispossession and loss of autonomy, as well as their current efforts to take charge of their affairs. Within First Nation organizations, this approach is often preferred when carrying out new programs or projects.

Generally speaking, use of the community development approach requires that the parties be open to working together and be willing to commit to a shared objective. In a First Nation setting, this approach also entails additional challenges, such as acknowledging and pooling both professional and First Nation knowledge;[10] dealing with a local and sometimes fragile context; and coping with exhausted human resources.

One of the criteria for selecting communities to participate in the Mental Wellness Pilot Project was that first-line social services (child and family services) be established or under development. These services were implemented in four pilot communities from 2006 to 2009 with the support of the FNQLHSSC according to a community development approach.[11] The goal of the MWT Pilot Project was to offer a continuum of services.

Applying the community development approach to the four selected action strategies allowed the MWT to develop a service offer and a program built upon local needs and strengths in which various partners would be involved. The MWT had to build a substantial and inclusive group around a general objective: improving mental and overall community wellness.

Four action strategies

The four selected action strategies for the MWT Pilot Project were community mobilization (population and structures); intersectoral collaboration; involvement of local and political leaders; and individual, community and organizational empowerment.

[10] First Nations have their own knowledge and life skills that differ from those taught in academic institutions for training professionals. “This knowledge is integral to a cultural complex that also encompasses language, systems of classification, resource use practices, social interactions, rituals and spirituality” (UNESCO, 1995–2012).

[11] For more information, consult the evaluation report on the implementation of first-line social services in four First Nation communities, available on the FNQLHSSC website.

Community mobilization[12]

Mobilization refers to the desire to act collectively. Mobilizing people involves getting actors committed to a push for change. Under the community development approach, mobilization is a vital factor that applies to every stage of the project. The population and both local and outside partners must be involved for mobilization to be successful. The main challenge associated with this strategy is establishing and maintaining a shared commitment among institutional actors and the population.

Intersectoral collaboration

Intersectoral collaboration is accomplished through effective communication mechanisms that enable local actors to establish a logical sequence of actions consistent with community goals. Intersectoral collaboration is at the forefront of the community mobilization process, for this is when community actors agree on the change needed, the main steps and the means to effect this change, the principles to guide and the criteria to evaluate their actions, etc. Engaging in a mutual commitment may lead the actors to collaborate again in the future. This entire process is one in which the participants, by forming and appropriating a common vision, develop a sense of ownership for the project and forge bonds of solidarity that may eventually serve other ends.

Involvement of local political leaders

Change within a community (individual behaviour, institutional programs or structures) is usually complex and occurs in successive stages. Effecting change involves the participation of many actors and is invariably a lengthy process. It is for this reason that the notion of commitment, and not simply participation, is an integral part of community development.

Individual, organizational and community empowerment

The process of empowerment, be it individual, organizational or community, is essentially the same; it is a process that leads from feeling helpless to take action for what is important for oneself (or for the group) to a state of readiness. This is particularly true for First Nations, given their recent history of oppression and assimilation. First Nation individuals may experience discomfort, a sense of inferiority, inadequacy and fearfulness, especially when dealing with the dominant culture (Legacy of Hope Foundation, 2009). Within First Nation communities, psychosocial intervention geared to empowerment and capacity building is a pertinent means for achieving lasting change.

Concretely, these action strategies enabled the MWT to adapt its service offer to meet cultural and community needs in ways the classical socio-sanitary model (service offer based on ob-

[12] The definition of the four action strategies was taken, in part, from the website of *La Clé*, which was specifically designed for the *Vers l'IMPACT* project *(*www.mobilisation-communautes.qc.ca, 2010) , subsequently listed as *Communagir*.

jectives and programs for a given population) cannot.

1.4. COMMUNITY CONTEXT PRIOR TO THE START OF THE PROJECT

Most of the information presented in this section is taken from the community portraits of Lac-Simon and Kitcisakik prepared by the local planning team during the consultations carried out in 2010 (internal document). Other information was collected by the FNQLHSSC research officer during the same phase through participatory observation during the project.

Before introducing the communities that participated in this project, let it be stated that the literature repeatedly mentions the social problems caused by the Indian residential schools, due to the manner in which the residential schools disrupted children's lives and the abuse some of the children suffered while at the schools. Even though this subject was not raised by the participants during the project consultations, it seems appropriate to address it now. The literature states that the residential school experience was a personal trauma that evolved into an intergenerational trauma. It has been widely recognized that most of the problems facing First Nations today are due in part to this attempted cultural assimilation:

> "Although the residential school system had largely closed down by the 1970's, its legacy of systemic abuse of Aboriginal children is still felt today. The schools' legacy also has had an intergenerational impact on today's Aboriginal youth, and the children and grandchildren of former students" (Legacy of Hope Foundation, 2003: 18).

In the literature, resilience (individual, family and community) to this historical trauma is often described as one of the First Nations' greatest strengths (AHF, 2004; 2008). The intergenerational impacts of the residential schools and First Nation resilience have been mentioned here so the reader may keep these crucial elements in mind while reading this report.

Two divergent communities

With nearly 1 500 residents, Lac-Simon has a population roughly three times the size of Kitcisakik. These communities are located approximately 40 km apart and both belong to the Algonquin nation.[13] They are united by a shared past, and many residents have familial bonds with people in both communities. Both Lac-Simon and Kitcisakik communities have their own ways of managing their affairs (political, administrative, community, etc.) and practising traditional activities. Mental health and addiction issues seem to be present in both, though the resources available locally for serving the population differ, as do their relations with the Quebec's health and social services network. According to the World Health Organization (WHO), mental

[13] See the map of First Nations of Quebec in Appendix 1.

health problems correlate with rapid social change, difficult working conditions,[14] discrimination, social exclusion, unhealthy lifestyles, risk of violence, poor physical health or human rights violations (WHO, 2013).[15] To varying degrees, some of these factors occur in the communities of Lac-Simon and Kitcisakik (Laresco, 2006). In recent years, a resurgence of certain mental health problems, such as anxiety disorders and alcohol and drug abuse, has been observed, and some mental illnesses, such as schizophrenia and bipolar disorder, have been diagnosed.

The following information paints a brief socio-economic portrait and describes the state of affairs for each of the community development approach action strategies prior to the implementation of the MWT Pilot Project in Kitcisakik and Lac-Simon. The objective for preparing these portraits is to identify project partners and describe how they worked together, as well as demonstrate how the MWT Pilot Project made a difference in the organization of mental health and addiction services in these two communities.

[14] This refers to the lack of human and material resources or to the depletion of human resources observed in a number of Quebec First Nation communities.
[15] WHO website, consulted in March 2013.

KITCISAKIK[16]

Source: FNQLHSSC

Kitcisakik is located in the La Vérendrye Wildlife Reserve, with the nearest urban centre, Val-d'Or, being 92 km away. The community territory covers an area of 12.14 hectares. As Kitcisakik does not have reserve status under the Indian Act, it does not have access to the same federal funding as communities with reserve status. In matters of health care, the community has signed its own agreements with the Quebec's health and social services network. The absence of reserve status is a historical choice made by the families of Kitcisakik. In dealing with the government at the time, this position was a clear statement of the people's desire for self-government. Today, the impact of that choice directly affects the population's quality of life. The community has no permanent infrastructure, and houses have no foundations, running water or electricity. Residents use the community's sanitary block, which is equipped with toilets, showers and laundry facilities. Private dwellings use generators to meet their basic domestic needs. Moving the community to a new site with modern infrastructure and reserve status as defined under federal legislation (AANDC) has been the subject of ongoing negotiations with the Quebec and Canadian governments for nearly 20 years, though this process is not endorsed by the entire population.

In the early 2000s, an elementary school called Mikizicec was built in the community. The earliest years of the community children's education was assured at Mikizicec, starting with kindergarten. In 2009–2010, when the community portrait was drawn, the school was teaching classes up to 4th grade.[17] Older children in the community continued their schooling in Val-d'Or, staying with host families or at the rehabilitation centre during the week. For decades, taking children out of the community for school disrupted familial bonds, and this situation had an impact on the development of parenting skills (Loiselle et al., 2011). There is significant demographic growth, with 9 to 16 births yearly. The average age of women at the birth of their first child is 22. In 2007, 60% of households had two parents, and 40% just one.

[16] The name Kitcisakik is used in this report to refer to the site at Lac-Dozois, not the one at Grand Lac Victoria.
[17] As of 2011–2012, classes at Mikizicec go up to 6th grade.

Table 1: Socio-demographic profile of Kitcisakik in 2009-2010

Total population	Residents	Non residents	% men	% women	% youth (under 18)	% adults (18 to 64)	% elders (65 +)
440	**380**	**60**	**51 %**	**49 %**	**43 %**	**53 %**	**4 %**

Source: Portrait of the communities of Lac-Simon and Kitcisakik, 2010.

Particularities of the cultural and social context

A review of the cultural documentation and information gathered (phase 1) by interviewing the population shows differences between elders, adults and youth. For example, the majority of adults of forty or older speak their mother tongue (Algonquin) fluently. However, those under that age speak less Algonquin, and their knowledge of this language drops with age. The first language learned at home by this segment of the population is French. Some teenagers and young adults have learned to speak Algonquin from others in the community, which indicates an interest in the Algonquin language and culture among the community youth.

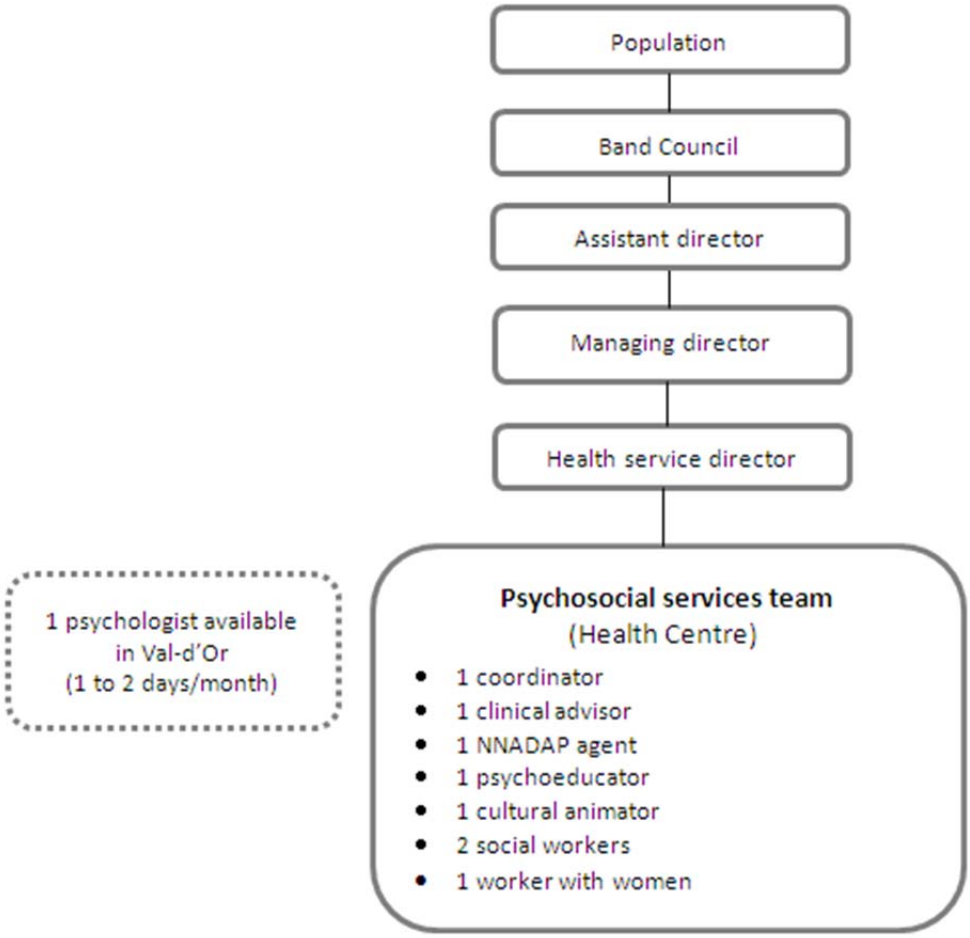
Some families and most of the elders still regularly visit the assembly site at Grand-Lac-Victoria. Certain community events, such as the Annual General Assembly (AGA) are held there. Fishing, hunting and berry picking are among the activities still practised on his territory. While not all community members follow traditional practices and ceremonies, like going to the sweat lodge, many are renewing with this part of their culture. This decision, however, is individual rather than collective. Traditional activities and practices are respected and tolerated, and a few sites devoted to these activities can be found on the outskirts of the community. In the fall of 2010, the community built a healing lodge in the forest (Lac Transparent).

Starting in the 1990s, a wave of sexual assault charges marked a turning point for this community. An unpublished study funded by the Abitibi-Témiscamingue health and social services board was conducted over a number of years among both men and women in Kitcisakik to document and support these disclosures and the ensuing healing process. In 2006, another study, this time conducted with different community representatives, reported that the violence of incest “was less prevalent than in earlier years, but was still hidden and hard to assess” (Laresco, 2006: 29). In Kitcisakik, follow-ups done in groups rather than one-on-one are preferred. When the 2010 consultation was done, a number of groups had already been formed within the community: bereavement group, proud to be parents group, parenting skills group, growth group, group of parental support and group of parents mobilizing.

Organization of psychosocial services

The following organization chart shows the structure of psychosocial services in Kitcisakik (including Widokodadin services),[18] all based at the health centre and forming a single large team with physical health services.

Figure 1: Structure of psychosocial services at Kitcisakik in 2009–2010[19]



The next section of the report features an overview of each community at the start of the project according to the action strategies of the community development approach. The objective here is to gain a better understanding of the social context in which the project was launched.

[18] Widokodadin is the Algonquin term used locally to refer to child and family services (FNCFS-AANDC Master Agreement), also called first-line services.

[19] The frequent turnover on the health centre team has to be taken into consideration. This figure is indicative only.

Mobilization of the population

In the course of gathering information for the MWT Pilot Project, the participants identified mutual support as being one of the community's strengths, though they admitted that this support tends to wane. Community support likely remains one of the community's strengths, since in answer to the question Which person or service do you turn to when you are not well?, most respondents stated that they would turn to another community member they trusted before turning to a service provider. This suggests a strong social network in the community.

Community members see each other as being hospitable, friendly and good-humoured individuals. However, the lack of participation in organized community activities has been identified as a weakness. Community first-line workers explained that volunteering and a sense of commitment have to be constantly stoked in the community, adding that: "[we] always turn to the same people, because they are the ones who usually get involved in things" (local actor, 2011).

Intersectoral collaboration

The retreat (lac-à-l'épaule) formula is routinely used by band council members, directors and community workers for such things as preparing the annual service plan. Those involved gather at a site away from the community to plan services for the coming year without the distractions of day-to-day activities. Intersectoral collaboration is prioritized and implemented by the Multisectoral Committee (representing all sectors of the community plus the band council) and the Child and Family Committee (comprising health, education and Child and Youth Protection Centre (youth centre) representatives).

Participants at the community development approach training offered by the FNQLHSSC in January 2010 said that they were ready to work together when:

- The values of fairness, respect, transparency, openness, recognition and trust were prevalent;
- Everyone's strengths were called upon, and the whole team was committed;
- Objectives were easy to understand and well explained;
- The proposed project was built around a common cause and was structured, relevant and would make an impact.

The participants mentioned there was a need for greater collaboration between the community service sector and band council, and between Native and non-Native workers.

Involvement by local and political leaders

Political initiative and strong leadership exist in Kitcisakik. In the 1990s, local leaders consulted the population to boost community involvement.[20] They officially signed a community involvement pledge in 1996, which the community reviewed in 2000 and unanimously adopted in 2005. The objectives of the community involvement pledge are to provide a better quality of life for all community members; to meet the needs of children and teenagers; and to assist and support parents in their roles and responsibilities (Kitcisakik website, 2013). Sustaining the desire to be involved in community affairs does, however, pose a challenge.

A mostly female band council was elected in November 2009. When the training offered by the FNQLHSSC in the planning phase was given in January 2010, the band council stated its commitment to the community development approach. The political leaders believe in this approach and see it as important. According to local resources, this approach is not always easy to apply. In fact, the involvement of some partners remains a challenge.

Empowerment

Individual and community empowerment is hard to identify, and information about this is sparse in the community portraits of Lac-Simon and Kitcisakik (2010). Where organizational empowerment is concerned, first-line workers in Kitcisakik note that apart from the Annual General Assembly (AGA), there are few events at which the population can meet the band council. They feel that it would be useful to hold extraordinary general assemblies or other mechanisms to better keep people informed.

Conclusion

Kitcisakik is a community that, at first glance (and when we limit ourselves to read the literature), seems one of the poorest communities in Quebec. With housing stock lacking modern amenities, it is true that Kitcisakik is materially disadvantaged compared to other communities. However, a strong social fabric, sense of solidarity and desire to take charge of community affairs is evident. Kitcisakik exemplifies openness, as the community has a long history of non-Natives, or *Tcigoji,* working there, and the intersectoral approach is valued.

[20] For more information on community involvement at Kitcisakik, see the community's website.

LAC-SIMON

Lac-Simon is located about 32 km from Val-d'Or. The community has had reserve status since 1962. In 35 years, the registered population has more than tripled (in 1975, there were only 454 registered members).[21] The documentation shows that rapid demographic growth may cause problems in many areas, such as the demand for services; local economy; housing; infrastructure and the socio-political fabric. This portrait illustrates that the community faces a number of challenges.

Source: Wikipedia

According to information gathered by the local planning team in 2010, the majority of people aged 15 and up were in common-law unions. There was an average of 56 births a year, with many mothers under the age of 18.

Table 2: Socio-demographic profile of Lac-Simon in 2009-2010

Total population	Residents	Non residents	% men	% women	% youth (under 18)	% adults (18 to 64)	% elders (65+)
1 756	**1 438**	**318**	**51 %**	**49 %**	**41 %**	**54 %**	**5 %**

Source: Portrait of the communities of Lac-Simon and Kitcisakik, 2010.

Cultural and social context

In the summer of 2009, the community was faced with a major social crisis when it experienced a wave of suicides. At the height of the crisis, community police recorded six suicides and 83 attempts. These events prompted the community to mobilize and seek support from various partners: FNQLHSSC, Health Canada, AANDC, MSSS and the *Secrétariat aux affaires autochtones* (SAA). These partners met with community representatives several times. In the fall of 2009, following recommendations, the Social Crisis Table was created. This initiative has subsequently evolved into the Social Action Project.

The events of 2009 show that many people in this community are suffering from psychological distress. The implementation of the Social Crisis Table that become the Social Action Project,

[21] Returnees to the community and those newly added to the band list, with many of these registrations occurring from 1985 to 1990 following the adoption of the new *Indian Act* (Bill C-31), must be taken into account.

paired with the MWT Pilot Project, succeeded in mobilizing diverse actors who would not have otherwise come together. The flurry of projects that followed sowed confusion among the population and local workers. What may seem like an exercise of duplication and waste actually served to strengthen the community's ability to coordinate and organize its emergency services.

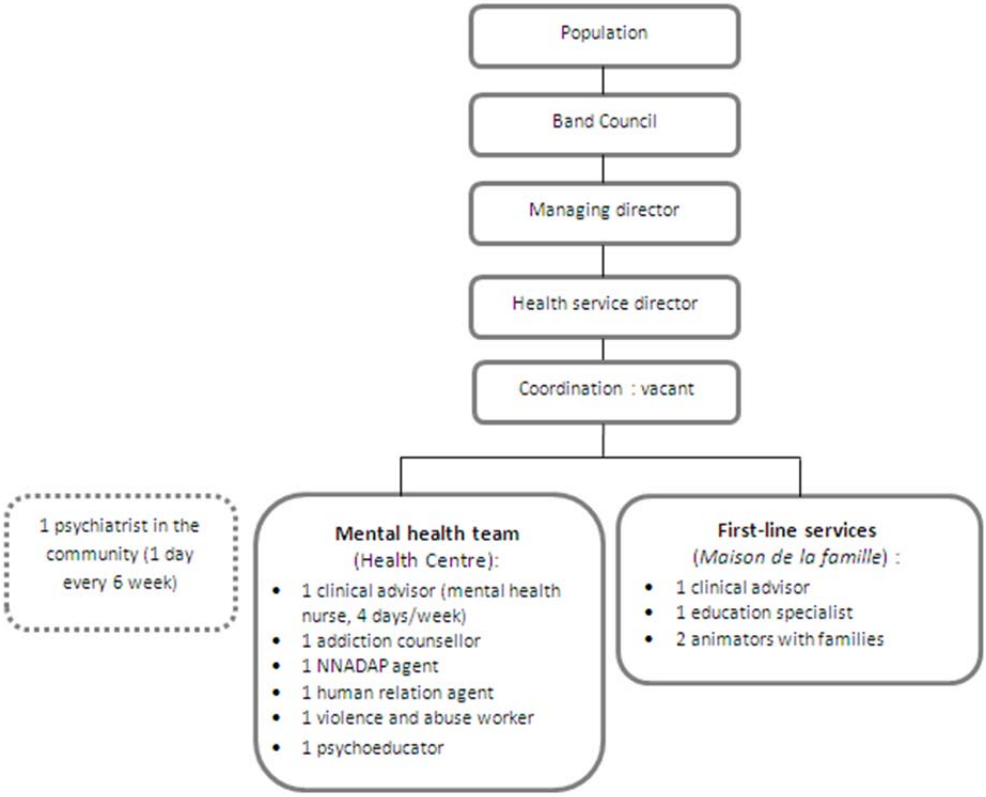
The community has lost some of its traditional healing knowledge and practices. Those that have been retained include forest retreats, spiritual ceremonies and fasting. Not everyone in the community follows traditional healing practices, though they have been gaining in popularity recently. In the wake of the social crisis, the community organized a traditional ceremony in January 2010 to help the population heal. Cree and Innu spiritual leaders were invited for the occasion. The activity was very well attended.

Organization of psychosocial services

For the past several years, Lac-Simon has had a local mental health and addiction team providing services through a social-sanitary approach (conventional office clinic). A first-line service team[22] had been in place since 2007. Though these report to the same coordinator, they are at different locations. The diagram below illustrates the local structure of psychosocial services during the planning phase of the MWT Pilot Project in 2010.

[22] This is a local term for child and family services (FNCFS-AANDC master agreement).

Figure 2: Structure of psychosocial services at Lac-Simon in 2009–2010[23]



Mobilization of the population

In the wake of the 2009 social crisis, a network of natural caregivers was formed in the community. When the local planning team was drawing the community portrait, there were about 30 people in Lac-Simon who had taken the *Sentinelle* training[24] to learn how to identify distressed individuals or those having suicidal thoughts, and steer them toward the appropriate resources. This mobilization was launched in response to a social crisis, which differs from spontaneously initiated mobilization, such as that associated with a project. This mobilization has nonetheless been sustained, and a number of suicide watches have been organized, especially over the Christmas holidays, with many natural caregivers with *Sentinelle* training taking part. During these periods and also during summer, a schedule of recreational activities was established to keep people mobilized and occupied.

For over ten years, the health centre has been organizing community kitchens, and since 2008, the *Maison de la famille* has been doing the same thing for its clientele. These activities are very successful. "People talk more. It's as if the setting makes them feel safer, they aren't being judged, and things are generally more relaxed" (local actor, 2010). The same applies to all group activities, such as workshops in the forest, during which "participants seem more in-

[23] High turnover in local teams needs to be taken into consideration. This figure is indicative only.
[24] Training offered by the FNQLHSSC social services sector.

clined to talk about their experiences" (local actor, 2010).

However, when the population is convened to meetings to share their achievements and obtain feedback, such as the AGA or the annual health services evaluation, community participation remains low.

Intersectoral collaboration

At the time of the consultation, local actors sought to improve intersectoral collaboration. The main challenge they faced was to ensure its sustainability. According to the data collected, "political instability in the community is still a factor that makes it hard to maintain and pursue collaborative action" (local actor, 2010). Staff turnover may hamper collaboration efforts within the community and with outside organizations.

The lack of collaboration leads to the duplication of services. In 2010, "the health centre, first-line services and youth centre were all offering services under the *Act respecting health services and social services*" (outside actor, 2010). One of the means identified for promoting intersectoral collaboration was "that it receives political, community and sector support" (local actor, 2010).

Involvement by local and political leaders

Though the Lac-Simon band council changed in 2009–2010, this did not affect council support for projects to develop community wellness. In terms of local leadership, Lac-Simon has some elders who practise and promote Anishnabe (Algonquin) culture. They are respected by the people and provide a degree of local leadership. "There are leaders and there are pillars of the community, but not in sufficient numbers. There are not many future leaders among the young. The pillars are tired; it is always the same people who are involved and being sought out" (local actor, 2010).

Individual, community and organizational empowerment

The information gathered about individual empowerment indicates that a portion of the community's population shows signs of addiction and shirks their responsibilities. According to a local source, "history has led to a widespread abdication of responsibility, and many members of the community are trapped in a culture of victimhood" (local actor, 2010). One of the objectives for the delivery of services to the population is to develop self-reliance and responsibility. First-line workers and the band council say that they are increasingly steering their efforts in that direction.

When the local planning team interviewed the population of Lac-Simon, young people had no real idea of what they could do to improve the wellness of their community, though some suggested "being clean" (sober), continue his studies and cleaning up the community. The women felt the best way to help the community was to volunteer and get involved, particularly with youth and elders; help one another; and take part in community meetings, activities and events. The men shared this view, saying that being involved and participating in meetings and organized activities would be a good way to improve community wellness. They also mentioned teaching traditional knowledge to and spending time

with the youth, as well as sharing their personal experiences. The elders saw the youth as the future of the community and believed they could help improve community wellness by encouraging the youth to take charge of their lives, stay in school and achieve their goals.

Conclusion

Many services are delivered in Lac-Simon. The high number of community workers is in response to Lac-Simon's high rates of crime and psychological distress (Laresco, 2006). The financial compensation offered under the Indian Residential Schools Settlement launched in 2007 has undermined vulnerable individuals. In some cases, "a negative emotional response caused by painful memories (…) has resurfaced as the survivors applied for the CEP [Common Experience Payment] or went through the IAP [Independent Assessment Process]. These responses range from feelings of sickness to loneliness, anger, panic, fear and depression" (AHF, 2010: xii).

At the time of the consultation, community workers agreed that they had seen an increase in alcohol and drug use in the community since the process began:

> "(…) although I think the residential school funding is winding down [but] the families of residential school survivors are still experiencing violence (…). And now, they just leave us like this. They have given out all this money. We've had to deal with periods of significant violence and drug and alcohol abuse because of all this money" (local actor, 2011).

It has been well documented that some communities experienced crisis levels of violence and drug and alcohol abuse after residential school survivors received their payments. The *Aboriginal Healing Foundation* addressed this issue in its 2007 report entitled *Lump Sum Compensation Payments Research Project: The Circle Rechecks Itself* or in *The Indian Residential Schools Settlement Agreement's Common Experience Payment and Healing: A Qualitative Study Exploring Impacts on Recipients* from 2010.

Let it be said that the people of Lac-Simon are eager to take charge of their affairs and adopt a healthy lifestyle. Some residents are strongly committed to their community, and much rests on their shoulders. These are the pillars of the community, the ones who take in foster children or host those who have completed therapy or emergency medical treatment and have nowhere to go. Much effort has been made recently to promote intersectoral work as part of the overall drive to improve community wellness.

1.5. COLLABORATION BETWEEN FIRST NATION COMMUNITIES AND THE QUEBEC'S HEALTH AND SOCIAL SERVICES NETWORK

The 2010 consultation of outside partners showed that collaboration between the Quebec's health and social services network and First Nation communities could be improved. The outside partners were very receptive to the MWT Pilot Project and wanted a seat with key community actors at the group or committee to improve cooperation in this area. They were also very sensitive to the prevailing situation in Lac-Simon and expressed an interest in perfecting their approach so that it corresponds more closely to First Nation needs and reality.

The openness expressed by partners in this administrative region has subsequently proved an asset. Further to the community development approach and the mandates derived therefrom, the MWT is to network and communicate with these partners. Their receptiveness bodes well for the MWT's future exchanges with them.

2. METHODOLOGY

The goal of the research-evaluation component was to:

- Document the processes for creating the community portraits and developing the action plan;
- Document the implementation processes for the MWT Pilot Project and service delivery;
- Identify findings and make recommendations.

The research-evaluation phase set out to answer the following questions:

- How has the project, which was developed based on local needs and strengths by using the community development approach, helped establish mental wellness services and activities that meet the needs of the participating communities?
- How has the MWT model helped set up a mental health service organization adapted to the participating communities that can operate with the provincial system?
- How has the MWT Pilot Project helped the participating communities to become more autonomous and assume greater responsibility in the area of mental health?

A number of semi-directed interviews were held throughout the project with actors from each community, including the MWT; outside actors, including partners in Quebec's health and social services network; and regional partners, such as the FNIHB-Quebec Region, MSSS and FNQLHSSC. The diversity of those interviewed meant a range of different points of view gathered about the Pilot Project and MWT activities.

The findings of this process evaluation stem essentially from qualitative data. A recognized analysis technique (iterative model) with N'Vivo analytical software was used. To ensure that the data could be reliably interpreted, data validation sessions were held with the actors consulted at each phase of the project.

The data from each community was processed independently from that of the other for the purposes of this research-evaluation, since local variables may have influenced the degree of implementation of the project and the community development approach. The communities have not been compared to one another. Instead, the data was analyzed with due regard to the local context of each community.

In order to help the FNQLHSSC research officer meet project research-evaluation objectives, it was decided to form a working group of experts in the following areas: community development approach, project evaluation and First Nation mental health. This group was actively involved in developing each step of the evaluation process.

Like with other research and evaluations conducted by the FNQLHSSC, this evaluation used a participatory approach and provided the FNQLHSSC clinical advisor and community actors with data for the planning and implementation phases. The whole process was consistent with the First Nations of Quebec and Labrador Research Protocol (AFNQL, 2005) and the First Nations principles of OCAP™.[25]

Some methodological limitations became apparent over the course of the project, especially when randomized data was being gathered in the communities. It would have been preferable to meet with the same actors on a regular basis to be able to gauge the evolution of their point of view, method of reasoning and perception, something that could unfortunately not be done. For a variety of reasons, including a lack of availability, some of the important actors could not be interviewed. As the findings obtained were associated with the specific context in which the project was implemented, this meant they could not be directly transposed to another context. Consequently, the principle of generalization cannot be applied.

In spite of these limitations, the findings obtained do yield an understanding of how the MWT Pilot Project was implemented by using the community development approach in the communities of Lac-Simon and Kitcisakik, as well as how it operates in conjunction with the Quebec's health and social services network. Moreover, the recommendations drawn from this research-evaluation go beyond a given local context and can be applied to all First Nation communities wishing to develop a MWT using this approach.[26]

[25] Ownership, Control, Access and Possession. For more information, go to the First Nations Information Governance Centre's website.

[26] For more information on the research-evaluation methodology used, contact the FNQLHSSC research sector.

3. FINDINGS

The findings cover the period from October 2009 to June 2012, namely the planning (October 2009 to October 2010) and implementation (November 2010 to June 2012) phases.[27] The manner in which they are presented illustrates how they relate to the four action strategies of the community development approach used in the project and to the local context of each community.

Before proceeding to the planning phase, it must be mentioned that the MWT Pilot Project was implemented through the successive hiring of two different teams (joint to both communities): the local planning team, and then the MWT. As shown further, the consultation process for the first phase initiated by mobilizing the population and both local and outside partners. The lack of MWT participation in the consultation turned out to be a constraining factor, because it took the MWT several months to integrate into the community, clarify its mandate and resume its mobilization activities.

3.1 PLANNING PHASE

The local planning team was hired to carry out mandates of the first phase: consultation, community portraits and joint action plan. A Local Steering Committee, which comprised a band council representative, the health service director from each community and the FNQLHSSC clinical advisor, was formed to support and approve any action taken (e.g. the hiring process and the action plan).

The Local Steering Committee felt it was important that the person conducting[28] the interviews in both communities be a First Nation member from one or another participating community. Indeed, this strategic choice encouraged the population to participate in the consultation (Lac-Simon N=119 and Kitcisakik N=30), yielding findings of interest. Given that the bond of trust is important in First Nation communities and that the subject of mental health was being addressed through a public consultation for the first time, local partners felt that an unfamiliar person would have taken a lot longer to reach as many people.

3.1.1 CONSULTATION WITH THE POPULATION AND LOCAL PARTNERS

The main objective of the consultation was to obtain the opinion of as many community members and community workers as possible. The topics covered and questions asked were devel-

[27] For information on the progress of the project during the third phase (July 2012 to March 2013), see the section on the context of the Pilot Project in March 2013 in this report.

[28] Initially, a secretary and two project officers were hired to form the local planning team. One man and one woman were hired as project officers, as it was decided locally that it would be better to have a man interview the men, and a woman interview the women. After several weeks, the male project officer quit, leaving his female counterpart to complete the consultation. As it turned out, there was significant male participation in the consultation, even though the person interviewing them was a woman.

oped by the local planning team with the help of the FNQLHSSC clinical advisor and research officer, and then approved by the Local Steering Committee. These topics and questions were determined with a view to developing a collaboration action plan based on each community's strengths and needs.

Community members were asked such questions as "What does good mental health mean to you?" and "What could you do to improve your community's wellness?" A leaflet explaining the public consultation findings was printed, delivered to every house and made available in public information stands.[29]

The consultation with community workers comprised the following questions:

1. In your own words, what is good mental health?
2. What are the mental health problems in your community, and which ones are of greatest concern to you?
3. What are the mental health and addiction services available to the population of your community?
4. What are the promotional and preventive activities available to the population of your community to reduce mental health and addiction problems?
5. What cooperative arrangements already exist between your teams and outside partners (CSSS, youth centre, Native Friendship Centre, etc.)?
6. What difficulties have you encountered in your dealings with outside partners, and how could you resolve them?
7. What is your view of the collaboration between the MWT and your teams of first-line workers (clinical support, training, caseload sharing, etc.)?

Note this last question could imply that the MWT was willing to take on some of the local caseload. These suggestions were given to prompt respondents to think about how the MWT might help them. The list of the MWT's achievements mentioned later in this report indicates that the aforementioned suggestions were misinterpreted by some overburdened workers, who believed the MWT was actually proposing to take on some of their caseload. The lesson learned here is that in this kind of consultation, it is important for the interviewer to clarify with respondents that not all their identified needs can be met. It should be clearly established that the process involves prioritizing needs within the framework of the MWT's mandate and its capacity to meet those needs.

During this phase, the local planning team tried different methods to contact participants and gather information. The following table gives examples of the methods used in each community.

[29] See Appendix 2 for the leaflets.

Table 3: Examples of consultation methods used with the population

Lac-Simon	Kitcisakik
Consultation with high school students (one focus group per class)	Written questionnaire
Individual meetings in participant's homes	Individual meetings
Small group meetings (e.g. women)	Use of existing groups (e.g. community kitchen)

Not only were the Social Action Project (created by the 2009 Social Crisis Table) and the MWT Pilot Project being implemented concurrently in Lac-Simon, both used an identical approach. To avoid duplication, joint public consultations were held for the two projects, and the questions asked to participants were basically the same. Simultaneously implementing two projects with similar objectives and a common approach sowed confusion among the population and community workers. It took some time for people to distinguish between the two projects and identify who worked with each.

This was the first time residents in Lac-Simon and Kitcisakik were being consulted on mental health issues. People said that they were pleased with the opportunity to express their views on the subject, but many added they would have liked to have had more time to think about and prepare their answers. The consultation could have been repeated every year over the course of the project to give participants the chance to reflect on mental health issues and maintain their degree of involvement in the project. As described later in the report, the many constraints faced by the MWT regarding the mental health project made this impossible.

3.1.2 CONSULTATION WITH OUTSIDE PARTNERS

The FNQLHSSC clinical advisor and research officer met with outside partners for the first time in October 2009 before the local planning team was even formed. The purpose of the meeting was to: 1- present the main project and evaluation objectives, 2- answer outside partner questions, and 3- gauge their interest in the participatory approach used. This was the first step toward mobilizing people to work together. The partners in question were representatives of the *Agence de la santé et des services sociaux de l'Abitibi-Téminscamingue*, the CSSSVO and the Lac-Simon branch of Abitibi-Témiscamingue youth centre.

Between February and April 2010, the local planning team and the FNQLHSSC clinical advisor conducted a consultation with the outside partners listed above, as well as with the Val-d'Or Native Friendship Centre, *Centre Normand*[30] and the Kitcisakik branch of the youth centre. The participants were asked the following questions:

1. What formal or informal collaboration arrangements already exist between your establishments and First Nation communities?
2. What difficulties have you encountered in working with the communities, and how could you resolve them?
3. How can the continuity of services between your establishments and the communities be assured?
4. How could your establishments and the MWT cooperate more closely?
5. What are your observations, clinical impressions and intervention approaches regarding the dual problems of mental health and addictions?

The findings show that outside partners want to improve the flow of and follow-ups on information exchanged with communities, and they feel the key is clearer and stronger lines of communication. They were also willing to adapt their activities so as to more closely meet the needs of their First Nation clientele. A summary of the solutions they identified appear in the table below.

[30] Abitibi-Témiscamingue regional public addiction rehabilitation centre. It has six points of service, including one in Val-d'Or (Centre Normand website, consulted in March 2013).

Table 4: Challenges and possible solutions identified by outside partners

CHALLENGES (faced by the Quebec's health and social services network)	POTENTIAL SOLUTIONS (proposed by the Quebec's health and social services network)
• Erratic communication; • Little information passed on; • Language.	• MWT members should sit on regional groups and committees; • The network would like to keep in touch with communities, even after emergency situations have been resolved; • Information shared with community partners (at meetings, etc.) should then be passed on to other local teams and the population; • Make more use of interpreters when delivering services.
• Lack of follow-up; • Lack of post-consultation action (liaison).	• One or two individuals in the community should serve as the regular contact person to improve communication with the network and ensure follow-ups are done (always deal with the same person).
• Few trained and clinically experienced workers in the community.	• One MWT member could join the Regional Clinical Committee; • Strike a clinical committee – the network proposes supporting the MWT by providing clinical support; • The network is offering to share its expertise, do coaching and supervision and give training.
• Capacity of outside partners to overcome prejudices toward First Nations; • Lack of cultural sensitivity.	• The network must show that it can do things differently; • The Agence de la santé et des services sociaux de l'Abitibi-Témiscamingue is working with the CSSSVO, youth centre and Val-d'Or Native Friendship Centre to develop a collaboration manual (how to intervene, who to contact, etc.); • The network would like to have a better understanding of the organizational and political structure of the communities – see the organizational chart, have a better grasp of federal programs offered in the community, etc.; • Network staff has already been trained to adapt services to First Nation culture.
• No protocol established or clear service agreement in place.	• Clarify roles and mandates (service offer) for internal sectors before developing protocols or service agreements; • Partnership must be based on genuine commitment and trust; • Clarify the community's needs and expectations regarding the network; • Computerize record keeping.

The planning phase lasted a year (from the hiring of the local planning team to the arrival of the MWT), during which six months were devoted to the consultation, analysis of the data gathered, establishment of each community's portrait and preparation of the action plan. Those activities sometimes proved quite demanding for the local planning team, who had no previous experience in this area. The FNQLHSSC provided invaluable support during this period: giving basic training in individual and group interview techniques, assisting with the local planning team in the first data gathering interviews (especially with the Quebec's health and social services network partners), keeping local planning team members motivated, jointly analyzing the consultation data gathered and helping to draft the communi-

ty portraits and the joint action plan.[31]

After the action plan was presented to the Steering and Oversight Committee (FNQLHSSC, FNIHB-Quebec Region, and MSSS) in June 2010, the local planning team was disbanded. The next four months were devoted to posting job notices for the MWT positions. Once again, the start of the second phase was a time when the FNQLHSSC's support was especially important. The FNQLHSSC human resources department and the MSSS partners shared their staffing tools and models, and the FNQLHSSC clinical advisor drew on his clinical expertise in mental health to coach community partners in developing selection grids and conducting interviews.

The flexibility of FNIHB-Quebec Region partners was helpful in the planning phase (extension granted).

The job postings went up several times before enough qualified applicants were found. Surprisingly, the position requiring the most job postings (N=3) was for the cultural and community worker. According to the Local Steering Committee, the difficulty in recruiting a local person for such a position on the MWT was due to two factors: those with the required skills were already employed, or else potential applicants did not feel they were qualified. Locally, cultural and traditional workers are seen as people who have travelled down a long road[32] who are serious about what they do and who are highly regarded by their peers:

> "When you go into this, you are told that there will be no alcohol, no drugs, no gambling. You have to be comfortable in your own skin. You have to have taken a long journey of self-discovery to promote culture, because we, as a nation, take culture very seriously. If you take that route, you have to have earned respect" (local actor, 2012).

Interestingly, those who were locally recognized for their knowledge of and commitment to culture and traditional practices showed no interest in the position: "They could not imagine someone being paid to do cultural work. It isn't part of their culture to say, *OK, I'll teach you to do this cultural thing, I'm being paid to do it. I'll go get the sweat lodge ready, I'm getting paid to do it, so come on*. This is not part of their mentality" (local actor, 2012).

Summary

Though first-line services (child and family services) were established in these two communities in 2006–2009 with the FNQLHSSC by using the community development approach, key local actors still expressed surprise at having to become so involved in project planning. It seems that more than one bottom-up project would be needed before actors grasp the issues involved, namely that problems need to be identified and priority action strategies determined locally.

[31] See Appendix 3 for the action plan prepared after the consultation.

[32] Metaphors of journeying or travelling are widely used by First Nations to illustrate the various stages to be crossed when going from point A (trauma; wounds; addiction) to point B (healing; wellness; autonomy). This emphasizes the First Nations' view that this is a long-term process (see AHF, 2006).

The local planning team felt the flexible framework was destabilizing, and the team members expressed the need for a more clearly defined framework. It turned out that the communities were not as familiar with the consultation process or the manner in which to draft an action plan as had been hoped when they were selected. More support from the FNQLHSSC was needed at every stage of the planning phase. The lesson learned here is that community development is an ongoing process and, in a context where many changes occur (e.g. band council, local teams), knowledge is not automatically transferred.

The planning phase is one of the most important in the overall process of implementing a project under the community development approach, and the time needed to see it through, including local capacity building needs, should not be underestimated.

Table 5: Lessons learned about planning

1. It is essential to allow sufficient time for this important phase. Mobilization for conducting consultations, painting a portrait of the context and developing a coordinated action plan takes time.
2. Not retaining the human resources used in the first phase for the second phase was a limiting factor. By remaining on the MWT in the second phase, these human resources would have been able to share their knowledge and help the other MWT members integrate into the community.
3. Having a local coordinator facilitate the integration of the other human resources into the communities proved beneficial.
4. Local resources permitting, it would be strategically sound to pair the person responsible for planning (project officer or coordinator) with a local mentor with experience in developing an action plan prepared with data from a consultation carried out using the community development approach. Alternatively, it would be helpful to prepare a training plan and set aside time over the first few months (+/- 6 months) to provide training tailored to the needs of the person hired (e.g. how to mobilize the community to support a project, how to empower others, how to conduct consultations using the community development approach and how to develop an action plan using consultation data).
5. It is important to clarify with the partners involved in the consultation that their requests may be answered only in part. Partners should be regularly consulted as the project proceeds (not just at the beginning, but throughout) to discuss and specify what can and cannot be done and why.
6. It would have been helpful in the context of this project to have an effective system of communication to keep partners and the population informed of project developments and answer any questions. Such a mechanism would also help sustain mobilization in support of the project
7. When putting up the MWT job postings, it would be better to target those living in the immediate area (no moving involved) and use generic titles to attract a wider range of applicants and identify people with the desired aptitudes and expertise (mobilization, networking, coordination development, cultural adaptation, ability to solve problems collectively, etc.).

3.2 IMPLEMENTATION PHASE

The implementation phase was done in two stages: implementation of the local MWT and MWT service delivery. This section of the report presents the findings for each stage.

Note that the Local Steering Committee made up of key actors struck to oversee the planning phase in Lac-Simon and Kitcisakik was dissolved prior to the implementation phase. This made it more difficult to sustain community mobilization and unite key actors in each community.

3.2.1 IMPLEMENTATION OF THE LOCAL MWT

The MWT was implemented over a period of approximately five months, from December 2010 to April 2011. The MWT had to complete its preparations before being able to offer services. The team members had to familiarize themselves with the project objectives and the community development approach. It was important they take the time to fully integrate the project vision and grasp the implications of using the community development approach. Obviously, every time a new member joined the team, he had to go through this same process.

Hiring MWT members

The job positions were posted for several weeks (August to October 2010). The communities hired a clinical advisor (psychologist), a mental health nurse, a social worker and a cultural and community worker, as originally intended. The MWT then comprised four members from different backgrounds who were working together for the first time. With no team coordinator (who should have been present from the outset), it fell upon the FNQLHSSC clinical advisor and the health directors in each community to promote the project vision. The FNQLHSSC clinical advisor also gave the newly hired MWT members two weeks of training during which they became familiar with the communities, since neither Lac-Simon nor Kitcisakik have such integrating process in their organization.

A notice was sent out in both communities announcing the arrival of the MWT.

Hiring locally known people is practical, because they are familiar with the local operation. They adapt more easily and integrate more quickly.

Following the departure of first the clinical advisor and then the mental health nurse in the first two months, the health service directors decided in regards of the next posting that only locally known candidates from the Val-d'Or region would be sought to fill the openings on the MWT.

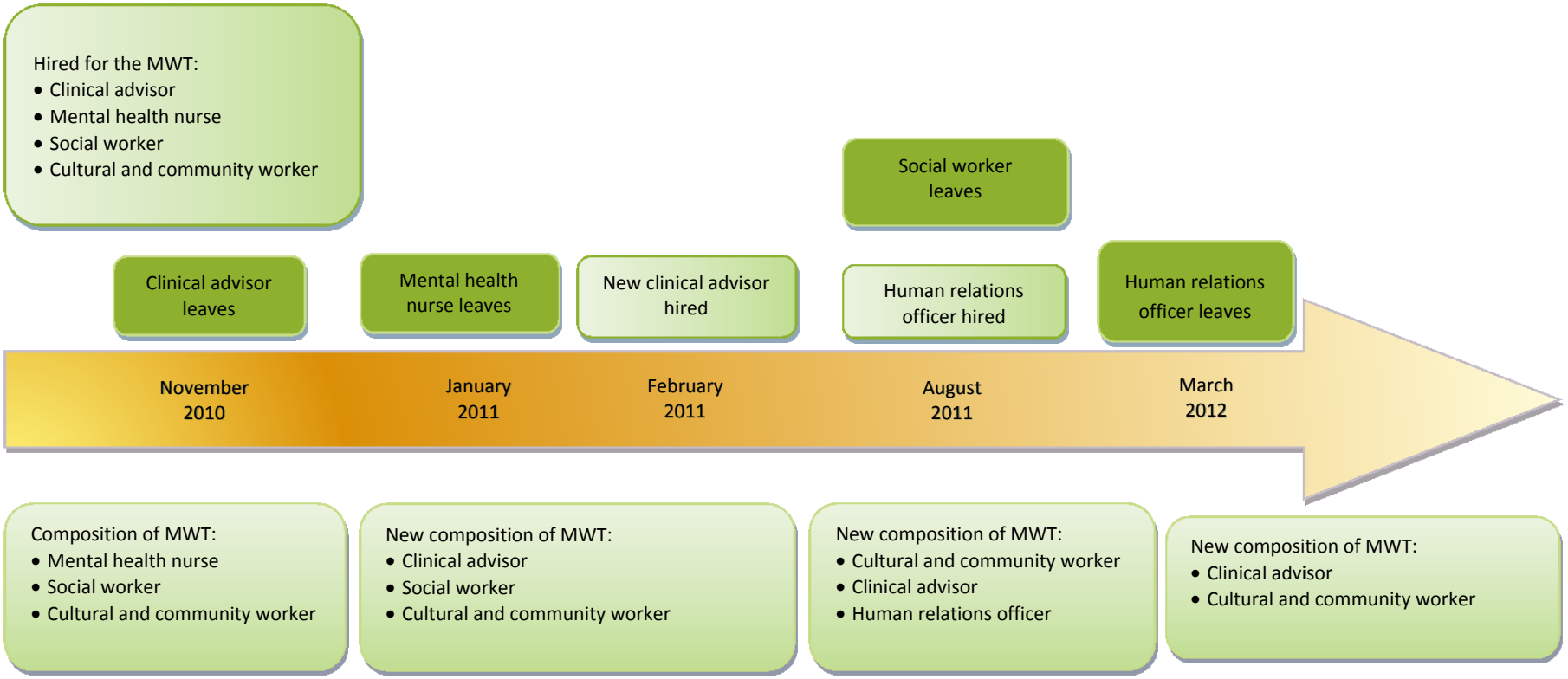
Thereafter, the MWT comprised:

- One cultural and community worker (as of November 2010)
- One social worker (from November 2010 to August 2011, and as of September 2012)
- One clinical advisor (criminologist specializing in mental health) (as of February 2011)
- One human relations officer (from August 2011 to March 2012)

Thus, from March to September 2012, the MWT comprised only two out of four members: the clinical advisor and the cultural and community worker. The figure below illustrates how the composition of the MWT changed over time. It must be noted that during the implementation phase, the team never had its full complement of four members. Turnover on the MWT was detrimental on several levels (see the Achievements section) and resulted in the loss of knowledge acquired during training. Given the circumstances, the FNQLHSSC clinical advisor spent a lot of time training MWT members.

The communities' desire for the local planning team to comprise mainly local First Nation individuals could not be met for the second phase of the project. The funding provider insisted that the three clinical members of the MWT be professionals with recognized degrees and/or belong to a professional order. Unfortunately, not many individuals holding these qualifications could be found in First Nation communities. This criterion was established to maintain a service quality and is directly related to Bill 21. Adopted unanimously by the National Assembly in June 2009, this legislation sets out the acts in specific fields, such as psycho-education, that may only be practised by mental health professionals with a reserved title (*OPP du Québec*, 2010). Note that in the field of mental health, there are major obstacles—some of which are legal—to having First Nation knowledge, expertise and skills recognized. The MWT was therefore composed of three non-Native and one Native members.

Figure 3: MWT member turnover



Already, the Quebec's health and social services network finds it difficult to recruit mental health professionals such as psychologists and nurses. These resources are in short supply, and this holds all the more true for a First Nation community, where working conditions are different from those in the rest of the network: multiple duties, inadequate pay for working in a northern region (no remote bonus) and local conditions that can be very demanding. In the case of the Vallée-de-l'Or, the low housing vacancy rate is another factor to be considered for resources arriving from outside the region. Quality accommodations are scarce and housing costs very high. In addition, the resources hired must be willing to accept frequent travel (considerable distance between Val-d'Or and the two participating communities, and the mileage allowance is not always included). In addition to the clinical skills required, the professionals hired to work with First Nations must be familiar with the communities and show cultural sensitivity, further shrinking the pool of applicants.

Achievement

Easing professional expertise criteria in exchange for someone who has a community profile.

Challenges

- Recruiting First Nation mental health professionals;
- Recruiting culturally sensitive professionals with a community profile;
- Retaining these professionals.

MWT's mandate

The MWT met on several occasions in the first few months after the members were hired to fully understand their mandates. While the action plan developed during the first phase established guidelines, it did not clearly define their individual duties nor provide information about the target clientele. Local and outside partners were met to establish their needs and priorities, thus confirming that what had been identified in the action plan was still valid. These meetings also allowed the MWT to adapt to new contextual factors and determine the overall implementation process.

The composition of local teams in each community changed between the planning and implementation phases.

The expectations about the MWT's role likewise evolved.

Hiring a First Nation liaison officer working with the CSSSVO was discussed at this time.[33] It was hoped that a First Nation individual would be able to serve as interpreter; provide information on and support for CSSSVO services; and improve the lines of communication between mental and physical health services in First Nation communities and the CSSSVO.

This preliminary work boosted MWT visibility in the communities and enabled team members to gain a better understanding of how services in each community were structured and delivered.

[33] A First Nations liaison officer could have been hired with funding from the Social Crisis Table, which became the Lac-Simon Social Action Project. Doing so would have benefited the entire Algonquin clientele of the CSSSVO.

Two months after being formed, the MWT developed a work plan for the remainder of the fiscal year (January to March 2011). A second work plan was drawn up for 2011–2012, which defined the tasks of each MWT member more clearly. The research-evaluation findings show that some mandates had not been met, while others, not foreseen at the outset, had been added. This turn of events was mainly on account of contextual factors and the community development approach, which requires that adjustment be made to accommodate local context and needs.

Confirming and clarifying mandates with local partners relaunched mobilization and initiated coordination efforts.

Three primary mandates had been initially established for the MWT (2010 action plan):

1. Provide clinical coaching, support and training for local resources;
2. Network and establish dialogue with local teams and outside partners;
3. Provide the population with clinical, cultural and community services.

Overall, all MWT members were expected to participate in interdisciplinary discussions, team meetings and the process for developing and evaluating MWT activities. It was also hoped the population of both communities would be brought together for training sessions and activities. Each MWT member focused on encouraging networking, co-intervention and co-facilitating with a view to capacity building among local mental health and addiction workers and establish sustainable lines of communication with outside resources, in a perspective of continuity and sustainability.

It was expected that the **clinical advisor** would lead, participate in and assist local resources with evaluation, orientation, consultation and treatment activities. The clinical advisor was also expected to:

- act as liaison with and as consultant for local and outside resources regarding complex mental health and/or behavioural cases with a psychosocial component;
- develop and lead mental health awareness and preventive activities to support other local programs and services;
- support the family and social circle of those with mental health problems;
- participate in developing mental health training workshops adapted to local needs with the collaboration of internal and outside resources;
- participate in groups and committees to promote collaborations and the continuum of services.

Note that the second clinical advisor did not serve as MWT coordinator, but did carry out several clinical coordination and leadership tasks for the MWT.

Rather than replace the **mental health nurse** in August 2011, job postings went up for a human relations officer (HRO). An assessment of the needs of the two participating communities indicated that the professional expertise of an HRO would enhance the MWT service offer. Furthermore, an HRO could assist the clinical advisor. The HRO was also expected to:

- lead and participate in evaluation, orientation, consultation and treatment activities adapted to the needs of the mental health clientele;
- act as liaison with and as consultant for local and outside resources regarding complex mental health and/or behavioural cases with a psychosocial component;
- in association with other team members and local resources, act as liaison between first-line and second-line services;
- lead mental health awareness and preventive activities to support other local programs and services.

The **social worker** was expected to perform psychosocial and group interventions as needed with the primary clientele: youth and families. The social worker was also expected to:

- support, train and coach local teams working with youth and families with mental health problems;
- organize and lead mental health awareness and preventive activities;
- work with local resources to follow up on young people with mental health problems and their families.

The **cultural and community worker** was expected to:

- mobilize the community and resources to support rallying projects;
- organize and lead cultural and community activities by encouraging community resources to be involved and drawing on local strengths;
- ensure culture and language are integrated into the development of MWT services and operations;
- act as resource person/consultant for the MWT and its partners regarding First Nation culture (including serving as interpreter), values and needs;
- act as liaison between the MWT, local resources and community members and work in concert with local actors and the Quebec's health and social services network.

Summary

The simultaneous hiring of four new resources was very hard on community partners. Even though no one quit the MWT over the first few months, the process of training and deploying a whole team exceeded local capacity to handle this task.

Creating the links needed for developing a team dynamic was a challenge, but the MWT members mentioned the changes that occurred in their team over the first few months was positive.

Achievement

Hiring new resources who demonstrated positive leadership within the MWT.

Challenges

- The simultaneous hiring of four new resources;
- Departure of two out of the four MWT members at the start of the implementation phase was demotivating for the remaining members.

Table 6 : Lessons learned about local implementation of the MWT

1. FNQLHSSC support and the hiring of individuals from and well-known in the region to join the MWT were factors that let the project move forward (do not abort).
2. Retaining the Local Steering Committee would have facilitated local mobilization and improved communication between the two communities.
3. Conducting team-building exercises, such as weekly team meetings or an annual one- or two-day retreat would have strengthened the bonds among MWT members. Any such mechanism would have sufficed, providing the MWT spent time together as a team. In addition, mechanisms for conflict resolution should be provided. The presence of a team coordinator (management and leadership) would have been facilitating at this level.
4. Identifying priority training needs and implementing individual training plans for the MWT members. Encouraging interaction with regional experts and taking advantage of the opportunity to forge new links..
5. Implementing a realistic work plan for the team with specific sections that call upon each member's expertise. Setting aside time to develop training by encouraging members to pool their knowledge.
6. Establishing trust-based relations with all partners is vital to the success of such a project.

3.2.2 MWT SERVICE DELIVERY

The delivery of clinical services to the population was the least developed of the MWT's three main mandates. Though workshops were given directly to the population and some people were coached on the use of outside services, the MWT's clinical members did not regularly follow up on cases (though they took on a few) or provide treatment. In the early stages, the MWT's strategy for integrating into the local structure of each community consisted of mobilizing partners (e.g. the validation of the MWT's work plan) and becoming involved in intersectoral collaboration (mainly by joining existing groups and committees). In light of what happened during the implementation of first-line social services in 2006–2009, the delivery of clinical services directly to the population was not a priority for the MWT members, as they feared being swamped by social emergencies, which would impede their ability to network, establish lines of communication, provide clinical support and encourage local capacity building.

By using the community development approach, the MWT members broke the cycle of curative intervention and fostered joint efforts with a view to effecting social change.

The MWT clinical members spent a lot of time providing ad hoc support to local partners, which was one of their major accomplishments.

Ultimately, services to the population were not developed as originally planned for the implementation phase.[34] In addition to the limited time allotted for this phase (less than two years), other factors imposed constraints. About halfway through the implementation phase, the requests for support from local actors (workers, clinical supervisors and managers) mushroomed. These unexpected requests monopolized much of the MWT's time (at this point, the MWT only comprised the clinical advisor, the HRO and the cultural and community worker). As the MWT did not track the time it spent supporting local resources, the amount of support is hard to quantify. Furthermore, the list of the MWT's achievements (e.g. developing tools and forms, and updating files) does not do all of their accomplishments justice. The large number of requests for clinical support made and the high turnover rate on the MWT sapped the motivation of the remaining MWT members and contributed to burnout on the team. It was therefore decided to continue with MWT activities rather than developing new mandates, such as taking on caseload.

The next section of this report describes the MWT's achievements, based on the three main mandates identified above: those benefiting both communities, those in Kitcisakik and those in Lac-Simon. This section also includes the challenges encountered during the implementation phase.

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[34] The MWT status in March 2013 section of this report indicates that the 2013–2014 service offer is supposed to include the development of direct clinical services to the population.

The next section of this report describes the MWT's achievements, based on the three main mandates identified above: those benefiting both communities, those in Kitcisakik and those in Lac-Simon. This section also includes the challenges encountered during the implementation phase.

Achievements benefiting both communities and the challenges encountered

During the first few months, the MWT drew up a work schedule so that at least one MWT member would be present in each community every day. Initially, the communities were concerned that the MWT would spend more time in the other community. This schedule assured the communities the MWT would be constantly present in both Lac-Simon and Kitcisakik. However, this schedule meant that the MWT members were practically never together in the same community, which, compounded by the high turnover rate on the MWT, did nothing to strengthen bonds among the members of the team. The MWT members generally worked alone and kept in touch by telephone, texting or e-mail. The MWT members mentioned that by the end of the second phase of the Pilot Project, it was not clear to all local partners that they were a team. In fact, the MWT members were better known for their individual rather than collective accomplishments.

Partners in each community have expressed satisfaction with the MWT's openness.

It was challenging for the MWT to form a group committed to a shared objective, given that two communities were involved and the high turnover on the MWT.

Mandate 1- Clinical coaching, support and training for local resources

In each community, this was handled by the clinical members, namely the clinical advisor, the social worker and the HRO. Here are some examples of the services they offered:

- Clinical counselling, coaching and listening to workers expressing the need to vent.[35]
- Coordination and/or cooperation with local teams in emergency situations (e.g. suicides and tragic deaths).
- Training and workshops (e.g. workshop in the form of a mental disorder quiz; basic training in establishing trust-based relationships) and the development of clinical tools.
- Co-facilitating groups (e.g. emotional management workshop with a women's group, anxiety or self-esteem workshops).
- Participation in discussing cases and developing treatment plans.

[35] Ventilation is a postvention strategy enabling "the people concerned to express their feelings freely, safely and without judgment (…)" [unofficial translation] (CRISE, 2008, consulted in March 2013).

Especially for this aspect, the clinical team members had to adjust to the local context and constant demands from each community. For example, when the MWT helped resolve a social crisis in one community, the schedule was compromised, since the MWT spent no time in the other community during the crisis. The bonds of trust established with the local resources in each community and the development of a good internal communication network were useful to, among other things, share information between communities or obtain clinical advice from a colleague in one of the two communities. Even though the 45-minute drive between Lac-Simon and Kitcisakik was a time constraint for the MWT, it ultimately proved beneficial, as it served to expand the clinical network. Consequently, the MWT members could confer with the clinical supervisor in either community.

In both Lac-Simon and Kitcisakik, the MWT underwent a period of adaptation before being able to provide clinical support and coaching to local workers. Prior to accepting the MWT members as trainers, the staff in both communities needed to know the person who was to coach them and establish a bond of trust with him. In a First Nation environment, the mistrust spawned by a heritage of colonialism between First Nations and non-Natives still exists, and non-Native professionals necessarily go through a period of acclimatization before the bond of trust is formed, especially with regard to clinical coaching. “Since it wasn’t clear what the MWT was going to do [and] until people understood what was going on, there was like some resistance. Some people were saying: “The *Tcigoji* [non-Natives] are not going to come here and tell us what to do” (local actor, 2012).

According to the literature, supervision is “a process for transferring professional knowledge, skills and values from a supervisor to a person being supervised. Even though this may not be a helping relation, the dividing line between personal life and professional life may sometimes be blurred” (OTSTCFQ,[36] 2010: 11). This may hold even truer for First Nation communities, where everyone knows everyone else and extended family ties are very important. When something serious, such as a suicide, occurs, everyone in the community is personally affected. This includes local workers, who may be shaken and feel a great need to vent. The MWT members with a clinical coaching mandate expressed their own needs for training in this area and on how to adapt their approach to a First Nation context. The MWT was given training on the strength model approach by the National Centre of Excellence in Mental Health, and medicine wheel training by a First Nation individual. Note that during social crises, the MWT provided both clinical and cultural coaching in each community. The legal expertise of one of the team members came into play on several occasions in both communities.

[36] *Ordre des travailleurs sociaux et des thérapeutes conjugaux et familiaux du Québec*.

The MWT's training mandate also involved developing training content, a task the MWT members felt would be best carried out by pooling their clinical and cultural knowledge, as this would allow them to develop training content adapted to the local culture that could be re-used, modified or further adapted by each community. However, given the MWT's already busy schedule and how much time developing original training content would have taken, another strategy was therefore adopted: to use existing training prepared by community mental health groups or similar organizations in the region. Some of these organizations visited the communities and gave their training jointly with the MWT members. To adapt this training to the communities meant for instance reducing the number of sessions needed or respecting the participants' desire to have periods of silence during the training. Unfortunately, the MWT was unable to reuse this training content and adapt it to communities so that it could serve as a multiplying agent for local workers, because the organizations had some concerns related to sharing their training content for the purpose of cultural adaptation for the First Nations context.

Achievement
Mental health training taken with recognized resources.

Challenges
Little mental health training is adapted to a First Nation context.

Mandate 2- Networking and liaison

The MWT networked and communicated with outside partners on behalf of both communities. Even though Kitcisakik had specific agreements with the Quebec's health and social services network, both communities expressed the need to develop partnerships for improving the continuum of mental health and addiction services.

Outside partners started to be mobilized in the first phase, mostly through meetings at which the FNQLHSSC clinical advisor presented the project, and then during the consultation (2009–2010). As proposed by the Quebec's health and social services network partners during the consultation (see Table 4), the MWT sat on different regional groups and committees, like the Vallée-de-l'Or RMC Mental Health Table. The MWT took advantage of the number of outside partners gathered for another initiative[37] to find a Continuing Improvement Committee. One of the group's first activities (initiated by the FNQLHSSC clinical advisor) was to bring community partners to visit the Malartic psychiatric hospital, and then have outside partners visit the communities of Lac-Simon and Kitcisakik. In both cases, it was the first time that partners had seen the other's infrastructure.

[37] In 2011, a member of the psychosocial service team from the Kitcisakik health centre gathered outside partners to attend a presentation given by the newly created regional child psychiatry department.

Continuing Improvement Committee

This committee's smooth operation has fostered openness among community and outside partners and overcome prejudice.

The Continuing Improvement Committee brought together key actors from the Lac-Simon and Kitcisakik health centre, the CSSSVO, the Malartic psychiatric hospital, the Val-d'Or hospital (emergency room), the community organization VALPABEM,[38] the region's child psychiatry services and the *Agence de la santé et des services sociaux de l'Abitibi-Témiscamingue*. The Committee's goal was to find ways to work together to improve service delivery to communities. Meetings were held approximately every six weeks, hosted alternately by the CSSSVO, Lac-Simon and Kitcisakik. By holding regular meetings in the communities, the outside partners gained a better understanding of the communities' internal structure and operations, a trust-based relationship was established with the communities and many barriers disappeared.

Implementing the MWT using the community development approach by scheduling time to establish partnerships and coordinate work with outside partners enabled the MWT to do what others did not have the time to.

> "What I noticed was that I was less hesitant about knocking on doors in Val-d'Or, sitting down with people and seeing what could be done...I know that I was fearful, too, because a few years earlier, I had been afraid to do that, but now I see that it works well. In fact, there was another place where I went to get services for the children. We have to sit down together. I do things the same way I learned from participating in the project. I will sit down with some actors to see how we can work together so that the children get those services" (local actor, 2012).

> "An adult psychologist [was assigned to the communities]. The community workers could call him. They would not. I told them, 'The communities will not call because they are used to coping with problems on their own.' Communities have always learned to handle things themselves, because it isn't always easy to network with the outside world. Back then, (…), that was it. Now people are more open, things are going well, and we are starting to work together'" (local actor, 2012).

The Committee's coordination efforts have helped them forge links, among other achievements:

- The development of a liaison file, which is a tool containing information on patients from one of the two communities who are admitted to the emergency room at the Val-d'Or hospital. The liaison file can be filled out by either a doctor at the emergency or a community worker, and serves to improve communication and patient follow-up care.
- A list of community clinical supervisors was prepared and given to the Val-d'Or hospital

[38] Vallée-de-l'Or community organization for families with a member suffering from a mental illness.

emergency department. Now the hospital may contact the right person in each community to ensure follow-ups of First Nation patients are done once they are discharged from the hospital and return in their community.

The relationships established within the Committee prompted the MWT members to become involved in other regional committees:

- The Regional Organizing Committee for the suicide prevention conference. As a result of the MWT's involvement, the Committee, for the first time ever, asked a First Nation community to host the conference. The *Colloque pour la vie* was held in Lac-Simon in February 2012 and was attended by over 100 people from the provincial and community networks and First Nation communities.
- The Organizing Committee for the Regional Mental Health Forum. This Forum was held in Rouyn-Noranda in April 2012, with some 30 First Nation members attending. It was the first time First Nations took part in the Forum.

Many benefits can be attributed to the creation of the Continuing Improvement Committee, though certain challenges were encountered as well. For example, the Committee was eager to have a First Nation liaison officer assigned to the CSSSVO and had this put on the agenda, although it was not directly reported to the MWT (but to the Social Action Project in Lac-Simon). Outside partners agreed that what was needed was:

> "to have someone from the community who would be there to serve as a liaison and who knows how things work in the community. I think this would make an even bigger impact. There is something we don't understand, that we don't know, because we can't see the whole picture. I think [the community] is a world unto itself, it's unique, and to me, as an outsider, there are many things I just don't get about that context" (outside actor, 2012).

The failure to hire a liaison officer (physical and mental health) was a demotivating factor for some outside actors. In spite of their goodwill, their attempts to coordinate efforts encountered obstacles. Regardless, they explored other ways to improve communication and the continuum of services. Contacts established through the Continuing Improvement Committee enabled the two communities to have one of their local workers named as child psychiatry liaison officer. This locally appointed resource serves as liaison between the community clientele and the child psychiatry unit of the Malartic psychiatric hospital.

There was added value in having members of the Steering and Oversight Committee (FNQLHSSC, MSSS and FNIHB-Quebec Region) and certain key actors from MSSS (managers) visit the communities to meet local and outside partners associated with the project. The interest shown in the MWT Pilot Project by senior MSSS personnel made an impact on community and outside partners. As this was the first time the communities had been visited within the scope of a pilot project, the local partners considered this a form of recognition and took the opportunity to discuss the challenges they face. The MWT members felt this visit boosted their credibility in the eyes of outside partners.

Achievements

- Lines of communication established between the communities and outside partners;
- Communities raised their profile across the region (Vallée-de-l'Or).

Challenge

Challenge of working with two communities and several partners (local, regional, provincial and federal) that shared a common vision and were mobilized around a single project.

Traditional activities were used for "healing" purposes and to expand local cultural knowledge.

Mandate 3- Cultural and community services for the population

Organizing and delivering cultural activities in association with local resources fell mostly to the cultural and community worker. Weekend forest retreats, sweat lodges and sharing circles were some of the activities organized with various local partners in each community. On several occasions, people from the two communities participated in these activities together. In both Lac-Simon and Kitcisakik, use of the Algonquin language was fostered, and efforts were made to get people to take part in the activities, such as by going door-to-door to remind people of an upcoming activity and encourage them to participate.

Each time a serious event occurred in one of the communities, the MWT cultural and community worker was personally affected.

During the implementation phase, the cultural and community worker repeatedly experienced bereavement.

Nonetheless, the evaluation findings show that several challenges arose for the position of cultural and community worker. For example, the person's mobilization and facilitation duties as consultant on First Nation's culture, values and specific needs for local and Quebec's health and social services network resources were not carried out. Support or coaching from a cultural resource with training skills in this area would have been helpful, even for someone like the cultural and community worker, who was a First Nation person from one of the participating communities and had in-depth cultural knowledge. Although all MWT clinical workers could count on the support of the clinical advisor, the cultural and community worker lacked the guidance of a "cultural coach." The cultural and community worker often said he felt isolated on the MWT, and this limited his effectiveness. This experience shows that it would be helpful for the cultural worker to have at least one other resource person from a First Nation background on the MWT to balance the knowledge available for each approach (clinical and cultural) and provide mutual support.

Achievement

Set up traditional site for use all year around by both communities.

Challenges

- Difficult for First Nation workers to carry out their mandates during social crisis;
- Local workers need to recover after dealing with tragedies in the community.

ACHIEVEMENTS IN KITCISAKIK

The MWT's achievements in the community of Kitcisakik were heavily influenced by the departure of the health centre coordinator and clinical supervisor (2010), the change in health management (2011) and the restructuring of the community's psychosocial services, which started in late 2011 and lasted throughout the implementation phase of the MWT Pilot Project. The clinical MWT members were kept busy supporting the restructuring of the community's psychosocial service sector, namely by assisting the community's human resource officer in meeting with all those involved in confirming and redefining their roles and mandates, clarifying the psychosocial service offer and following up once it was applied.

Requests related to restructuring took up much of the clinical team members' time. These diverse demands had to be analyzed by team members and may, in fact, have led the members to go beyond their initial mandate. Whenever possible, the MWT referred the requests for assistance to other resources or limited the number of requests the team accepted. Confusion reigned as a result of these requests, which were exacerbated by the gap in services resulting from the multiple vacancies on the health centre's psychosocial service team, and the MWT was quickly overwhelmed. Note that the bereavement experienced in Lac-Simon during the social crisis also affected a number of people at Kitcisakik. This, together with the restructuring of the health centre's psychosocial services and the turnover in key positions, exhausted the local team and overburdened the clinical members of the MWT.

The MWT had no fixed office in Kitcisakik, resorting to occupying whatever empty office was available or sharing one with their partners. The MWT also worked out of the band council office in Val-d'Or when they wanted more privacy, such as to develop training content.

Several individuals holding key positions in Kitcisakik psychosocial services quit. As of late 2011, the MWT was more involved in Kitcisakik than in Lac-Simon.

Mandate 1- Clinical coaching, support and training for local resources

Different people served as the clinical supervisor at the Kitcisakik health centre over several months, and the position sometimes remained open for lengthy periods between new hires. During gaps in services due to the unfilled supervisor position, the MWT clinical workers played a key role in providing coaching and clinical support to the health care workers. Some First Nation workers were wary of accepting the MWT at first. Once a bond of trust was formed with the MWT clinical workers, they soon found themselves overwhelmed with requests for assistance. One of the factors to consider when dealing with major clinical coaching needs are the personal ties between the community workers and the clientele they serve:

> "Half of our workers…when it comes to treatment, intervention, yes, they do it, but they are less comfortable following up afterwards, given everything they know about the individual…. [They] lack tools, lack experience. Because they know the

individual, they know about his condition. That always stays with them. When they intervene, that's the image they are left with. They find it hard to distance themselves from the situation. Yes, that's it. The other half of the first-line workers, those who come from the outside, handle things very well" (local actor, 2011).

The primary training need in Kitcisakik was for recordkeeping. Some workers kept computerized records, others kept hard copy records, and the remainder kept their progress notes on an irregular basis. The MWT took the time to review the existing paper forms, sensitized community workers to the importance of keeping records and provided basic training to workers who have needs in this area.

Achievement

The MWT's ability to set limits and not lose sight of its objective of building local resources capacity: providing support without taking over, and knowing when to step back.

Challenge

When the clinical MWT members were in the community, they spent most of their time meeting the needs resulting from vacant positions, such as clinical supervision.

Mandate 2- Networking and liaison

Networking and liaison work within the community began with presentations to confirm the MWT work plan with local teams. "[To] re-explain our role and verify their needs, and remind people that data had already been collected last year. This last point was something most had forgotten. The connection between our team and the data collected last year was not very clear" (MWT, 2011).

Networking and coordination work continued primarily through the existing groups and committees. These included the Kitcisakik Child and Family Committee, comprising representatives from every sector in the community and the band council, and the Multisectoral Committee, comprising community education, health centre and youth centre staff. The MWT's involvement led to creating new committees, like the Psychosocial Crisis Response Protocol Committee and the Organization Committee of the Addiction Conference.

The MWT played a key role as liaison between local and outside resources, including CSSSVO emergency services, the Malartic psychiatric hospital, child psychiatry services and the public trustee. In addition to the liaison work accomplished: "the coordination group [the Continuing Improvement Committee]…had a very positive impact on all of the RMC network partners. This helped put Kitcisakik on the map and show that we are not just Natives from the sticks, left to fend for ourselves, and that we have a right to just as many services as everyone else" (local actor, 2012).

Achievement

Established liaison with various outside resources.

Challenge

Getting a significant number of First Nation representatives from the community to sit on local and outside groups and committees.

Mandate 3- Cultural and community services to the population

The cultural and community worker was closely involved with local resources. As part of a bereavement group, he performed traditional services, such as practising smudging ceremonies and giving the opening or closing prayer. He also took part in locally organized sweat lodges, promoted the Algonquin language and asked individuals who were familiar with local traditions to share their knowledge.

The services and activities developed had a strong traditional aspect character. With the change in management at the health centre, there was a desire to shift the focus of services towards culture and the community. It was proposed to have the MWT cultural and community worker paired up with local resources. Ideas for activities were put forward, such as telling traditional legends to children in a primary school class. These new requests overwhelmed the MWT cultural and community worker. To help him cope, a personal work plan was developed with support from the MWT clinical advisor.

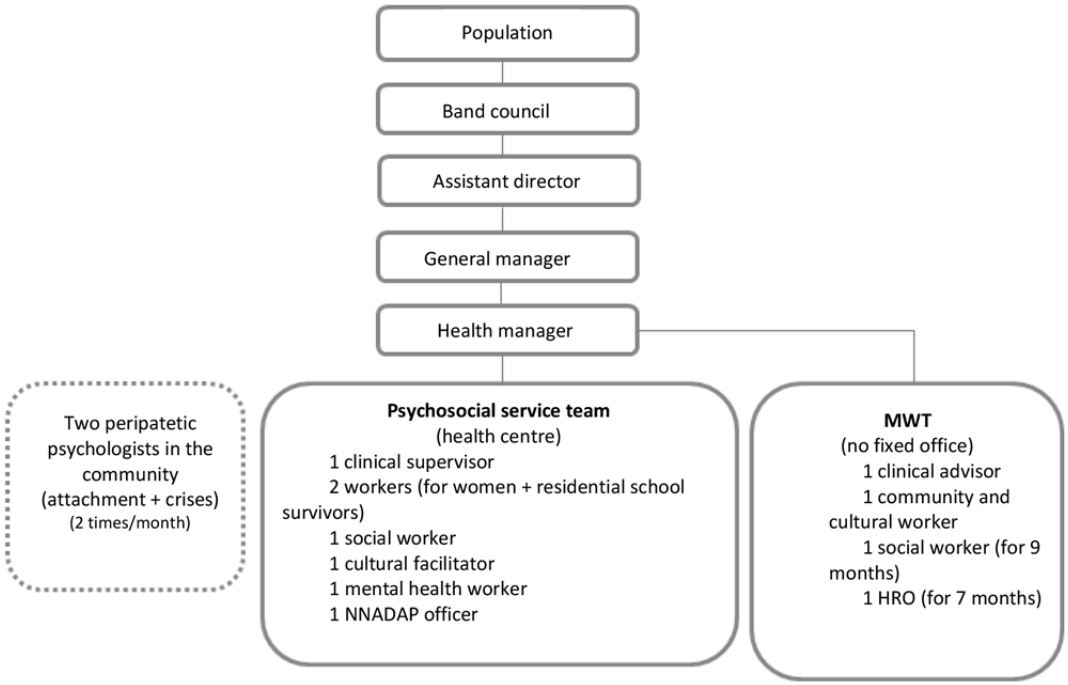
The population outreach techniques used in Kitcisakik were different from those used in the cultural worker's home community (Lac-Simon), primarily because relations were not as developed in Kitcisakik. One technique used to reach out to the population was to walk around the community and engage in informal conversations, then use these discussions to verify the needs of the individuals or groups of individuals spoken to.

In Kitcisakik, a great deal of time was spent listening, providing culturally appropriate advice (teachings) and making informal home visits.

Achievement
Promoting culture, language and the transfer of knowledge.
Challenge
Reorienting activities as required.

The following figure shows how the MWT was integrated into Kitcisakik's local structure. Two peripatetic psychologists now travel to the community to treat the population directly.

Figure 4: The MWT's integration into the Kitcisakik psychosocial services structure[39]



Conclusion

Starting in late 2011, the MWT increased the time it spent in Kitcisakik. In light of the disruptions and restructuring that shaped the implementation phase, some basic steps first had to be taken locally (defining first-line workers' tasks, record keeping and clinical supervision) before the MWT could develop direct clinical services for the population. The last part of this report on the status of the Pilot Project in March 2013 shows that this component will be central to the MWT's service offer since the Pilot Project ended.

[39] The frequent changes within the health centre's psychosocial team must be taken into consideration. This figure is indicative only.

ACHIEVEMENTS IN LAC-SIMON

The MWT's achievements in Lac-Simon were primarily influenced by the presence of a mental health and addiction team, including a clinical supervisor and a coordinator, in the community. The action plan prepared after the first stage of the MWT Pilot Project did not specify how the MWT would work with this team in the community. This lack of clarity and the questions local partners were asked during the consultation (see section 3.1.1) led to confusion and raised concerns about the duplication of services and local partners' expectations regarding the MWT. The unease arising from the unclear mandate was shared by MWT members, who did not know how to respond to questions about clarifying their role in the first few months of the implementation phase.

In Lac-Simon, the MWT was called upon for assistance more often at the beginning of the implementation phase, while the effects of the social crisis were still being felt.

The local context in Lac-Simon was a significant implementation factor regarding the constraints encountered by the MWT. When the MWT arrived in the community in the winter of 2010-2011, the repercussions of the 2009 social crisis were still being felt. Most of the community workers were overwhelmed and experiencing burnout:

> "When a loss occurs in a dramatic fashion, there are always 30-40 people who come for counselling [and] who are upset. Already, we might have about 40-50 more people coming to see us the following week. That drains my team's energy. (…) But many things happened after the last suicide, it made a bigger impact. I was looking at the number of clients who sought counselling. It was 80…126." [In relation to that suicide?] "Yes (…) in January, there were fewer people, I think we had 60 [people who came to see us]. All of a sudden, that number doubled" (local actor, 2011).

After their first few weeks on the job, the MWT mobilized to take part in an emergency intervention with the other local teams. At the time, the MWT's mandate and the role of each of its members had not yet been clarified. The MWT's participation in the emergency intervention enabled the local teams, as well as the MWT itself, to better understand how the MWT could contribute to the community's wellness.

One of the challenges encountered by the MWT in this community was that its offices were not at the health centre. This limited interaction between the MWT and the local mental health and addiction team and compromised the MWT's efforts to boost their visibility. Consequently, local partners were less likely to call upon their services.

Mandate 1 – Clinical coaching, support and training for local resources

In Lac-Simon, the clinical aspect primarily took the form of the MWT's involvement in social crisis interventions, including the coordination of the emergency intervention protocol.
The MWT also jointly hosted public workshops with actors from different sectors: *Maison de la famille*, the school and health centre. These workshops included one on

self-esteem and another one on teaching parents how to recognize signs of distress in their children (*Surveille les signes;* unofficial translation: Watch for signs). In the summer of 2012, a group for children between the ages of 7 and 12 with a close mentally-ill relative was formed to improve their understanding of mental illness and teach them how to interact more effectively with that family member. The activity was very successful. From five to eight out of the eight registered participants—three boys and five girls—attended every meeting over the activity's five-week run.

The MWT also gave clinical coaching to the youth centre worker in order to incorporate promotion and prevention into the centre's recreational activities, as well as to the high school to develop a postvention protocol. Clinical support was also provided to develop intervention plans and support those living with a mental illness, along with their families, in their dealings with outside resources.

The primary need of the local mental health and addiction team was for the MWT to take charge of individual follow-ups for the most severe mental health cases (e.g. schizophrenia). Since the MWT rarely had its full complement of four members, it focused on local capacity building, networking and similar activities in accordance with the community development approach, but could not meet all expectations in these areas. Moreover, it took the MWT a number of months to respond to the local mental health and addiction team's request for training (basically the time needed to develop the training). In the end, establishing a relationship of trust with the local mental health and addiction team proved challenging.

Achievement

Coordinating emergency multisectoral interventions.

Challenges

Interaction between the MWT and the local mental health and addiction team.

Mandate 2 – Networking and liaison

The liaison work with outside resources has a direct impact on users. They have better services in the network.

The intersectoral collaboration work in Lac-Simon was primarily accomplished through MWT members joining local groups or committees, such as the Multisectoral Committee, or participating in the Social Action Project to plan social care services. The main objective of the Multisectoral Committee was to gather the various sectors of the community (health centre, youth centre, first-line services, police department, Social Action Project, Maternal and Infant Health (MIH) program, the education sector and the MWT) so they could, among other things, eliminate the duplication of services and coordinate their activities and services in the field.

Following the implementation of three projects under the community development approach (first-line services, social action and MWT project), a change occurred in Lac-Simon in terms of intersectoral collaboration, in particular with regard to social crises:

> "I can say things have completely changed from the time I intervened in a crisis when I arrived as a worker in July 2009 and when I intervened last week. (…) We really took the time to sit down and look at what we do and who does what. It went really well. We met up again the next morning to debrief" (local actor, 2011).

Although intersectoral collaboration has improved over the last few years, the challenge lies in maintaining this level of collaboration, ensuring that all of the parties remain committed to this course of action.

Every Lac-Simon partner met within the framework of this research-evaluation process applauded the MWT's success at networking and serving as liaison with outside resources. Even though the MWT did not provide treatment or take charge of follow-ups, the relationships established with the key individuals from different outside services facilitated and improved access to these services.

Achievement

Greater accessibility to outside services for the community.

Challenges

Mobilizing all key actors in the community.

Mandate 3 – Cultural and community services for the population

In Lac-Simon, the cultural and community worker was often called upon to serve as advisor on local culture, customs and language to non-Native MWT members, who often asked him to confirm approaches, translate conversations from Algonquin to French (or vice versa), and assess the impact in the community of events that occurred outside office hours. Generally speaking, the cultural and community worker made it easier for the other MWT members to interact with families and the community.

During social crises, the cultural and community worker also participated in interventions by going to people's homes to see how they were doing, listening to them and going with them to the appropriate resources. The cultural and community worker was actually from Lac-Simon, which made things easier, especially during delicate situations. He was often called upon for assistance, like to support bereavement groups.

When the MWT arrived, a few local resources well-known in the community were already organizing traditional activities there (sweat lodges, forest retreats, smudging ceremonies, etc.). The health centre's local mental health and addiction team had already been incorporating traditional activities into its service offer for a number of years. The addition of another traditional practitioner, namely the MWT cultural and community worker, bolstered the delivery of traditional services to the population. The challenge, however, was to work with local traditional resources. Little by little, they began to ask the MWT cultural and community worker to take part in activities they organized. Ultimately, these resources learned to work together.

Achievement

Strengthening the cultural service offer in the community.

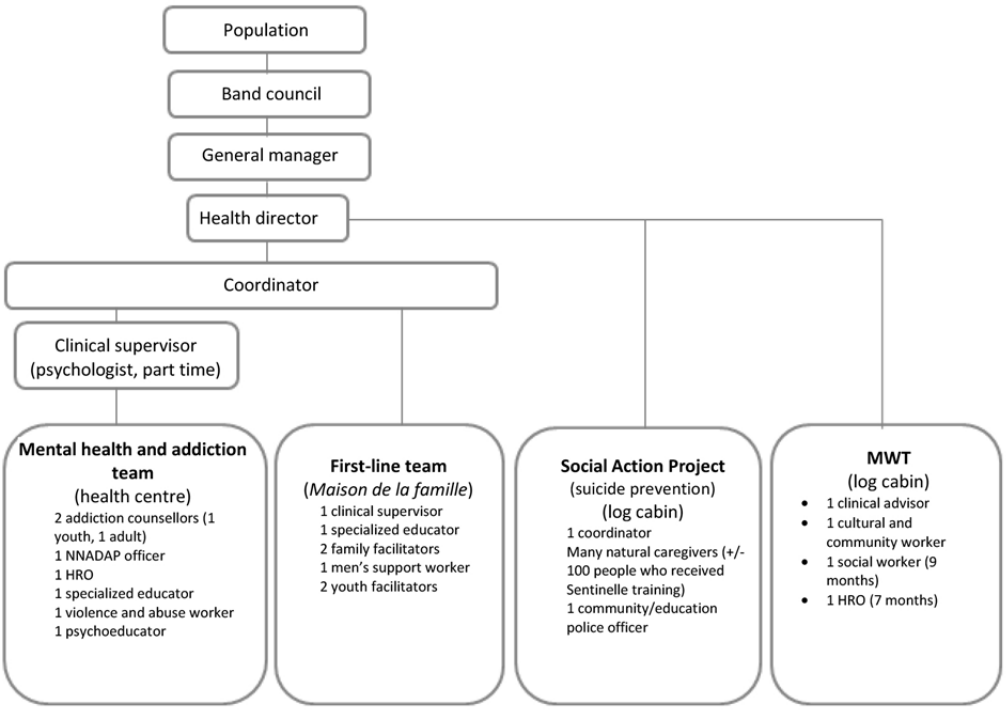
Challenges

Working with existing traditional resources.

Integration of the MWT into the local structure

By comparing the following figure with the one illustrating the structure of Lac-Simon's psychosocial services before the arrival of the MWT (Figure 2), it can be seen that another project was also integrated into the structure (Social Action Project), the coordinator position had been filled and a psychiatrist no longer visits the community.

Figure 5: The MWT's integration into the Lac-Simon psychosocial services structure



Conclusion

In Lac-Simon, the MWT is recognized for its networking and liaison work with outside resources and the impact this has had on improving service accessibility. Unlike most of the actors in the community, these accomplishments were part of the MWT's mandates, and a great deal of time was allocated to it. MWT members also demonstrated they had the know-how and soft skills required to build relationships of trust, mobilize key actors and implement and maintain inter-sectoral collaboration in the scope of this project.

The following table illustrates the lessons learned with regard to the overall implementation of the MWT's services and marks the end of the section on the findings relating to the implementation phase.

Table 7: Lessons learned about the implementation of services

1. Participating in existing committees or groups (local and outside) facilitates integration.
2. Means must be implemented to mobilize the community (e.g. a communication system to keep the public informed).
3. It must be ensured that the MWT clinical advisor receives clinical supervision, such as by developing a partnership with the region's CSSS.
4. Practising traditional activities is considered as a personal choice, and it is one that is not endorsed by the entire community. The MWT's cultural role needs to be clarified during the community consultation in the first phase (each community should define it clearly).

3.3 OVERVIEW

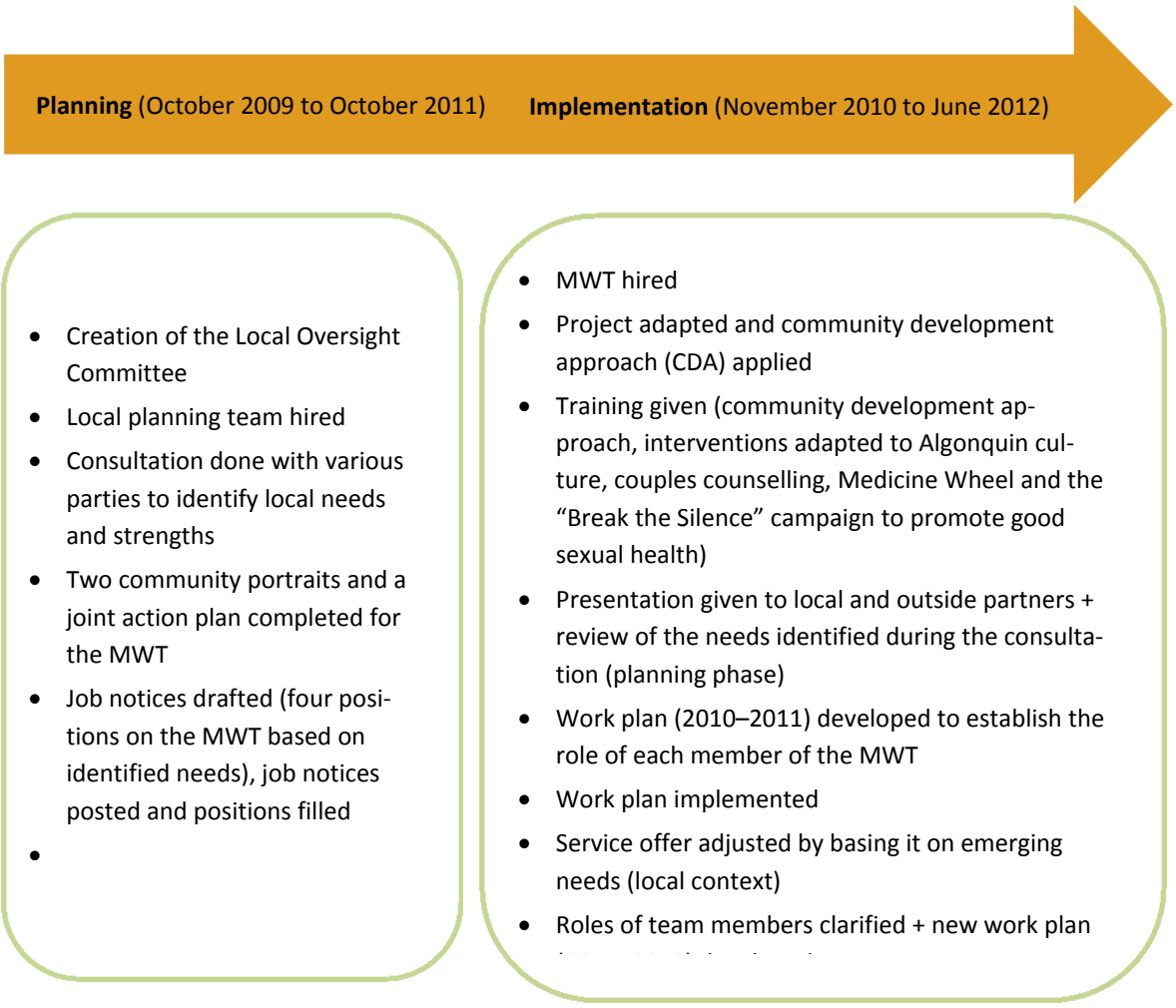
For the overall project evaluation, interviews were conducted with the local, outside and regional actors who were met in the first two phases in order to get their impression of the MWT Pilot Project and recommendations for similar projects in the future.

The findings from this last data collection are presented below. The following will be reviewed in this report: the planning and implementation phases, the project's initial expectations and objectives, and whether they have been achieved or not and why. A review of the FNQLHSSC's support for the project is also offered. The report ends with recommendations for similar projects First Nation communities may want to develop in the future.

3.3.1 MAIN PLANNING AND IMPLEMENTATION PHASES

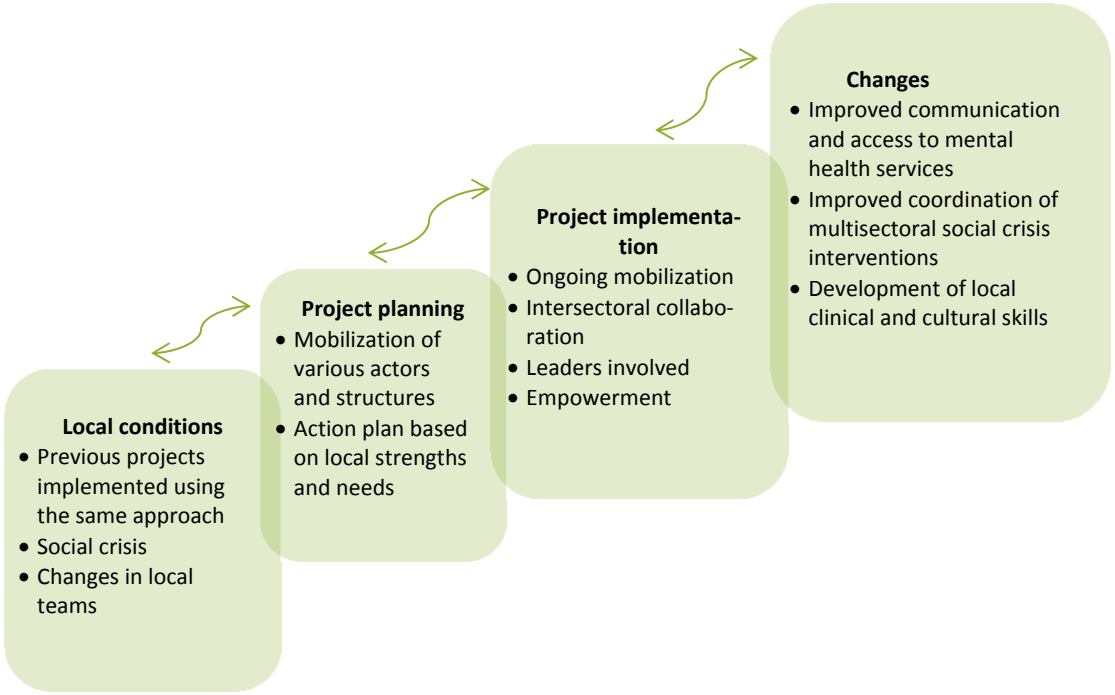
The following figure describes the planning and implementation phases of the MWT Pilot Project.

Figure 6: Implementation process for the MWT Pilot Project



These steps are not necessarily taken in linear sequence under the community development approach. Some, such as the hiring of MWT members, the confirmation and clarification of the MWT's mandates or MWT training, had to be repeated or modified following review and approval by the actors concerned. The path to implementing change is rarely direct. In fact, it is often necessary to go back and forth along the path, and sometimes even deviate from it (*Communagir* 2012–2013) before a change is effected. The figure below illustrates this non-linear path.

Figure 7: Real sequence of the MWT Pilot Project implementation process



The changes that occurred in the community (transition from the initial local conditions to those at the end of the project) should be seen as dynamic and need to be constantly fuelled. Achieving the targeted changes is not an end in itself and various contextual factors can influence how or if these changes endure or are enhanced. For the sake of example, let's say one of the goals of the MWT Pilot Project was to have the communities and the Quebec's health and social services network sign a memorandum of understanding (MOU) on mental health and addictions. Any change among the actors in local or regional organizations may affect the future implementation of the MOU. The watchwords for implementing a project based on the community development approach are: iterative process, adjustment and flexibility.

3.3.2 ATTAINMENT OF INITIAL OBJECTIVES AND EXPECTATIONS

One of the objectives of this Pilot Project was to verify whether the **mobile MWT model** (a multidisciplinary team that combines psychosocial and cultural approaches) would better meet the needs and be suited to coping with the dual problem of mental health and addictions in First Nation communities.

The findings of the research-evaluation show that the MWT model provides an added benefit to First Nation communities. As exhaustion, a lack of specialized resources, frequent turnover on the teams and waves of social crises give rise to collateral issues (workers personally affected by a crisis and an increased demand for services), the MWT's mandate to provide port and advice, serve as a liaison and foster local capacity building made it easier for local teams to carry out their tasks. Furthermore, by including a cultural and commu-

nity component in its service offer, the MWT was able to meet a number of needs and reach a wider range of people (population, workers, leaders, etc.).

The initial model (psychologist as clinical supervisor, mental health nurse, social worker and "traditional healer") and the requirement that MWT clinical workers have specific mental health training and preferably be members of a professional order was deemed unrealistic by community partners. The simultaneous hiring of four new resources, including three non-Native professionals unknown in the community, posed a number of challenges for local partners. The MWT model would be more effective if the composition of the team were more stable and the members of the team were either First Nation members or were culturally sensitive and have community profile. The use of strategies that do not involve simultaneously hiring a number of new resources would also be a key factor.

The fact that **the MWT divided its time between two communities** was not always easy on the team, mainly because of the travelling involved and the differences in community needs and practices. It is uncommon for community partners to share human resources with the other community. While outside resources, such as youth centre staff, do sometimes work in both communities, local resources (hired by each community) are rarely shared. The communities had to adapt to this splitting of the MWT's time. Among other things, the project was jointly managed by the health director in each community.

The second objective of the Pilot Project was to confirm whether the **use of the community development approach** would effect more change than the top-down logic normally used to implement programs in First Nation communities.

Establishing a Local Steering Committee (key local leaders were involved in every step of the planning phase) greatly helped participating communities take ownership of the MWT Pilot Project. Having key local actors help define project objectives by basing them on the actors' needs and the community's strengths made it much easier to then mobilize and work with these actors. The consultation done with outside partners during the first phase revealed that First Nation partners did not hold the seats reserved for them on regional boards and committees. One of the most significant changes was the creation of a Continuing Improvement Committee on which sat directors, coordinators, the MWT and the clinical supervisor of each community.

The community development approach is demanding and requires significant involvement, so much so, in fact, that in a context where human resources are already overworked and sometimes exhausted, using this approach may be a limiting factor. As the purpose of using this approach is not to make more work for local actors, they should be trained in using this approach and an alternative way for them to work together should be found. Overall, community development is a promising approach for implementing projects in First Nation communities, just like any other approach that favours mobilization and empowerment. Certain factors must first be evaluated, however. Simultaneously implementing a number of new projects in Lac-Simon and Kitcisakik created too much work for local resources, and thus was a limiting factor.
The local capacities of participating communities should be assessed at the start so that a training plan and an implementation plan can then be developed. The time and

energy required to mobilize actors around a project and keep them mobilized should not be underestimated, hence the importance of selecting local participants.

The objective of the research-evaluation component was to verify whether the MWT Pilot Project would **increase participating communities' autonomy and responsibility for their own mental wellness**. This objective was inspired by the community development approach, specifically the strategy for developing empowerment.

It is likely too early to say whether this objective was attained, given that the time it would take for any change to be effected in the community would only be noticeable after the MWT Pilot Project had ended. However, it is possible to say that misconceptions about mental illness were dispelled in each of the participating communities. The public consultation at the beginning of the project stimulated discussion. Thereafter, the public workshops, training sessions and mental illness support groups and the participation in public events allowed continuing to demystify the subject within communities. Local actors also confirmed that people are talking more about mental wellness now than they were four years ago.

Improved organization and coordination of social emergency intervention measures was also noted, and partners (communities and the Quebec's health and social services network) have overcome certain pre-conceived notions. The suggested response to this issue is that accumulated and in-depth positive experiences in mental health, similar to those of the MWT Pilot Project, will make a difference in how mental wellness is addressed locally. In addition, by pooling the efforts of as many actors as possible (education, public safety, health, first-line services, housing, band council, etc.), major changes related to autonomy and accountability will gradually be observed. Perseverance and continuity over time are the key issues to consider.

3.3.3 FNQLHSSC SUPPORT THROUGHOUT THE PROJECT

The mandate of the FNQLHSSC is to improve the health and promote physical, mental, emotional and spiritual wellness of First Nation individuals, families and communities. This regional organization strives to improve the accessibility of health and social services by ensuring they are culturally appropriate, respectful of First Nation autonomy and developed by First Nation agencies that are recognized and approved by local authority. One of the duties of the FNQLHSSC staff is to assist designated community representatives to develop and implement culturally appropriate services that meet local needs. The degree of the FNQLHSSC's involvement depends on how the needs are defined by the communities, with a view to maximizing the chances for the successful implementation of new projects or programs.

The FNQLHSSC clinical advisor had to travel extensively to provide support during the first phase and the beginning of the second phase of the MWT Pilot Project. Once the MWT was implemented in the community and relationships had been established with local and outside partners, the FNQLHSSC's support was reduced. The clinical advisor change at the FNQLHSSC also contributed to temporarily reducing the support provided to the communities by the FNQLHSSC. Once again, it was possible to observe that the creation or not of a relationship of trust between the partners is crucial and influences the quality of working

relationships. During the final phase, requests for FNQLHSSC support from the communities were rather occasional. After the Pilot Project ended, the FNQLHSSC continued to provide the communities and the MWT with support when asked (Figure 8). Below is a summary of the support given to communities during each phase of the Pilot Project, according to the community development approach.

Support provided during planning

During the first phase of the MWT Pilot Project, the FNQLHSSC provided support and guidance directly to the local planning team and local managers (Local Steering Committee). The FNQLHSSC assisted the local planning team in preparing questions for the consultation. The FNQLHSSC clinical advisor shared her knowledge through observation by conducting the first interview with the community, by helping the project leader conduct the second interview, and then by letting her conduct the third interview on her own, after which the two of them did a post-mortem on the interview. Without the FNQLHSSC's assistance during the first phase, the project would likely not have respected the community development approach. To these communities, planning a project like this one and implementing a joint action plan based on the data gathered during a consultation conducted by local person are not common practice. Had this support not been given, it would have been much easier for the communities to give this mandate to an outside consultant. As communities are only starting to plan such a project themselves, the FNQLHSSC had to provide significant support to help them accomplish this task.

The support given to local managers by the Local Steering Committee pertained mainly to developing job descriptions for the MWT positions, conducting preliminary interviews and holding follow-up interviews. For example, certain clauses in their contracts were negotiated by the FNQLHSSC clinical advisor. She also provided them with information about the mandate that awaited them in the communities. The clinical advisor's mental health expertise facilitated this part of the hiring process.

Support provided during implementation

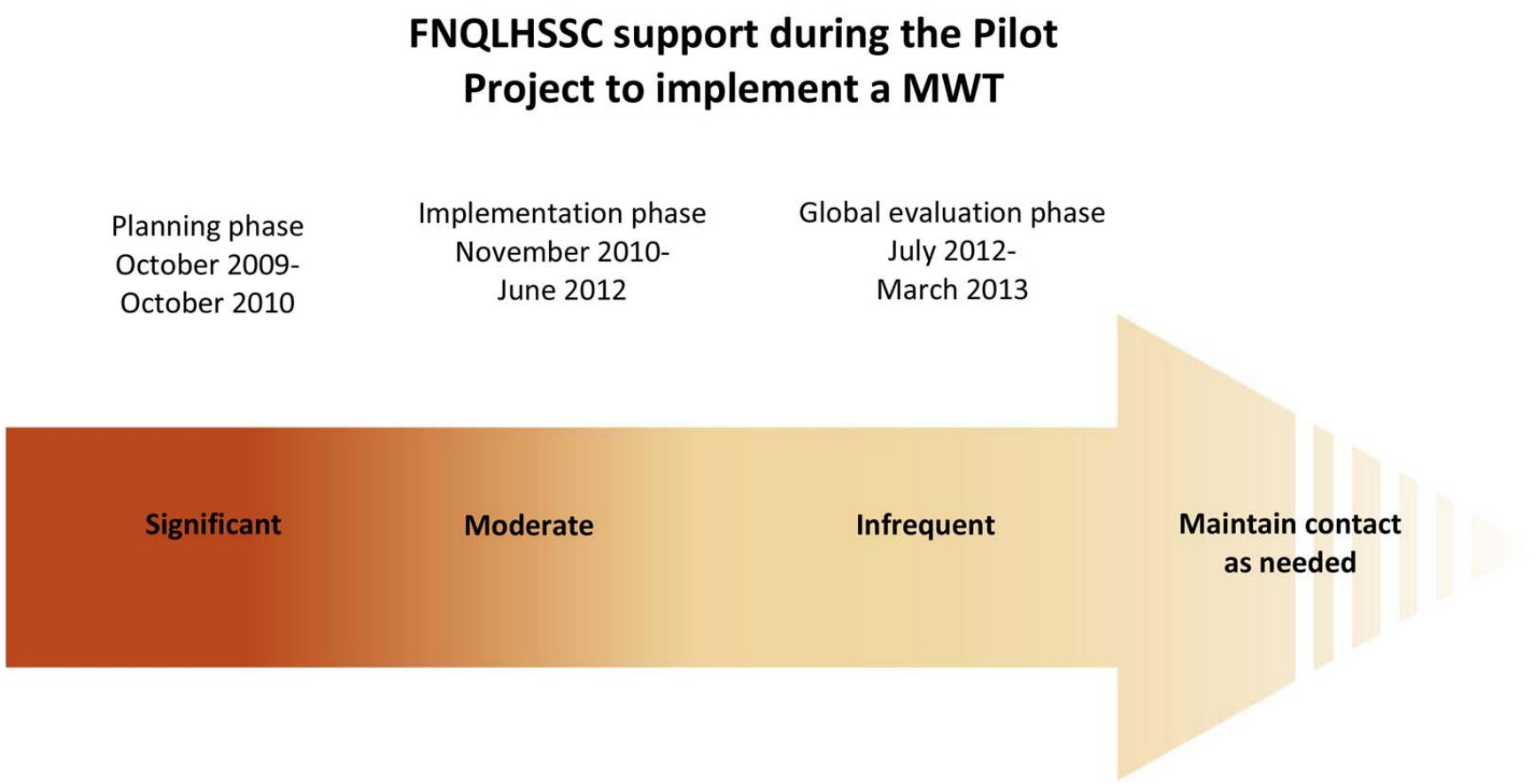
After the MWT started its work, the human resource position in one of the communities was vacant, and the one in the other community had just been filled. During this period, the FNQLHSSC provided more than support and assistance. For example, the FNQLHSSC organized most of the activities for the MWT's two-week orientation, by explaining project objectives and the MWT's mandate (presentation of the action plan), giving training sessions and introducing the MWT to outside mental health partners (visits to facilities in both communities).

During the second half of the implementation phase, the FNQLHSSC clinical advisor took maternity leave. The clinical advisor who replaced her did not have the same relationship with the MWT. At this point, the MWT began consulting local community or Quebec's health and social services network resources more frequently. As a result of this change, the MWT gradually became autonomous, and its need for FNQLHSSC support was more occasional.

The importance of developing a relationship of trust

The research-evaluation findings show that the support and guidance provided by the FNQLHSSC in both participating communities were crucial, especially during the first phase (planning) and at the beginning of the second phase (implementation). Without this support, implementing the project according to the community development approach would likely not have been possible. Furthermore, it was necessary for FNQLHSSC representatives and the communities to establish a relationship of trust in order for the FNQLHSSC to support the communities. Again, turnover in mid-project is a limiting factor and can present challenges in providing support.

Figure 8: Degree of FNQLHSSC support over time



3.3.4 LESSONS LEARNED AND GENERAL RECOMMENDATIONS

This evaluation of the MWT Pilot Project identified the lessons learned and the key factors that contributed to the Project's overall success. The following recommendations were made in the hope that they would serve to inspire and guide other First Nation communities in Quebec wanting to implement their own MWT under the community development approach. These recommendations are also intended for the partners who helped implement the project.

Recommendations for communities

Local leaders (politicians, managers and informal leaders) must participate in any joint action taken to improve the wellness of their community. Mobilizing all key community actors and maintaining their level of involvement in the project may be challenging, however. Each actor has to contribute in some manner, and the power to take action has to be shared. Conflict resolution strategies should be developed in case misunderstandings occur.

Recommendations:

- *Sensitize local actors about mental wellness;*
- *Ensure they are willing to get involved in a community project.*

When a community agrees to participate in a pilot project which financial sustainability is not guaranteed, the partners involved should consider implementing a strategy to address this and explore possible options from the outset. Pilot project host communities are in the best position to decide how new services should be integrated into their service offer. Freeing up local resources to carry out mental wellness mandates should be considered in the interest of sustainability. Although this strategy could be difficult to implement in a community with limited resources, doing so would reduce the number of challenges related to the integration of a new team, the availability of offices and housing in the community and the project's financial sustainability. For a project like this one where the team must divide its time between two communities, the participating communities must agree to share their resources.

Recommendation: *Ensure the sustainability of community mental wellness services.*

All new employees (whether non-Native or First Nation members) working in the community for the first time must receive a minimum of training on local practices and, where applicable, local culture and history. Pairing new employees with a mentor from the community is an option worth exploring. Mentorship is also recommended for First Nation employees from the community to help them become familiar with their new duties. After a few weeks, new employees should be met to discuss their level of satisfaction and ensure they are acquiring work-related knowledge. This process would increase staff retention and preserve the cultural component of the services offered to the community.

Recommendation: *Implement a formal orientation procedure for new employees.*

Any ambiguity associated with a pilot project or new initiative aimed at testing, drawing lessons from or modifying a course of action can make it difficult to establish an implementation plan. An implementation plan involves outlining the major project planning and implementation phases, defining the objectives of each phase, targeting key partners and priority activities, establishing an approximate timeline and identifying the actors responsible for taking action. The implementation plan should be flexible and adapt to needs as they arise. The general purpose of such a plan is twofold: it allows those working on the plan to consider all the activities involved and provides a global, long-term view of the project.

Recommendation: *Develop a project implementation plan by consulting the community.*

Recommendations for regional First Nation organizations

In accordance with their mandate to guide communities and help them achieve self-determination, regional First Nation organizations should consider a strategy that allows the greatest number of partners to be involved from the outset in the project planning and development phase. Striking an advisory committee comprising representatives from the participating communities, outside resources, the regional First Nation organization involved, and the federal and provincial governments would bring together the various actors with a role to play in the project. This would also give them the opportunity to identify their expectations, needs and concerns, as well as be the first step toward mobilization and cooperation.

Recommendation: *Get all partners involved as of the project development phase.*

Communities will rarely refuse to participate in a new project to enhance their service offer when funding is available. All conditions required for a project's success should quickly be established and integrated into the criteria for selecting the participating communities. Hiring a whole new team and integrating it into the community is a demanding process for the communities. The selection criteria should establish that at least one local resource with work experience in community development be available to supervise the new team during the first few months. If it is not possible to find such a resource, it is recommended that strategies be developed based on local capacities and reviewed whenever local teams undergo major changes.

Recommendation: *Analyze the community's local capacity to accommodate a new project and apply the community development approach.*

In Quebec, the MWT Pilot Project was one of the first initiatives in the field of mental health and addictions to be implemented in First Nation communities. It was noticed that few existent trainings concerning these subjects are adapted to First Nations culture. At the request of communities, the regional First Nation organizations concerned must promote the development of training on mental health and address the dual problem of mental health and addictions. The training offer should target key local actors so that they can be-

come multiplying agents in their community. To offset the loss of knowledge resulting from turnover on local teams, training should be offered to everyone: specialists in the field, partners from other sectors, managers, band council members and the general population. It is important that all of these tools be offered to the communities at the outset so they may be gradually adapted and improved.

Recommendation: *Provide communities with culturally adapted mental wellness tools.*

Recommendations for the different levels of government

Establishing relations based on respect and collaboration between the federal and provincial governments and First Nation organizations is essential for implementing a project of this nature. The Steering and Oversight Committee for this Pilot Project comprised representatives from these three groups and fostered service cohesion and complementarity. It is crucial that each level of government be involved in every phase of the project. Project sustainability should be at the top of the list of priorities for the government partners.

Recommendation: *Maintain a tripartite committee (federal, provincial and First Nations) throughout the project to facilitate cooperation and ensure service cohesion and complementarity (including project sustainability).*

4.CONCLUSION

When we compare the original objectives with what was actually accomplished by the MWT, we see that some of the original objectives were ultimately met. When the findings are presented from the perspective of the community development approach and the local context of each community is taken into consideration, the MWT's achievements can be examined from a new angle. Ultimately, the MWT accomplished much with little while overcoming difficult challenges.

The data show that, over time, the MWT gained credibility with local, outside and regional partners. At the end of the Pilot Project, the MWT was well established in Lac-Simon and Kitcisakik. The support the MWT provided to local resources was very much appreciated, as was the network and liaison work carried out with outside resources. In addition to improving communication and service accessibility, networking also helped break the communities' isolation and decrease resistance on both sides. The clinical support/coaching and networking mandates were appropriate for a First Nation setting, where there is significant turnover because employees are regularly overworked and suffering from burnout. The respect for local culture was an added benefit, even though the MWT's cultural and clinical services were associated more with individual MWT members than with the team as a whole. The multidisciplinary nature of the MWT not only facilitated interaction between non-Native members and the local population, but it also bolstered community involvement, especially during social crises.

The biggest issue associated with the Project was the repeated departures of human resources, first from the local planning team, and then from the MWT. One solution to decrease the number of these departures would be to hire resources from the community who are competent in the field of mental wellness. With an eye to long-term development and ensure local succession, promotional campaigns should be conducted with First Nation youth to encourage them to study in this area, whether in an academic environment and/or through traditional healing methods. On a macro level, regional actors could consider working with representatives from the communities and academia to create a body of literature on mental wellness that is adapted to First Nations and that includes a cultural component. The Quebec MWT Pilot Project was one of the first initiatives in the field and should be the starting point for larger ones.

PORTRAIT OF THE MWT IN MARCH 2013

The third and last phase of the Pilot Project consists of an overall assessment and thus does not list the achievements of the MWT from July 2012 to March 2013. This, the final section of the report, provides information as a complement to the findings presented herein. It is interesting to paint a portrait of the MWT at the very end of the Project. The MWT continues to become integrated into the local structure of both communities.

MWT

In August 2012, the social worker returned to his position as planned and is continuing his work with the youth and family clientele. After a one-year absence, a few weeks were required before he resumed his activities with the schools, *Maison de la famille*, youth centre and similar organizations in both communities. In March 2013, a fourth person was hired to round out the MWT: a mental health worker, whose duties are similar to those of the HRO. The successful candidate has several years' experience in another position in both communities, which greatly facilitates his integration into Lac-Simon and Kitcisakik. Having a full complement of members on the MWT strengthens the team and fosters group cohesion (team meetings are now held regularly). The service offer[40] was also defined, and the 2013–2014 MWT work plan now incorporates direct services to the population. For example, new treatment groups will be established in Kitcisakik, following the request made during the study conducted among men and women in that community. The mental wellness worker on the MWT would be responsible for forming these groups. In Lac-Simon, the MWT is now invited to take part in the health centre's mental health team meetings, and mechanisms for the teams to cooperate more effectively are being developed.

Funding

In October 2011, the FNIHB informed all MWT Pilot Projects at a national meeting that they would receive one year of funding in addition to the four years that were initially promised. In Quebec, this new funding will allow the MWT to pursue its activities in both communities until March 2014. However, at the time this report was being written, financial sustainability had not been guaranteed. Fearing the project may be terminated, both communities wrote a letter expressing their concern. Cancelling the funding for this project, as was done for many projects in the past, would be perceived locally as a breach: the ties created during the projects would be broken, and the communities would be reticent about participating in similar projects in the future. The FNQLHSSC supports the pilot communities in their lobbying efforts with the funding provider.

Finally, the FNQLHSSC, MSSS and FNIHB are maintaining their mental health partnership through a project launched in 2011 to develop cooperation protocols in mental health and addictions between the First Nations of Quebec communities and their respective CSSS. Efforts to improve the accessibility to and sustainability of mental health services and addictions for First Nations are ongoing.

[40] See Appendix 4 for the MWT service offer.

GLOSSARY

Anishnabe/Anicinapek: Algonquin word referring to the people of this Nation. It is spelled differently in Lac-Simon and Kitcisakik.

Bottom-up logic: "The desire of local actors to prioritize their issues and develop appropriate action strategies. Bottom-up logic is divided into two other forms of logic (Proulx 1997): autonomous logic, which is based on practice self-determination requirements, and complementarity logic, which refers to the request to institutionalize and integrate programs derived from top-down logic, often for financial survival" [unofficial translation] (Fournier et al., 2001 in Bourque and Favreau, 2003: 302).

Cultural safety: "Cultural safety takes us beyond cultural awareness and the acknowledgement of difference. It surpasses cultural sensitivity, which recognizes the importance of respecting difference. Cultural safety helps us to understand the limitations of cultural competence, which focus on the skills, knowledge, and attitudes of practitioners. Cultural safety is predicated on understanding power differentials inherent in health service delivery and redressing these inequities through educational processes" (Spence, 2001 in Aboriginal Nurses Association of Canada, 2009: 2).

First Nations: "In 1980–81, the Joint Council of the National Indian Brotherhood used the term 'First Nations' for the first time in their Declaration of the First Nations. Symbolically, the term attempts to elevate Aboriginal peoples to a status of 'first among equals' in their quest for self-determination and self-government alongside the English and French founding nations in Canada. The term is not used by Aboriginal peoples outside Canada" (The Canadian Encyclopedia, 2012).

Local and indigenous knowledge: "Local and indigenous knowledge refers to the understandings, skills and philosophies developed by societies with long histories of interaction with their natural surroundings. For rural and indigenous peoples, local knowledge informs decision-making about fundamental aspects of day-to-day life. This knowledge is integral to a cultural complex that also encompasses language, systems of classification, resource use practices, social interactions, ritual and spirituality. These unique ways of knowing are important facets of the world's cultural diversity, and provide a foundation for locally appropriate sustainable development" (UNESCO, 1995–2012).

Mental wellness: In general, mental health refers to the pursuit of personal happiness, fulfillment in life, overall wellness and a sense of accomplishment or mastery (World Health Organization, 2008 in Kirmayer, Whitley and Fauras, 2009). For First Nations, this concept additionally emphasizes balance and harmony among the many dimensions of life experience. These include family and community relationships, spirituality, and connection to the land and the environment (Castellano, 2006; Stout, 1994; Henderson, Robson, Cox, et al., 2007; Kirmayer, Fletcher and Watt, 2008 in *ibid*.). The term "mental wellness" encompasses

not only mental health, but also every sphere of community life. Suicide, alcoholism and substance abuse are viewed as a disturbance or imbalance in the wellness of a community and are incorporated into the concept of mental wellness (FNQLHSSC and FNIHB-Quebec Region, 2009).

Research-evaluation: There are a variety of theoretical and practical approaches to evaluation. The purpose of this report is not to judge using criteria foreign to the logic of local behaviour, but rather to assess, from a community development perspective, how people work together to support others in the community. For this reason, the term "research-evaluation" was chosen. More specifically, the research-evaluation approach uses specific research methods and produces knowledge, only in the context of an evaluative approach, that is to say, being close to the local concerns and context, with the ultimate goal of helping communities.

Resilience: "(…) a resilient person is someone who manages to have a good life outcome (for example, a steady job, long-term marriage and overall well-being) despite being exposed to situations that carry a high risk of emotional, mental or physical distress" (Rutter, 2001 in AHF, 2003: 5).

Top-down logic: "(...) Refers to government policies and programs to appeal to communities and is divided into two forms of logic: the logic of prescriptive expertise, based on the power of experts to determine the content of programs to meet the communities predetermined needs, and the logic of empowerment, which refers to the active engagement of communities to address the determinants of health. These two approaches are particularly active in the field of public health" [unofficial translation] (Fournier et al., 2001 in Bourque and Favreau, 2003: 302).

REFERENCES

Aboriginal Healing Foundation – AHF (2003). *Aboriginal People, Resilience and the Residential School Legacy*, 77 pages. Available at: http://www.ahf.ca/downloads/resilience.pdf

Aboriginal Healing Foundation – AHF (2004). *Historic Trauma and Aboriginal Healing*. 121 pages. Available at: http://www.ahf.ca/downloads/historic-trauma.pdf

Aboriginal Healing Foundation – AHF (2006). *Final Report of the Aboriginal Healing Foundation, Volume I, A Healing Journey: Reclaiming Wellness*. 471 pages. Available at: http://www.ahf.ca/downloads/final-report-vol-1.pdf

Aboriginal Healing Foundation – AHF (2007). *Lump Sum Compensation Payments Research Project: The Circle Rechecks Itself*, 195 pages. Available at: http://www.ahf.ca/downloads/newest-lsp.pdf

Aboriginal Healing Foundation – AHF (2008). *From Truth to Reconciliation: Transforming the Legacy of Residential Schools*. 446 pages. Available at: http://www.ahf.ca/downloads/from-truth-to-reconciliation-transforming-the-legacy-of-residential-schools.pdf

Aboriginal Healing Foundation – AHF (2010). *The Indian Residential Schools Settlement Agreement's Common Experience Payment and Healing: A Qualitative Study Exploring Impacts on Recipients*. 205 pages. Available at: http://www.ahf.ca/downloads/cep-2010-healing.pdf

Aboriginal Nurses Association of Canada (2009). *Cultural Competence and Cultural Safety in Nursing Education, A Framework for First Nations, Inuit and Métis Nursing*, 15 pages, Available at: http://www.anac.on.ca/Documents/Making%20It%20Happen%20Curriculum%20Project/FINALFRAMEWORK.pdf

Assembly of First Nations of Quebec and Labrador – AFNQL (2005). *First Nations of Quebec and Labrador Research Protocol*, 78 pages. Available at: http://www.cssspnql.com/docs/centre-de-documentation/protocole-recherche-eng.pdf?sfvrsn=2

Bourque, D. and L. Favreau (2003). *Le développement des communautés et la santé publique au Québec*. Service social, Vol. 50, no. 1, pp. 295–308.

Community portraits of Lac-Simon and Kitcisakik (2010). *Analyse de la collectivité et des besoins*. Mobile mental wellness team project. Internal document.

CRISE (2008). *Application des connaissances scientifiques en prévention du suicide*, Available at: http://www.criseapplication.uqam.ca/

First Nations and Inuit Health Branch – FNIHB (2009). *Proposed evaluation framework for the approach of the mental wellness team to mental health and addictions services in Aboriginal communities*. J.A. Chouinard**,** K. Moreau and J.B. Cousins, Centre for Research on Educational and Community Services, University of Ottawa for the FNIHB, Health

Canada. Internal document.

First Nations of Quebec and Labrador Health and Social Services Commission – FNQLHSSC (2009). Facilitator's report. Orientation committee, mobile mental wellness team, 2009. Internal document.

First Nations of Quebec and Labrador Health and Social Services Commission – FNQLHSSC and the First Nations and Inuit Health Branch – FNIHB-Quebec Region (2009). *Information and orientation document, pilot project for the implementation of a mobile mental wellness team in two Quebec First Nation communities*, revised September 2009, 30 pages. Internal document.

Kirmayer, L. J., B. Whitley and V. Fauras (2009). *Community Team Approaches to Mental Health Services and Wellness Promotion*, a report prepared for Health Canada, First Nations and Inuit Health Branch. Culture and Mental Health Research Unit, Institute of Community & Family Psychiatry, Jewish General Hospital, 138 pages. Available at: http://www.mcgill.ca/tcpsych/sites/mcgill.ca.tcpsych/files/Report15.pdf

Laboratoire de recherche pour le soutien des communautés - Laresco (2006). *Étude de besoins en matière de services sociaux dans trois communautés autochtones de l'Abitibi-Témiscamingue* (Kitcisakik, Lac-Simon et Pikogan). D. Thomas, S. Dugré, P. Le Blanc and J-A. Connelly, 125 pages. Available at: http://www.uqat.ca/telechargements/info_entites/Services%20sociaux%20Algonquins%20Final%202006.pdf

Legacy of Hope Foundation (2003). *Where are the children? Healing the legacy of residential schools*, 64 pages.

Loiselle, M., A-L. Bourdaleix-Manin and M. Potvin, with the collaboration of C. Joly (2011). *Le retour des jeunes enfants dans la communauté algonquine de Kitcisakik : une recherche-action visant l'engagement de la communauté envers la santé et le bien-être des enfants*. Research report: phases II, III and IV. Chaire Desjardins en développement des petites collectivités, Université du Québec en Abitibi-Témiscamingue, 216 pages. Available at: https://depot.erudit.org/bitstream/003576dd/1/Loiselle_et_al_Rech_action_Kitcisakik_2011.pdf

Ordre des travailleurs sociaux et des thérapeutes conjugaux et familiaux du Québec – OTSTCFQ (2010). *Guide sur la supervision professionnelle des travailleuses sociales et des travailleurs sociaux*, 64 pages. Available at: http://www.otstcfq.org/docs/documents-accueil/guide_supervision.pdf

Van Galeen, R. P., P. K. Wiebe, K. Langlois and E. Costen (2009). "Reflections on Mental Wellness in First Nations and Inuit Communities." *Mentally Healthy Communities: Aboriginal Perspectives*. Canadian Institute for Health Information, pp. 9–16.

Websites consulted:

Centre Normand: http://www.centrenormand.org/

Communagir: http://www.communagir.org/

CSSSVO: http://www.csssvo.qc.ca/

Kitcisakik: www.kitcisakik.ca

Ordre des psychoéducateurs et des psychoéducatrices du Québec: http://www.ordrepsed.qc.ca/Psychoeducateur/loi21.aspx

The Canadian Encyclopedia: First Nations. http://www.thecanadianencyclopedia.com/articles/first-nations

UNESCO. *Local and Indigenous Knowledge Systems*: http://www.unesco.org/new/en/natural-sciences/priority-areas/links/related-information/what-is-local-and-indigenous-knowledge/

Wikipédia. Simosagigan: http://fr.wikipedia.org/wiki/Simosagigan

World Health Organization – WHO: http://www.who.int/en/index.html

Suggested websites:

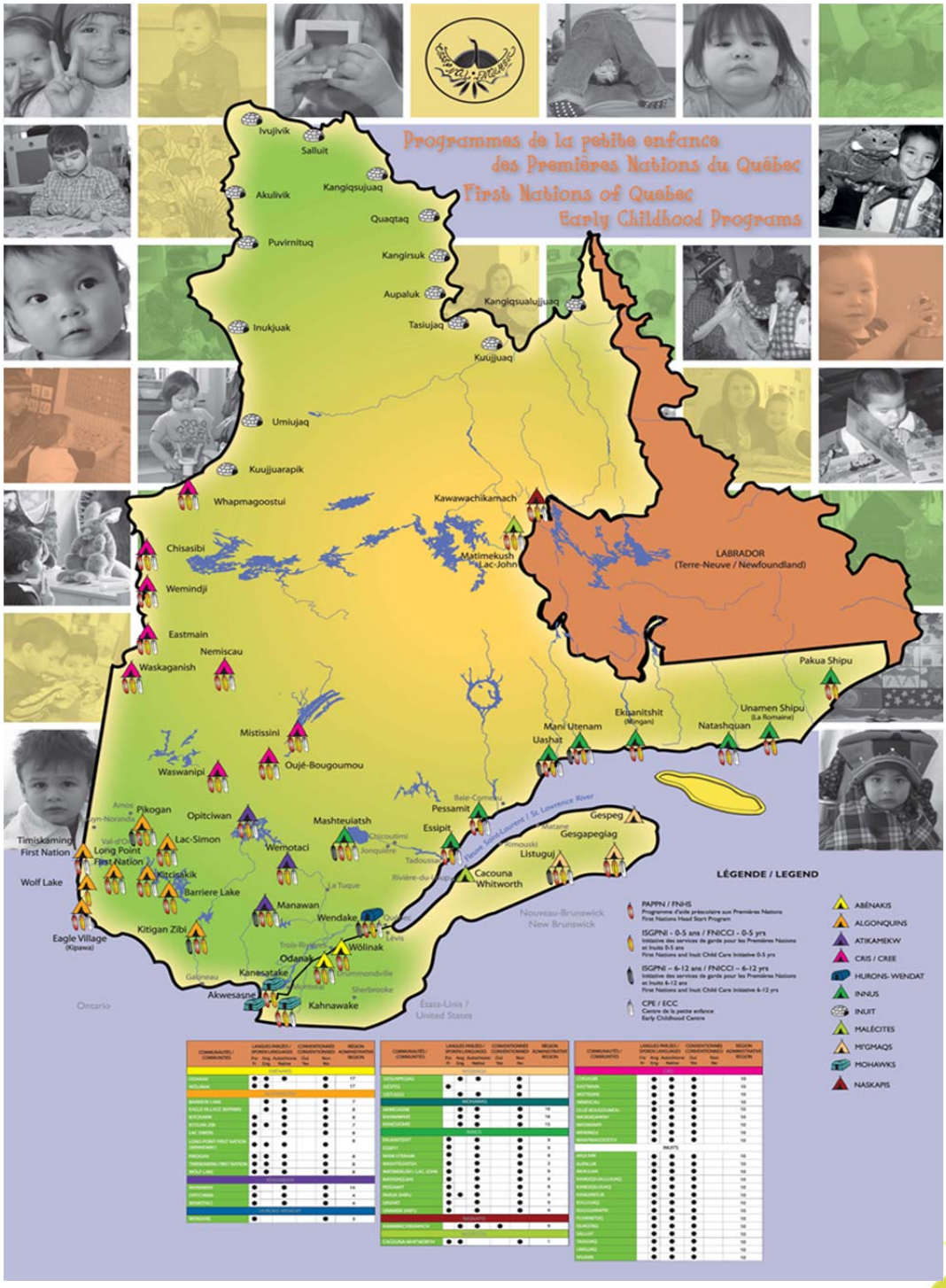
First Nations Information Governance Centre: http://www.fnigc.ca/

FNQLHSSC: http://www.cssspnql.com/en/fnqlhssc

National Centre of Excellence in Mental Health – NCEMH: http://www.douglas.qc.ca/section/cnesm-298?locale=en

APPENDIXES

APPENDIX 1: MAP OF QUEBEC FIRST NATIONS



APENDIX 2: PUBLIC CONSULTATION FINDINGS

Do you agree with what was said?

We hereby invite you to contact us if you have any questions or comments about the data collected or the project itself.

Would you like to add some information? Would you like to share some ideas? Please contact us!

Perhaps you are interested in joining the team? Would you like to know what type of services will be available? Keep track of the job offers that will be posted in June or contact us by calling 819 736-2107 or on the cell phone 819 860-9569.

Kitci Migwetc to all for participating!

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MENTAL WELLNESS PROJECT

Kitcisakik and Lac Simon

Kitcisakik Women

Here is what you said or suggested concerning our mental wellness project.

Results for Kitcisakik Women (18-64 years of age)

We met with 30 community members, including 10 men, 17 women and three elders. The youth were not met but will be when the mobile team is in place. Herewith is a summary of meetings with Kitcisakik women. Only the more common answers have been indicated here.

What is sound mental health?

1. Taking care of yourself first (love yourself, be comfortable with yourself, have positive thoughts).
2. Being sober.
3. Keeping busy (work, activities, group of friends, keeping the spirit busy).

What are the most significant mental health issues in the community?

1. Alcohol and drug abuse.
2. Physical and psychological violence in general but particularly towards children.
3. Schizophrenia.

What are the services offered in the community and elsewhere for people suffering from a dependency or a mental health issue?

In the community, the services most known to women include:

1. Frontline services.
2. Drug addiction service.

Outside the community, the services most known to women are therapy services.

What is missing in the community in order to improve the wellness of the community?

1. Specialized workers (in mental health, for abusers, psychologists).
2. Anishnabe mental health workers.
3. Cultural and traditional activities (sharing circle, Anishnabe legends, dancing, healing).

What can I do to improve the wellness of the community?

1. Support, help, listen and encourage people with mental health issues.
2. Some women don't know what they can do to help and others believe they are doing enough.

Which people or service do I turn to when I don't feel well?

1. Most women turn to their friends, family and/or a trusted person.
2. Many turn towards services.
3. A few prefer staying alone.

What are the community's strengths and weaknesses?

Here are the primary strengths listed by the women.

- People are friendly, good natured and have a good sense of humour.
- There are more services and activities in the community.

(Some said having no strength anymore and/or couldn't identify any.)

Here are the primary weaknesses listed by the women.

- Drug and alcohol abuse. (The lack of respect was also mentioned for people who are sober versus those in recovery and a lot of judgment towards them).
- Gossiping and and/or rumours.
- The lack of assistance and trust among people.

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Kitcisakik and Lac Simon

Kitcisakik Elders

Here is what you said or suggested concerning our mental wellness project.

Results for elders (64+ years of age)

We met with 30 community members, including 10 men, 17 women and three elders. Herewith is a summary of meetings with the community's three elders. Only the more common answers have been indicated here. Here are the results obtained for most of them.

What is sound mental health?

1. Having positive thoughts, healthy thoughts.
2. Being well balanced, in harmony.
3. Being in contact with nature (waking up early, seeing the sun rise and set).

What are the most significant mental health issues in the community?

1. Suicides (for youth in particular).
2. Alcohol and drug abuse.
3. Communication between youth and elders.

What are the services offered in the community and elsewhere for people suffering from a dependency or a mental health issue?

The elders are unaware of the services. There is a communication barrier between the elders and the services on account of language.

What is missing in the community in order to improve the wellness of the community?

1. The Anishnabe language.
2. Returning to the Anishnabe culture (since the arrival of the Dozois, the culture has disappeared).

What can I do to improve the wellness of the community?

1. Do not use drugs or alcohol.
2. Have stability in all areas of life.
3. Learn to respect those who use drugs or alcohol (do not judge, etc.)

Which people or service do I turn to when I don't feel well?

1. Towards awareness (refers to the teachings from their parents and grandparents).
2. Towards another elder if needing to talk.
3. They don't use the services.

What are the community's strengths and weaknesses?

The elders didn't identify any strengths, other than perhaps home care services which they appreciate. This service was considered a weakness because on pay days, there is no service at home.

In addition, the elders no longer feel respected. Slot machines are also considered a weakness. (When accompanied to Val-d'Or they explain that they often have to wait in the car and wait for the driver who is playing the slots).

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MENTAL WELLNESS PROJECT

Kitcisakik and Lac Simon

Lac Simon Women

Here is what you said or suggested concerning our mental wellness project.

Results for Lac Simon Women (18-64 years of age)

We met with 119 members of the Lac Simon community (12 men, 31 women, 72 youths and 4 elders). Herewith is a summary of the meeting with the 31 women from the community. Only the more common answers have been indicated here.

What is sound mental health?

1. Having a balanced life (routine of 8hrs of activities, 8hrs of work and 8hrs of rest. Taking a nap in the afternoon, avoiding drugs and alcohol).
2. Progressing through life (accepting yourself, taking care of yourself, feeling good about yourself, having self-esteem).
3. Returning to Anishnabe values (respect/honesty/sharing/humility, traditional language and teachings).

What are the most significant mental health issues in the community?

1. Abuse and dependency (financial, alcohol, drugs, etc).
2. Sexual abuse and the code of silence.
3. Violence in all its forms (domestic, psychological, etc.).
4. Suicide.
5. Gossiping, judgment and criticizing between community members.

What are the services offered in the community and elsewhere for people suffering from a dependency or a mental health issue?

1. The Health Centre: the physical component and healing activities in the forest are much appreciated. In terms of mental health, a lack of confidentiality was mentioned, too much instability and employee turnover.
2. Frontline services.

Outside the community, treatment centres and the Youth Centre were the most identified. Shelters for women were also mentioned frequently.

What is missing in the community in order to improve the wellness of the community?

1. More recreational activities (parent/children activities, legends told by the elders, walking groups, karaoke nights).
2. More healing in the forest, sharing circles, groups of women in the forest and therapy components.
3. Call centre 24/7 (telephone, blog, etc.).

What can I do to improve the wellness of the community?

1. Volunteer and get involved in particular with the youth and elders.
2. Help one another, participate, get involved in community events, meetings and activities.

Which people or service do I turn to when I don't feel well?

1. Most women turn to informal people: their friends, family, a trusted person or they go for a walk. It was noted that services were not always available "here" and "now" when they need them.
2. Only a few of them seek help from the Health Centre.

What are the community's strengths and weaknesses?

Here are the primary strengths listed by the women.

1. Mutual assistance when someone dies.
2. More communication and openness than before.
3. Good sense of humour.

Here are the weaknesses:

1. Lack of mutual assistance (especially between people who use drugs and alcohol and those who don't).
2. Lack of communication and openness.
3. Judgment and gossiping (in particular between those in recovery and those who still use).

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MENTAL WELLNESS PROJECT

Kitcisakik and Lac Simon

Lac Simon Men

Here is what you said or suggested concerning our mental wellness project.

Results for Lac Simon Men (18-64 years of age)

We met with 119 members of the Lac Simon community (12 men, 31 women, 72 youths and 4 elders). Herewith is a summary of the meeting with the 12 men from the community. Only the more common answers have been indicated here.

What is sound mental health?

1. Exercising, being physically active, doing exercise.
2. Being sober (not using drugs or alcohol) and setting a good example.

What are the most significant mental health issues in the community?

1. Violence in all its forms (in particular sexual abuse).
2. Alcohol and drug abuse.
3. Gossiping between community members.

What are the services offered in the community and elsewhere for people suffering from a dependency or a mental health issue?

1. The Health Centre was mentioned and in particular the substance abuse services, nursing services and MCH.
2. Outside the community, the Val-d'Or hospital is the most well known for men.

What is missing in the community in order to improve the wellness of the community?

In general, the men expressed that they would like more resources such as:

1. A place where they could meet and talk among men.
2. Anishnabe care workers for men.
3. Coffee club meetings for men (like the women).

Which people or service do I turn to when I don't feel well?

The men indicated that they turn towards the services at the Health Centre as much as towards a person they trust such as a friend, family...

What can I do to improve the wellness of the community?

1. Get involved by participating at the meetings in the community and by organizing activities.
2. Share traditional knowledge (in particular to the youth).
3. Spend time with the youth.
4. Share our experience and our stories.

What are the community's strengths and weaknesses?

1. The men consider that the community activities represent strength at Lac Simon.
2. The men identified the following weaknesses:
3. Judgment, gossiping.
4. Substance abuse.

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MENTAL WELLNESS PROJECT

Kitcisakik and Lac Simon

Lac Simon Elders

Here is what you said or suggested concerning our mental wellness project.

Results for Lac Simon elders (64+ years of age)

We met with 119 members of the Lac Simon community (12 men, 31 women, 72 youths and 4 elders). Herewith is a summary of the meeting with the 4 elders from the community. Only the more common answers have been indicated here.

What is sound mental health?

1. Being in contact with nature and returning to the forest.
2. Having balance in all aspects of life (personal, couple, family, with the environment, etc.).

What are the most significant mental health issues in the community?

1. Alcohol and drug abuse.
2. Placement of children.

What are the services offered in the community and elsewhere for people suffering from a dependency or a mental health issue?

Most of the elders do not use the health services since they are not provided in the Anishnabe language.

What is missing in the community in order to improve the wellness of the community?

1. The Anishnabe language should be more present in the services, communiqués, etc.
2. Anishnabe autonomy should be developed (e.g. volunteer participation by members without giving prizes).
3. More community and cultural activities (e.g. organize dances after meetings like before).

What can I do to improve the wellness of the community?

"We must encourage our youth to take charge of their lives, to go back to school and achieve their goals. They are the community's future."

Which people or service do I turn to when I don't feel well?

1. Half the elders follow in their ancestors' footsteps and turn towards Anishnabe beliefs (e.g. awareness).
2. One elder out of four turns towards an Anishnabe person who speaks Algonquin.
3. One elder out of four turns towards a care worker at the Health Centre

What are the community's strengths and weaknesses?

The elders didn't identify any strengths.

Here are the weaknesses they identified:

1. Loss of their culture, tradition, Aboriginal identity, teachings.
2. Gossiping.

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APPENDIX 3: MENTAL WELLNESS TEAM ACTION PLAN

1st GENERAL OBJECTIVE: Bolster first-line mental health and addictions services offered in the pilot communities

SPECIFIC OBJECTIVES	MEANS/ACTIVITIES	TIMELINE	PARTIES RESPONSIBLE	PARTNERS	SUCCESS INDICATORS
#1: Capacity building for local teams	• Clinical supervision of local first-line workers	Clinical supervision needs evaluated in the **fall of 2010** *Supervisory meeting start date to be confirmed with the MWT*	• Clinical advisor (clinical supervisor) • Mental health nurse • Social worker	• Local clinical supervision resources from both communities • First- and second-line provincial mental health and addiction teams • FNQLHSSC clinical advisor	• Number of supervisory meetings a month • Regular meeting schedule • Number of sectors and employees requesting clinical supervision

1st GENERAL OBJECTIVE: Bolster first-line mental health and addictions services offered in the pilot communities					
SPECIFIC OBJECTIVES	**MEANS/ACTIVITIES**	**TIMELINE**	**PARTIES RESPONSIBLE**	**PARTNERS**	**SUCCESS INDICATORS**
	• Information, awareness and training workshops for local teams: 1. Mental health 2. Mental illness 3. Post-traumatic stress 4. Bereavement 5. Mental health screening	Training needs evaluated in the **fall of 2010** *Workshop start date to be confirmed with the MWT*	• Clinical advisor • Mental health nurse • Social worker • Cultural and community worker	• Band councils of both communities • Health directors of both communities • Internal partners (health, schools, first-line services, natural caregivers, etc.) • Psychiatrists • CSSS • Community organizations and resources	• Number of training sessions given • Regular training schedule • Number of sectors and employees taking part in the workshops and training sessions • Increase in number of mental health cases detected

1st GENERAL OBJECTIVE: Bolster first-line mental health and addictions services offered in the pilot communities					
SPECIFIC OBJECTIVES	**MEANS/ACTIVITIES**	**TIMELINE**	**PARTIES RESPONSIBLE**	**PARTNERS**	**SUCCESS INDICATORS**
	• Joint follow-up with local resources, who do follow-ups with individuals with a mental illness or their families	Concurrent with service implementation *MWT start date to be confirmed in the **fall of 2010***	• Entire MWT	• Internal partners who do follow-ups with individuals with a mental illness or their families	• Retention rate of local first-line workers • Less burnout among first-line workers • Number of files being jointly followed up on • Number of monthly follow-ups
#2: Increased accessibility of mental health and addiction services	• Establish protocols and service agreements: - Reference process for first- and second-line services - Clientele with two conditions - Post-treatment/post follow-up	After the meeting with outside partners in the fall of 2010 to present the MWT and action plan *Date to be confirmed with the mobile team*	• Clinical advisor • Mental health nurse • Social worker	• Band councils • Health directors • CSSS • Regional health and social services agency • MSSS • Centre Normand • Treatment and therapy centres	• Shorten waiting lists for first- and second-line services • Service accessibility problems identified • Number of service agreements and protocols written and signed

1st GENERAL OBJECTIVE: Bolster first-line mental health and addictions services offered in the pilot communities					
SPECIFIC OBJECTIVES	**MEANS/ACTIVITIES**	**TIMELINE**	**PARTIES RESPONSIBLE**	**PARTNERS**	**SUCCESS INDICATORS**
	• Participate in committees: - Addiction committee - Intersectoral youth committee - Multi committee (Kitcisakik) - Relaunch the issue table in Lac-Simon • Sensitize outside partners and non-Native employees to First Nation reality, values and needs by: - Organizing information and awareness workshops - Organizing meetings in the community with partners - Inviting partners to attend community and cultural events	*Starting in the **fall of 2010** and ongoing thereafter*	Entire MWT	• Community organizations and resources • FNQLHSSC clinical advisor	• Number of committees and regularly scheduled committee meetings • Satisfaction of users and their families • Number of information and awareness workshops organized for partners • Number of outside partners attending each workshop • Number of meetings with community partners • Number of outside partners attending community events

1st GENERAL OBJECTIVE: Bolster first-line mental health and addictions services offered in the pilot communities					
SPECIFIC OBJECTIVES	**MEANS/ACTIVITIES**	**TIMELINE**	**PARTIES RESPONSIBLE**	**PARTNERS**	**SUCCESS INDICATORS**
#3: Services implementation: **MENTAL ILLNESS AND ADDICTION PREVENTION**	• Information and awareness workshops organized for the population: 1. Mental health 2. Mental illness 3. Addictions 4. Difficult emotion management (anger, sadness, hate, etc.) 5. Self-esteem	*Once services are implemented after team appropriation period (about 3 months)* ***(September to late December 2010)*** Information and awareness sessions will be organized **every month** for the **general population** **Monthly** activities will also be organized for the **special needs** clientele (children, adolescents, etc.)	Entire MWT	• Band councils • Targeted internal partners (health, schools, first-line services, natural caregivers, etc.) • CSSS • CMHA-Quebec • Centre Normand • CJAT • Police • Community organizations and resources	• Number of information and awareness sessions held • Information and awareness sessions held regularly • Number of community members participating in sessions • Increase in number of mental health and addiction cases detected
	Distribute mental health information in both communities through different media	*Starting when the MWT is implemented:* - During mental health week in May - During community events - During school activities - Other	Entire MWT	• Band councils • Health directors • Local resources for translation into Algonquin • Internal partners • Population of both communities • CMHA • CSSS • FNQLHSSC	• Number of bulletins distributed per year • Number of articles published per year • Number of posters distributed per year • Number of pamphlets distributed per year • Number of activities held • Public participation

1st GENERAL OBJECTIVE: Bolster first-line mental health and addictions services offered in the pilot communities					
SPECIFIC OBJECTIVES	**MEANS/ACTIVITIES**	**TIMELINE**	**PARTIES RESPONSIBLE**	**PARTNERS**	**SUCCESS INDICATORS**
SCREENING AND EVALUATION	• Develop screening and clinical evaluation tools • Screen children and adolescents at risk or with behavioural or psychosocial adaptation problems • Do a clinical evaluation to identify the mental health problem or the presence of mental illness • Make recommendations for therapeutic treatment/follow-up • Support and advise local resources	*Once services are implemented after team appropriation period (about 3 months)* ***(September to late December 2010)***	• Clinical advisor • Mental health nurse • Social worker	• Internal partners • Regional health and social services agency **(tools)** • CSSS **(tools and training)**	• Number of screening and clinical evaluation tools developed per year • Number of clinical evaluations per month • Number of screenings per month • Number of referrals per month
REFERRALS AND LIAISON	• Direct and refer individuals to community resources and services, as required • Direct and refer individuals to first- and second-line services in the provincial network, as required	*Once services are implemented after team appropriation period (about 3 months)* ***(September to late December 2010)***	Entire MWT	• Internal partners in both communities • First- and second-line services in the provincial network • CSSS • Treatment centres • Community organizations and resources	• Number of support and advisory meetings held with internal partners per month

1st GENERAL OBJECTIVE: Bolster first-line mental health and addictions services offered in the pilot communities					
SPECIFIC OBJECTIVES	**MEANS/ACTIVITIES**	**TIMELINE**	**PARTIES RESPONSIBLE**	**PARTNERS**	**SUCCESS INDICATORS**
TREATMENT / THERAPEUTIC FOLLOW-UP	• Develop clinical intervention tools • Individual follow-ups • Support parents and teach them how to handle a child with problems (e.g. FASD, aggression, hyperactivity, etc.) • Support families dealing with a loved one with a mental illness • Men's group (Lac-Simon, etc.) • Therapeutic forest retreat (couples, women, men, youth, grieving families, etc.) • Sharing and healing circle (elders, etc.)	***Progressively** after the appropriation phase by the MWT and the clarification of roles, mandates and cooperative efforts with internal and outside partners*	Entire MWT	• FNQLHSSC clinical advisor • First- and second-line mental health and addiction services in the provincial network • Supervisory and therapeutic follow-up resources in both communities • Community organizations and resources • Elders • Natural caregivers	• Number of individual follow-ups per month • Number of group follow-ups per month • Number of family follow-ups per month • Number of therapeutic retreats per year • Number of sharing and healing circles held per month • Improvement in parenting skills • Increase in individual and community wellness

2nd GENERAL OBJECTIVE: Encourage and support the development of cultural and community wellness activities

- **The Anishinabe / Anicinape language should be promoted and taught during all cultural and community activities**

SPECIFIC OBJECTIVES	MEANS/ACTIVITIES	TARGET PARTICIPANTS	TIMELINE	PARTIES RESPONSIBLE	PARTNERS	SUCCESS INDICATORS
#1: Strengthen cultural identity and the pride of being Anishnabe / Anicinapek	**Traditional and cultural activities:** - Hunting and fishing - Traditional foods - Traditional dances - Stories and legends	Entire population of both communities	The team will have to develop a **calendar of monthly activities** in association with the other sectors and programs in both communities	• Cultural and community worker along with other MWT members, depending on the activity and needs	• Band councils • Elders • Natural caregivers • Traditional healers from the outside • Kitcisakik cultural worker • Health centres • First-line services • Schools in both communities • Youth centres • Population of both communities	• Number of activities organized per year • Educational aspect on improving wellness included • Number of participants per activity • Overall participant satisfaction • Use of Anishnabe / Anicinape during activities
	Promote the use and teaching of the Anishnabe / Anicinape language	Elders, adults, young adults and youth in both communities				
	Forest retreat (*reconnect with nature and culture)*	Entire population of both communities				

2nd GENERAL OBJECTIVE: Encourage and support the development of cultural and community wellness activities

- **The Anishinabe / Anicinape language should be promoted and taught during all cultural and community activities**

SPECIFIC OBJECTIVES	MEANS/ACTIVITIES	TARGET PARTICIPANTS	TIMELINE	PARTIES RESPONSIBLE	PARTNERS	SUCCESS INDICATORS
	Honour role models and share success stories in both communities	• Entire population of both communities • Need expressed by youth and elders in particular	Depending on the event, such as • Graduation • Evening homage • Community meal	Cultural and community worker along with other MWT members, depending on the activity and needs	• Band councils • Kitcisakik and Lac-Simon schools • Kitcisakik knowledge and know-how centre • Health centres • First-line services • Youth centres • Population of both communities	• Number of activities to honour individuals held per year • Boost in sense of belonging to and pride in being a member of the Anishnabe / Anicinapek Nation • Increase in self-esteem among community members • Use of Anishnabe / Anicinape during activities
#2: Strengthen intergenerational bonds	Community meals	Entire population of both communities	The team will have to develop a **calendar of monthly activities** in association with the sectors and programs in both communities	Cultural and community worker along with other MWT members, depending on the activity and needs	• Band councils • Kitcisakik and Lac-Simon schools • Knowledge and know-how centre • Or-et-des-Bois high school in	• Number of annual activities held that are aimed at a multi-generational clientele • Number of youth in a relationship with the elders • Use of Anishnabe
	Coffee time with a specific theme	Entire population of both communities • Need expressed by the youth and men of Lac-Simon				

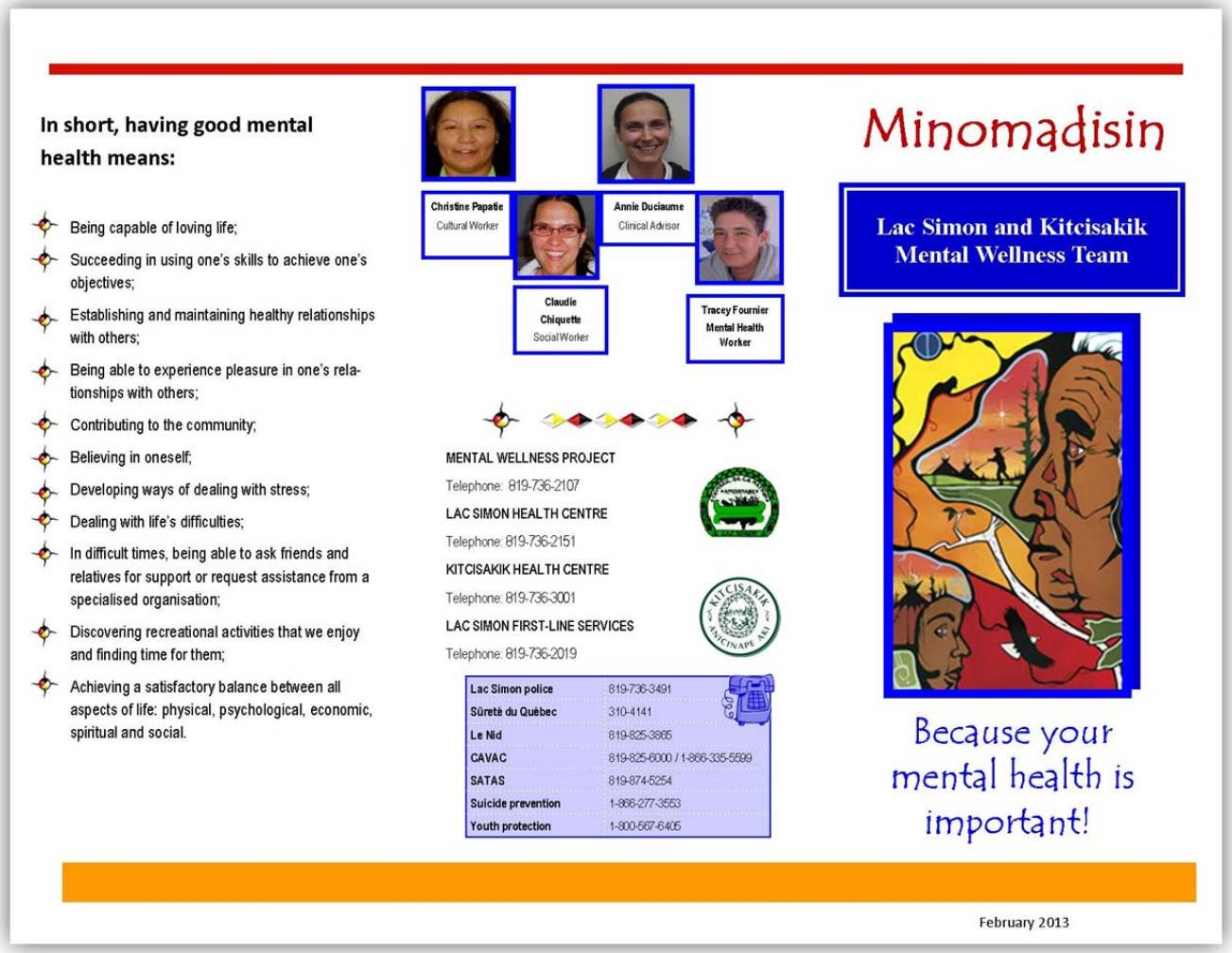
2nd GENERAL OBJECTIVE: Encourage and support the development of cultural and community wellness activities

- **The Anishinabe / Anicinape language should be promoted and taught during all cultural and community activities**

SPECIFIC OBJECTIVES	MEANS/ACTIVITIES	TARGET PARTICIPANTS	TIMELINE	PARTIES RESPONSIBLE	PARTNERS	SUCCESS INDICATORS
	Parent/child activities (parental bonding)	Parents and children in both communities			Val-d'Or • Health centres • First-line services • Youth centres • Elders' residence in Lac-Simon	/ Anicinape during activities
	Youth / elder activities	Youth and elders in both communities				
#3: Promote health by holding sport, outdoor and recreational activities	**Sport activities:** - Volleyball, broom ball, softball, hockey, etc. - Walking group - Tournaments between both communities	• Population in both communities • Walking group (women from Lac-Simon, among others) • Youth want more sport activities	The team will have to establish a **calendar of monthly activities** in association with the other sectors and programs in both communities	Cultural and community worker along with other MWT members, depending on the activity and needs	• Band councils • Kitcisakik and Lac-Simon schools • Knowledge and know-how centre • Or-et–des-Bois high school in Val-d'Or • Health centres • First-line services • Youth centre • Community organizations and resources	• Number of sport, outdoor and recreational activities held every month • Sport, outdoor and recreational activities are held regularly • Population is aware of monthly activity program • Number of participants • Use of Anishnabe / Anicinape during activities
	Recreational activities: - Watching movies - Educational play for youth - Karaoke evenings	• Youth from both communities • Women from both communities • Any other group that expresses the need				
	Outdoor activities: - Camping - Going in the forest	•Youth, men and women from both communities •Any other group				

2nd GENERAL OBJECTIVE: Encourage and support the development of cultural and community wellness activities ❖ **The Anishinabe / Anicinape language should be promoted and taught during all cultural and community activities**						
SPECIFIC OBJECTIVES	**MEANS/ACTIVITIES**	**TARGET PARTICIPANTS**	**TIMELINE**	**PARTIES RESPONSIBLE**	**PARTNERS**	**SUCCESS INDICATORS**
		that expresses the need				

APPENDIX 4: MWT SERVICE OFFER



In short, having good mental health means:

- Being capable of loving life;
- Succeeding in using one's skills to achieve one's objectives;
- Establishing and maintaining healthy relationships with others;
- Being able to experience pleasure in one's relationships with others;
- Contributing to the community;
- Believing in oneself;
- Developing ways of dealing with stress;
- Dealing with life's difficulties;
- In difficult times, being able to ask friends and relatives for support or request assistance from a specialised organisation;
- Discovering recreational activities that we enjoy and finding time for them;
- Achieving a satisfactory balance between all aspects of life: physical, psychological, economic, spiritual and social.

MENTAL WELLNESS PROJECT
Telephone: 819-736-2107
LAC SIMON HEALTH CENTRE
Telephone: 819-736-2151
KITCISAKIK HEALTH CENTRE
Telephone: 819-736-3001
LAC SIMON FIRST-LINE SERVICES
Telephone: 819-736-2019

Lac Simon police	819-736-3491
Sûreté du Québec	310-4141
Le Nid	819-825-3865
CAVAC	819-825-6000 / 1-866-335-5599
SATAS	819-874-5254
Suicide prevention	1-866-277-3553
Youth protection	1-800-567-6405

Minomadisin

Lac Simon and Kitcisakik Mental Wellness Team

Because your mental health is important!

February 2013

Context

The Mental Wellness Team is a pilot project that has been funded by Health Canada and supported by the FNQLHSSC since 2009. The composition of the team, its mandate and its roles were all developed based on the needs expressed by the populations of the two communities (Lac Simon and Kitcisakik) and on the recommendations made by the local and external partners. The team is active in both communities and offers services in connection with mental health while integrating the cultural aspect.

To date, many activities, training sessions, workshops and awareness initiatives have been carried out.

What is mental health?

Mental health is a state of psychological and emotional balance that allows for having a sense of well-being with oneself and having satisfying relationships with others while being able to cope with life's difficulties.

Mandate and services of the Mental Wellness Team

To enhance community well-being by providing clinical and cultural mental health services, while supporting the local teams.

Services offered to the population:

- Mental health awareness and prevention services.
- Intervention services intended for groups and families that are affected directly or indirectly by a mental health problem.
- Anishnabe cultural and spiritual activities.

Services offered to the local teams and their managers:

- Awareness, information and training
- Clinical discussions and support
- Council and advice

The team also works in collaboration with the resources of the public and community network in order to foster the accessibility and continuity of the services provided in the area of mental health to the community members. Everything is done through:

- The involvement of the members of the team in the various committees and events.
- The development of agreements and protocols between the various mental health services that exist both inside and outside of the community.

The determinants of mental health

Mental health is connected to both collective and personal values. It is influenced by one or more factors that are referred to as the determinants of health. The determinants can hep us to understand why certain people are experiencing mental health issues.

Here are the main determinants of mental health

- Income and social situation
- The social support network
- The quality of the education received
- Employment and work conditions
- The social and physical environments
- The geographic context
- Parental guidance and the attachment bond
- The health services received
- Culture
- The biological and physiological components
- Etc.

COMMISSION DE LA SANTÉ ET DES SERVICES SOCIAUX
DES PREMIÈRES NATIONS DU QUÉBEC ET DU LABRADOR
FIRST NATIONS OF QUEBEC AND LABRADOR
HEALTH AND SOCIAL SERVICES COMMISSION

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