



Aboriginal Mental Wellness Plan

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Mental, Physical, Emotional, and Spiritual balance is at the core of Aboriginal worldviews and way of life.



Interior Health
Every person matters

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“One cannot consider mental wellness without considering the connectedness to all aspects of the mental, physical, emotional, and spiritual. This consideration should not be just centred on the individual but on the family and to the community as a whole”.

- Interior Health Aboriginal Health and Wellness Strategy 2015-2019

Foreward

Executive Director, Mental Health and Substance Use

Far too often the concept of mental health is actually presumed to be another name for mental illness; whereas, mental wellness is perhaps a more active or current portrayal of both an ongoing process and intended outcome of care. The development of an Aboriginal Mental Wellness Plan is a positive first step to explicitly acknowledge the need for an inclusive system of care with corresponding commitments for change. This change needs to come about through open discussion with individuals, family members, and communities, and the ongoing commitment to have this discussion with curiosity and humility. Only through those mechanisms can we build a system that is respectful of the needs of the Aboriginal population, and ensure it justly supports the journey to wellness. I am excited for and committed to this work and look forward to seeing the positive outcomes that will accompany this Plan.

Dave Harray

Corporate Director, Aboriginal Health, Interior Health

Mental wellness has been identified as a clear priority for Aboriginal peoples within Interior Health (IH) boundaries ([IH Aboriginal Health and Wellness Strategy 2015-2019](#)) (Interior Health, 2015). IH through this Aboriginal Mental Wellness Plan, is committed to pathways for change to improve the mental health and wellness of all Aboriginal populations. The Plan outlines specific areas of action that the organization will achieve through our commitment to continued engagement, partnering and input. We are well on our journey to building stronger relationships and linkages to better respond and support Aboriginal individuals, families and communities. I believe with the combined efforts outlined we can see a marked improvement in the mental health and wellness of Aboriginal peoples and how we deliver our services.

Bradley Anderson

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As well we would like to thank all the participants who were a part of providing feedback on the focus areas and actions included through surveys, interviews, and presentations. All was a part of informing and shaping this Plan.

Executive Summary

In order to achieve our shared vision...

All First nations, Métis and Aboriginal people in the Interior are supported in a manner that respects the customs, values, and beliefs to achieve and maintain mental wellness and positive, healthy living regardless of where they live. *(First Nations Health Authority & BC, Ministry of Health, 2013)*

Improving the mental wellness of Aboriginal peoples is a goal of one of four priorities outlined in the Interior Health (IH) Aboriginal Health and Wellness Strategy 2015-2019 (IH, 2015). This IH Aboriginal Mental Wellness Plan (Plan) sets a clear path to work towards that goal through improving access to Mental Health and Substance Use (MHSU) programs and services for Aboriginal peoples within the Interior of British Columbia (BC). It also addresses the other strategic priorities of advancing cultural competency and cultural safety; ensuring meaningful participation; and improving health equity for all Aboriginal peoples.

This Plan is based on the voice of Aboriginal peoples, families, communities, and those that work with them in the Interior of BC. As such, guiding principles for this Plan are influenced firstly by Aboriginal worldviews which set the foundation for action. They embed a strong focus on patient, family and community centredness, consensus, equity, meaningful engagement, interconnectedness and impact.

Through the review of available information, evidence based and/or promising practice literature, and the engagement of key stakeholders, five areas of focus that have emerged are:

1. Develop and Enhance Family & Community Based Prevention, Promotion, Awareness & Self-care Supports
2. Participate in Meaningful Engagement
3. Build Trauma-Informed, Culturally Safe IH MHSU Services
4. Increase Equitable Access, Improve Transitions and Reduce Barriers
5. Apply a Continuous Quality Improvement Lens

These areas of focus include actions we can take in the near future as well as steps that will be foundational to achieving meaningful change and transformation potentially benefiting many generations to come. In order to monitor our work towards achieving lasting long-term change, the Plan includes desired outcomes to guide evaluation of its impact.

This Plan will require committed leadership with a willingness to implement evidence informed and promising practices for Aboriginal peoples as well as innovation through collaboration and partnership. The Plan includes alignment of work with the IH MSHU Program Plan 2017-2020, the emerging First Nations Health Authority (FNHA) Interior Region Mental Wellness framework and community plans moving forward. Also, continued alignment with the Ministry of Health priorities regarding primary and community care and mental health will occur. Yearly progress reports and an evaluation of the Plan will take place to ensure we are on track, while also remaining flexible enough to make needed changes or act on opportunities.

Background

Good mental health and wellbeing is known to be vital to overall good health and is the foundation of strong and resilient individuals, families and communities (IH, 2015). This is not a new concept to Aboriginal peoples who have always had a holistic perspective on health with the understanding that ‘wellness’ comes from seeking balance within ones mental, physical, emotional and spiritual being. Nationally, provincially and regionally, mental wellness has been identified by Aboriginal and Government leaders as a health priority. The Government of BC recently announced the formation of the Ministry of Mental Health and Addictions to oversee this priority area.

IH serves a large geographical area covering approximately 237,000 square kilometers, including a number of rural and remote communities and a population of approximately 731,680 people. IH is mandated by the Government of BC (1996) *Health Authorities Act* to plan, deliver, monitor and report on health services across the continuum of care (staying healthy, getting better, living with illness and chronic conditions, and coping with end of life) for residents within its boundaries inclusive of groups that identify as Aboriginal. This includes services for those experiencing mental health and substance use concerns. Knowing this, IH strives to improve the health of the population they serve, through various mechanisms, including the MHSU Program Plan 2017-2010 which outlines priority areas of focus (BC Statistics, 2016).



Through numerous engagement sessions with Aboriginal peoples in IH, health priorities were identified and incorporated into the development of the Aboriginal Health & Wellness Strategy 2015-2019 ([IH Aboriginal Health and Wellness Strategy 2015-2019](#)) (IH, 2015). One of the pillars set out in this strategy is to develop an Aboriginal Mental Wellness Plan for IH. This was further supported by First Nations engagement sessions related to mental wellness and is in alignment with the BC Ministry of Health’s Policy Objectives for Mental Health and Substance Use, Rural and Remote Health Services and Primary Care. It also aligns with objectives in the First Nations Health Authority, BC Ministry of Health & Health Canada (2013), “Path Forward” – BC First Nations & Aboriginal Peoples Mental Wellness and Substance Use 10 Year Plan, and other national, provincial and research directives moving to improve the mental health and wellness of Aboriginal peoples.

As we move forward, it is recognized that concrete actions are required in order to meet the needs of Aboriginal peoples to improve wellbeing. With this in mind, this document is presented as a Plan of Action, rather than a set of strategic directions. It sets forth a course of action based on the information we have and experiences that have been shared through Aboriginal communities in our region.

This Plan is the first for IH to focus specifically on the mental health and wellbeing of the Aboriginal population which is important in addressing inequities and achieving positive health outcomes for all¹.

¹ This is supported by accrediting organizations and best practices.

First Nations, Métis & Aboriginal Peoples in Interior Health

Successfully achieving our shared vision for Aboriginal mental wellness requires close collaboration with Aboriginal patients, families, communities, and partners, in order to shape the implementation of the key focus areas identified.

Drivers of Change...

- Request from Aboriginal population and organizations to improve MHSU programs and services and explore alternate delivery models
- Requirements to provide patient-centred health services
- Need to improve the health outcomes of the Aboriginal population

A set of actions are outlined in this Plan to move towards improved Aboriginal mental wellness. They are based on our current understanding of the needs of Aboriginal peoples, IH's current operations as well as trends and challenges that may impact delivery of services into the future. This will build upon the work conducted within the various active and working Aboriginal tables in IH, from Letter of Understanding (LOU) tables and the Partnership Accord Leadership Table, to the Interior Aboriginal Wellness Committee.

Within the IH region approximately 53, 770 individuals have self-identified as Aboriginal, which is close to 7.7% of the overall population.

There are:

- 58% of Aboriginal peoples living off-reserve in urban/rural environments, and the remaining 42% living on-reserve,
- 3 local health areas, Kamloops, Central Okanagan & the Cariboo-Chilcotin, have a higher portion of Aboriginal individuals,
- 54 distinct First Nations communities receiving services from IH,
- 7 Nation territories: Tsilhqot'in, Secwepemc, Dākelh Dené, St'at'imc, Syilx, Nlaka'pamux,
- Ktunaxa (Figure 1), and
- 15 distinct Métis Chartered Communities (Figure 1).

It is important to note that each of these territories and communities have distinct, rich cultures and beliefs that provide a foundation for working collaboratively in this endeavor to improve mental wellness.

Figure 1: Aboriginal identity within the IH region.



A Case for Change

Factors affecting mental health among Aboriginal populations are often multifactorial and complex; for example, the effects of colonization, residential schools, land appropriation and child welfare intrusion have been known to lead to learned violence, loss of language, loss of emotional security and family connections, and erosion of First Nations and Aboriginal culture (First Nations Health Authority, BC Ministry of Health & Health Canada, 2013).

While mental health and wellness is regarded as one of the most important health issues affecting Aboriginal peoples, there is a lack of information and data on specific mental health indicators, including the breakdown of data specific to Aboriginal populations (e.g. by geography) that could help guide program planning and implementation (National Collaborating Centre for Aboriginal Health, 2012). It is well understood that mental health issues experienced by many Aboriginal peoples often stem from the erosion of Aboriginal culture and values leading to socio-economic marginalization (Browne, McDonald & Elliott, 2009). Further, First Nations and Aboriginal peoples often have difficulty in accessing health care services besides facing other social inequities that directly or indirectly affect mental health of individual or communities. On the other hand, it is not uncommon to encounter resilient or “Mentally Healthy” communities rooted in the strengths of Aboriginal culture and worldviews (Canadian Institute for Health Information, 2009) Canadian Institute for Health Information.

This Plan is based on a review of key literature and reports, available data and information, and importantly, the depth of experience and voice of Aboriginal partners.

Literature provides us crucial context. As stated earlier, historical determinants, such as the legacy of residential schools, have negatively impacted the mental wellness of many Aboriginal peoples today. According to First Nations and Inuit Health (2016): “A research project commissioned by the Aboriginal Healing Foundation found that 75 percent of the case files for a sample of Aboriginal residential school survivors contained mental health information with the most common mental health diagnoses being post-traumatic stress disorder, substance abuse disorder and major depression”.

Further, authors Reading, Kmetz and Gideon (2007) stated that the 2002/2003 Regional Health Survey showed that when emotional and mental health support was needed, only 24% of Aboriginal

The legacy of colonization is just one factor that influences mental health...

According to Health Canada, health, including mental health is “determined by complex interactions between social and economic factors, the physical environment and individual behaviour.”

Known as the “determinants of health”, this concept refers to a spectrum of contextual factors that influence health outcomes and help to determine an individual’s overall health status. In this way, mental health in First Nations, Métis & Aboriginal communities is equally influenced by political context, community infrastructure and resources, and the social environment in which the people live” (Kielland & Simeone, 2014)

individuals sought help from a family doctor and only 5% sought support from a psychiatrist and/or psychologist, while roughly 2% received support from a crisis line worker.

The authors noted that this may be a symptom of inadequate access to appropriate, trauma-informed, culturally safe mental health services. This is reinforced by the many experiences shared during the development of this Plan.

Information from Métis Nation BC (MNBC) indicated:

- In 2008, over a quarter (27%) of Métis girls (12-19) had deliberately cut or injured themselves without trying to kill themselves. In 2013, this increased for Métis girls to 36%; and
- In comparison to non-Métis youth (First Nations and Non Aboriginal), Métis youth were less likely to rate their mental health as good or excellent (71% vs. 81%) (McCreary Centre Society, 2016).
- Also, key findings of the “First Nations Health Status and Health Services Utilization 2008/2009 and 2013/14 – Interior Region” noted that:
 - o Depression rates increased among First Nations 0-17 years old but in adulthood were lower than for non-First Nations; and
 - o First Nations have a higher use of substance use services compared to non-First Nations.
- As well, the BC Provincial Health Officer’s (2009) report on the health and well-being of Aboriginal peoples in BC indicated that:
 - o In IH, the hospitalization rates for suicides and attempted suicides were 2.6 times higher in Status Indians than other residents; and
 - o 67.5 per cent of Status Indian mental health patients in IH received community follow-up for mental health conditions once they had been discharged from the hospital for a period of 30 days, compared with 81.5 per cent of other residents; as well
 - o Between January 2003 to December 2007, among the 81 children and youth that died by suicide in BC, 15% were identified as Aboriginal (BC Coroners Service, 2008). Similarly, the suicide rates among Status Indians youth aged 15-24 years were 3.09 times higher than other residents in 2009-2013 (BC Provincial Health Officer, 2015).

Opioid Overdose

Currently, the surveillance data on suspected opioid overdose reported by IH emergency departments through enhanced overdose surveillance indicate that 20% of the patients presenting to the emergency departments self-identified as Aboriginal. Given that Aboriginal peoples represent

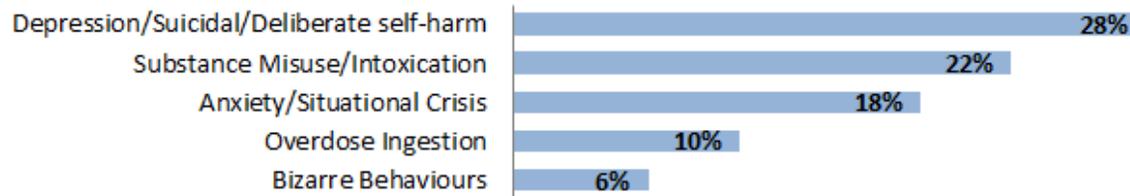
approximately 7.7 % of the total IH population, Aboriginal peoples are overrepresented among patients with suspected opioid overdoses.

Within IH there is limited comprehensive data available to provide an in-depth review of the Aboriginal population needs in the region. Strengthening continuous quality improvement, data availability and quality and performance monitoring is one area of focus for this Plan. Information was obtained from available Aboriginal Self-Identification (ASI) data² for three of IH's larger acute sites (Vernon, Kelowna & Penticton) in 2014/15 and it showed (BC Provincial Health Officer, 2015):

11.4%	of IH MHSU inpatient cases are self-identifying as Aboriginal while they represent only 7.7% of the overall population
28.0%	of the IH MHSU emergency department visits by Aboriginal patients were related to depression / suicidal / deliberate self-harm ³
22.0%	of the MHSU emergency department visits by Aboriginal patients were related to substance misuse and intoxication

As well, Figure 2 gives the top five reasons for MHSU emergency department visits by self-identified Aboriginal patients during 2014/2015.

Figure 2: The top five reasons for IH MHSU emergency department (ED) visits⁴ by self-identified Aboriginal patients



² Please note: Aboriginal Self-Identification (ASI) involves self-reported data obtained from patients during registration at an acute facility. ASI data will only represent the Aboriginal population who visits one or more of IH's acute facilities and those who choose to self-identify as Aboriginal during registration. Due to small sample sizes in some communities, data often needs to be reported in an aggregated format.

³ Using the MHSU Canadian Emergency Department Information Systems (CEDIS) codes

⁴ CEDIS codes of MHSU Emergency Department visits, 2014/15 for Kelowna, Penticton and Vernon hospitals.

Self-identified Aboriginal peoples were also:

- Younger than the general MHSU population,
- Had shorter hospital stays than the general MHSU population,
- Had shorter hospital stays if they lived in rural or remote LHAs than if they lived in urban LHAs,
- had a lower ALC rate than general MHSU population, and lastly
- Using “The Top 10 MHSU Case Mix Groups” the most common reason for Aboriginal patient hospitalizations related to MHSU were for: Substance Use; Depressive Episode and Schizophrenia/Schizoaffective Disorder.

All of the information above describes the critical need to understand mental health of Aboriginal peoples, the interplay of risk and protective factors that influence mental wellness and adapt holistic and culturally appropriate approaches to address deficiencies and learn about strengths.

Our Shared Vision: Shaping a Plan Forward

We are working together to bring to life a shared vision set out in the *A Path Forward: BC First Nations and Aboriginal People's Mental Wellness and Substance Use – 10 year Plan: A Provincial Approach to Facilitate Regional and Local Planning and Action* as well as bring to life the strategic priorities outlined in the *IH Aboriginal Health and Wellness Strategy* (First Nations Health Authority, BC Ministry of Health & Health Canada, 2013; IH, 2015). In support of this vision, we are working hard to ensure that:

Our Goals...

- Improve the mental health and wellness of Aboriginal people through improvement of services, supports and health outcomes
- Ensure the Plan reflects individual and family needs and are community-driven and Nation-based
- Promote mental health and wellness and reduce harmful substance use

“All First Nations and Aboriginal peoples in the Interior region are supported in a manner that respects customs, values, and beliefs to achieve and maintain mental wellness and positive, healthy living regardless of where people live”.

The needs of Aboriginal peoples and the capacity of the health system to provide care are fundamental steps in developing a thoughtful set of actions. The recommended actions outlined in this Plan are focused on addressing known gaps in the IH MHSU system and programs and services with a focus on building on existing strengths and opportunities.

Through the work of the IH Aboriginal Mental Wellness Advisory Committee and linkages with First Nations, Métis and Urban Aboriginal partners, opportunities exist to: Enhance Aboriginal specific MHSU service components; Increase the use of trauma-informed, culturally appropriate therapy options and connections with traditional medicine and ceremonial practices; improve trauma-informed and culturally safe practices of IH staff with particular focus on MHSU staff; Improve access to all levels of MHSU services and information; Review current IH contracts for opportunities to improve Aboriginal cultural competence of providers and services; and, Improve earlier intervention and awareness of MHSU services.

Leveraging current Ministry of Health, FNHA and IH directions in mental health, primary and community care and rural and Aboriginal health⁵, this Plan sets a path to work in partnership and collaborate on shared priorities to improve Aboriginal mental wellness.

⁵ The Ministry of Health has outlined priority for the BC health system. The *Setting Priorities for BC Health* document and related policy papers can be found on the BC Government Ministry of Health website.

Our Approach

Aboriginal peoples must be complete partners in the design and delivery of health programs and services to benefit individuals and their communities, and research evidence must be blended with the knowledge and life experience of Aboriginal practitioners and leaders. Further to this “Initiatives require culturally sensitive strategies that are situated within Aboriginal worldview[s], in order to sustain long-term, community-based change” (BC Ministry of Healthy Living and Sport, 2009). Provincially and within health authorities, agreements have been signed with First Nations and MNBC, which speak to this commitment to work collaboratively and in partnership.

When attempting to improve health and well-being of Aboriginal peoples, it is recommended that the geopolitical and cultural diversity be taken into consideration, which has been reinforced by many First Nations, Métis and urban Aboriginal partners within the IH region (Reading, Kmetc & Gideon, 2007).

Stakeholder Involvement

Critical to the success of this Plan is the involvement and leadership of Aboriginal individuals, families, communities and organizations, as well as health care providers. To guide the development of this Plan an Aboriginal Mental Wellness Advisory Committee (AMWAC) was established with members from IH, FNHA, MNBC, urban Aboriginal organizations and the Patients Voices Network, as partners in the design of recommendations outlined in this Plan.

In addition, the draft recommendations developed were shared back to our Aboriginal partners and IH MHSU leaders, to provide feedback on whether important aspects were missed in the Plan and if they felt the areas of focus and actions would improve the current system. Feedback from consultations, meetings and surveys were also included in the finalization of the Plan (Appendix B).

Collective Accountability

This Plan helps to create a pathway to ensure improvements are implemented for the mental wellness of Aboriginal peoples in the Interior. We also strive to achieve results based accountability beyond just the development of the Plan; integrating this through the creation and selection of measurements in the evaluation, and ensuring continuous communication about progress with key stakeholders. This Plan will be successful with shared accountability and responsibility of all involved as we move forward together to achieve desired results.

“Healing must be centred on traditional understanding...

...of interconnectedness and wholeness...addressing the physical, emotional, mental and spiritual aspects of person, family & community.”

(Mussell, Cardiff & White (2004))

Guiding Principles

Recognizing that culture, traditions, and language are foundational to healthy Aboriginal individuals, families, and communities; the AMWAC sought to identify principles that have and will continue to guide the focus, approach and implementation of the Plan. The Committee considered guiding principles from FNHA, IH, and Ministry of Health (Appendix A), and turned to the breadth and depth of experience of committee members to bring attention to the following principles:

Person, Family & Community Centredness⁶:

Rights, respect, and inclusion of family and community are necessary.

Use of a Consensus Model:

Collaborative language and relationship building are used to come to consensus through dialogue; There is shared contribution i.e. to how we develop actions.

Equity Lens:

There is an equal voice in Planning efforts; there is equitable consideration for i.e. all communities (not just larger communities); there is purposeful action towards removing barriers to access.

Meaningful Engagement:

There is an internal and external component of engagement for IH; internal engagement inclusive of not just leadership. Planning and actions are strengths based. “We will commit to engage stakeholders in dialogue when significant changes in the Planning and delivery of services are being considered within their communities⁷”; we seek grass roots engagement and feedback on identifying the key components of this Plan and its future implementation.

Interconnectedness and Impact:

Planning services and support will not be viewed in isolation of each other or in isolation of the community or population they serve. Their interconnectedness and impact to community will be understood and included in decisions.

⁶ Additional information can be found about the BC Patient & Family Centred Care Framework at http://www.health.gov.bc.ca/library/publications/year/2015_a/pt-centred-care-framework.pdf

⁷ Charter the Course: Interior Health’s Planning Principles and Consideration for Change. February 2012.

Opportunity to Improve Aboriginal Mental Wellness

Desired Outcomes

As we move forward towards our vision, change will mean improved and meaningful access to IH MHSU services that are trauma-informed, culturally safe, and developed in collaboration with Aboriginal individuals, families, communities and partners. This is supported by Accreditation Canada standards for Mental Health Populations & Community-based Mental Health Services & Supports⁸.

Through implementation of this Plan, IH aims to:

- Improve Awareness of and Access to MHSU Services,
- Advance Collaboration and Care Coordination,
- Create Welcoming, Trauma-Informed and Culturally Safe Environments, and
- Establish Continuous Quality Improvement of Services with an Aboriginal Health Lens.

Pathway (Theory) for Change

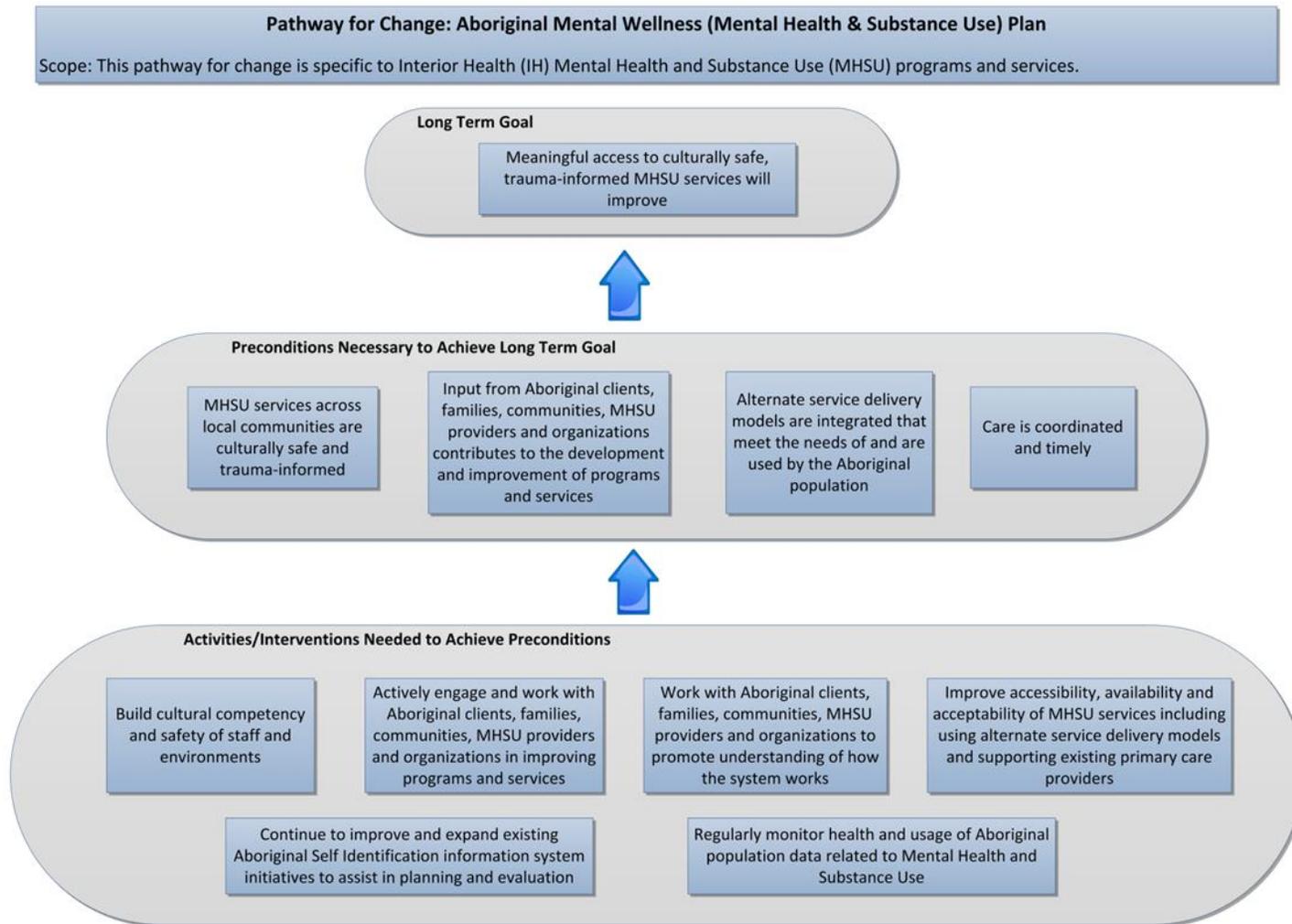
As stated above, improving meaningful access to trauma-informed, culturally safe, MHSU services is the long term goal for this Plan. To achieve that goal, four requirements need to be achieved, which include:

- Ensuring MHSU services are trauma-informed and culturally safe,
- Engaging with and collecting input from Aboriginal patients, their families and communities along with MHSU providers and other organizations, to develop and make improvements to programs and services,
- Integrating alternate service delivery models that meet the needs of Aboriginal patients, and
- Ensuring care is coordinated and timely.

The Pathway for Change (Figure 3) describes some of the activities that need to occur to achieve the Plan's long term goal.

⁸ For more information see www.accreditation.ca.

Figure 3: Pathway for Change: Aboriginal Mental Wellness Plan



Through Five Areas of Focus

Literature and feedback from key stakeholders (Appendix B), and communities⁹ indicates timeliness, trauma-informed and culturally safe services; an individuals' awareness of what is available; and involvement of families and communities, can have a significant impact on whether or not services are accessed by Aboriginal peoples. Meaningful engagement can ground healthcare through respectful, collaborative care planning, and communication between individuals, their families, and their primary and community care providers.

In order to work towards meeting the desired outcomes outlined in the previous section, this Plan includes five areas of focus:

1. Develop and Enhance Family and Community Based Prevention, Promotion, Awareness and Self-care Supports
2. Participate in Meaningful Engagement
3. Build Trauma-Informed, Culturally Safe IH MHSU Services
4. Increase Equitable Access, Improve Transitions and Reduce Barriers
5. Apply a Continuous Quality Improvement Lens

All areas of focus are interconnected and essential to improving the system of care which supports the mental wellness of Aboriginal peoples. Therefore it is important to note that although areas of focus in the next section of this Plan are presented in an order, there is no intent to demonstrate a higher priority amongst them.

The next phase for the Plan is to develop service workplans for focus areas that identify who will be leading the actions, appropriate resources needed and the anticipated timeframe. These actions and workplans will align with the IH MHSU Program Plan 2017-2020 and other related internal and external plans where appropriate.

⁹ Feedback on the proposed Plan and actions was obtained through consultations and surveys with key stakeholders.

Area of Focus 1: Develop and Enhance Family and Community Based Prevention, Awareness and Self-care Activities

Much of the literature about where Aboriginal peoples tend to seek help, points to family and culture first (Tlanusta Garrett et al., 2014). Working with Population Health, Promotion and Prevention, Home Health, MHSU and other programs, there is an opportunity to: collaborate with individuals, families and their community to improve awareness of preventative and self-care services and how the health system works; increase support for patients in accessing traditional healing options and community supports with partners as ways to support healing and maintaining wellness; and create environments and care plans that include prevention and self-care.

In order to enhance empowerment and increase participation in family and community life, strengthen resilience, increase protective factors and decrease risk factors; care practices need to focus on restoring linkages to cultural strengths (Health Canada, 2015).

What do we want to achieve?

- Improved awareness and understanding of mental health and wellness programs, and how to access the health care system
- Enhanced self-care programs with an Aboriginal health lens
- Increased knowledge of MHSU
- Increased individual, family and community awareness of healthy living to support mental wellness
- Support implementation of healthy public policy related to MHSU

How will this be achieved?

- Better inform Aboriginal individuals, their families and organizations about the services and support programs available to them within IH and provincially
- Create and disseminate MHSU information and resources in a culturally appropriate relevant format i.e. adapting MHSU information, brochures
- Create, implement and/or develop self-care programs, and peer support related to MHSU at local community levels i.e. building resiliency skills
- Reduce stigma and increase MHSU knowledge for individuals, families and communities through community education opportunities
- Work with partners i.e. FNHA to increase the awareness of healthy living to maintain mental wellness with Aboriginal individuals, families and communities
- Support development and implementation of healthy public policy related to MHSU with First Nations, Métis & Urban Aboriginal stakeholders

Area of Focus 2: Participate in Meaningful Engagement

Engagement of First Nations, Métis and urban Aboriginal communities and individuals in timely and meaningful ways during planning, implementation and review of services, as well as when care is provided, is highlighted in the IH Aboriginal Health and Wellness Strategy 2015-2019. It also gets to the core of honouring the Letters of Understanding signed with Nation partners. During the planning and review of mental health and wellness services, it is important to recognize the diversity of Aboriginal communities and that a “one size fits all” approach is NOT appropriate. Models of care should be adapted to specific regions utilizing facilities, other resources and unique aspects of these regions as well as engaging with community members (Harte & Bowers, 2011).

“The best way to improve the clinical skills and cultural appropriateness of assessments by psychiatrists and providers is to develop better partnerships with Aboriginal Mental Health workers and Aboriginal services” (Wand, Eades & Corr, 2010, p.46)

There is a need for stronger coordination between programs and services, sectors and jurisdiction; care needs to be patient-centered; assuring timely connection and increased access to services; and increased cultural relevancy across services and supports” (Health Canada, 2015)

What do we want to achieve?

- Expanded opportunities for Aboriginal patients, families, communities and external Aboriginal MHSU service providers to participate in service development and evaluation

How will this be achieved?

- Actively engage the voice of the patients, families and communities and external Aboriginal MHSU service providers in program & service development and evaluation
- Provide cross training education opportunities that are developed to increase capacity and relationship with external Aboriginal MHSU service providers
- Identify education opportunities to support a higher degree of partnership and communication when providing services for shared patients with external Aboriginal service providers (including education on relevant legislation i.e. Mental Health Act)

Area of Focus 3: Build Trauma-Informed, Culturally Safe Mental Health & Substance Use Services

Improved trauma-informed and culturally safe practices and services will have direct positive impacts on the health of individuals and families. Services that are trauma-informed and culturally safe influence the acceptability, relevance and experience of health services. IH MHSU staff may participate in trauma-informed training and cultural safety training while working at IH. This training and the application of what is learned can be improved through further imbedding these teachings in MHSU staff orientation and education sessions as well as through provision of ongoing learning opportunities for staff.

There is evidence that increasing the cultural competence of clinicians and spaces results in increases in the utilization of services and the positive outcomes for Indigenous patients, especially when assessment for cultural resilience or other strengths which may be protective factors is embedded (Berry & Crowe, 2009; Stathis et al., 2012; Durey, Wynaden, Barr & Ali, 2014)

What do we want to achieve?

- Welcoming, trauma-informed and culturally safe health facility environments
- Improved staff local cultural competency and safety and trauma-informed practices
- Expanded collaboration opportunities between IH MHSU and external Aboriginal MHSU service providers
- Services and practices are more trauma-informed, culturally responsive, competency based, and patient and family-centred

How will this be achieved?

- Embed Aboriginal cultural competencies in IH MHSU staff orientation pathways (regional and local as available)¹⁰
- Integrate Aboriginal content into MHSU trainings and increase number of staff completing PHSA cultural safety training. i.e. Trauma-informed practice training to include historical context (intergenerational impacts of colonization, residential schools)
- Provide regular, ongoing learning of evidence informed practices and services for Aboriginal populations.
- Support opportunities to collaborate and cross train with external Aboriginal MHSU service organizations
- Utilize or build trauma-informed cultural assessment tools and treatment modalities when working with Aboriginal populations
- Enhance environments where MHSU services are delivered to be welcoming and safe with appropriate colours, art work, natural environments in view throughout facilities/website/resources
- Support implementation of Aboriginal health and workforce development
- Enhance and/or include cultural competency and safety language and expectations in all IH MHSU focused contracts

¹⁰ Although this Plan is focused on IH MHSU staff, stakeholders have identified opportunities for this training to occur with IH's Acute and Emergency Room staff as well.

Area of Focus 4: Increase Equitable Access, Improve Transitions, and Reduce Barriers

Access, availability and acceptability of MHSU services play a role in improving equitable access to and movement between services. Socio-economic factors, cultural/language protocols, historical experiences with health care, as well as distance and weather can contribute to limited access and availability of health services for Aboriginal populations. In addition, accessing services may be impeded by Aboriginal peoples, both patients and service providers, being unaware of what services are available and how they can access and better communicate/refer to them.

Tlanusta Garrett et al. (2014) state that members of a community may be unaware of the presence of services or their utility even though services are available.

What do we want to achieve?

- Improve awareness of what services are available and how to access them
- Enhance service delivery models to improve service access and acceptability for Aboriginal peoples
- Improved and clarified pathways of care to and between services for Aboriginal patients
- Improved connections between service providers, patients and their families
- Advance collaborative work with primary care providers
- Improve communication and transitions between providers
- Increased care coordination and partnership with patients, families and care providers

How will this be achieved?

- Broadly advertise services and treatment modalities available in language that is culturally relevant, and provided through multiple mechanisms – brochures, internet site, social media
- Use alternate service delivery models that are integrated to meet the needs of the Aboriginal population – telehealth, online, mobile, co-location, in-reach, outreach, extended hours (Kowpak & Gillis, 2015)
- Work with and support existing primary care providers i.e. Family Doctors and Nurse Practitioners, through education, Aboriginal specific information, and enhanced pathways
- Work with Aboriginal individuals, families, and health professionals to promote understanding of how the health system works i.e. referral and treatment pathways and process and use of emerging technologies such as e-Health.
- Develop improved discharge and/or transition processes i.e. between acute care, emergency departments, MHSU community services and First Nations and Aboriginal community services
- Create standardized processes for flow of information between internal/external health care providers and cross-system services

Area of Focus 5: Apply a Continuous Quality Improvement (CQI) Lens

CQI efforts provide a means for IH MHSU services to: Reflect on progress and achievements in providing trauma-informed, culturally appropriate health care; Identify gaps in organizational and clinical practice; and identify priorities for actions to improve the delivery and outcomes of healthcare, through organization-wide initiatives and programs to Aboriginal patients across the organization; and Ensure greater systemic effort and accountability for a whole-of-health-service CQI approach to health care and health outcomes for Aboriginal peoples. This requires the ability to participate in and obtain relevant and meaningful data, information, research and stakeholder feedback.

Key factors improving the quality of care delivered to Aboriginal patients includes ongoing education and training, incorporating culturally-sensitive and secure assessment tools, increasing awareness of cultural protocols, and a willingness to engage with Aboriginal culture and practices (Durey, Wynaden, Barr & Ali, 2014)

Appropriate response requires health-assessment information that accurately reflects Aboriginal ethnicity and geographic location while effectively negotiating jurisdictional complexities. (Smylie & Anderson, 2006)

What do we want to achieve?

- Improved ability for shared planning to continuously improve services with an Aboriginal Health lens
- Improved ability to monitor service utilization and health outcomes of the Aboriginal population
- Improved ability to identify and incorporate emerging trends, and practices into service improvements
- Established continuous feedback mechanism between Aboriginal stakeholders and IH

How will this be achieved?

- Develop patient feedback mechanisms with Aboriginal stakeholders that are consistently measured and reported
- Develop a process to regularly monitor health and service usage and areas for quality improvement, in order to be responsive to emerging trends & areas requiring improvement
- Collaboratively develop indicators to monitor progress with First Nations, Métis and Aboriginal partners
- Continue to improve and expand existing Aboriginal Self Identification information system initiatives to assist in planning and evaluation
- Distribute research funds by IH for MHSU initiatives equitably to invest in Aboriginal research opportunities to add to literature and evidence base

Monitoring Success

The use of Indigenous ways of knowing and understanding health and healing...

...can enrich health-assessment data sets and improve their relevance and usefulness for community level Planning and evaluation...The support of First Nations, Inuit and Métis communities in the further development and evaluation ... is an important health assessment priority

(Smylie & Anderson, 2006)

Development of a reporting and accountability structure for ongoing monitoring of the Plan is essential to determine if changes described in the focus areas have had positive impacts for Aboriginal peoples' mental wellness.

An evaluation framework is being developed by the AMWAC for the Plan (Appendix C). The intent of this framework is to evaluate three areas of the Plan over a period of two to three years. The first phase will look at continuous quality improvement as it relates to IH data for this population and performance monitoring. The next phase will focus on MHSU care providers identified in the Plan to understand their experiences delivering trauma-informed, culturally safe services to Aboriginal peoples in IH. The final phase of the evaluation will focus on the patient and family experience to determine if this Plan has achieved its intended outcomes to improve meaningful access to trauma-informed, culturally safe MHSU services for Aboriginal peoples in IH.

Work is continuing to be completed on the evaluation framework. Specifically, there is a need to collaboratively develop and identify useful evidence and indicators with First Nations, Métis and Aboriginal partners that allow us to monitor and manage use of services, the health of the population as well as the success of the Plan (Health Canada, 2015).

As well, overall progress on this Plan will be shared with Aboriginal partners through existing formalized tables and communication process i.e. Partnership Accord Leadership Table, Letter of Understanding tables.

Conclusion/Closing the Circle

For Aboriginal peoples the path to mental health and wellness needs to be first grounded in Aboriginal worldviews which is founded on holistic and cultural perspectives, which both understand and take into consideration the impacts of colonialism and all of the atrocities that come from this in order to start to move forward. IH is committed to working with Aboriginal peoples to achieve success in the improvement of mental health and wellness. This Plan has outlined a case for change; five areas of focus; and a commitment to monitor progress that will assist in providing a framework on which to move forward.

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Glossary of Terms

Aboriginal

The descendants of the original inhabitants of North America. The Canadian *Constitution* recognizes three groups of Aboriginal people — Indians, Métis and Inuit. These are three separate peoples with unique heritages, languages, cultural practices and spiritual beliefs (Aboriginal Affairs and Northern Development Canada, 2012).

First Nations

A term that came into common usage in the 1970s to replace the word "Indian," which some people found offensive. Although the term First Nation is widely used, no legal definition of it exists. Among its uses, the term "First Nations peoples" refers to the Indian peoples in Canada, both Status and non-Status. Some Indian peoples have also adopted the term "First Nation" to replace the word "band" in the name of their community (Aboriginal Affairs and Northern Development Canada, 2012)

Métis

People of mixed First Nation and European ancestry who identify themselves as Métis, as distinct from First Nations people, Inuit or non-Aboriginal people. The Métis have a unique culture that draws on their diverse ancestral origins, such as Scottish, French, Ojibway and Cree (Aboriginal Affairs and Northern Development Canada, 2012)

Cultural Competency

An approach that focuses on practitioners' attaining skills, knowledge, and attitudes to work in more effective and respectful ways with Indigenous patients and people of different cultures (Ward, Branch & Fridkin, 2016).

Cultural Safety

An approach that considers how social and historical contexts, as well as structural and interpersonal power imbalances, shape health and health care experiences. Practitioners are self-reflective/self-aware with regards to their position of power and the impact of this role in relation to patients. "Safety" is defined by those who receive the service, not those who provide it (Ward, Branch & Fridkin, 2016).

Trauma-Informed

Trauma-informed practice means integrating an understanding of trauma into all levels of care and avoiding re-traumatization or minimizing the individual's experiences of trauma. Providing trauma-informed practice is an overall way of working, rather than a specific set of techniques or strategies; it recognizes that some people will need more support and different types of support than others (BC Provincial Mental Health and

Substance Use Planning Council, 2013).

Equity

'Equity' is distinct from 'equal' or 'same'. Equitably distributing services, providing equitable access, equitable resources etc., which means responding differently according to different needs in order to reduce or compensate for unequal barriers, risk, vulnerability, resources, etc. in order to support the attainment of equal outcomes among different population groups. Treating the population as if everyone could equally benefit from a service, program, policy change, or information etc., has created health and social disparities that could have been avoided by treating group equitably (taking differences into account) (Health Equity Council, 2011).

Aboriginal Worldviews

A worldview is a set of beliefs and values that are honoured and withheld by a number of people. A worldview includes how the person or group interacts with the world around them, including land, animals, and people. Every person and society has a worldview. Many societies pass on their worldview to their children to ensure worldview continuity.

Appendix A: FNHA, IH and MOH Policy Objective Principles and Values Considered For This Plan

Consideration was and continues to be taken of the following Planning principles from key stakeholders.

FNHA Planning Principles:

- FNHA uses their shared Vision, Values, and Principles, as well as their Seven Directives to help ground and design their Plans/Planning:
 - Persons supported in a manner that respects their customs, values, and beliefs
 - Follow the 7 Sacred Teachings – Truth, Love, Respect, Courage, Humility, Honesty, Wisdom
 - Directives – Community Driven and Nation Based; Increase First Nations Decision Making and Control; Improve Services; Foster Meaningful Collaboration and Partnership; Develop Human and Economic Capacity; Be without Prejudice to First Nations Interests; Function at a High Operational Standard

IH Planning Principles from Charting the Course¹¹:

- Quality, safe clinical care: **Quality, safe clinical care** will be delivered. Individuals will have a **positive experience** with how health services are delivered and provincial and national standards and guidelines will frame service delivery.
- Access to health services: Individuals will have **access** to health services in a manner that will facilitate **equitable outcomes**. Access might look different depending on the community. Innovative ways to support access through non-traditional service delivery models such as tele-health, outreach, or by using skilled practitioners in new roles will be pursued.
- Sustainable: Health services provided will be **sustainable**. Sustainability will be achieved by focusing on staying healthy and minimizing demand. Services will be affordable in terms of finances, achievable in terms of the availability of health human resources, and able to be maintained over time.
- Evidence informed and based on population need: Service delivery will be **evidence informed** and based on **population need**. Population health indicators will be used to identify disparities and identify populations with the greatest health needs. **Prioritization of needs will be based on defined criteria, and resources** will be placed where the gains in health improvement and disease management can be most effective.

¹¹ Charter the Course: Interior Health's Planning Principles and Consideration for Change. February 2012

- Interconnectedness and impact: Services and supports will not be viewed in isolation of each other or in isolation of the community or population they serve. Their **interconnectedness and impact to a community** will be considered.
- Staff will be supported: **Staff will be supported.** They will have safe and healthy working environments, be engaged, and work in a positive culture and climate.
- Engage stakeholders: We will endeavor to **engage stakeholders** in dialogue when significant changes in the Planning and delivery of services are being considered within their communities.
- Collaboration: **Collaboration** with other provincial system partners will occur. This includes other health authorities and provincially organized programs.
- Quality and operational efficiencies: **Service quality and operational efficiencies** will be pursued through **integration** and economy of effort or the consolidation of resources. Innovation will support these efforts.
- Accountability and communication: Clear lines of **accountability and communication** will exist.

Principles and Values Referenced from MOH policy objective papers¹²:

- | | |
|---------------------------|----------------------------------|
| - Patient Centered | - Coordinated |
| - Inter-professional | - Quality Improvement |
| - Integrated | - Information Technology-Enabled |
| - Comprehensive | - Cost Effectiveness |
| - Population Health Needs | - Flexibility and Innovation |
| - Shared Responsibility | - Team Based Approaches |
| | - Cultural Safety |

¹² Interior Health and MoH Principles and Values Cross Walk. Health System Planning, Interior Health. July 14, 2016.

Appendix B: Summary of Métis Nation BC & Urban Aboriginal Feedback from Reviewing the Plan

Most Responses Are Supportive of the Focus Areas and Actions

Examples of some responses:

- “I believe you have covered the most significant aspects” (Community Member)
- “I am glad to see culturally appropriate MH education/information and info collection be area of focus” (Community Member)
- “Nothing missed” (Community Member)
- “This is the perfect way to start making a difference. Thanks for sharing this!” (Leader)
- “Sounds awesome, people need this to happen. Keep pushing and working hard.” (Unknown)
- “Thank you for making changes needed to assist our too often traumatized Aboriginal people.” (Leader)
- “You are on the right track; yes I believe this will change things; seems comprehensive” (Leader)

Focus Area Specific Comments

Focus Area I –Develop and Enhance Family and Community Based Prevention, Awareness and Self-care Activities

- “Maybe it’s too clinical for people, leaving an uncomfortable gap making it un-approachable.” (Unknown)
- “Need to provide parents education and information to support children” (Leader)
- “Need to provide Aboriginal communities with more general information about mental health and substance use, there is still a lot of fear” (Frontline Staff)
- “Any materials developed need to reflect all three Peoples (First Nations, Métis and Inuit). All Indigenous People need to see themselves reflected in services and programs in order to know they can access them.”(Leader)
- “Yes. If patients had a better understanding of treatment pathways and referral process it would be easier to work as a team to complete the referral.” (Leader)

Focus Area 2 – Participate in Meaningful Engagement

- “Yes, continual opportunities for training builds capacity in the aboriginal community as we tend to share knowledge.” (Leader)
- “Give the opportunity for all the Aboriginal agencies to review your materials for feedback. Our organization is often overlooked and we don't hear of these things until they are published. Do the research and contact everyone in the community. Give that opportunity to all agencies and give them the choice to respond or not. Otherwise, if the opportunity is not given, it looks like another form of oppression and favoritism.” (Frontline Staff)
- “Thank you for the opportunity to participate and offer input. One challenge that I believe is likely shared among all Aboriginal service providers is the challenge of staff capacity to fully engage in planning. Many of our agencies are small, proposal driven and staff are generally providing more than one function so even delegating work is challenging. It is a complicated dilemma as it is important to have Aboriginal representation at the table to discuss, plan, review and implement improved culturally safe services for the Aboriginal population, however, our agencies are not adequately funded to support our meaningful involvement. If we are not at the table, it is not a reflection of non-interest but likely a lack of time and capacity. How do we play a meaningful role when our plates are so full?” (Leader)

Focus Area 3 – Build Culturally Safe, Trauma-Informed Mental Health and Substance Use Services

- “With these steps, we can begin creating a new generation of educated, respectful humans. Whether they identify as aboriginal or not.” (Leader)
- “It really starts with the health of IHA staff and how they conduct themselves around Aboriginal patients, families, communities, other IHA departments, colleagues, and service providers.” (Frontline staff)
- “The most effective way to serve Aboriginal People is to deliver services from a culturally safe space where Aboriginal People: (a) feel they belong, (b) can see themselves reflected, (c) can access services by practitioners that are well educated on historical factors, inter-generational trauma and the recommendations of the Truth and Reconciliation Commission, and (d) that incorporate traditional teachings and practices in services.” (Leader)
- “What is cultural competency? You need some kind of community feel. Aboriginal peoples gather for song, dance, culture, bonding. Just because you paint the walls and hang a picture doesn't mean it's more cultural. Provide the actual culture by teachings, maybe even mentors to bring in the community.”(Unknown)
- “Understand the community you are serving before creating a culturally appropriate format. This cannot be a Pan Indian creation. I

remember being in a rural Ktunaxa community and being offered workshop materials that were heavily West Coast in context. These materials spoke loudly to the incompetence of the developers and to great misunderstanding of the community I was in. It is critical to develop materials that reflect the community you are serving. In the case of Urban Aboriginal communities, be inclusive of many Nations and pay tribute and respect to the Nation of the Traditional Territory you are in, even if the MH services are separate for services offered on reserve.” (Frontline Staff)

- “People coming in for help upon hearing language/s spoken and seeing elders makes them feel at ease. They are more open to learning.” (Frontline Staff)
- “Include in these brochures and direct services help for intergenerational trauma and residential school survivors. Train IHA MH staff to do this type of work.” (Frontline Staff)
- “Access to health care is only one part. I would like access to culturally relevant and safe health care from practitioners who understand the depth of the aboriginal cultures locally.” (Community Member)
- “I think that it would also be helpful to have elders on staff who can talk to people who are in need of services, this could complement the social worker service that is available for mental health concerns (and substance use).” (Community Member)

Focus Area 4 – Increase Equitable Access, Improve Transitions, and Reduce Barriers

- “I really hope so because education is truly the first step to making a lasting difference. People need to know what aboriginal mental health and substance use services there are.” (Leader)
- “You’re going to need to have safe places to meet where they feel safe.” (Unknown)
- “Many people don't have a family doctor and use the walk-in clinics. This is a poor option, especially for aboriginal people. Services should have an outreach component.” (Leader)
- “Equitable cannot always be percentage per population when it comes to number of beds and counselors and such. Smaller communities need to have a higher percentage of services in order to avoid removing people from their families and/or having families become financially vulnerable in order to stay close to their ill family member. “(Leader)
- “There is still the issue of what is provided for ON reserve members, and what is offered for OFF reserve members... would be good to close this gap.” (Frontline Staff)
- “Coming from a rural area, it is hard to get to urban centres for services. Some of the counselling sessions could possibly be done on a

conference or webinar.” (Frontline Staff)

- “Need to focus on GP’s not just NP’s; they need information on MHSU to better support patients.” (Leader)
- “Assist physicians related to medications.” (Leader)
- “If IHA is planning to do outreach/in-reach services, provide professional training to the staff of these organizations as well, so they understand the role of IHA in their organization and so they can speak to it/promote it.” (Frontline Staff)
- “In rural communities, ensuring privacy is paramount, especially in more "fish bowl" communities. Having options for patients to access the MH clinician, for example in-office visits or by phone. Also, have a mix of first-come-first-serve and appointments. Many patients don't go see the clinician due to craphshoot wait times and/or all appointments taken early in the day.” (Frontline Staff)
- “Transportation is also an issue. Many aboriginal people live on reserves and in rural areas where transportation to and from appointments may be hard to access.”

Focus Area 5 – Apply a Continuous Quality Improvement Lens

- “I like that this is titled with a Continuous Quality Improvement.”
- “This sounds positive. Please note that it is extremely important that the Aboriginal Community be involved in the development of any tool to gather information that is relevant.”

Additional Comments

- “You have hit on many of the concerns with FN community members in our area; another issue is when they have tried to access IHA services with a mental health rep they get put on a "wait list" to be seen/assessed. Nine times out of ten people are in crisis when they come in to see someone and need to see someone asap - being told you have to wait to see whomever puts a huge damper on them returning for assistance. ... How they are treated when they 1st come through an organizations doors will set the tone for how they feel about walking through that door again.” (Frontline Staff)
- “Front desk staff at clinics can make it difficult for those who need to see their regular practitioners who struggle with mental illness on a same day basis in order to avoid emergency room visits or relapse/escalation of symptoms, despite a doctor requesting such... For the sake of safety, the following needs to be avoided... youth who are taken out of their community due to mental illness cannot just be released into the community of the acute care facility. This has been known to happen and these youth are now more vulnerable because they are in a large foreign city without family/school etc. I understand confidentiality, but from age 16 and with a mental illness

this can be very unsafe.” (Leader)

- “Provide more than a voicemail option at IHA MH; have a person answer the phone and if a person leaves a voicemail, call back. For example, I recently had an aboriginal patient who needed and contacted adult MH services in Kamloops. He called IHA 4 months ago and hasn't had a return phone call. The patient should NOT have to be continuously calling IHA for services.” (Frontline Staff)

Appendix C: Draft Evaluation Framework Summary

EVALUATION PURPOSE

What are the main reasons for the Evaluation?

- Accountability: Monitor the implementation and impacts of the Aboriginal Mental Wellness Plan (Plan)
- Determine if the Plan's goals were met (are services more culturally safe/trauma-informed, more accessible etc.) through evaluation of the patient/family experience
- Determine what is working well? Have there been any positive experiences to learn from? Where can we improve?

FOCUS OF THE EVALUATION

What will we evaluate (which project/program or aspect/domain of a project/program)?

- To what extent was the Plan implemented as intended; were there any barriers to implementation? What were the successes?
- To what extent has the data quality/stewardship improved since the Plan was implemented
- Provider experience: cultural competency and safety- has a shift started to occur resulting in decreasing racism; is care more client and family focused?
- Patient/Family (patient centered) experience –have the changes in services moved clients forward in their healing journeys?

EVALUATION QUESTIONS

What do you specifically want to know that you don't know now?

- Continuous Quality Improvement-Data/Performance Monitoring (one year post implementation)
 - To what extent has the data for this population improved (see rubric) since the implementation of the Plan:
 - Is more data available one year after the Plan was implemented (at time of evaluation)
 - Is Aboriginal data more visible to the organization (i.e. dashboards)?
- Primary Health Care Support (1+ years post implementation)
 - To what extent do primary health care providers feel supported to provide safe environments and culturally appropriate treatments etc.?
 - To what extent do care providers/clinicians feel their patients are supported by the system?
 - Has this changed since the implementation of the plan?
 - What barriers remain, that might prevent patients from accessing services and following through with treatment?
- Client/Family (client centred) Experience (two year post implementation)
 - To what extent do individuals/families feel safer in receiving IH MHSU services?
 - To what extent have promotion activities increased awareness of IH MHSU services/programs (and supporting programs) for patients and families?
 - To what extent do patients and families feel like they can access/or have accessed IH MHSU services
 - Are Aboriginal individuals more willing to access IH MHSU services?
 - To what extent were Aboriginal patients and families involved in IH MHSU program development and planning over the last two years?