
Clearing the Path for Community Health Empowerment:

Integrating Health Care Services at an Aboriginal Health Access Centre in Rural North Central Ontario

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Abstract

The article provides a critical examination of the rewards and challenges faced by community-based Aboriginal health organizations to integrate the rapidly evolving provincially- and federally-funded Aboriginal health program streams within an existing mainstream rural and federal First Nations health care system in Ontario. The shift to self-governance in health care means Aboriginal health organizations are dealing with rapid organizational changes. In addition, community health program planners at the First Nations level are faced with the challenge of developing local Aboriginal models of care and integrating these within the often-conflicting backdrop of the existing mainstream model of community health. While political leadership and health organization typically both have mandates to work towards the health and well-being in their communities, the two sectors may not always have the same expectations on how to realize these goals. While autonomy in the development of services is essential to self-determination in health, there is also a need for Aboriginal health agencies to collaborate regionally in order to improve health at the community level in the most effective and timeliest manner. Using the example of the mental health and traditional Aboriginal health services, this article provides an analysis of the role of an Aboriginal health access centre in regional community health empowerment.

Key Words

Aboriginal health care services, community based health care, health empowerment, integrated health services, Aboriginal health, Aboriginal healing and wellness strategy, self-governance, health transfer, mental health, traditional Aboriginal medicine

INTRODUCTION

The comparatively high rates of health and mental health problems experienced by Aboriginal communities in Canada have been documented extensively in the health literature.¹ Although the health profile of Aboriginal communities changed rapidly during the later half of the 20th century and infectious diseases declined dramatically, they were by no means eradicated. The diseases of westernization such as diabetes, obesity and heart disease, and health conditions related to the consequences of colonization – particularly family violence, addictions and trauma related to accidents and violence – emerged as important com-

munity health and mental health concerns. The health problems commonly found in Aboriginal communities in Canada are similar to those experienced by other Indigenous Peoples worldwide, particularly those who share a history of colonization and encroachment of industrial forces on traditional lifestyles. Yet, in contrast to many other countries, where health services are inadequately funded in rural areas, primary health care in Canada is relatively advanced in terms of services and resources, despite the inherent difficulty in providing health services to remote northern Aboriginal communities.

Over the past decades, it has become evident that increasing the access to mainstream Canadian primary

health care services without addressing the broader political, cultural and environmental determinants of Aboriginal health will not have a significant impact on improving Aboriginal health and mental health status. For example, Young noted that although the Canadian model of health care delivery to remote communities is more comprehensive than those of the advanced economies of other circumpolar countries, “there are other aspects of primary health care, namely, community participation, self-reliance, and self-determination, that have not received much attention until recently.”² The impact of cultural relevance, community control and self-determination on the effectiveness of primary health care did not receive much attention with health policy makers until the late 1980s when the broader socio-political aspects of Aboriginal self-determination and self-government surfaced to the Canadian public consciousness.

It could be argued that the federal government began to respond to the pressures of Aboriginal groups for self-determination with the release of the *Indian Health Policy* in 1979.³ However, the document failed to propose a mechanism to realize its goals of community development and intersectoral collaboration in Aboriginal health care. In 1986, the Department of Health and Welfare advanced the release of the *Indian Health Transfer Policy* as an option to begin serious negotiations concerning the transfer of Aboriginal control over health care to the local level.⁴ The long term goal of the health transfer policy is to improve health at the community level by supporting the development of community-based and culturally-appropriate health programs, while maintaining federal guidelines on mandatory programs for areas such as communicable disease, environmental health, registration of health professionals, and emergency response planning. Without a doubt, the health transfer policy does provide greater community involvement in health care. However Aboriginal groups have time and again asserted that they seek control over, not involvement in, health care.⁵

During the past decade, Ontario has taken an innovative and unique approach to the governance and provision of health care services for Aboriginal People. It has the potential to serve as a model for other provinces and territories. In 1993, Ontario began to reshape the province’s approach to Aboriginal health care services by adopting an Aboriginal health policy developed after extensive community consultation.⁶ A year later, the Aboriginal Healing and Wellness Strategy (AHWS) was created based on this policy and a provincial Aboriginal family violence prevention

strategy. The unique intersectoral governance of AHWS employs a consensus model for decision-making, involving 10 ministries and eight Aboriginal organizations representing all Aboriginal People, including non-status Indians, Inuit and Métis.⁷ The AHWS funds and supports the development of community-based health and mental health care services designed to improve Aboriginal health status and reduce family violence in Aboriginal communities within an Aboriginal model of care. AHWS programs emphasize community-driven, culturally-appropriate services; accessibility to primary care and a continuum of services; and general improvements to access to western and traditional Aboriginal medicines. As such, the province has made great strides in sharing control over health services with Aboriginal stakeholder organizations and is becoming a leader in this aspect, not only in Canada, but also in the world.

To accomplish its goals, AHWS funds various types of Aboriginal community-based health initiatives in Ontario, including 10 Aboriginal health access centres (AHAC). While these community health centres offer programs that are as diverse as the Aboriginal communities they serve, their primary focus is to improve access to culturally-based primary health care services while responding to gaps in services at the community level. This article discusses the rewards and challenges of working towards the integration of Aboriginal health access centre programs within existing rural health care services and the evolving federal First Nations health care system at one AHAC in North Central Ontario. This analysis is based on the author’s experience as a research and evaluation co-ordinator working in a supportive role to facilitate the development of integrated Aboriginal health services at the Noojmowin Teg Health Centre on Manitoulin Island, a provincially-funded AHAC.

INTEGRATED HEALTH SERVICES AT NOOJMOWIN TEG HEALTH CENTRE:

Rewards and Challenges

Manitoulin is the world’s largest freshwater island. It is located within Lake Huron and Georgian Bay in North Central Ontario. A bridge on the north-eastern tip connects the island to the mainland. The closest urban centre, Sudbury, is about 160 km away. The Manitoulin District is home to about 11,000 residents. The population is made up of about 4,500 Aboriginal People and 5,500 non-Aboriginal people. Figure 1 shows the location and population size of the seven local

First Nations communities. The largest, Wikwemikong Unceded Indian Reserve, has an on-reserve population of about 2,600 while the smallest community, Zhiibaahaasing First Nation, has an on-reserve population of less than 50 people.

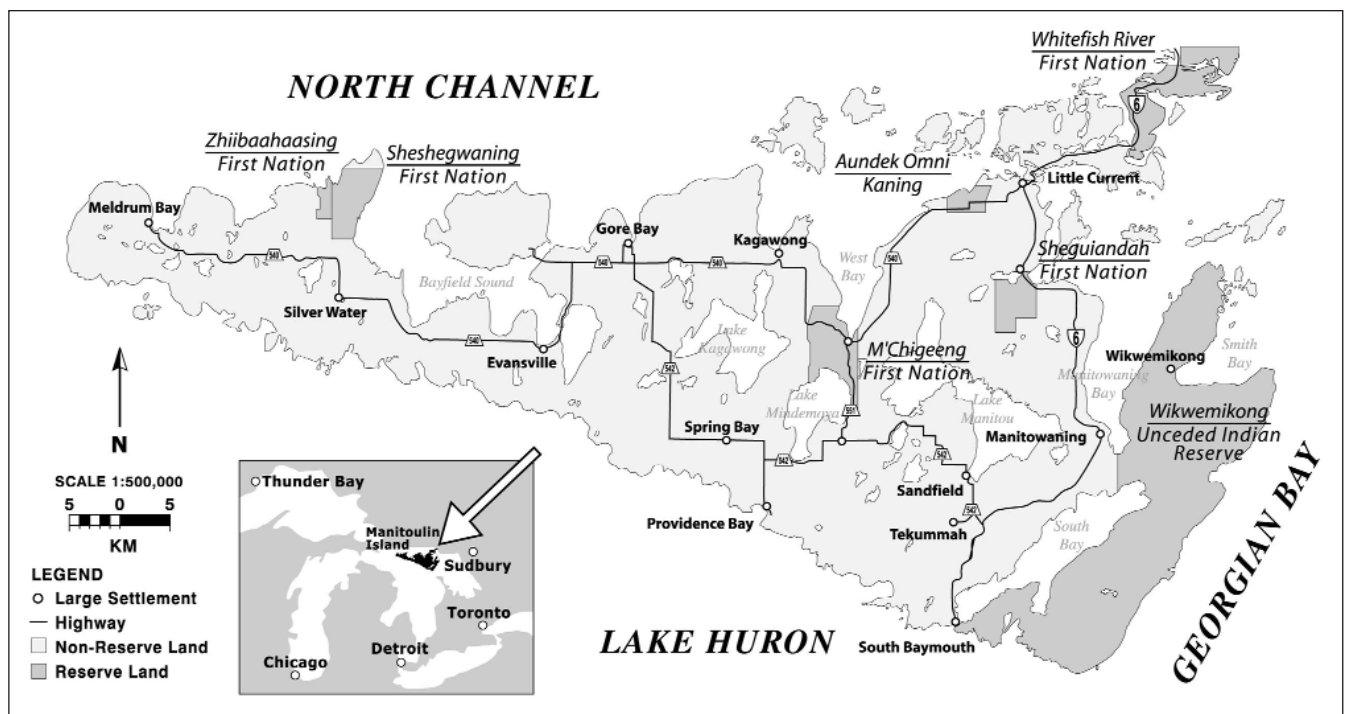
Pre-Existing Health Services

Complex and at times disjointed layers of Aboriginal health services already existed in the Manitoulin District when the Noojmowin Teg Health Centre began operation in 1997. Three years earlier the seven First Nation communities in the Manitoulin District transferred the delivery of community health services under the federal health transfer initiative under three separate agreements. It was not only feasible, but also financially advantageous for the two larger communities to transfer individually. The five smaller communities transferred under one agreement, resulting in the creation of three local health authorities. This arrangement enabled the smaller First Nations to share human resources such as community health nurses, a case manager, a mental health worker, and administrative staff under one tribal health organization. Other staff could be employed at the community

level, such as community health representatives (CHRs), National Native Alcohol and Drug Abuse Program (NNADAP) workers, and clerical support staff, while ensuring health programs were delivered within the guidelines of the mandatory health programs of the First Nations and Inuit Health Branch (formerly known as Medical Services Branch). In 1996, the three transferred health authorities jointly developed a proposal for a provincially funded AHAC to provide specialised health services on a regional basis. Figure 2 provides a diagram of the health care partnerships and service provision model of the federally-funded community health services and the provincially-funded regional AHAC services.

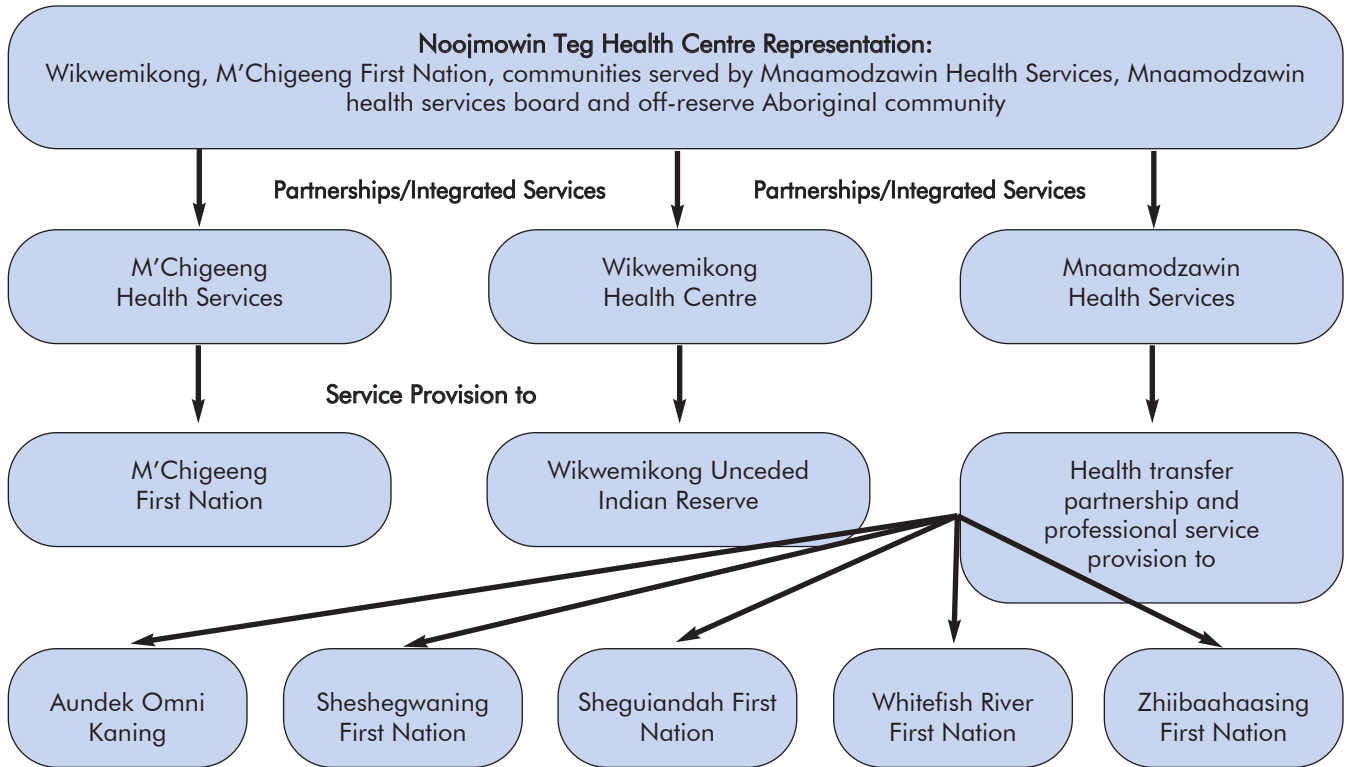
The program priorities for this AHAC were largely based on community consultations undertaken during the pre-health transfer needs assessment. Today, the Noojmowin Teg Health Centre provides specialized, community-based services in extended-practice nursing, psychology, nutrition, traditional Aboriginal medicine, physical activity promotion, heart health, health research, and program evaluation to seven First Nations communities in the Manitoulin district. Programs are designed to bridge community-identified

Figure 1: Map of Manitoulin Island with Location of First Nations Communities



First Nations in the Manitoulin District with estimated Aboriginal on-reserve population size as of 1998 in parentheses: Aundeck Omni Kaning (320), M'Chigeeng First Nation (800), Sheguiandah First Nation (120), Sheshegwaning First Nation (100), Wikwemikong Unceded Indian Reserve (2,600), Whitefish River First Nation (340), Zhiibaahaasing First Nation (35)

Figure 2: Diagram of Manitoulin Area Health Care Partnership and Service Provision Model



gaps in services. These are in turn provided through partnerships with eight community-based First Nations health agencies including community clinics, health authorities, and a semi-regional tribal health organization. The centre emphasizes a holistic Aboriginal approach to health, which acknowledges and promotes physical, mental, emotional, and spiritual health and well-being. In addition, the programs are developing innovative approaches to community health, specifically addressing the health and mental health consequences of multigenerational traumas such as residential schools; loss of language and cultural identity; and erosion of traditional lifestyles. In short, over the past five years, the Noojmowin Teg Health Centre has provided services through an integrated culturally-based model of service provision in collaboration with the existing First Nations health services and networking with mainstream health services agencies.

One of the primary goals during the first years of operation was to work towards the integration of Noojmowin Teg health services within the complex organizational structure of the existing federally-funded First Nations health services. The Noojmowin Teg health board intended to achieve meaningful collaboration between all local Aboriginal health services providers and put a strong emphasis on partnership

development. In order to establish program objectives and activities, the organization developed mechanisms for extensive collaboration among the four regional Aboriginal health boards, health directors, and community health workers in the seven First Nations. Making integrated services feasible took initiative, dedication, desire, and a commitment on the part of boards, staff and partner agencies to collaborate through a process of consensus to make things work for everyone involved.

For program planning purposes, consensus among the AHAC, individual First Nations health care agencies, tribal health care agencies, and the political leadership in First Nation communities needed to be reached on an ongoing basis. This is still true today, after maintaining a successful partnership for five years. Noojmowin Teg staff still participate in Noojmowin Teg planning activities as well as planning activities sponsored by partner agencies. Accountability issues are carefully negotiated on an ongoing basis to ensure equitable service provision to all First Nations. This is a difficult task due to the differences in size and location of communities. During the start-up phase of the AHAC, several days per month were taken up by collaborative planning activities. This regional approach to planning was time consuming and taxing for many frontline work-

ers who felt their time could be more effectively spent on client contact. However, the process provided the basis for the beginning of integrated health care services. It allowed health professionals and paraprofessionals to learn about their co-workers' scope of practice within the developing multidisciplinary team. This was particularly important since all staff were new to the experience of working on a team with the diverse skills sets and work experiences held by First Nations community program staff and the specialized health services staff. All staff had to adapt to deliver services based on an evolving model of care, in collaboration with a new multi-disciplinary and multi-cultural team. While the vast majority of the community program staff were members of the local Aboriginal community, only half of the 10 original staff members at the AHAC were Aboriginal and only two health care providers had local community ties. The non-Aboriginal staff members ranged in their background in working with Aboriginal communities. While some had extensive experience working in Aboriginal communities, others were completely new to it. Participation in planning activities provided an informal opportunity for the AHAC staff to learn more about the specific health priorities, organizational culture, and program expectations of each First Nations community. While this was a valuable exercise in the early phases of the AHAC program development, more efficient ways of identifying gaps in services and maintaining co-ordination of care will have to be developed in the future.

CONSTANT FLUX:

The Rapid Evolution of the Aboriginal Health Care System

Many First Nations in Canada are actively taking control over health services through transfer agreements with Health Canada. Communities are designing and implementing community-based, culturally-appropriate services. In the Manitoulin District, the diversity of available programs and the administration of these services have changed rapidly over the past 10 years as local First Nations have engaged in the health transfer process. In addition to the services originally provided under the federal health transfer initiative, the management of other services such as the Canadian Prenatal Nutrition Program,⁸ the Aboriginal Head Start Program On-Reserve,⁹ and the First Nations and Inuit Home and Community Care Pro-

gram¹⁰ have also transferred to the First Nations or tribal council level during the past decade.

While these health programs are urgently needed within Aboriginal communities, the transfer of health programs, coupled with the rapid growth in other community-oriented programs causes health services to be in a constant state of flux. This provides special management challenges. A positive aspect of this situation is that First Nations are able to approach service development creatively and experiment with different community-based and culturally-appropriate solutions to local health priorities.¹¹ More negatively, communities are expected to design and deliver programs that operate within the often rigid parameters of governmental funding agencies. Funding agencies' working definition of culturally-appropriate services often does not match First Nations' vision for the delivery of health care in their communities.

Funders' expectations can be rigid in their reporting requirements or desired program outcomes. They can vary tremendously between funding streams and may even change mid-stream. The pressure on different programs to generate a variety of predetermined health outcomes provides a particular challenge to the provision of integrated services. Often, there is an expectation to connect specific health outcomes to a particular funding stream without taking into account the bigger picture such as the existence or absence of complementary programs and support systems at the community level. In addition, a funding stream may target improvements in health for a particular age group. At the community level however, it does not make sense to restrict clients from a program based on age. In particular, families affected with multigenerational issues require a continuum of care with services geared to all members of the family in order to be effective. In order to prevent overlap in services, service provision must be constantly negotiated with all Aboriginal health agencies as programs started under short-term funding are discontinued or new program streams become available. As a result, program priorities are frequently adjusted and staff and partner agency roles renegotiated.

Continuous changes in health systems do not allow for an adequate maturation and evaluation phase for newly developed community-based health services. This circumstance poses further challenges to the development of integrated health services. Short-term funding for community programs is problematic since programs can run out of funding just as momentum and community trust is created. This leaves clients discouraged and the impact of the program undeter-

mined. As communities are developing innovative approaches to health care, time and resources to conduct evaluation research is critically important for community health empowerment. Agencies require the ability to identify effective and ineffective aspects of their programs.

Community health empowerment is also compromised by other factors. It is difficult to develop a self-sufficient, needs-driven, and evidence-based approach to health programs in First Nations communities because there is a general lack of appropriate culture-based health indicators to measure the impact of new programs. In general, the development of health indicators has not been a priority in the Canadian health care system until recently. The lack of valid and reliable health indicators is making it difficult to track changes in health across the country. Recognizing this problem, Health Canada has sponsored research to develop nationally comparable indicators.¹² How useful these indicators will be in tracking Aboriginal health and mental health status requires further investigation. The difficulty of developing indicators that reliably track conditions such as reduction in family violence and improvements in community healing or Aboriginal health status are enormous.¹³ This is largely due to two main reasons. Firstly, the complexity of the impact of colonial forces that have led to ill health in Aboriginal communities are poorly understood from a biomedical and social science perspective. Secondly, the development of indicators and benchmarks for Aboriginal health must be based on an Aboriginal framework for health and will likely show regional variation. For example, many Aboriginal Elders and healers are able to explain the effect residential schools had on the health and well-being of their community using a traditional Aboriginal perspective or framework. While the notion that stress contributes to chronic illnesses has become accepted from a biomedical perspective, there is no scientific framework to deal with the health effects of complex stressors affecting Aboriginal communities, such as multi-generational trauma or loss of language and cultural identity.

Ongoing program and organizational adjustments also take a toll on human resources. The roles of health care workers are frequently changing. This adds to the stress of an already demanding job and contributes to a high staff turnover rate. The experience at the Noojmowin Teg Health Centre clearly shows staff retention is not merely a question of staff possessing or lacking community ties. The staffing complement at this centre has ranged from 10 to 15

employees. Only four staff members have held their positions continuously over the five years the centre has been operating. Some positions, including dietitians, nurse practitioners, and administrators have turned over three or four times during this five-year period. The positions with both high and low turnover rates were held by both Aboriginal and non-Aboriginal staff members. Some had family ties in the Manitoulin District. Some did not.

This does not take away from the fact that more Aboriginal health professionals are urgently needed. As new community-based health care positions are created, the need for Aboriginal health care professionals such as physicians, psychologists, dietitians, therapists, nurses, and administrators increases dramatically. Male Aboriginal health care providers are particularly scarce. They are especially needed to improve the generally low use of health care services by men in the community. At Noojmowin Teg, male service providers have consisted exclusively of traditional healers. This may be a factor in explaining the effectiveness of the traditional health services program in reaching male clients. Today, there are many experienced Aboriginal health professionals working at the community level. However, the demand for their services still heavily outweighs their availability. For example, dietitians are urgently needed in community nutrition programs to address the high rates of chronic illnesses, particularly the clinical management and prevention of obesity, diabetes, and heart disease. Yet, according to statistics from the Aboriginal Nutrition Network of Canada, there are currently only 12 Aboriginal dietitians in Canada. Only eight of these professionals are actually working in the field of nutrition. While the number of Aboriginal dietitians is expected to double over the next several years, the high levels of chronic illnesses in Aboriginal communities point to the fact that many more are needed to provide culturally-based services.¹⁴

Due to the relative scarcity of Aboriginal health professionals, many Aboriginal health organizations are faced with difficult hiring choices. Should the health centre make it a priority to hire staff who have the necessary knowledge of Aboriginal communities and culture even if it means some staff are less experienced on a professional level? Should they hire staff who lack some of the expertise and will require on-the-job training? Appropriate training may require university-based education. This is costly, time-consuming, and often unavailable in northern areas.

Unemployment rates are high in most Aboriginal communities. According to government statistics, the

1996 unemployment rate among First Nations People living on-reserve was 29 per cent.¹⁵ However, actual rates, particularly in northern communities, are often much higher. From a community governance perspective, it is empowering that community statistics indicate an improvement in employment rates and that community agencies employ a high percentage of Aboriginal workers.

In addition, this hiring approach can assure an agency that its new co-worker will not struggle with cross-cultural service provision. However, it can also lead to tremendous pressure and job burnout for Aboriginal health care workers. For example, recent graduates generally benefit from the mentoring and clinical supervision by experienced professionals in their discipline. However, Aboriginal staff members may be expected to perform their job in a leadership position right from the start. Similarly, workers who require a lot of on-the-job training may be left feeling frustrated and overwhelmed by the responsibility associated with providing care to many high needs clients.

In order to provide an empowering work environment for staff, it is important to have a clear understanding of the workers' skill level and educational background and to match this to their position. Otherwise, Aboriginal staff may be subjected to unrealistically high community expectations.

A formal approach to capacity building is therefore of key importance to community health empowerment. Staff need to be able to identify areas of necessary skill development candidly and keep track of and assess their progress. For example, capacity building support for mental health staff may consist of counselling skill development, clinical supervision, and mentoring by experienced health professionals, as well as individuals with traditional knowledge.

An alternative is to hire a proportion of non-Aboriginal staff, with the awareness that some may work very well in Aboriginal communities while others may lack knowledge or appreciation of Aboriginal culture and communities or have a low aptitude for cross-cultural patient encounters. Both situations contribute considerable stress to the health care delivery system. Frequently, non-Aboriginal professionals are hired as an interim measure to fill vacant specialized positions. Sometimes there are even advantages to services provision in small communities. Since non-Aboriginal providers are typically much less entrenched in the community they work in, some clients perceive them as providing more confidential services. However, cross-cultural service provision is at

times seen as a challenge from the point of view of non-Aboriginal providers and Aboriginal clients. This is especially true when providing services to Elders and clients who speak English as a second language. It is important to understand that the comfort level with the provision of community health services by non-Aboriginal providers varies considerably with each provider and each client. The key is to provide ongoing cultural sensitivity training to all staff who are not from the local community.

DEVELOPMENT OF TRADITIONAL ABORIGINAL HEALTH SERVICES

Contrary to many countries in Europe, Africa and Asia, medical pluralism has not been part of the development of Canada's health services. Therefore, alternative and traditional Indigenous healing systems have not been government supported in the past.¹⁶ Over the past decade, however, governmental funding sources are increasingly acknowledging the importance of culturally-appropriate services in contributing to improvements in community health and the right of Aboriginal People to access traditional Aboriginal health services. One of the goals of the traditional health services program at the Noojmowin Teg Health Centre is to provide clients with culturally-appropriate care and to integrate traditional Aboriginal medicine within the health centre setting. While this sounds simple, providing traditional healing services in the new cultural setting of a health centre requires much groundwork, because traditional healing practices have evolved based on Aboriginal cultural frameworks, not western primary care models.

Traditional Aboriginal healing has always been a vibrant and complex health care system. Practiced in all Aboriginal communities in the past, this knowledge has been eroded in many communities due to the consequences of colonization. Most Aboriginal communities are currently experiencing a resurgence of traditional Aboriginal knowledge and beliefs. As Aboriginal health centres plan to incorporate traditional Aboriginal medicine services in their program, it is important to understand that each community and each individual is unique with respect to their expectations, familiarity and level of comfort with traditional Aboriginal medicine.

Providing Aboriginal healing services in a clinical setting provides a unique challenge for health centres. For example, mainstream health professionals are regulated by various agencies. Adherence to their policies ensures that professional standards are main-

tained and protects the rights of clients and providers. However, determining the expertise of traditional healers is less clear-cut from an agency perspective. The Canadian government has acknowledged that the determination of qualifications of traditional healers or medicine people and self-regulation will have to be addressed by Aboriginal Elders and the larger Aboriginal community.¹⁷ It is a sentiment that is clearly shared by the Aboriginal community. In the past, when virtually all community members had some first-hand knowledge of traditional medicine, the legitimacy of medicine people was determined at the community level. The regulation of medicine people was informal and based on the different oral traditions of each community. Therefore, it is expected that there will not be just one way to determine the legitimacy and the qualifications of traditional healers. The identification of legitimate healers may be based on local Indigenous knowledge and include processes not readily understood by people who are not immersed in an Indigenous worldview. Discussions around policy development for traditional healing practices in a health centre setting will need to take place at the community level. Sufficient time and resources are required to address community concerns about the protection of Aboriginal medicine, as well as the rights of healers, clients and health organizations. In the interim, as legal responsibilities of health centres and traditional healing for clients are yet to be determined on a national level, it leaves uncertainties in risk management for health centres and traditional health service providers alike.

While traditional Aboriginal healing has been practiced for thousands of years in Aboriginal communities, the integrating of traditional Aboriginal health services with western clinical health services is groundbreaking. Professionals responsible for developing these new forms of services have the task of identifying areas where Aboriginal and western health systems can interface and provide an opportunity for collaboration between practitioners. Program co-ordinators work on overcoming many barriers to integrate traditional Aboriginal medicine. Health care practitioners trained in western approaches are typically in need of extensive cultural sensitivity training in order to appreciate the benefits of Aboriginal medicine. Clear guidelines are still needed from professional licensing bodies to assure mainstream health professionals that collaborating with traditional Aboriginal health care providers will not put their license at risk.

At the community level, there are complex and at times conflicting expectations for traditional healing

services. At the Noojmowin Teg Health Centre, many demands are placed on the Traditional Healing Services Co-ordinator who manages the traditional healing services. Traditional co-ordinators carry a large proportion of the responsibility of developing health centre protocols or guidelines for providing traditional Aboriginal medicine in a health centre setting. The protocols must ensure protection for traditional healers, clients and the health care organization while protecting the integrity of Aboriginal healing methods. The development of such guidelines must be based on local Aboriginal beliefs and customs, negotiated and agreed upon by the appropriate community stakeholders, reviewed by legal counsel, and endorsed by the appropriate health boards. Similar to all writings based on Aboriginal traditions and knowledge, it is important to recognize that the information is owned locally. Transplanting locally developed guidelines to other regions or unrestricted sharing of the details of the guidelines may not be respectful of local customs and should only occur with the expressed agreement of the people who developed them. Communities interested in developing guidelines may find it easier to seek out a community or agency willing to share their experience, such as the community processes necessary to develop such guidelines. At the Noojmowin Teg Health Centre, a community-based research process was used to provide the basis for traditional healing services protocols. It includes consultations with community Elders and individuals with traditional knowledge and historic research. Agencies that decide to engage in the process of developing guidelines need sufficient time and adequate support, including human and financial resources, to succeed. At this point, the traditional healing services at Noojmowin Teg and the western health care providers usually work in a co-operative, multidisciplinary fashion, mainly interacting through referrals back and forth. A full interdisciplinary integration model for traditional and western healing services, with ongoing case-by-case collaboration between practitioners, blending both healing systems has not been implemented at this point.

INTEGRATED MENTAL HEALTH SERVICES

The First Nations clinics on Manitoulin Island employ community-based mental health workers who are funded under diverse funding streams including federal programs such as the National Native Alcohol and Drug Abuse Program, the Building Healthy Communities Program, the First Nations and Inuit Home and Community Care Program, and the provincial Aboriginal Healing and Wellness Strategy. Most of

these funding sources have not been specifically designated for community mental health. However, these funding streams are flexible enough to allow communities to address mental health, which is generally under funded. As a result, the community mental health workers' roles vary tremendously within communities. Depending on their expertise, they provide direct client services such as mental health intake and assessment, short-term and crisis support, mental health and additions counselling, and referrals to specialist services. Some community mental health workers are not responsible for direct client contact, but rather for designing and implementing community mental health promotion programs.

Recently, several new mental health-oriented programs have been added to the existing services in many Aboriginal communities based on short-term funding from the Aboriginal Healing Foundation (AHF). The AHF was established to disburse a \$350-million Healing Fund set up by the Government of Canada over a five-year period (1998 to 2003). The fund is intended to address the multigenerational impact of the residential schools system on Aboriginal Peoples including the legacy of physical and sexual abuse. The AHF has focused on funding community-based healing initiatives. Projects are normally funded for a period of one year. Some multi-year projects with proven track records have been renewed under this initiative for several years. However, there are no provisions for an extension of this healing initiative beyond the five-year time frame.¹⁸ AHF programs are administrated by various organizations including health, social services, and cultural agencies. While agencies are aware of the time-limited nature of AHF projects, it is difficult to find alternative funding sources for initiatives such as programs for youth at risk or the development of services to deal with sexual abuse at the community level. This leaves agencies with the difficult choice of either not addressing many aspects of the residential school legacy or running the risk of being forced to shut down a successful program one or two years after initiating it. This leaves clients unsupported and vulnerable. The reality is that many agencies will develop proposals based on short-term funding streams hoping that more stable funding may be available in the future, particularly for programs that can demonstrate success.

In the area of mental health in the Manitoulin District, clinical counselling is provided at the community level by several layers of services. As a semi-regional health services provider, Mnaamodzawin Health Ser-

vices provides the services of a mental health case manager on an outreach basis in five small communities under the health transfer budget. Similar to the community mental health services, the resources for this semi-regional mental health program are not designated for mental health services by the First Nations and Inuit Health Branch. The two larger First Nations communities on Manitoulin Island provide clinical counselling at the community level. The Noojmowin Teg Health Centre provides psychology services on an outreach basis at health centres in all local First Nation communities and to Aboriginal People living off-reserve. In the outreach model, mental health team members travel to local First Nations to offer services to clients either at their local health clinic or at the client's home. This model varies substantially from the mainstream model where clients are required to travel outside of their First Nations community to meet the counsellor in a mental health office. In the Manitoulin area, professional services such as psychology were not readily accessible before the development of the Noojmowin Teg health services. However, it has become clear that there is a high demand for these services at the community level. Due to high rates of usage and the resulting waiting periods, Noojmowin Teg has expanded services from a single psychologist position to 1.5 positions with additional contract services whenever funds permit. The contract services are mainly used to support traditional healing services for clients affected by residential school experiences and multigenerational violence.

The North Eastern Mental Health Corporation (NEMHC) provides another layer of mental health services. NEMHC provides psychiatric services and a consulting therapist on a limited contract basis, normally a few days per month. NEMHC is a provincially-funded organization providing services for seriously mental ill clients for much of Northern Ontario. In First Nations health clinics, the community mental health clinic is managed locally. However, workers normally operate within NEMHC policies and procedures. Although a Native advisory committee has a representative voice on the board of directors of NEMHC, there is no formal mechanism to represent a First Nations community perspective in the planning or provision of these services.

With mental health workers who are socially entrenched in the community they serve, clients of the mental health program often perceive confidentiality as an issue. In First Nations communities, family relationships are an important aspect of community life. Most individuals have well-established relationships

in their community, which are shaped by complex extended family networks. Clients and community health care workers often share one another's history. For some people, this can lead to a particularly therapeutic environment. However, for others, these close community and kinship ties become a barrier to accessing services, particularly mental health services. As a result, a significant number of clients in the Manitoulin area welcome referrals to the integrated regional services providers of Mnaamodzawin Health and Noojmowin Teg. Clients are given the additional choice of meeting professionals in their home community clinic, the client's home, or another health centre. This significantly improves clients' access to mental health services compared with other, more common service provision models.

REWARDS OF INTEGRATED SERVICE PROVISION

Many barriers need to be overcome to establish integrated services at health centres in Aboriginal communities. Nevertheless, the experience at the Noojmowin Teg Health Centre shows there are definite benefits for clients, communities and health centre staff. For health centre clients, health services are becoming increasingly seamless, holistic, and community-based. Specialized care such as the services of psychologists, traditional Aboriginal healers, nurse practitioners, and dietitians are now provided through an outreach model at the community level. Follow-up services can often be shared with community clinic staff. This allows for the beginning of wrap-around services. Many staff members experience this team approach as the foundation for integrated services at Noojmowin Teg. The team process has the potential to contribute towards building community capacity and can help improve the client-practitioner relationship.

A model for true collaboration between western and traditional Aboriginal health practitioners is still in the developmental stage. Nevertheless, community health empowerment is clearly strengthened. Clients are now able to choose between western and traditional Aboriginal health services, or a combination of both, without being subjected to negative reactions by health care providers. The health centre staff work towards tailoring services to the identified needs of each community. They contribute to community health empowerment by collaborating with community staff and health boards in the planning of services and by enhancing the existing strengths and resources in each

community. Traditional as well as the specialized health services provided on an outreach basis are much in demand in local communities. Waiting lists are growing for many of these services.

CONCLUSION

Similar to regional Aboriginal health care networks elsewhere in Canada, integration of health services in First Nations communities in the Manitoulin District is required at many different levels in order to improve service. There is a need for integration of federal and provincial Aboriginal health services; integration of mainstream rural and urban health services with First Nations-based health services; integration at the First Nations level among community health service and community sectors such as social services, housing and education; and, further integration between western community health services and traditional Aboriginal health care.

Integration of health services is by no means complete and some fragmentation of services remains to be resolved. However, the implementation of an Aboriginal health centre program in the Manitoulin area has contributed to an improved continuum of care and access to much sought-after specialized health care services. The partnership between the Noojmowin Teg Health Centre and the local federally-funded health authorities is contributing to local health empowerment in many ways. Due to the larger catchment area, Noojmowin Teg programs often act as catalysts for regional approaches to health care and improved inter-agency collaboration among Aboriginal organizations with long histories of working independently. For example, in the area of health research, Noojmowin Teg assumed a co-ordinating function to support the development of a regional research committee with representation covering all of the local communities. This committee has developed Aboriginal research ethics and research protocols based on local values.¹⁹ The committee plans to develop a research agenda in the coming year. For traditional Aboriginal health services, Noojmowin Teg has provided a forum for regional collaboration on the development of policy guidelines for the provision of Aboriginal medicine in a clinical setting. Newly implemented regional mental health networking meetings allow professional and paraprofessional mental health staff to address common issues including professional development, regional service planning, and the development of health information technology for mental health. Providing services to a greater number of people allows Noojmowin Teg to provide specialized health care as

a community-based service. This enables Aboriginal organizations to share control over these services with the communities they service.

ACKNOWLEDGMENTS:

I would like to thank reviewers of earlier versions of this manuscript including Bernadette deGonzague, Dr. Barbara Erskine, Glenn Hallet, Mariette McGregor-Sutherland, Marjory Shawande, and Dr. Wayne Warry. They provided me with thoughtful comments. I would also like to thank the editors and anonymous reviewers of this document for their helpful suggestions. Views expressed in this article, and any errors or omissions, are the sole responsibility of the author. This research was supported by the Noojmowin Teg Health Centre and a doctoral fellowship by the Social Science and Humanities Research Council of Canada.

ENDNOTES

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8. The Canadian Prenatal Nutrition Program (CPNP) is a national program to address the health of high-risk pregnant women, improve birth outcomes and to promote breastfeeding. Program components include nutrition counselling and nutrition supplementation. A First Nations and Inuit committee was established to support the development of the Aboriginal component. The First Nations and Inuit Health Branch (FNIHB) of Health Canada is responsible for the portion of the program intended for Aboriginal communities.
9. The Aboriginal Head Start Program was established in 1995 to enhance child development and school readiness of Aboriginal children living in urban centres and large northern communities. In 1998, the program was expanded to include "on-reserve" Aboriginal communities.
10. The First Nations and Inuit Home and Community Care Program provides basic home and community care services delivered primarily by trained and certified personal care/home health aide workers at the community level and supported by registered nurses. The program is developed at the local level to integrate with existing programs and services. The program is funded through the First Nations and Inuit Health Branch (FNIHB).
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The Information Centre on Aboriginal Health (ICAH) will be a national database of Aboriginal health information and resources.

The National Aboriginal Health Organization is creating the Information Centre on Aboriginal Health to help direct both individuals and health care professionals to resources they can use to promote and improve health for themselves, their families and in Aboriginal communities.

The Information Centre on Aboriginal Health is an innovative way to ensure First Nations, Inuit and Métis people have easy access to relevant resources on health and well-being.

ICAH will allow you to search an English-French-Inuktitut Web site and virtual library for information on Aboriginal health, careers and training in the health field, Indigenous knowledge, programs and services for Aboriginal Peoples, and much more.

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