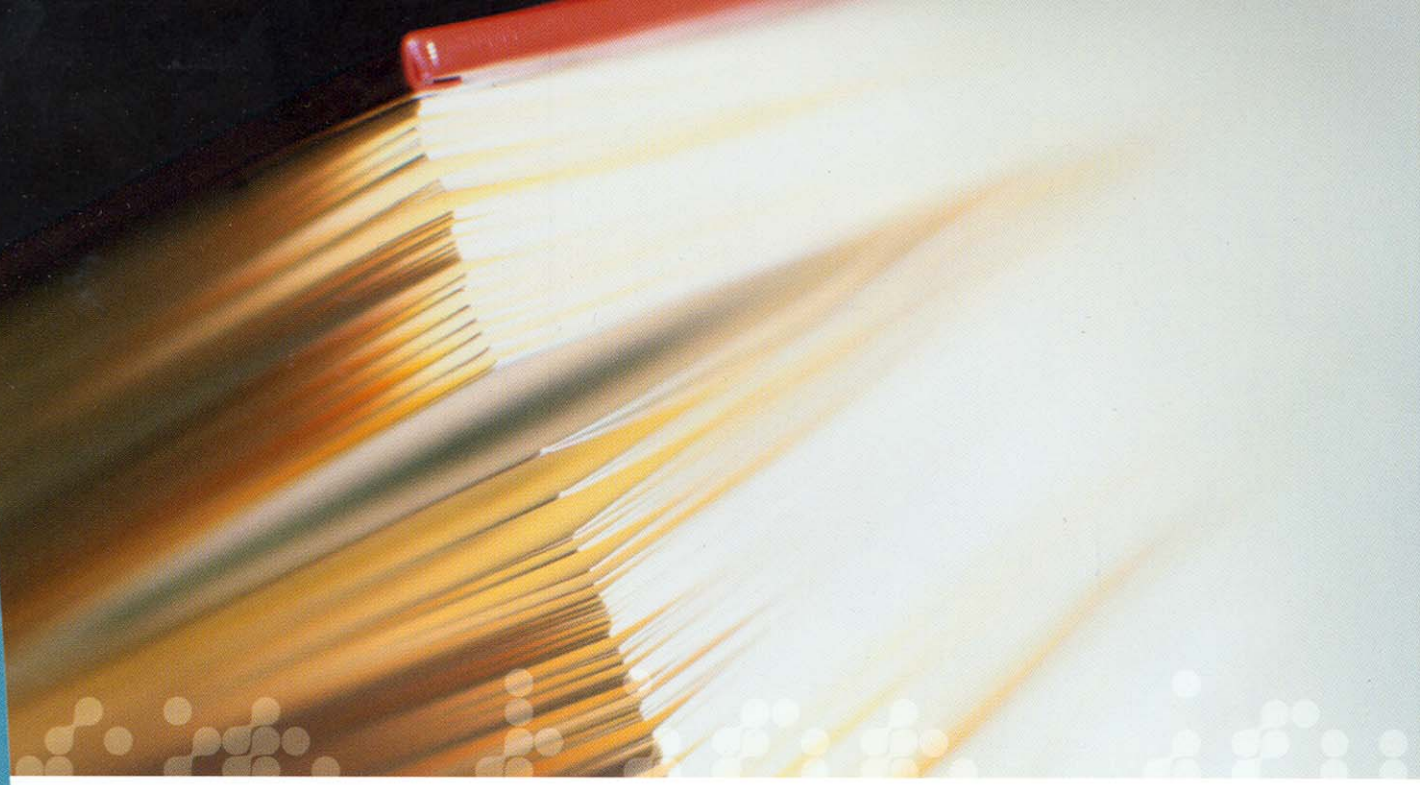

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CONTEXTUAL STUDY OF MENTAL HEALTH SERVICES IN THE CREE IIYIYIU ASCHII

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CONTEXTUAL STUDY OF MENTAL HEALTH SERVICES IN THE CREE IIYIYIU ASCHII

DIRECTION DE RECHERCHE, FORMATION ET DÉVELOPPEMENT

FEBRUARY 2008

Institut national de santé publique Québec

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Lily and Denise

FOREWORD

The “Projet Dialogue” research program focuses on the organizational and contextual factors that influence the quality of primary care mental healthcare services delivered by teams of professionals working in Quebec’s Health and Social Services Centres (Centres de santé et de services sociaux (CSSS)). Specifically, this four-year project is designed to assess the impact of the new *Plan d’action en santé mentale 2005-2010: La force des liens* (Quebec’s mental health action plan (QMHAP) [2] developed and implemented by the Ministère de la Santé et des Services sociaux du Québec (MSSSQ). The proposed changes are to be implemented as part of the process of structural reform taking shape through the creation of the CSSS and the introduction of local service networks (Réseaux locaux de services (RLS)) in each CSSS territory. This research program is jointly under the direction of the INSPQ’s Dr. Louise Fournier, PhD, in the capacity of researcher, and the MSSSQ’s Dr. André Delorme, M.D., in the capacity of decision-maker. Several other researchers are also collaborating on this project. Project Dialogue was initially designed to target 15 CSSSs and their local service networks.

In the summer of 2006, the Aboriginal Health Unit of the INSPQ, in partnership with the CBHSSJB and the Nunavik Regional Board of Health and Social Services (NRBHSS), requested that the research program be broadened to include the regions of northern Quebec referred to as “Terres-Cries-de-la-Baie-James” (Iiyiyiu Aschii) and Nunavik. This initiative stems from an analysis presented by the partners in these regions regarding the suboptimal conditions of access to healthcare and the continuity of care provided to individuals with mental illness living in remote First Nations and Inuit communities. Supported by the scientific literature, the findings cited in the report are related not only to physical distance from major urban centres, but also to a combination of geographic, cultural and organizational variables. The present research program offers an opportunity that is congruent with the policy of the QMHAP in conducting additional research to facilitate adapting the Mental Health Action Plan to meet the needs and peculiarities of the different ethnocultural groups across Quebec. Its objective therefore is to identify the approaches and organizational structures best suited to promoting access to mental healthcare services and continuity of the care for individuals requiring these services in the regions of Terres-Cries-de-la-Baie-James and Nunavik.

This research program features four components: a contextual study (conducted in 2006-07); an organizational review (2007); a clientele study (2008-09) and a knowledge transfer component that is to be ongoing for the duration of the program. In addition, the project has a fully functional Website with English-language pages that may be accessed at: www.inspq.qc.ca/dialogue. Following a series of interviews conducted during two focus groups in the fall of 2006, this report presents the findings of the contextual study component regarding Iiyiyiu Aschii, the northern Quebec region inhabited predominantly by the Crees. A separate report will address the findings of a similar investigation conducted in Nunavik, a region inhabited primarily by the Inuit.

HIGHLIGHTS

1. The CBHSSJB has for the past several years identified mental health as an intervention priority.
2. The lack of infrastructures within the community for individuals in crisis situations, the lack of supervised accommodation for clients suffering from severe mental health problems and the housing shortage for personnel all contribute to an increased frequency of transporting clients outside of Iiyiyiu Aschii and add to the risk of clients becoming lost in the system.
3. Youth and women must be identified as priority target groups by the MHP. All individuals suffering from severe mental health problems would benefit from improved follow-up aimed at social reintegration.
4. Several factors affect the mental health of the Eenou, including absence of cultural continuity, lack of housing, drug and alcohol use, widespread prevalence of chronic illness and lack of activities. A mental health program must adopt a global approach to intervening in these areas.
5. Promotion and prevention activities in mental health must be aimed both at family and community ability to take action.
6. Many individuals are reluctant to resort to services because of the lack of adequate staffing available between services to meet the level of needs and the risk in a small community of being labeled.
7. Sustained, adequate financing and constant, recognized leadership are necessary for the long term survival of the QMHAP.
8. The Government of Quebec must make an effort to adapt its national policies to the realities facing northern regions. A starting point would be the translation of its action plans, including the Action Plan for Mental Health (QMHAP), into English.
9. The interprofessional collaboration essential for offering quality mental health services is hampered by many factors, including the absence of unique files, instability of resources and lack of formalized modes of communication. Added to this is a level of confusion and misinformation due to many other factors: lack of integration of the various services, including traditional approaches, persistent ambiguity surrounding the notion of confidentiality, few interdisciplinary meetings, confusion in leadership and misinformation on all sides regarding roles that leads to lack of confidence between health and social services providers.
10. The notion of collaboration between health and social services must be extended to schools, community, church, traditional services, families, community.
11. Very little exists in the way of statistics related to the state of mental health of the Eenou.

12. The goal in integrating traditional resources is to diversify the current service offering. Documenting this body of knowledge before those who hold it disappear has therefore become an urgent priority. There is at the same time a parallel need for the non-aboriginal healthcare providers to improve their understanding of issues of a cultural nature and their knowledge of community initiatives and resources.
13. The setting up of a systematic method for following up on clients and implementing preventive mental health approaches would potentially contribute to diminishing the incidence of crises. Such services however cannot be supported by the current primary healthcare providers who are busy looking after crisis situations, overworked, and needing to respond to emergencies and man the clinic. Furthermore, they lack the necessary experience and training in mental health, show little interest in mental health and lack the necessary support, which is not surprising considering the absence of agreements with psychiatric services and the lack of continuity of presence of psychologists in the region.
14. Individual psychological services are appreciated by healthcare practitioners and clients alike. Group approaches would also be welcomed.
15. A good number of healthcare providers are dealing with their own personal wounding or are constantly exposed to difficult situations in the course of their professional practice. An employee support program and group verbalisation sessions could offer an essential service in this regard.
16. In the field of mental health, the training needs are considerable, especially in the areas of screening, traditional approaches, mental health problems and management, and follow-up aimed at both rehabilitation and social reintegration.

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LIST OF ABBREVIATIONS AND ACRONYMS

AHF	Aboriginal Healing Foundation
ASIST	Applied Suicide Intervention Skills Training
CBHSSJB	Cree Board of Health and Social Services of James Bay
CLSC	*Centre local de services communautaires* (local community service centre)
CSSS	*Centre de santé et de services sociaux* (health and social services centre)
INSPQ	*Institut national de santé publique du Québec* (Quebec Public Health Institute)
JBNQA	James Bay and Northern Quebec Agreement
LSN	Local service network
MHP	Cree Mental Health Program
NRBHSS	Nunavik Regional Board of Health and Social Services
MSDC	Multi-Services Day Care
MSSSQ	*Ministère de la Santé et des Services sociaux du Québec* (Quebec Ministry of Health and Social Services)
QMHAP	*Plan d'action en santé mentale du MSSS 2005-2010* (Quebec mental health action plan)
SDBJ	*Société de Développement de la Baie-James* (James Bay Development Corporation)
SEBJ	*Société d'Énergie de la Baie-James* (James Bay Energy Corporation)

1 INTRODUCTION

This report includes a description of trends in the offering and delivery of mental health services in Iiyiyiu Aschii over the last 10 years. Familiarity with this context is essential to understanding both the current organization of healthcare services and their impacts on service users – two aspects that will be examined in greater detail at subsequent phases of this research project. An array of information sources were used to produce this report and include: the direct sharing of knowledge and views with members of the CBHSSJB mental health team; numerous previously drafted and published reports, articles and documents; and the information gathered during the two focus groups attended by some 20 participants from Iiyiyiu Aschii whom our regional and local contact individuals identified as being key informants. These focus groups were held November 14, 2006 in Chisasibi and November 16, 2006 in Mistissini. At future stages of this project, the other communities in Iiyiyiu Aschii will be called on to share their experiences and expectations. Care has been taken to present as faithfully as possible the information we have gathered bearing on primary mental healthcare services for people suffering from mental health problems in Iiyiyiu Aschii.

In July and August 2007, information from the focus group was compiled and sent to the participants for validation. Their comments are integrated into this version.

This report is divided into two main parts. The first part describes the mental health situation in the predominantly Cree-inhabited territory known as Iiyiyiu Aschii and deals specifically with intervention priorities, target groups, and the incidence of mental health problems. The second part covers various aspects of the mental healthcare services currently offered, including the number and type of resources available; the level of integration among resources; specific factors to be taken into consideration when implementing a regional mental health action plan; and various items facilitating the adaptation of projected mental healthcare services in accordance with the needs of the inhabitants of Iiyiyiu Aschii. The reader should note that whenever statements from focus group participants refer specifically to one of the two communities consulted, the identity of the community in question is indicated in parentheses. Otherwise, the statements are considered representative of both groups.

2 THE STATUS OF MENTAL HEALTH IN IIYIYIU ASCHII

2.1 TERRITORIAL DISTRIBUTION OF HEALTHCARE SERVICES

Prior to Christianization, every member of an Aboriginal band held “medical knowledge” though in varying degrees. Certain plants and preparations were used to relieve wounds or alleviate particular ailments. In cases deemed to be more serious, the group relied on the expertise of healers. The first annual visits by physicians in Cree territory date to around 1903, with the first hospital facility, an infirmary, opening in Chisasibi in 1930. During this period, the local community was located at Fort George, itself located on an island in James Bay. The 1950s were witness to the first home construction programs, which led to the sedentarization of the various bands inhabiting Iiyiyiu Aschii. Sedentarization, the organization of society into village communities, and the arrival of so-called Western healthcare services combined to produce major changes in the ways the Cree of Iiyiyiu Aschii conceive of health, illness and care. The 1950s also coincide with the period when Cree children were first enrolled in residential schools located outside of the territory. At these schools, the children were forbidden from speaking their language or referring to traditional beliefs, thus estranging them from their traditional culture. There, some children were also exposed to a range of physical, mental and sexual abuse. The impacts of this cultural uprooting, which continued until the early 1970s, are perceptible among Quebec’s Aboriginal populations even today. Indeed, the term “ethno-stress” is often used to describe the series of rapid, radical change that undermined Cree identity [3].

In 1975, the Government of Quebec, the Government of Canada, Hydro-Québec, the Société de Développement de la Baie-James (SDBJ, otherwise known as the James Bay Development Corporation), the Société d’Énergie de la Baie-James (SEBJ, otherwise known as the James Bay Energy Corporation), the Cree nation and the Inuit signed the James Bay and Northern Quebec Agreement (JBNQA). Under the provisions of this agreement, a total of $225 million were paid out in the form of compensation in return for use of their land [4]. It also enabled the signatory Aboriginal peoples to exert a considerable degree of political, economic and social control over their lands. It should be noted that lands defined as being Category I and II are exclusively reserved, respectively, for the purposes of occupancy or use and development by the Aboriginal peoples, but nevertheless represent only a very small proportion of the entire territory traditionally considered as Cree or Inuit land. Founded in 1978, the CBHSSJB was given full responsibility for providing health services and social services throughout the territory of health region no. 18, known as “Terres-Cries-de-la-Baie-James,” which encompasses the lands associated with the nine Cree villages of Waswanipi, Oujé-Bougoumou, Mistissini, Nemaska, Waskaganish, Eastmain, Wemindji, Chisasibi and Whapmagoostui. As such, this health region straddles two Quebec administrative regions – “Nord-du-Québec” (region 10) and “Nunavik” (region 17), respectively [5-7]. The situation in respect of jurisdictions can be a source of confusion, since the CBHSSJB is also charged with providing services to the Crees of Iiyiyiu Aschii when they are at their traditional camps – i.e., on lands outside of those belonging to their villages proper.

Source: CBHSSJB, 2006

Figure 1 James Bay Cree Health Region

The CBHSSJB is considered to be the sole health authority in the region. Until only recently, it consisted of two Local Community Health Centres (Centre locaux de services communautaires (CLSC)) which oversaw CLSC service points located in each of the nine villages in Iiyiyiu Aschii. In particular, the regional administrative body known as the Coastal CLSC, located in Chisasibi, is responsible for the delivery of care at service points in Chisasibi, Waskaganish, Eastmain, Wemindji and Whapmagoostui, whereas the regional administrative body known as the Inland CLSC, located in Mistissini, oversees the care offered at the service points in Waswanipi, Oujé-Bougoumou, Mistissini and Nemaska. According to focus group participants, there are marked differences in the attitudes and views of the communities inhabiting each of these two sub-regions coming under the authority of the CBHSSJB. Accordingly, the last several years has seen a trend toward the decentralization of regional care management to the community level.

Table 1 Population of the nine Iiyiyiu Aschii communities

Communities	Population in 2006
Waswanipi	1,473
Oujé-Bougoumou	606
Mistissini	2,897
Nemaska	642
Waskaganish	1, 864
Eastmain	650
Wemindji	1,215
Chisasibi	3,972
Whapmagoostui	812
TOTAL:	14,131

Source: 2006 Census data, Statistics Canada [8].

2.2 PRIORITIES FOR INTERVENTION

According to the participants implicated in the research project and the documents consulted, mental health has constituted a priority for action in Iiyiyiu Aschii for several years now, affecting as it does several aspects of daily life. Nonetheless, as priorities go, providing adequate mental healthcare services has until now amounted to little more than an ideological direction, as few practical measures have been actually implemented with a view to meeting the needs of individuals afflicted with mental health problems, whether chronic or transitory in nature, whether slight or severe in intensity or scope.

At a special general assembly on healthcare issues held by the CBHSSJB in Oujé-Bougoumou in 1999, a presentation on the MHP set out several priorities for intervention, including [9]: the implementation of prevention-based approaches to mental health problems and mental health promotion strategies; the training of primary and community-based healthcare resources with a view to promoting teamwork; the staging of training sessions by visiting psychologists on behalf of primary healthcare providers; the integration of traditional approaches to mental healthcare; the reinforcement of the aid and assistance provided to health and social workers; the implementation of effective inter-service referral procedures; the development of tools supporting the work of psychologists with adults, youth, children and families; and improved support, by the individuals and organizations responsible for coordinating the MHP, for the local resources in each of the communities concerned. For the most part, these priorities concord with those mentioned by the members of the two focus groups. The latter also stressed that it was important to avoid stigmatizing, as much as possible, the mental healthcare service clientele. To begin with, they advocated changing the name of the program, in keeping with a similar suggestion put forward previously to use the term of “Holistic Health”[10]. Furthermore, some participants mentioned that the use of the word “program” as in “CBHSSJB Mental Health Program”,

because it's not already a program and gives the wrong impression to those who expect a program.

"When Health Canada started giving money for wellness for mental health activities in the communities and they had money to hire a mental health worker, the community had trouble when they came to post the job and no one would want to be associated with it. They changed it to family support worker." (Mistissini focus group)

2.3 AT-RISK TARGET GROUPS

Participants were unanimous that certain groups must be treated in priority in the implementation of mental health measures – namely, youth and women. Other groups mentioned during the interviews were the health and social workers themselves, individuals afflicted with severe mental health problems; men; and the elderly. The choice of these groups was also borne out by various written documents on the subject.

Young people account for a sizeable proportion of the population of Iiyiyiu Aschii and, from the time of the beginning of the MHP in 1995, moreover, they were identified as a group to whom interventions should be dedicated as a priority [11]. Members of the focus group mentioned a range of risk factors to which youth are exposed, including: drugs; alcohol; idleness; depression; suicidal thoughts; violence; sexual violence and abuse; the lack of human, material and monetary resources and the lack of recreation and activities. They are also subject to the stress associated with the pressure to succeed at school, although the difficult living conditions they could encountered. It was also pointed out that cultural references are disappearing and generation gaps are becoming wider. Members of the focus groups were concerned by the scarcity of services tailored to the needs of youth in their communities. Given the lack of adapted services for youth, the Youth Protection becomes a gateway for young with mental health needs. That could constitute a factor explaining the high number of cases reported to youth protection authorities in this region. In 2001-02, 19% of the young people inhabiting Iiyiyiu Aschii had an active file with the youth protection authorities [3]. As one participant from the Chisasibi emphasized, Cree youth tend to become parents early on in life, at a time when very often they are ill-equipped to take on this new role. A member of the Mistissini focus group pointed to the high level of psychological distress experienced in schools and an increase in the number of youth protection interventions.

The participants identified women as constituting an at-risk group, given the heavy social burden they are expected to shoulder, as they are often the center of their families. They are also at greater risk of undergoing sexual violence or psychological distress (e.g.: post-partum depression*),* both of which contribute mightily to destabilizing mental health.

"They ask for sleeping pills and they won't tell you why." (Mistissini focus group)

Participants voiced their preoccupations concerning health and social workers, who are faced with difficult situations and who nevertheless have few means for dealing with them. These people present higher risks of burnout, depression, absenteeism, alcoholism, and etcetera. Finally, individuals afflicted with severe mental health problems and their families

should be made a priority by the actions of an eventual mental health program [12, 13]. Some participants also mentioned the importance of taking greater care of the mental health of the elderly, whose needs often go ignored. And yet, these same people have seen their way of life undergo a series of drastic changes, with the result that, in many cases, their self-esteem has been impaired or diminished. Many older members of the Cree nation regularly experience feelings of deep apprehension or even despair [3].

2.4 INCIDENCE OF MENTAL HEALTH PROBLEMS

According to focus group participants, the incidence of mental health problems and the number of associated interventions has risen over the past 10 years. A similar trend can be seen in the number of funding requests made to the Aboriginal Healing Foundation (AHF). The AHF has been providing funding for a community-based healing initiative operated in Mistissini for several years now. Participants claimed that mental health problems occur at a higher rate in Iiyiyiu Aschii than elsewhere in Quebec. Furthermore, they suggested that resources be allocated in keeping with this reality – namely, that the prevalence and incidence of mental health problems should constitute the basis on which resources are earmarked for actions rather than on the number of individuals inhabiting the territory, such as the provincial Action Plan in mental health envisages it. Mental health problems can assume a variety of forms, but in the view of participants, crisis situations are what the local health and social workers are most often called on to respond to. These individuals often have to intervene in situations of suicidal crisis or in response to cases of violence, sexual abuse and unresolved trauma. Participants said they saw an increase in the number of consultations for stress, post-traumatic stress, depression, anxiety attacks (panic) and psychoses. A literature review conducted in 2003 noted that the most frequent types of chronic mental health problems were schizophrenia and chronic depression, alongside occurrences of borderline personality disorder, attention deficit disorder, bipolar disorder, anxiety disorder, and attempted suicide [3].

“Almost everyone I see has post traumatic stress.” (Mistissini focus group)

In 2006, the main reasons for consulting psychological services were [14]: marital problems (9.2%); family problems (8.5%); problems relating to grief and the loss of loved ones (7.6%), problems of anxiety (7.8%); and depression (6.4%). The suicide rate in Iiyiyiu Aschii is close to the overall Quebec average, but the rate of attempted suicide among the Crees inhabiting the region is eight times higher than elsewhere in the province [3]. For the period extending from 1982 to 1992, 18% of individuals who attempted suicide were suffering from depression at the time [3]. Finally, a Statistics Canada survey commissioned and paid for by the CBHSSJB and MSSSQ in 2003 reported that 8.1% of the inhabitants of Iiyiyiu Aschii had a poor image of their mental health [15, 16] – thus representing the worst such rate across Quebec, for which the overall average was 4.9%.

2.5 MENTAL HEALTH RISK FACTORS

The high prevalence of mental health problems is due in particular to the presence of a range of risk factors such as cultural discontinuity; the lack of housing; problems associated with drug and alcohol use; the high incidence of chronic illnesses; and the lack of activities and projects providing individuals with opportunities for healthy personal development.

Cultural discontinuity is the result of numerous, occasionally abrupt changes that have occurred in the First Nations' ways of life. As concerns the Crees in particular, their nation has rapidly shifted from a way of life founded on small family clans to village-style living on the reserves created during the last 50-odd years. In 1981, in response to the risks of flooding stemming from the construction of the La Grande hydroelectric generating facility, the entire community of Chisasibi moved from Fort George island to a surer setting ten kilometres inland on the south shore of the same river. According to some, the wholesale move may well have triggered a feeling of collective grief still perceptible in 2007.

Such views shape the opinion of a number of participants, according to whom the Cree communities are in a crisis situation, as several inhabitants continue to feel that they have their lost their way in the successive waves of change. Further, the cultural identity of the First Nations was considerably shaken by the arrival of the missionaries and the establishment of the residential schools that condemned traditional approaches. Participants also mentioned intergenerational traumas that appear in the form of stress and psychological malaise that are passed down from one generation to the next. In a context shaped by the legacy of still recent physical and sexual abuse and in which the extended family no longer has the solid social footing it once possessed, today's parents have to evolve on several different levels at the same time, while also seeing to the education of their own children. In short, they must deal with the repercussions of their personal suffering, in the present time and into the future, on their relationships with the older members of their family, spouse and children as well as on their ties with their community and social environment.

According to a participant from Mistissini, with cultural discontinuity has resulted in the breakdown of the extended family, which also discontinued the traditional support networks that were once available to all family members. Health and social services professionals had to pick up where traditional support networks left off, and were quickly overwhelmed by the nature and scope of the problems encountered and of the requests for help that follow. The situation is compounded by the fact that non-Aboriginal workers are aware that they do not possess a good understanding of the cultural issues to be able to offer help that is culturally adapted.

"Before we lived with our grandfather, grandmother, aunts and uncles. Tepee style. We lived together where the children would be looked after mental wise, health wise, safety wise. It's that saying; it's everyone's responsibility to raise a child. That's the system we had. And that teaching we have, was gone once we had the new houses. With all separate rooms. It was a big change for us and we have to mend that change." (Chisasibi focus group)

Individuals who hold traditional knowledge must preserve it by passing it on to future generations. An urgency to preserve this traditional knowledge exists, as many fear that

information will be lost with the death of traditional knowledge keepers. Thus it comes as little surprise that focus group participants believe that the Cree inhabitants of Iiyiyiu Aschii need to recover a positive cultural identity. On this score, the scientific literature emphatically agrees, for it has shown, numerous times over, that the cultural discontinuity resulting from rapid changes, sociocultural forms of oppression, marginalization and a lack of self-determination are all factors underlying the high prevalence of mental health problems encountered among the Aboriginal peoples of Quebec and Canada [17, 18].

According to the participants, drug and alcohol abuse has become a major problem in the communities of Iiyiyiu Aschii since the development of a road system linking the region to the southern areas of Quebec. Participants suggested association between the increase in substance abuse and the increase in panic and anxiety attacks and the growth in violence. An additional element mentioned by members of the focus group involves the often underestimated impacts of chronic diseases such as diabetes on individuals' mental health. Finally, the participants ascribed some of the inactivity or idleness exhibited by a portion of the population to a lack of outlets for self-accomplishment and an insufficient offering of recreational or leisure activities.

3 MENTAL HEALTH RESOURCES AND SERVICES IN IIYIYIU ASCHII

Mental health resources are services that offer primary care services (general practitioners, nurses and social services providers (community workers)); psychological and psychiatric services; care services based on traditional healing approaches; rehabilitation services and prevention activities. These resources are under the CBHSSJB and provide significant services through the community administrations of Cree Nations. There are also other services offered by external resources. At the present time, while mental health services are offered in the region, they are not provided within the framework of a comprehensive program.

3.1 PRIMARY CARE SERVICES

Primary care services are offered in each of the nine Cree communities and are available year-round 24 hours a day at local service points. As such, they constitute the gateway to the health system. The normal hours of operation are Monday to Friday from 8:30 a.m. to 5 p.m.. During evenings, nights and weekends, a roster of primary care nurses and community workers are on call and may be reached by cell phone at all times. The primary care provider contacted evaluates whether a telephone consultation with the client is sufficient or whether he or she should meet the caller or even mobilize additional resources, including physicians on call who also may be reached by cell phone at all times. Chisasibi is also home to a regional hospital offering 32 beds for short- or long-term stay as well as primary and secondary care services.

Prior to 1996, mental health services were provided primarily by physicians, nurses and community workers staffing in the primary care service points across Iiyiyiu Aschii. During this period, these professionals received little in the way of support in their efforts to provide mental health services to those in need of help and support [9]. Following the setting up of the MHP and the team of psychologists (see section 2.2), primary care providers say they noted a decrease in stress levels within Cree communities and an improvement in some individuals' situations [9]. However, by definition, primary care providers are on the front line of assistance, and in this capacity continue to be heavily relied on by the mental healthcare service clientele. According to focus group participants, since only visiting psychologists were present from time to time, primary healthcare providers were often left on their own to deal with individuals in a crisis situation. In Chisasibi, it is possible to hospitalize severe cases and to keep them under observation for a certain time, but in Mistissini and the other communities, such individuals are referred to hospitals in Val D'Or, Amos, Chibougamau or Montreal due to the lack of resources and infrastructures necessary to keep them in safety in care facilities.

Participants pointed out that the existing care facilities are not staffed with psychologists on a permanent or regular basis and accessing help involves the collaboration of several distinct social services. For their part, physicians and nurses desire a greater degree of collaboration among social services. Social services providers noted that when a crisis situation occurs, they must provide care to the family of the person experiencing distress and are thus

unavailable to take part in care teams. Members of both focus groups agreed that primary care services are inadequate to meet the demand for help and support among individuals faced with mental health problems. In particular, they noted the lack of training in screening and case management procedures and the insufficiency of professional and personal support provided to primary care providers (health & social). Furthermore, a service provider's credibility appears to be intimately bound up with his or her social identity, such that for several primary care providers hailing from the communities, it is difficult to maintain their credibility among their fellow citizens. This explains why one focus group participant (Chisasibi) proposed that community workers originate in communities other than those to which they were assigned.

"As front line workers, we have to deal with our families, our own grandchildren. There a lot of things as front line workers we know are happening in the community, we celebrate with them, we party with them and we know what's happening." (Chisasibi focus group)

Some members of the Mistissini focus group also pointed out that because no one is able to perform competently in all fields, many primary care providers take little interest in mental health. When combined with a rather heavy workload, this disinterest also explains why few efforts have been accomplished in mental health prevention/promotion by primary care providers to reduce crisis situations. Finally, several participants expressed concern about the development of administrative structures at the expense of building up primary care teams. In their view, the number of programs continues to expand, while at the same time, there is a shortage or even a total absence of primary care providers in the field to implement them. The participants felt that their administrative bodies were somewhat unresponsive to their opinions and needs. In this connection, it should be noted that the documents consulted contain little information about primary care teams. This situation of itself should be a cause for concern, considering not only the high incidence of mental health problems, as reported by participants, but also the fact that for those at-risk individuals who may experience a serious mental health situation or crisis, such teams are the first resource they have to turn to.

At the time of the interviews conducted in November 2006, no local care team specifically dedicated to mental health problems had yet been set up. A project was currently underway to set up regional mental healthcare teams in Chisasibi and Mistissini with the mandate to train and support local care teams. Development efforts had, however, encountered delays because of the difficulty in recruiting candidates for these new teams in the Cree Communities.

"In mental health, one of our major concerns is to develop teams. Local teams that will receive training and support from the regional team, so they will have roots in the system and roots in the community." (Chisasibi focus group)

Finally, some participants were at a loss as to why Cree nurses who received training in the South had to wait three years before returning to practice in their community. They suggested that regional authorities look into this situation with a view to amending the current policies.

"The Cree nurses who graduate should be able to return home working with a mentor before their 3 years are up. […] This person has a lot of knowledge and skills and can be supported as she gains experience. This will ensure continuity." (Mistissini focus group)

3.2 THE MHP AND PSYCHOLOGICAL SERVICES

The MHP was launched in 1995 with the appointment of a coordinator and assistant. As soon as they took office, they proceeded to conduct consultations throughout the communities of Iiyiyiu Aschii. In particular, these consultations served to establish the need to offer psychological services in addition to the services already provided at the time by physicians, nurses and community workers [11, 12]. The model selected for application consisted of adding a range of psychological services to the existing service offering [11, 19] including:

- Individual consultations
- Training of other health and social workers
- Psychological evaluations on behalf of the local community service centre and the youth protection agency [14]
- Mental health promotion and prevention activities
- Support for schools, youth group homes in Chisasibi and Mistissini and a regional youth rehabilitation centre in Mistissini
- Psychosocial assistance in crisis situations [14].

In 1996, a single psychologist was visiting four communities on a sporadic basis. Beginning in 1997, these services were made available in all nine villages, with at least one psychologist visiting each village four times a year. In communities where the demand was higher for such services, a second psychologist was added [12]. By 1998, inadequate funding led to cutbacks in the psychological resources available in the field [20]. At that point, the number of visits made by psychologists to the communities fell from four to three per year and the emergency interventions provided by the team of psychologists, special projects, and team support measures were also scaled back. These cuts were met with dismay and consternation by the Crees of Iiyiyiu Aschii [20]. In 1999, the newly appointed head of the Mental Health Program petitioned to have the number of mental health professionals increased to eight per year so as to ensure greater continuity of healthcare [9]. Thus, as of 2001-2002, a team of six to seven psychologists was able to provide services every six to seven weeks in their assigned villages [21]. In 2003, a counsellor joined the team of psychologists in the village of Waskaganish, whose inhabitants wished to have access to a resource person having a more prominently religious orientation. At this time, every community was visited by two psychologists, one male and one female [22]. In 2004, the number of psychologists' visits was increased to once a month [23]. By 2005, more than 25 psychologists and therapists were offering services outside of Iiyiyiu Aschii to members of the Cree population who either did not reside in one of the nine James Bay communities or whose particular situation required an emergency consultation in the absence of a psychologist in the community at the time the need arose [24].

As of 2006, the regional Mental Health Program team is made up of the Program Director, the Assistant to the Program Director, a social worker and secretarial/administrative support (all women), as well as six visiting psychologists, a religious counsellor, and a psychologist with a specialization in evaluation. Every community in Iiyiyiu Aschii can avail itself of the services of two psychologists (male and female), who take turns staying in the community approximately two weeks per month. The users of these services thus have the option of consulting a psychologist of the gender they feel most comfortable with. Referrals to psychology services are primarily authored by primary care providers and a visiting psychiatrist, who periodically makes the rounds to the villages of Waskaganish, Mistissini and Nemaska. It is also possible to request an appointment directly without having to go through another health professional. The number of individual consultations with psychologists has risen steadily over the last several years. Between 1996 and 1999, 1,500 individuals were seen either by a psychologist, a psychiatrist or a traditional healer [9]. Between May 2005 and May 2006, no fewer than 2,469 consultations were given by the psychologists and the religious counsellor [14]. In addition, the number of consultations performed outside the Cree communities increased, in keeping with the rising number of Crees living outside of the communities. The CBHSSJB pays for services rendered to members of the Cree nation who, although Status Indians, do not reside in one of Iiyiyiu Aschii's communities.

According to most participants, psychological services are on the whole appreciated by members of the Cree communities [9, 14]. Primary care providers also have a favourable opinion of the contribution of psychologists, who carry out in-depth investigations and provide better follow-up for mental health clients. Primary care providers stated that they often had a hard time listening and devoting their full-time attention to such clients because of the very high user rate of these services, their own lack of knowledge on the subject, and the high employee turnover rate. This being said, the psychologists appeared to spend the better part of their time in individual consultations and thus had little time left over for other activities such as promotion, group activities or training [21, 22]. In addition, a number of focus group participants mentioned that the time required to effect rotation between two psychologists could take so long that a delay of up to two months could occur. In short, under the current mode of operations, communities are required to function without the help of a psychologist for more than two weeks per month, a situation that complicates the work of local primary care providers. Users also complained about the limited availability of psychologists. One participant in the Mistissini focus group pointed out that primary care providers have the option of phoning a psychologist for consultation regarding a treatment plan. Similarly, some primary care providers highlighted the need to increase the number of psychologists in order to improve service continuity. They noted that everything runs efficiently whenever the psychologist is in the community.

"I'm not saying the psychologists are the only solution, but they are a stopgap. […] I need a psychologist right there when they come in and usually when they come in, they are able to get a 24 hour appointment." (Mistissini focus group)

The option of hiring a full-time psychologist instead of relying on a team of visiting psychologists was previously evaluated in 2003 [14]. On the basis of the research conducted

to this effect, there are no advantages – in terms, primarily, of cost-benefit scenarios – to hiring a full-time psychologist, for the reasons listed below [1]:

- Even though the salary of one full-time psychologist is lower than that of a psychologist hired on a contractual (i.e., temporary or part-time) basis, the expenses associated with fringe benefits and housing negate any difference in cost. Thus, the budget required to pay seven psychologists working half-time on behalf of the Mental Health Program is the same as that required to hire three full-time psychologists.
- For the same salary, a full-time psychologist spends more time in communities than do the visiting psychologists. However, as the experiences in other Aboriginal communities have shown, a full-time psychologist in charge of several communities spends more time in the village where his or her office and home are located.
- Burnout occurs more frequently among psychologists who spend more time in the communities.
- The confidences of community members are considered to be held in safety by visiting psychologists, who leave communities in between their stays locally; as a result, users of psychological services trust these professionals more than they do full-time psychologists.

Participants in the Mistissini focus group suggested that including group work (i.e., therapeutic activities) in the offering of psychological services might constitute a worthwhile alternative, in view of how the Crees generally appreciate group discussions. In this connection, one participant from the Mistissini focus group described a group experiment surrounding a family crisis that had been conducted in her home community. Two external resources were hired to conduct the activities, which proved to be a success despite having entailed considerable effort. Some of the participants also pointed out that local primary care providers are often confronted with a credibility gap in the eyes of their fellow community members that has the effect of compromising their ability to act effectively. This response to resolve this family crisis was set up through the community services by people from the community working together, not through the CBHSSJB services.

3.3 PSYCHIATRIC SERVICES

Focus group participants only just touched on psychiatric services and, likewise, the documents consulted as part of the present research program had scant little information to offer on the subject. At the time of its inception, the MHP was, aside from offering psychological services, supposed to begin work recruiting psychiatrists and developing a small psychiatric care unit in Chisasibi [19]. A report dating back to 1997 stresses, moreover, the need for psychiatric services among individuals suffering from severe mental health problems and among their families as well [12, 20]. In 1999, De Sutter and Ratt noted that the offering of psychiatric services provided by visiting psychiatrists continued to be incomplete [9]. At the present time, psychiatric services are provided by one visiting psychiatrist rather unevenly across Iiyiyiu Aschii.

In the view of some group discussion participants, so long as psychiatric services are absent, the offering of mental health services will remain incomplete, for three reasons: 1) the

psychologists are unable to monitor the use of medication; 2) the professional support of primary care providers is inadequate to deal with some complex cases of mental health, and 3) psychiatric services are needed for cases of chronic mental illness which psychologists do not deal with. The general practitioners, nurses, community workers and psychologists encountered during this study were in favour of improving access to psychiatrists since they could benefit from this resource when confronted with problems in establishing a diagnosis, selecting courses of treatment, or gaining opportunities for training.

"We can't just send everyone to Montreal because we don't have a psychiatrist here." (Mistissini focus group)

The administrators overseeing the MHP anticipate that the primary care teams will soon have access to a psychiatrist on call 24 hours a day; in addition, they are seeking to have a psychiatrist on hand in the community at least one week per month. Telepsychiatry offers a promising avenue for improving collaboration, diagnosis and training. Some of the Mistissini focus group participants voiced their view that the deciding factor in assigning a psychiatrist should be the wide prevalence of mental health problems in Iiyiyiu Aschii along with the number of cases, as opposed to the size of the population inhabiting the territory.

"Our 13,000 don't measure up to have a psychiatrist so our 13,000 is like 80,000 for mental health issues." (Mistissini focus group)

3.4 SERVICES BASED ON TRADITIONAL CARE (HEALING) MODELS

Both focus groups discussed at length ways of better integrating traditional approaches into current mental health services. Traditional methods typically involve good listening skills and, as well, include a holistic view of life, which places values on a balance between the mental, spiritual, emotional and physical. For each person, the task is to achieve a balance between all four aspects over the course of the four main life stages represented by childhood, youth (adolescence), adulthood and old age [25]. Aboriginals depict this balance through the Medicine Wheel, which combines these various aspects, as shown in Figure 1.

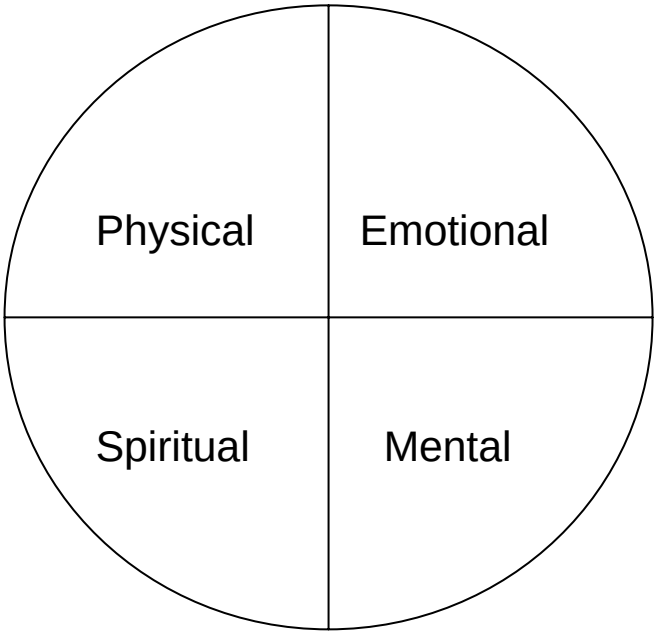

Figure 2 Medicine wheel

The focus group participants do not disregard psychological or "Western" approaches to mental healthcare, but instead view traditional methods as worthwhile alternatives while promoting the preservation of local knowledge [26]. Furthermore, it is their view that interventions by health and social providers should take into fuller consideration the cultural aspects of Cree society.

"A mental health program should have several programs, and at this time there are only the psychological services. According to the medicine wheel, this is not balanced." (Ratt, 2006)

One participant from the Mistissini focus group explained that a person who is seeking to be healed will show a tendency to return to his or her roots. From this point of view, traditional healing approaches and models are the reflection of a community-wide need. Several of the Aboriginal participants expressed their desire to re-appropriate such elements of their culture which, as was mentioned above, are in danger of disappearing at this time or in the near future. One example that participants gave concerned ways of treating depression, which formerly included a change of surroundings and active listening. Thus, in Cree tradition, families moved whenever one of their members became depressed. Several of the Aboriginal participants recalled the benefits of various traditional activities on individuals' mental well-being, such as travelling to one's camp in the bush. This being said, for a variety of reasons, such activities are no longer within everyone's reach – depending, for example, on whether or not a person enjoys ready access to motorized vehicles enabling him or her to travel into the bush.

"In the bush, everyone is pulling together to help each other out. You don't have any doctors and nurses in the bush." (Mistissini focus group)

In addition to the wealth of information we were able to gather from the focus groups, the review of previously existing documents enabled us to chronicle the various phases in the development of traditional healing services since the inception of the MHP. In 1996, following a series of requests by the inhabitants of the Cree communities, a limited offering of traditional mental health services was made available in Chisasibi [9]. The MHP has demonstrated its receptiveness to traditional care services while at the same time maintaining that they should be used with a degree of caution and in a manner that is mindful of local values [12]. Such prudence may stem from the fact that the services of traditional healers by no means meet with universal approval in the communities, as reported in a number of the documents consulted and confirmed by several of the focus group participants. Some people refrain from turning to methods condemned at one time by the missionaries and the doctrines of Christianity.

In 1997, a traditional healer visited Chisasibi four times in a year's time. While those who consulted him reported that they were highly satisfied with these services, budget cuts put an end to this initiative in 1998 [12]. Other initiatives based on traditional healing approaches were subsequently launched, although a 1999 report states that they have remained on the fringes compared to other so-called Western approaches. In response to this observation, the Mental Health Program has taken on the responsibility of facilitating their integration [10]. Thus, in 2000, the plan of action developed by the MHP proposes adopting an approach to the delivery of mental health services that is more holistic and "wholistic." This being said, the development of traditional approaches is faced with a range of obstacles. For one, it is very expensive to hold rituals and ceremonies in the communities, as the people who present them must travel a considerable distance from outside Iiyiyiu Aschii. Thus, it has been suggested that the emphasis be placed on those local natural healthcare providers who are able to offer this type of service.

In August 2001, the general assembly of the Grand Council of the Crees of Quebec and regional authorities mandated the CBHSSJB to take steps to integrate traditional concepts of healing into the healthcare services currently being offered to the Cree population. In keeping with this new mandate, a proposal entitled "An Integrated Approach to Health & Social Services in James Bay". Stipulates that one of the goals of the CBHSSJB is to incorporate holistic, community-based services, which includes promoting traditional healing practices, with a view to offering more culturally attuned services [26]. Despite such intentions, traditional healing services have not yet been made available in a structured format, and people continue to request having them included in the care offering. In 2004, the community of Chisasibi again petitioned the Mental Health Program to make available the services of traditional healers, and to present them as a legitimate alternative. All the same, a combination of factors continues to hamper the emergence of these approaches, including a lack of funding facing the CBHSSJB and non-recognition – i.e., the absence of some form of healer certification. This problem is compounded by the fact that traditional healers continued to be recruited from outside of Iiyiyiu Aschii, which means added expense [23]. Since 2005, the MHP has reiterated its interest in incorporating traditional methods into its care offering, but a lack of funding has prevented it from translating its objectives into reality.

"Since many of the traditional native interventions provided by elders already take place outside of the Mental Health Program, it is clear that there is a need for such interventions, which should be considered legitimate and should be treated as legitimate interventions." (Ballou, 2006: 22)

3.5 REHABILITATION

The MHP has, since the time of its inception, planned to make available homes designed for the social reintegration and rehabilitation of individuals afflicted with chronic mental health problems for whom a standard psychological approach was ill-suited [10, 20]. In particular, these services were intended to foster the development of personal and social skills that would enable these individuals to enjoy greater autonomy. Other target actions include offering support to families and creating a support/assistance network. In 2000, a supervised home for eight people, the Chisasibi Residential Resources Centre (often referred to locally as the *Fourplex*) was opened in Chisasibi. Initially, the residents were supervised by custodians having no specific animation training for this clientele. In 2002, two local "activity workers" were hired to organize and hold stimulating activities for the clientele [14]. As it turned out, the arrival of these two new human resources had mixed results, since they were called on to play the role of custodian rather than that of educator. Combined with the lack of psychiatric resources, this situation has meant that the residents of the *Fourplex* have received little animation, reducing their chances of rehabilitation and social reintegration.

"There is a lack of follow-up for clients who are seriously mentally ill. There is also a lack of stimulating activities for the chronically mentally challenged who are hospitalized in Chisasibi." (Lauretta McKenzie, 2002)

In 2005, a task force was set up to evaluate the needs of the Fourplex target beneficiaries and to implement more fully adapted services. As a follow-up to the recommendations of this group, plans have been made to hire a temporary coordinator responsible for establishing the services required to ensure the full development of this type of beneficiary [27]. The new coordinator will be called on to propose a structure that encompasses residential, vocational and rehabilitational services, in addition to working with the MHP, the social service clinics, the public health service clinics, the new Multi-Services Day Care (MSDC), Chisasibi's other partners, and the other Cree communities [27]. It is important to note that a similar recommendation was previously included in the Mental Health Program's 1999-2000 annual report [14]. Until the present time, however, only Chisasibi has provided this type of services. The members of the Mistissini focus group mentioned that the absence of supervised housing posed serious problems for their community and other Cree communities that are witness to a number of cases of severe mental health problems. In their view, this type of service should be made available to all nine communities.

"We have resources for chronic mental disease in Chisasibi but every community should have access to these services, have real access to these services so the person with real needs could be integrated into their own community." (Mistissini focus group)

3.6 MENTAL HEALTH PREVENTION/PROMOTION ACTIVITIES

According to the focus group participants, those individuals seeking mental healthcare services often do so when they are experiencing a crisis. In their view, many of these crises could be avoided by implementing systematic monitoring/follow-up procedures as well as preventive approaches in all communities. They stressed the need to better equip members of the Cree Nation for dealing with life's trials and tribulations, including birth and death (and grief) as well as with issues of depression, physical and sexual abuse, substance abuse, and suicide. Likewise, measures must be implemented to ensure that individuals struggling with such problems do not remain shut off and alone from others. Furthermore, in the participants' view, a preventive approach should, as a priority, target families over individuals so as to re-establish the responsibility of families with respect to the well-being of their members. Participants also mentioned that care should be provided to victims of violence, obviously, but also to the perpetrators of violence, in consideration of the fact that both parties will again encounter each other in their community. There is a risk of repeat episodes of violence if interventions are not targeted at both the victim and the offender. Participants feel that prevention should begin from childhood. At this time, however, the emphasis of care interventions continues to be on the clinical aspects of primary services. This responsibility should be shared among services and the communities.

"There has always been a lack of preventive action due to the great demand for consultations and very limited resources. Preventive action is an important way to move forward by helping community members before problems become serious enough to require professional intervention." (Ballou, 2006: 23)

"We need more community empowerment. We cannot do much until the community is taking action. In the south, we have lots of peer support groups and here we don't have that. As a nurse I can do something but the community also has to do something." (Mistissini focus group)

The focus group participants voiced their concerns over the absence of an assistance program for CBHSSJB employees, who need support in managing work-related stress, substance abuse, or other stressful events. On this point, a number of participants mentioned that they were able to hold debriefing meetings with peers and co-workers on an as-needed basis. Such meetings had proven to be very helpful although, it must be noted, the success of this approach very much depended on the individuals in place. A review of the available documents provided a basis for chronicling developments in some of the already established prevention programs. This being said, most of these programs are no longer active, which goes to show just how major an issue the long-term continuity of promising initiatives remains. It should also be noted that several of these programs were set up by the communities and not by the CBHSSJB.

The "Marital Harmony Program" was launched in Oujé-Bougoumou in 1996 and in Chisasibi in 1998, in collaboration with the federal program known as "Brighter Future." The six-month intensive counselling service for future spouses is designed to reduce the incidence of spousal violence and aggressive behaviour toward children and teaches couples practical

anger management techniques. This program met with a positive reception among the members of the two communities, and was provided by an external resource [20]. A request was put forward in Chisasibi so that these counselling services would be provided by loca couples.

In 1997, another prevention-based program, the “Inner Child Workshop Project”, which was oriented toward families and which used traditional methods, was implemented in Chisasibi, Nemaska and Waskaganish. Considerable positive feedback was received in connection with this program, and many requests for its reinstatement continue to be received. Continuing forward with this project became impossible due to inadequate funding [14]. Another project, centring on theatre therapy, was launched in Chisasibi and Mistissini in 1997, and was described as a great success [20]. The purpose of this project was to prevent solvent abuse by youth. Under this project, two plays dealing with abuse, violence and other mental health problems and which targeted youth in particular, were presented to several groups of young people and their parents. This project does not seem to have been carried over. In 2001, someone was hired to supervise the setting up of a Suicide Prevention Hotline in Iiyiyiu Aschii, and yet this help line never became operational [14]. By 2006-2007, a number of activities were being conducted across Iiyiyiu Aschii to promote various help lines available in Quebec. Despite this initiative, there continue to be requests for establishing services of this kind that are specifically adapted to the needs of the region. Again in 2001, radio programs were broadcast about the negative impacts of gambling and stress on members of the Cree communities. Likewise, a brochure on these subjects was produced but was never distributed systematically throughout Iiyiyiu Aschii.

At the present time, the CBHSSJB is implementing a number of programs that may indirectly touch on aspects of mental health. For example, the new perinatal program is designed to prevent mental development lags and problems of social adaptation among children. Another project (Programme Chî Kayeh) dealing with the sexual health of youth in Secondary III and IV is designed to assist them to develop skills that will enable them to make healthy choices with respect to sexual well-being, social relationships and the prevention of unwanted pregnancies, foetal alcohol syndrome and various forms of substance abuse. Health workers will be given training in 2007 on the prevention and detection of drug and alcohol abuse. They will also be given tools enabling them to implement interventions better targeted for this type of healthcare recipient. Finally, in 2007, nine positions were created for school nurses who will in particular play a role in preventing the development of mental health problems among school-age children.

3.7 OTHER SERVICES

We should recall that some individuals faced with social or mental problems do not wish to consult primary care providers in service points (clinics) for various reasons, including issues of confidentiality. In some cases, moreover, the mental health services were provided by informal caregivers or church leaders meet their needs. Also, parallel to the development of the services offered by the CBHSSJB, in the late 1990s a number of villages, including Waskaganish, Nemaska, Mistissini and Whapmagoostui set up mental health services to provide the members of their communities with services that had not previously been offered

by the CBHSSJB. In particular, these services were designed to meet the needs of the community – as defined by the community. For example, Nemaska offers a healing program under which a community worker and a psychiatric nurse provide services full-time.

For the past several years, a Mistissini initiative designed to pair an individual in need with a natural healthcare provider has been funded through the AHF. This program that has met with considerable success is carried out under the auspices of the local Band Council and not the CBHSSJB services. This program is supported by one part-time Aboriginal psychologist and eight informal caregivers who have received training in counselling techniques. These eight individuals generally meet service users during the evenings and on weekends, as they hold down other jobs during the week. They are paid for their care-related work. They were recruited among the participants at a conference on community approaches to healthcare and have, in addition, completed personal healing work. These informal caregivers appear to be consulted primarily by young people and adults. The Mistissini Initiative also includes a component dedicated to healing circles in the form of camps for men, women or couples. Efforts are underway to form a similar circle for young people at similar camps although youth healing journeys have been held for number of years. The psychologist attached to this program provides phone support to natural healthcare providers whenever she is away from the community. Discussions with the Mistissini focus group brought out the fact that while the Aboriginal social and healthcare workers were familiar with these services, the non-Aboriginal physicians and nurses taking part in the discussions were unaware of them.

As for the CBHSSJB, a project to develop a healing lodge is currently in the planning phase and a consultant was hired in the summer of 2006 to assist in the project [28]. Once completed, the lodge will offer a range of services related to: drug, alcohol and other abused substances detoxification; personality building and Cree identity; and mental health promotion/prevention activities in the form of a Family Community Healing Centre. The underlying objective of these services is to provide healing programs and activities in the various communities of Iiyiyiu Aschii to ensure the physical, spiritual, emotional and mental well-being of individuals (cf.: Figure 1: Medicine Wheel).

3.8 INSTABILITY OF THE PROFESSIONAL AND ADMINISTRATIVE STAFF

Participants noted a high level of instability among the primary care providers (health & social) which is likely a direct result of a combination of highly stressful working environment, difficult working conditions associated with the remote locations and chronic understaffing problems [3]. This chronic lack of primary care providers also partially explains why it is difficult to provide effective interventions and why service providers are continually dealing with crisis situations [3]. With regards to medical services, the region has to rely on visiting or replacement physicians to offer services in the communities, a situation that makes it difficult to develop interprofessional confidence and continuity in the doctor-patient relationships.

"The doctor who sees the patients in emergency is not necessarily the same one who sees them on the ward; or who sees them on the returns visits. This means there has to be a multidisciplinary approach. And we need to have a social worker in the hospital." (Chisasibi focus group)

The same type or extent of instability can also be observed among the Cree staff, many of whom go on extended sick leave or eventually leave the local health or social services, creating a high turnover rate. Those who stay are faced with major sources of stress. Things appear to be holding steady among the team of psychologists. Part of this stability is likely due to the use of visiting rather than resident psychologists.

The Cree public lost confidence in the system due to the numerous changes at the level of the MHP director position. Since October 1995, the program has seen five such program heads come and go and three interim officers replace each program director upon departure. As the result of these repeated changes in administrative personnel, support for local teams has weakened and several promising initiatives have had to be abandoned (e.g., training; the integration of traditional healing approaches into the existing offering of healthcare services; prevention programs). A review of the available documents also shows that a new plan of action was implemented with each change in program head. Until now, the MHP owes its stability primarily to the ongoing efforts of the assistant to the program head, Ms. Daisy Ratt, who has worked in her current capacity since 1997.

"There has been a constant lack of continuity in staff, management and psychologists, which has fragmented the program and reduced its effectiveness […] Until community members perceive the Program as stable and consistent, it will never be truly effective in the long-term." (Ballou, 2006: 23)

3.9 LEVEL OF INTEGRATION OF PRIMARY CARE RESOURCES (FRONT-LINE)

The participants in both focus groups mentioned that there was work to be done improving the ties and relationships among all the various care services. This being said, difficulty in achieving solid teamwork between the primary healthcare and social services providers involved in providing mental health services appears to be the rule [29]. In a study on interdisciplinary collaboration among primary care team in Iiyiyiu Aschii, almost all participants (physicians, nurses, community workers and psychologists) said they had encountered problems achieving good collaboration between care providers in the services offered to the individuals experiencing mental health problems [29]. In particular, they pointed to a number of specific factors: the lack of means provided for coordination purposes, the few formal agreements established among services providers and among the different care units, the additional difficulties stemming from interprofessional communication in an intercultural environment, the persistent mutual distrust occurring between health workers and community workers, and the ambivalence of the leadership of the team.

"We talk about integrating services, but I think there are major gaps. We say that it should be and there are some things that are missing before it can happen. Of course there is always a leader, but it will not happen until we know what the needs are at your level of services on the front-line taking care of the people." (Mistissini focus group)

Thus, individuals appearing at health care services often end up being referred to social services or visiting psychologists since unstable staffing levels and heavy workloads mean that health workers have a very difficult time conducting the necessary follow-up with service users. Unfortunately, when an individual who is often in crisis continues to appear at the clinic or social services, the health workers say they have a difficult time accessing information recorded by either the social services workers or psychologists for case management. For health workers, such situations constitute a source of frustration when they are trying to provide quality care to the same person over and over. Some primary healthcare and social services providers also report decreased confidence in other team members due to a misunderstanding of their roles and responsibilities. There are also issues regarding the various levels of confidentiality. One participant from the Mistissini focus group stated that in his view, some social services providers gave the impression of lacking confidence in their actions and held back from fully assuming their position on the team. Another discussion participant stressed the importance of clearly identifying leaders within any multidisciplinary team and also mentioned the need to create a forum for discussing service delivery problems. Some members of the Mistissini focus group believed this was the responsibility of the supervisors and managers of the local teams and the regional network.

"Supervisors and managers need to encourage, track, supervise and make connections between services." (Mistissini focus group)

"We were supposed to be talking about integration but there is none. How can we get a good system because I don't know what any of you do?"(Mistissini focus group)

The planned arrival of a mental health worker in each community is designed specifically to facilitate the integration of primary care resources. Until such time arrives, a number of participants claimed that the communities were already in crisis and that the MHP should be taking action right now to improve the level of service integration, which should, furthermore, be defined together with primary care providers and managers at the community level. More specifically, participants thought that steps should be taken to reduce the distrust that had built up between the providers of health and social services, clarify the roles and duties falling to the respective teams, and come to an agreement as to what is meant by the term "integrated services". Some participants were stunned by the extent to which it was difficult to achieve an integrated vision in small communities such as these. Other focus group members felt that the physical separation of health and social activities between different buildings further complicated the task of integrating services. For them, teamwork would likely be greatly facilitated once the clinics finally brought all services together under one roof. All in all, however, participants agreed that the first item of business was to get everyone to sit down at the same table together and begin talking – *now*.

"We all have to be on the same level of understanding about what integration means. We all have to work together at the community level, but we all have to understand first what that means and it must be supported at all levels and through all levels of management right up to the Board." (Mistissini focus group)

"I think we have a good team there, but as for me, when I was there, we did not have a lot of collaboration with other services and I think it's the same in the community. We have to do more to work together. We have to recognize the resources we have. A lot of work has been done already." (Chisasibi focus group)

As one participant from the Chisasibi focus group pointed out, work would also have to be done to integrate services with the schools, as well, such as involving teachers, social workers, psychologists, advisors or student affairs liaisons. Furthermore, as participants and the review of the available documents makes clear, efforts and plans to achieve greater integration between primary care services should also see to granting a specific role and place to traditional care services. A review of the available, relevant documents shows that initiatives are regularly undertaken to foster the incorporation of traditional healing methods in the offering of services. In 1996, the Regional Mental Health Networks project was developed for the purpose of promoting the integration of locally based interventions. In conjunction with this effort, a series of meetings was held with members of the Band Councils and school boards in seven of the Cree communities [11]. A presentation of the MHP made at Oujé-Bougoumou in 1999 specifically mentions the desire to combine "Western" medical methods with traditional healing approaches so as to create greater balance in the service offering [9]. In 2002, a proposal entitled "An Integrated Approach to Health & Social Services in James Bay" was presented to the Executive Director of the CBHSSJB. According to this proposal, the CBHSSJB should incorporate services based on a holistic approach that would fit better with the culture and the needs of Iiyiyiu Aschii [26].

As of the year 2007, traditional healing approaches have not yet been implemented according to any well-structured plan. It is also important to note that on this point, non-Aboriginal health professionals voiced certain reservations of their own concerning a number of points. They mentioned the extent to which crisis situations draw on their energies, an historical lack of the appropriate resources when such situations occur, and the capacity, which they deemed dubious, of traditional care services to respond quickly and effectively to the serious, sudden needs of this clientele. Furthermore, they felt unequipped to provide someone wishing to use traditional healing approaches with the right referrals, as they had no information or training on how to go about it.

"In the CBHSSJB there is a heavy reliance on outside help from consultants who are viewed as the experts as demonstrated in the medical model. The experts have been trying to solve problems by making recommendations, yet they fail to make a difference… It is time to begin a new process that fosters empowerment of the Eeyou/Eenou people in the decision-making process." (Kitchen, 2002)

"I know in Ontario they have centres with traditional healing, sharing circles, traditional healing on one side and Western medicine on the other or both. And I think this is a way for providing holistic approaches to health." (Chisasibi focus group)

3.10 PRIMARY, SECONDARY AND TERTIARY LEVELS OF INTEGRATION

The quest for service integration also concerns the links between general and specialized services. At the present time, an individual requiring care may be sent to Chisasibi, Val d'Or or Chibougamau for evaluation by a physician, particularly if he or she is suicidal. This situation stems from the current scarcity of resources that prohibit keeping such individuals in the communities (with the exception of Chisasibi). With the option of using one of several referral centres, however, comes the increased risk of losing track of vulnerable individuals. When individuals requiring care consult locally, they are usually monitored by the social, medical, nursing or psychological services available in their community. Sometimes, primary care providers ignore procedures to promote links between different levels of services and poorly understand the role of the other services. They therefore continue to work independently. A participant from the Chisasibi focus group gave the example that only a few individuals were referred to secondary care services offered by MSDC because healthcare providers were lacking information on this new resource. As focus group participants noted, it was by no means unusual for a person referred to a major hospital for examination to be sent back to his or her community without any local primary care provider being informed. This is the kind of situation that produces gaps or discontinuities in service, as the appropriate steps were not taken to ensure that follow-up was coordinated with local services and primary care providers. The discussion participants also mentioned that while medical consultation reports written up at external hospitals were generally forwarded to physicians, not all Cree communities were able to maintain the presence of these professionals locally on a continuous basis. As a result, a lag occurs in keeping the other local primary care providers posted on recent developments so they can be prepared for situations requiring their intervention.

"Occasionally we have to send these people down south for assessment and there is basically no connection. Four weeks later, you'll get a list from the Royal Victoria showing that the patient was seen and sent home." (Chisasibi focus group)

"Large villages have permanent physicians. In smaller communities, the nurses have a lot of responsibility. Nurses call us and we call the psychiatrist on call in Montreal, but that is rare. Normally we might organize a change in medication. Sometimes the person may be sent to Chisasibi or another hospital like Chibougamau or Val d'Or to the emergency for assessment by the physician, especially if the person is suicidal." (Chisasibi focus group)

3.11 INFORMATION-GATHERING AND -SHARING SYSTEMS

While participants did mention the need to establish effective modes of communication between primary care providers working in different service units, the discussions also brought to light numerous barriers to understanding, such as geographic distance; unstable staffing levels; the lack of formal communication procedures and channels; the absence of shared files or insufficient information recorded in them; vague or incomplete understanding of confidentiality issues; the lack of interdisciplinary meetings; high turnover in the upper administrative personnel; and divergences in the way to communicate.

Primary care providers practice different types of communication [29]. Among those working in the health sector, the preference is for written communications to allow appropriate follow-up with service users. Among those working in the social service sector, face-to-face discussions between healthcare providers is the preferred method of communication. Discussions are viewed as promoting and deepening mutual relationships whereas writing is considered more impersonal. Indeed, among social services providers, getting to know each other are essential to creating a team that works well together. On the other hand, for reasons of confidentiality, these health service providers are not authorized for access to the files kept by psychologists. Now, as has already occurred several times in the past, individuals who received care from health services while undergoing a crisis were thereafter referred to psychologists and community workers. The problem is that if health workers are called on to provide care to these same users who are again in crisis, they will have few clues as to what actions or courses of treatment were prescribed and/or implemented between the first and second episode. All in all, information sharing between the various service units is limited and does not allow the various care units to fully understand a given situation. In the opinion of a member of the Mistissini focus group, the advent of electronic files could prove helpful in improving access to information. Other participants, however, were dubious as to whether community workers would keep better records simply because files became available in electronic format. A member of the Mistissini focus group pointed out that primary healthcare providers were the ones with the best grasp of the scope and scale of mental health problems, thus making it imperative to find a way to help them to document these problems.

Into this equation, one must then also factor the tendency common to small communities of conveying information informally, in the hallway or around the water cooler [29]. This results in losing track of data because the staff failed to document the information. This shortcoming is all the more serious considering the high employee turnover rate. Furthermore, these kinds of problems must also be viewed against the broader context of a culture whose members attach considerable importance to oral expression and to a non-linear style of sharing information.

While service providers in the same unit generally have the opportunity to meet on a regular basis, it is often difficult to gather service providers attached to different units or sectors (e.g., health services, social services, community resources, schools, etc.). Focus group participants working in healthcare also mentioned the difficulty they encountered when attempting to gain access to the files held by youth protection officers or social services providers. Conversely, social services providers found it hard to gain access to a file kept by health workers. Furthermore, part-time employees and visitors were rarely informed of changes made to existing services or policies and procedures [29]. It is also worth mentioning that ineffective communications between primary care providers and their administrative superiors could also create problems.

Finally, participants mentioned the serious problem surrounding confidentiality issues. Several professions are required by law or by their professional order to maintain information they hold confidential. They were of the opinion that in a small community such as theirs, some confidential issues somehow became common knowledge. Moreover, in the past,

people were normally informed of current issues and could participate in coming up with a solution. The notion of confidentiality until fairly recently did not figure in their mental landscape and that could explain why, today, some confusion still exists surrounding the concept of confidentiality.

"You talked about confidentiality but there was none. Everyone knew about everything. These are stories of people with anxiety and aggression – and everyone knew." (Mistissini focus group)

3.12 TRAINING NEEDS

Focus group participants pointed out that there was a range of primary care training needs in connection with mental health issues – for example: establishing accurate profiles of the mental health problems presented by service users; identifying the modes of mental health intervention best suited to the case at hand; questions related to the discerning use of traditional healing approaches, prevention techniques, and followup based on prognosis for successful rehabilitation and social reinsertion of mental health beneficiaries [1, 30]. As the review of the available documents has made clear, there is a continuous demand for training.

Everyone agrees that the training sessions provided to date have, as a rule, been very helpful, but everyone also agrees that there are not enough of them [9]. In addition, turnover among primary care providers means that training programs have to be repeated; further, training programs and intervention tools have to take into account the cultural framework within which care is to be delivered [17]. The training sessions given by the psychologists to the social workers and training programs such as ASIST (Applied Suicide Intervention Skills Training) are greatly appreciated. It is true that efforts to transfer knowledge and support local care teams can be of varying intensity depending on the psychologist. On the other hand, the question of the contribution of the professionals to training has not yet been really clarified [25]. Group discussion participants feel that training in subjects related to mental health should also be targeted at other community resources and the public at large. It is thought that healthcare providers from the community who have several years of experience to their credit could contribute to any future training sessions of this kind.

"When you have other women who can tell people what a post partum depression is, then you don't need psychologist." (Mistissini focus group)

4 DISCUSSION: SPECIFIC FACTORS FOR CONSIDERATION WHEN IMPLEMENTING A REGIONAL MENTAL HEALTH ACTION PLAN

Variables likely to have an impact on the implementation of a mental health action plan were discussed in relation to the topics of infrastructure, setting, community and service user characteristics, local, regional and provincial bodies, care units, and healthcare providers.

4.1 INFRASTRUCTURE

The information gathered during the focus group discussions or during the document review reveal problems of infrastructure that could compromise the quality of mental health services in the communities of Iiyiyiu Aschii. They consist of: 1) a lack of the necessary infrastructures to ensure that individuals in crisis receive the mental healthcare services they require; 2) a lack of supervised housing for facilitating the social integration of service users with severe mental health problems (with the exception of Chisasibi); and 3) a lack of general housing, which hampers efforts to recruit new human resources with the ability to provide support to teams in the communities. As well, forum participants identified the absence of meeting rooms – or any means to partition off the physical premises used by the various service teams in some communities – as drawbacks to collaboration.

4.2 SETTING

Because the Cree communities are generally not only far apart from one another but also located at considerable distances from urban centres, recruiting and keeping service providers from outside of the region can be difficult, thus making for high staff turnover. Furthermore, such remote conditions mean that transportation costs are high whenever beneficiaries are referred to services outside of Iiyiyiu Aschii for lack of similar care options in the local communities. Each one of the nine Cree villages constitutes its own small community with between 600 and 4000 individuals in which everyone – service providers or individuals requiring healthcare services – knows everyone else. Thus, unlike in bigger communities or urban environments, not only are the inhabitants of these villages unable to lead their day-to-day lives in anonymity but also the service providers can be personally involved in particular problem situations.

4.3 USERS

Implementing a regional mental health action plan requires the consideration of several factors specific to the context of service delivery in Iiyiyiu Aschii. These include: the high proportion of youth among its population, viewed against the backdrop of an inadequate current service offering and the urgent need to develop services more appropriate to the needs of this clientele; the heavy social burden shouldered by women, who are themselves an at-risk group for whom specific services must be targeted; the need to find the means or opportunity of tackling mental health problems in a way that is mindful of their complexity, since such problems often occur in combination with substance abuse or chronic illness such

as diabetes; finally, the legacy of pain and anguish associated with cultural discontinuity, in response to which it is critical to restore the ability of families and communities to take action.

The user-to-services relationship also needs to be better understood, for it would seem that many people hesitate to use services at all. Thus, even though the prevalence of mental health problems is higher among First Nations than among non-Aboriginal populations, the rates of hospitalization for such causes is lower [31]. It has been argued that this underutilization of mental health services stems from the lack of fit between the offering of services made available to Aboriginal populations – whether living in remote areas or in urban centres – and the realities experienced by the various Aboriginal groups in question [18]. In addition, some participants suggested changing the name of the mental health program, noting that from their point of view and based on how the term appeared to be used, “mental health” was often misunderstood and frowned upon. A medical diagnosis confirming the presence of a mental health problem would, it was feared, amount to labelling someone as having problems and thus prompt some individuals to refrain from consulting health services in relation to such needs. Furthermore, according to one participant, the services offered by the Band Council were perceived as being less threatening than those offered by health services.

4.4 LOCAL, REGIONAL AND PROVINCIAL BODIES

The success of efforts to implement a new regional mental health action plan depends on the active involvement of local, regional and provincial bodies. This being said, it would appear that a number of factors related to administrative apparatus have impeded the development of mental health services in the communities of Iiyiyiu Aschii. For example, a number of Cree participants decried what they perceived as the under-representation of Crees among these positions. There is as well a degree of confusion about which leaders do what at the local and regional levels. The participants noted that several initiatives had failed due to the departure of individuals. Furthermore, since many hired positions were unstable (i.e., uncertain to be filled once their current holders left), changes implemented lasted sometimes only as long as the term of duty of the person who initiated them. The difficulty in identifying leaders has also had the result of detracting from the support available to local healthcare providers.

Ironically, in view of the above observations, focus group participants had the impression that over the past several years, most efforts had been directed at consolidating the administration. There was also a fear that any future additions to the administrative staff would come at the expense of the primary care teams. Indeed, recent administration-related developments appeared to have left several participants bewildered. Their bewilderment stemmed from the context of shortages: even though mental health services were identified as a major priority beginning in 1993, they had, as a rule, been underfunded, particularly during the first years of program roll-out. For example, year 1998 witnessed an overall decrease in visits by psychologists, emergency interventions, support for schools, training for primary care providers, development of traditional healing services as well as the abandonment of promising programs or initiatives. If funding were provided on a regular,

adequate basis, developing a long-term perspective toward care, inclusive of prevention-based activities and approaches [30] would be possible.

Concerning Quebec as a whole, the QMHAP contains practically nothing about the realities experienced by remote areas and does not address the need to adapt several of the proposed measures in response to the specific requirements of First Nations. Indeed, the only reference to Aboriginal populations is found in relation to Quebec administrative regions 10, 17 and 18, regarding adjustments needing to be made to regional per capita expenditures – adjustments to be made on the basis of the 2003-04 estimate of service production costs, in view of the low density of the populations concerned [2]. This document moreover, much to the dismay of participants, is available only in French.

4.5 SERVICES

With regards to services, the raising of specific difficulties and obstacles that reflect the current situation allowed for a better understanding of the challenges posed in implementing a Mental Health Action Plan. Among primary care teams, very often the same people must look after responding to emergencies, running the clinic, and carrying out prevention activities. With few resources available to the social service teams or the health teams, they had the impression that care efforts were concentrated on putting out fires without actually providing clients with the aid and support they require. In this regard, some participants stressed the importance of incorporating local resources into service delivery approaches so as to ensure greater continuity of care.

Furthermore, participants identified a series of problems related to services: a lack of collaboration between primary care providers working on the various teams; a lack of integration respecting the care provided by the various teams, including integration of traditional healing approaches; and a lack of trust in and recognition of the respective roles assumed by healthcare workers and social workers. Health care providers recounted the difficulties in referring urgent cases to social service teams or dealing with them outside the clinic's hours of operation. Follow-up/case management was further complicated by the absence of a single user file, difficulty gaining access to the files held by other teams, and the incomplete data recorded in case files. In fact, very few statistics have been generated by health and social service teams. The group participants mentioned that the confidentiality-related requirements were often cited as the reason why statistics were not compiled.

Psychological services were, on the whole, much appreciated by primary care providers and service users alike. However, the discontinuity occurring between the services currently offered throughout the region has made the job of primary care providers a more difficult one. In addition, much more emphasis has been placed on individual consultation than on group-based approaches, which tend to be beneficial in certain situations. Several participants would like to see fulltime phone access to a psychologist. Integrating traditional healers among the other service providers brings up a number of particular challenges. Aboriginal participants expressed their interest in providing more opportunity for the contributions of the elders; it was also their view that informal caregivers are in a better position to reach certain

clientele groups such as youth. Several participants also voiced their desire to renew contact with their cultural roots.

As the review of relevant documents describing developments in the creation and implementation of such services since the 1990s shows, dedicated infrastructures and funding have however been slow to materialize, despite repeated petitioning to obtain them. Projects deemed as being positive were subsequently abandoned for lack of the means and resources required to pursue further. The program currently being operated in Mistissini under the auspices of the Aboriginal Healing Foundation, which relies on informal caregivers, is little known among non-Aboriginal healthcare providers. It would appear that the contribution of service providers hailing from First Nations communities and trained to provide support according to a non-official approach have received little if any recognition or encouragement. Furthermore, the Quebec health ministry's plan of action does not, in its current form, incorporate concerns of a culture nature.

4.6 SERVICE PROVIDERS

Aboriginal care providers say they are well acquainted with service users, whereas non-Aboriginal care providers appear to have little grasp of culturally-related issues, even after having spent several years in Cree communities. Of those, moreover, several appeared to have little experience or interest in mental health. Aboriginal focus groups participants pointed out that in order to intervene effectively among individuals in need, they first had to confront their own personal suffering and in order to do that they required support in order to make headway on the healing process. As was mentioned by several Aboriginal participants, it was only after they had completed their own healing process that they felt equipped to aid members of their family and, thereafter, of their community.

Several of the primary care providers attending the focus groups said that they had personally experienced difficult situations in which they had received little support; in this connection, they stressed the fact that they and their co-workers were exposed to the risk of burnout. As there is currently no employee assistance program, vulnerable service providers must turn to the services provided by their co-workers, which means there is some risk that they will choose not to consult at all. A member of the Mistissini focus group noted that "group debriefing" meetings held following crisis situations could be very helpful to the individuals concerned in terms of alleviating their professional burden. It is also worth mentioning that the already existing workshop entitled "Care for Caregivers" should, in the opinion of participants, be offered on a regular basis. Finally, considering that service providers in Aboriginal communities generally had an aversion for overly formal lines of authority, future efforts to implement the mental health action plan should make all appropriate room for informal, neighbourly relationships.

5 PROJET DIALOGUE: FUTURE STEPS

The information contained in this report provides a general portrait of the current situation of mental health services in Iiyiyiu Aschii. Within the scope of Projet Dialogue, future visits are planned to update the information annually.

Also planned are steps to complete the overview of the contextual and organizational characteristics of the region[1] through additional research that will be conducted at the local level. We hope subsequently to link these contextual and organizational characteristics to client care experiences. Our goal is to provide guidance to regional decision makers, local authorities and local resources for putting health services into place that are best adapted to the needs of the population of Iiyiyiu Aschii.

[1] Such steps are conditional on program funding.

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