A Community Partnership to Explore Mental Health Services in First Nations Communities in Nova Scotia

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ABSTRACT

Objective: This study aimed at identifying the gaps, barriers and successes/solutions associated with mental health services in Mi'kmaq communities in Nova Scotia.

Methods: Community-based participatory research, which is consistent with Ownership, Control, Access and Possession principles of research with Aboriginal communities, was employed for this work. Health directors of the 13 Mi'kmaq communities in Nova Scotia were involved with the research question, design and write-up of the study. This qualitative descriptive study consisted of open-ended structured interviews with consumers, family members and health care providers. Systematic data collection and analysis of interviews present an understanding of issues of mental health services in the communities.

Results: The findings identified barriers and successes/solutions in mental health services in First Nations communities, where services and resources are different from those in more urban communities. Core programs, covering aspects of education, collaboration and culturally relevant community-based services, were identified as solutions to problems identified by participants. Service providers specified core funding for services as essential for continuity and sustainability.

Discussion: While efforts have been made in the past to address mental illness in Mi'kmaq communities, many of these efforts have been proposal driven or crisis oriented. The need for community-based, culturally appropriate, coordinated and sustainable services is evident on the basis of the study's findings. The final report has been disseminated to local community members, participants, Atlantic First Nations and Inuit Health Branch, the Provincial Department of Health and the Atlantic Policy Congress to provide evidence that can inform policy and practice related to mental health in Mi'kmaq communities in Nova Scotia.

Key words: First Nations; mental health; community-based participatory research; OCAP principles

La traduction du résumé se trouve à la fin de l'article.

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Nationally, mental health has been identified as the top health priority by the Assembly of First Nations.^{1,2} Regionally, the Mi'kmaq Health Research Group has identified areas for improvement, a major one being mental health services.³ In Nova Scotia, 73% of Mi'kmaq people live in First Nations communities, and analgesics, sedatives and antidepressants are the highest category of drug claims in this population.⁴ While several studies have investigated Aboriginal mental health and services related to suicide and substance abuse,⁵⁻⁷ minimal research has been done specifically about mental illness.⁸

Current best practices recognize that psychiatric rehabilitation models framed under assumptions based on metropolitan urban areas are problematic.⁹ Further, the literature stresses the need to integrate and coordinate an interdisciplinary team approach¹⁰ and to address the cultural appropriateness and relevance of services.¹¹⁻¹³ Most significantly, Aboriginal perspectives and knowledge remain largely absent from the dominant discourse around mental health care. This arises from the socio-political marginalization of Aboriginal people and the design of services for individuals with severe mental illness (3% of the Canadian population), which fail to address the unique and complex concerns of Aboriginal communities.¹⁴

METHODS

Community-based participatory research^{15,16} was the approach for this qualitative descriptive study aimed at increasing understanding of the gaps, barriers and successes/solutions in mental health services in Mi'kmaq communities. Health directors of the 13 Mi'kmaq communities invited university researchers to conduct the study. The health directors and researchers carefully adhered to Ownership, Control, Access and Possession principles for research with Aborigi-

nal communities.^{17,18} Health directors collaborated with the university researchers on decisions about the research question, interview guide, design, data collection, write-up and dissemination. The academic researchers conducted the structured, open-ended interviews and analyzed the data in consultation. The study was approved by ethics review boards at Dalhousie University and the Mi'kmaq Ethics Watch. Approval was also obtained from the 13 chiefs. Teleconferences with the health directors from the 13 Mi'kmaq communities were conducted by two of the researchers during proposal writing and after analysis and then completion of the study.

Data collection

Health directors wanted consumers, family members and health care providers interviewed to provide a broad range of understanding. The interview guide for all three groups focused on questions about participants' experience with mental illness, identifying

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Table 1. Criteria to Participate in the Study

Family member	<ul style="list-style-type: none"> • Close relationship with a consumer • Not necessarily related to a consumer participating in the study
Service provider	<ul style="list-style-type: none"> • Community-based service provider or visiting service provider in a Mi'kmaq community in Nova Scotia having regular close association with consumers of mental health services
Consumer	<ul style="list-style-type: none"> • Individual from a Mi'kmaq community with a mental health concern not necessarily a diagnosis of a mental illness • 16 years of age or older • Not currently in an addictions program • Speaks English • Able to sign an informed consent

the gaps and facilitators to mental health services, as well as solutions. Health directors contacted eligible participants to determine their interest in participating in the study (See Table 1 for eligibility criteria). Convenience sampling¹⁹ was the method of participant selection for all three groups. Consumers were defined as adults living in First Nations communities who had a mental illness and were not currently involved with an addictions program; health directors wanted to focus on mental illness and not addictions, as addictions have been the top priority for services.

To provide equitable representation, the number interviewed in the three groups was based on population size (1 from each group for communities under 400, 2 from each group for those with 401 to 1,499, and 3 from each group for communities with a population of 1,500 and over). The 13 communities in Nova Scotia are rural with no bus service to major tertiary health care settings and limited access to transportation within the community. Two of the 13 communities have a population size greater than 1,499. The research assistant followed up with the health directors to arrange interviews.

One researcher (AV) obtained informed consent and conducted the interviews. All interviews were audio-taped except one with a consumer who requested that only notes be recorded. A total of 22 telephone interviews, 45 to 90 minutes in length, were conducted with health care providers (Figure 1 describes their positions). Individual face-to-face interviews, also 45 to 90 minutes in length, were conducted with 15 consumers who were identified as clients with long-term or episodic mental illness or having a major mental health issue. Four family focus groups, lasting 2 to 4 hours in length, involving a total of 16 family members, were conducted with the help of the research assistant. The majority of family focus group participants were female (n=14) and two were male; the relationships included mother, daughter, brother, sister or partner.

Confidentiality and anonymity were maintained at all times; focus group members were asked to respect the privacy of participants. Anonymity was maintained by ensuring that the reported characteristics and quotes of participants were not ascribed to any one individual.

Data analysis

The tapes from the interviews were transcribed, and data were analyzed using content thematic descriptions.²⁰ Data from all three sets of interviews were analyzed concurrently. Thematic analysis identified common themes. Thematic coding and patterns from the transcripts provided meaningful data to describe what it is like for Mi'kmaq people living in a First Nations community with a mental illness. NUDIST software was employed for efficiently storing, organizing and retrieving data. Key strategies for trustworthiness included triangulation of data sources and auditing the research process through the use of field notes.¹⁹ Constant comparative

Figure 1. Position of health care providers interviewed

analysis was done by comparing the accounts of each interview. This process continued until all interviews were compared with each new interview.²¹ These analytic strategies reduced the chance of bias and added to the validity and thoroughness of the inquiry. The data were organized under the categories of barriers, successes and solutions (see Table 2). The gaps in mental health were considered as synonymous with the barriers identified in the data.

RESULTS

The responses of consumers, providers and family members were similar yet reflective of the interviewees' context. For example, consumers did not know who was responsible for what or how long a service such as a counselor would be available; providers discussed the lack of funding and the need to write proposals to ensure that services would be provided. The following highlight the major themes under the categories of barriers, successes and solutions.

Barriers to effective mental health services

Barriers to effective mental health services were lack of coordination of services and sustainability of current efforts, transportation issues, lack of culturally relevant and appropriate services, difficulty obtaining a diagnosis, communication issues, stigma and confidentiality. As one health care provider noted:

Lack of funding is the biggest one. There just isn't funding available. We exist on sort of a patchwork of funding from a variety of sources that requires us to pretty much seek out our funding on a yearly basis. We're proposal driven; there's no core funding for the services.

Consumers also said that they did not know who was responsible for what, whom they could talk with or how long the service (i.e. a counselor in the community) would be available:

There's nobody there; they got like services for people like addicts and they've got services for almost everything else. But if someone's depressed, like what do you do? Like, there's no where really to go; there's not a certain person. You talk with a doctor; he'll just write you up a prescription. That's it.

The issues specific to the difficulty of obtaining a diagnosis, communication and culturally appropriate tools for assessment and follow-up were also raised as barriers to effective mental health services. As one traditional healer in the study acknowledged:

And if you don't have the adequate measuring tool, culturally appropriate questions, then sure people are going to fail.

Table 2. Major Themes

Barriers	<ul style="list-style-type: none">• Lack of coordinated services• Lack of sustainability of services• Lack of culturally relevant services• Transportation issues• Difficulty obtaining a diagnosis• Communication issues• Lack of confidentiality• Stigma
Successes	<ul style="list-style-type: none">• Community-based activities• Working together• Fitting within an Aboriginal context
Solutions	<ul style="list-style-type: none">• Therapist in the community• Aboriginal health care providers• Non-Aboriginal providers responsive to Aboriginal culture and history• Model specific to Aboriginal Peoples• Specific education with<ul style="list-style-type: none">– community members– community leaders– family members– health care providers

Others spoke of the need for an Aboriginal context, for example: *I guess just being cautious about Western labels, because, depression... is it depression, or is it the effects of intergenerational trauma and loss that might be a very appropriate response, right. And oppression, you know, racism, that people may look like they're depressed, but maybe they're just dealing with the effects of all of that, and medication and cognitive behavioural therapy might not be the answer.*

Participants spoke of stigma as something that needed to be addressed and understood in their communities. Stigma as a major barrier was something that most participants said was a significant challenge that needed to be overcome. Some family members and consumers reported having personally overcome this challenge, yet expressed the need to “de-stigmatize” mental illness in the community. They said reducing the barriers created by stigma would enable community members to seek help as freely as they would seek help for an “ingrown toenail.”

What has worked well

Some consumers talked about how they have been “feeling great” over a certain number of years and what had helped them achieve this stability. As one consumer said, “If it weren’t for having a therapist, I probably wouldn’t be here talking.” They also talked about activities in the community that helped them, such as exercise programs, art classes, doing volunteer work and being employed. As well, having the support of an employer and the support of family and friends was identified as helpful.

Health care providers discussed the structural components that aided them in providing services, such as team work and inter-agency collaboration within the community, with the opportunity to have regular meetings. Also, building relationships with provincial regional hospitals, mental health units and emergency services was suggested as being very important by some health care providers and as potentially providing more comprehensive care:

Right now ... through collaboration, I'm able to become involved in the process to try to get people seen and to try to give some history and some background to the ER when they are assessing someone, that they tend to use in their assessment. So I think that's a step in the right direction and it has potential for making somebody's visit to the ER more fruitful, but it's early stages yet.

Health care providers also spoke of specific types of activities in the community that they felt were effective, such as drop-in centres, case management, and having regular therapists in the com-

munity and access to proper referrals. Being able to offer options for consumers was identified as important.

For most of the family members in the focus groups, success was discussed in relation to having their family member feel well and be given supports. One family member spoke positively of the accessibility of counseling available in the community:

Things have changed, because now she has [name of counselor] visiting her constantly. [name of counselor] has set her up with somebody from the Mental Health in [town]. They recognize it and they're putting in the steps that need to be taken. But I think she's very fortunate, not everybody has the services that [consumer] has.

Some health care providers discussed methods that were successful, such as the medicine wheel, smudging, making drums and including the Aboriginal context. Although not all counselors are First Nations themselves, being of Aboriginal heritage was seen as a helpful asset because “it bridges that gap a little bit.” If someone was not of First Nations heritage, service providers said that having knowledge of Aboriginal culture, traditions and the history of residential schools was important.

What are the solutions?

Participants said that the need for mental health therapists in the community should take priority over the concern of “everyone knowing everyone’s business”. They commented that while keeping conversations private and confidential was important, hiding the need to seek mental health services or keeping it secret was not helpful and was a barrier to improving mental health services. The following quote from a family member illustrates how the balance of confidentiality and community-based services was expressed:

We can't guarantee absolute, positive confidentiality, but if you have a medical illness, and your family wants some help, maybe you'll just have to take that as good enough for this community. In order to have the service in the community, you have to accept some limitations and the limitation might be somebody will see you going in the building. But I think that's worth the trade-off, quite frankly, to have it in the community.

Many participants said the counselors and therapists should be Aboriginal: “In this day and age, it should be Aboriginal people helping Aboriginal people.” They commented that Aboriginal counselors are “culturally sensitive to First Nations people, like, residential school survivors”. Participants said that if community-based services could not be offered by an Aboriginal person, the priority should be that the counselor be knowledgeable about and “sensitive to an Aboriginal context and the Aboriginal culture, and more responsive to those type of things”. Some health care providers talked about the importance of implementing an “Aboriginal model of mental health delivery ... that’s specific to the Aboriginal people.”

Education was identified as a major priority by all participants. Education in many forms was discussed, such as increased awareness for community members. Specific workshops for teachers, RCMP and Band members is reinforced by this quote from a consumer:

The band council needs to be educated on mental health and not be scared at seeing us “crazy people”... They're scared of people with mental illness, so if they're enlightened about certain mental illnesses, they wouldn't be so, so, you know, scared of people, right.

Appropriate mental health educational requirements for health professionals were also identified by all participants. This quote from a health care provider explains:

My background's in education, so I don't have a lot of, like I think social work background would be a big asset for this job. I have some counseling.

The need to increase awareness about mental illness with culturally appropriate workshops, pamphlets, newsletters and education programs was seen as necessary to decrease the stigma, break down barriers and fears, and increase understanding of mental illness.

DISCUSSION AND CONCLUSIONS

This research demonstrates that mental illness in Mi'kmaq communities requires considerable attention. The major issues are lack of coordinated, sustainable services in the community, culturally appropriate services, after-care services, difficulty obtaining a diagnosis, confidentiality, stigma, transportation and lack of knowledge about mental illness. The problem of Western labels used to diagnose a mental illness in First Nations Peoples and the need for culturally appropriate assessment tools warrant further investigation. The study findings are specific to Nova Scotia and therefore cannot be generalized to all First Nations communities. The focus was on mental illness and therefore excludes community members with addictions. The results do not reflect the perspectives of all consumers, family members or health care providers; however, they have identified issues consistent with the literature, and participants have provided significant ways to address the issues.

While efforts have been made to address mental illness in Mi'kmaq communities, many of these efforts have been proposal driven or crisis oriented. The findings in this study support the necessity of core funding for mental illness services to enable systematic program planning and evaluation processes. Funding should reflect need rather than maintaining what has been historically transferred, and per capita funding should be reassessed, as some regions receive less than others, as is the case in the Atlantic Region.²² Moreover, core funding would raise the profile of mental illness in Mi'kmaq communities and support the sustainability of services that are culturally and contextually responsive. Services for mental illness that are visible and not couched under the guise of suicide prevention or mental wellness programs are needed to promote understanding of mental illness in Mi'kmaq communities.

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RÉSUMÉ

Objectif : Repérer les lacunes, les obstacles et les réussites/solutions associés aux services de santé mentale dans les communautés Mi'kmaq de la Nouvelle-Écosse.

Méthode : Nous avons employé la recherche participative communautaire, car elle respecte les principes d'appropriation, de contrôle, d'accès et de possession (ACAP) de la recherche auprès des communautés autochtones. Les directeurs des services de santé des 13 communautés Mi'kmaq de la Nouvelle-Écosse ont participé à l'élaboration des questions de recherche, à la conception et à la rédaction de l'étude. Qualitative et descriptive, cette étude comportait des entrevues dirigées avec des questions ouvertes menées auprès d'utilisateurs, de membres de leur famille et du personnel soignant. La collecte et l'analyse systématiques des données d'entrevues a permis de comprendre les enjeux des services de santé mentale dans ces communautés.

Résultats : Nous avons relevé à la fois des obstacles et des réussites/solutions dans les services de santé mentale des communautés des Premières nations; dans ces communautés, les services et les ressources sont différents de ce que l'on trouve en milieu urbain. Les problèmes signalés par les participants semblent pouvoir être résolus par des programmes de base couvrant à la fois l'instruction, la collaboration et les services communautaires adaptés aux différences culturelles. Et selon les fournisseurs de services, le financement de base est essentiel à la continuité et à la viabilité des services.

Discussion : Ce n'est pas la première fois que l'on s'attaque à la maladie mentale dans les communautés Mi'kmaq, mais bon nombre des efforts passés ont découlé de propositions de projets ou ont été déployés en situation de crise. Notre étude montre qu'il existe clairement un besoin de services communautaires adaptés aux différences culturelles, coordonnés et durables. Le rapport final a été diffusé aux résidents locaux, aux participants, à la Direction générale de la santé des Premières nations et des Inuits – Région de l'Atlantique, au ministère provincial de la Santé et à l'Atlantic Policy Congress [of First Nations Chiefs]; les données probantes qu'on y trouve peuvent éclairer les politiques et les pratiques en santé mentale dans les communautés Mi'kmaq de la Nouvelle-Écosse.

Mots clés : Premières nations; santé mentale; recherche participative communautaire; principes ACAP