COMMUNITY-BASED MENTAL HEALTH INITIATIVES IN A FIRST NATIONS HEALTH CENTRE: REFLECTIONS OF A TRANSDISCIPLINARY TEAM

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ABSTRACT

As a case study on collaboration, this paper is a first person account from a psychologist and a social worker and their experiences developing and piloting community-based mental health programs for a rural Albertan Cree community. We provide an overview of two such pilots, the Family Wellness Program and the Community-based Anger Management Workshops. Here we reflect on our attempts to integrate mental, physical, emotional, and spiritual considerations consistent with the community cultural context. Each of these programs have been developed and offered within both interdisciplinary and multidisciplinary contexts involving counsellors, teachers, nurses, and community Elders from within and outside the community. Such dynamic programming has evolved into transdisciplinary community-based mental health initiatives that have enhanced community wellness but also taxed these rural service providers. Together we share our reflexivity, outlining some of the issues, challenges, and inspirations in our separate and collaborative work in our attempts to foster mental health and community wellness for this resilient but marginalized population.

Keywords: collaboration, anger management, community psychology, social work, rural practice, Aboriginal people

Providing culturally responsive clinical services within a community mental health model requires a solid understanding of the social forces and context shaping our lives and the lives of the communities we serve. Key competencies for culture-centred services include: self-awareness, understanding the world view of our clients, using appropriate intervention skills and techniques, and involvement in organizational developments (Arthur and Stewart, 2001). This case study sharing is a first person account of the experiences of two professionals working together as agents of change. With that in mind, we wish to begin with a brief personal placement. Judi is a Canadian woman who lives and works in her lifelong rural community of St. Paul, Alberta. She is an academic and practising registered psychologist who has travelled to work in Frog Lake First Nation for seventeen years. Darrell is a Cree man and proud member of Frog Lake First Nation, a small rural Aboriginal community in Canada. He lives off reserve and travels to his home community to provide services as a registered social worker. We have worked separately and collaboratively in this community. Here, we want to share our experiences developing and piloting community-based mental health programs. We have sought the guidance and permission of community Elders, specifically Francis Quinney and Doris Okanee, who, as gifted helpers and respected Cree Elders, consented to our sharing these stories and encouraged us to publish this article as a teaching tool.

The programs we highlight here arose out of dissatisfaction with existing services which tended to
have individualistic, deficit-based, and treatment-oriented approaches. In our opinion existing programs often lacked full participation even in a community with few resources. Stigma was apparent in community discussions and low attendance could have been related to the focus on “client-only” participation where support persons were not normally welcomed to programs offered. Finally, much of the existing programming was targeted (and funded) for a specific need and unable to be responsive to the myriad of underlying associated issues. These programs arose in the spirit of community psychology as they have “a more ecological, strengths-based, prevention-focused approach” (Nelson and Lavoie, 2010, p. 79). We will introduce you to this community and the issues it faces, the community-based anger management and family wellness programs we have piloted, how we seek to collaborate as change agents, and where we hope to take community wellness in this small, rural, Cree community.

**FROG LAKE FIRST NATION**

Alberta has 3 three treaty areas and 140 reserves. Frog Lake First Nation is a Cree band with 2500 members, approximately 1000 of whom live in the community and the surrounding area (Norther Development, 2010). This remote community, approximately 300 kilometres north-east of Edmonton, is one of beauty and solitude with rolling hills encompassing a small tree-lined lake. The land is rich in oil and gas resources but the community and its members are economically disadvantaged. There is a range of federal funding but locally administered community services with a focus on self-governance (Frog Lake First Nation, 2010). We worked together in the Morning Sky Health and Wellness Centre where most programs are developed and delivered collaboratively between professionals and community members. These authors were the only staff members specifically identified as offering mental health services (Judi as the psychologist and Darrel as the “mental health worker”) but we would argue that it is an artificial distinction to separate mental health and physical health. The other programs—addiction counselling, nursing, home care, prenatal, and maternal child health—should all be considered together with the programs that we worked with to offer community health services.

When collaborating with Canadian Aboriginal people to support their mental, spiritual, and emotional health, it is essential to understand their history. Aboriginal people, particularly those living on reserve, continue to suffer disproportionately from poverty, poor health, violence, suicide, drug and alcohol addiction (Abadian, 2000; Walker, 2006). This has been attributed to complicated unresolved trauma (Abadian, 2000; Walker, 2006; Whitbeck et al., 2004) that began with genocidal government policies (Pagans, 2001). This includes a historical loss of social and kinship structures and systemic racism (Poonwasie and Charter, 2001).

A lack of public infrastructure on reservations compounds the problem with a lack of critical behavioural health services and providers to address this multigenerational holocaust. (Tafoya and Del Vecchio, 2005, p. 53)

Knowledge and awareness of multigenerational trauma and the client’s specific context is essential. Techniques, sometimes described as “culture as treatment” have been found to be an effective means of countering traumatically induced social pathology (Abadian, 2000). In our experience, many of these are beneficial, particularly: group healing techniques, family involvement, incorporation of spiritual and cultural ceremonies, use of medicine wheels, and story-telling (Cashin, 2001; Pagans, 2001; Poonwasie and Charter, 2003; Romanow and Marchildon, 2003).

**COMMUNITY-BASED ANGER MANAGEMENT**

We begin with an overview of our community-based anger management program. Judi works collaboratively with the local National Native Alcohol and Drug Abuse program. Interdisciplinary team meetings often focussed on agency, community, and client pressure for a formalized anger management service. The addiction counsellors saw potential in such a preventative intervention for family relational issues and other addiction-based issues. As a psychologist, Judi is a proponent of the benefits of group therapy and psycho-education groups but questioned the merits of offering a short training to “manage anger.”

The original half-day psycho-education session on anger has now evolved into a 2 day program that includes prayer, art therapy, cultural teachings, psycho-education, group sharing circles, and relaxation training. The focus is on identity, multigenerational trauma, power and control, and developing support networks. This ongoing development sequence has included planning meetings, debriefings, and direct collaboration with program participants. Community Elders are frequently consulted and periodically attend the program. Core aspects of the program integrate physical, mental, emotional, and spiritual aspects of anger with a focus on wellness rather than pathology consistent with our understanding of local Cree cultural teachings. Transportation and food are provided and the training takes place at a neutral community location with time balanced between indoors and out, in conversation and in activity, in sharing and in teachings. This program, ongoing for three years, is offered four times a year. Participants complete written evaluations at the end of the program and other professionals are invited to attend both to participate and to provide consultative evaluations on the program itself.

This program is now offered monthly with growing acclaim (and demand) from within and outside of the community. Some community members have attended the program several times and espouse the benefits of ongoing wellness training. Most participants sign up voluntarily based on word of mouth recommendations. Judi has been pleasantly surprised by how this program continues to evolve with community and participant collaboration and is happy that she has learned more than she has shared.

This program has also been taxing. The other program leader is also the only male NNAADP counsellor who has a mandate to provide intervention and prevention of addictions in a community rife with alcohol and drug abuse. Common themes in addiction services have been the high unemployment rate, chronic alcoholism in older males, and a growing number of youth abusing drugs. There are high levels of reported cannabis abuse but even higher rates of reported crack cocaine, cocaine, and ecstasy abuse in addition to alcohol abuse and dependence. Judi only comes to the community twice weekly and there is often a waiting list for her services. Time spent planning and offering these anger management sessions means days where no individual or crisis services are available from either of these providers. Large numbers of referrals from other programs raises questions of responsibility for service delivery and its associated costs. Judi feels torn between providing a service that makes a real difference and is becoming truly “owned” by the community and working outside the scope of her contract. If successful, such programming could mean reduced individual or crisis services in the long term. Several participants have taken the program more than once indicating that community-based services. Ideally, we would like to monitor the number of crisis and individual service requests comparing times when there were group programing available and prior to it being offered.

Present concerns about the utility of this program are outweighed by the inspirations received from this program to date. In one offering there were only six male participants, most of who have been implicated as aggressive, high-risk resident drug dealers. All indicated that participation in the anger management program was only to avoid breaching probation and being reincarcerated. The facilitators employed additional strategies to carefully constructed and debriefed during the training including measures for confidentiality, extra clarification of roles, and choosing a private yet accessible setting. The final art works done by these participants were colourful, symbolic, and presented with deeply reflective statements about power, racism, rational thinking, and personal responsibility.
Uncharacteristically, hugs and tears were shared as day one's art was ceremonially burned. One of the older participants asked to lead the closing prayer which began long after the program was suppose - ed to have been finished. Leaving the facility, Judi heard the men discussing how they will structure their own support group. In the final debriefing, the program leaders agreed that they had originally been apprehensive about working with this group. Together we shared some of the teachings we re- ceived — rather than what we gave — to this group.

**Family Wellness**

Next, we want to share our experiences with the Family Wellness Program. Darrel, the co-author of this paper, was in a new role as the community mental health coordinator. He worked with a community member and teacher who has the role of maternal child health coordinator. This coordinator had ex- pressed concern that many of the mothers she deals with are teens and that she had effectively integrat- ed Elders into the community program but could not engage the young fathers. Darrel had strong rela- tionships with the community youth based on over a decade as a trusted school counsellor. Together they devised a Family Wellness Program — an un- funded collaboration between their programs.

The structure of the existing program allowed for workshops, crisis intervention, and support to single mothers that might have had outside referrals facilitated by the mental health coordinator. This evolved to include a family wellness component that directly involved Darrell, this development incorporated cultural teachings. Elder support, psycho-education, group sharing circles, and regular home visits and individual counselling sessions. There was more focus on identity, self-care, and relational health rather than strictly parenting. The program aimed to empower rather than to teach. The maternal health coordinator focuses her individual and group efforts on the mothers in the program. Darrel's involvement went beyond psycho-education groups to include individual and group work with the fathers in an attempt to en- gage them in family processes as fathers and men with a focus on both the responsibilities and joys of this role. Together they acted as co-counsellors of- fering couple counselling to these young parents to balance perspectives and focus on larger relational concerns. Community Elders acted as consultants and attended various sessions within the program teaching, sharing, and supporting these young par- ents. The school supported students who are in the program by providing program flexibility and other agencies refer parents in a progressively more pre- ventative way. This program ran for two years with groups meeting once to twice monthly. Participant evaluations were completed orally with the nursing staff assigned to the mothers in the program.

Such dynamic programming enhanced com- munity wellness by taking focus off “at-risk young mothers” and shifting it to ways that the communi- ty could collaborate to foster and strengthen the families of the future. Darrel, a dedicated father, was able to share his own parenting successes and fears in ways that inspired his own parenting while role modelling for the young parents in the program who often see child rearing as typically done by mothers or grandparents rather than by both parents.

One of the more taxing aspects was justifying Darrell's time. His involvement meant a direct ser- vice role rather than the expected coordination role, lessening his availability for community and crisis concerns. Additionally, the maternal child health program has had so many referrals that interdisci- plinary collaborations with other members of the health centre (including Darrell) most often oc- curred over lunch hour or otherwise outside of regular working hours. Crisis management — rather than coordination — frequently interfered with sched- uled activities. We worried that program instability within the health care environment may have meant risk to program sustainability if program leaders left their current roles and that such changes could fos- ter a sense of transference issues if they were seen in a cul- turally appropriate way as parent figures. It is with sadness that we acknowledge that before this article was published funding for Darrel's position was abolished and the program reverted back to the expected coordination role, lessening his availability for community and crisis concerns. Additionally, the maternal child health program has had so many referrals that interdisciplinary collaborations with other members of the health centre (including Darrell) most often occurred over lunch hour or otherwise outside of working hours. Crisis management — rather than coordination — frequently interfered with scheduled activities. We worried that program instability within the health care environment may have meant risk to program sustainability if program leaders left their current roles and that such changes could foster a sense of transference issues if they were seen in a culturally appropriate way as parent figures. It is with sadness that we acknowledge that before this article was published funding for Darrel's position was abolished and the program reverted back to the original maternal child health program.

The primary inspiration for the program leaders had been teenage parents reporting effective com- munication strategies and sharing successes and support with their peers. Given the high teenaged birthrate in the community, these program partici- pants could be future leaders and role models in a significant way. It is our hope that they continue to benefit from community support despite the sudden and premature termination of the Family Wellness Program.

**Collaborating as Agents of Change**

There are many forms of collaboration in professional practice. In our work we have interagency relation- ships where we collaborate with professionals of varying disciplines from other agencies such as teach- ers, social workers, counsellors, and nurses for pro- gram ideas and referrals. Each of the pilot programs that we have described also involved multidisciplin- ary teams where members cooperatively provided discipline-specific contributions. Judi has contrib- uted as a psychologist, and Darrell as a social worker.

Our initial successes followed interdisciplinary col- laboration which is “the deliberate pooling and ex- change of information and knowledge that crosses traditional disciplinary boundaries” (Crossley et al., 2008, p. 231). Collaborating in this way allowed us to begin to address the complex, multifaceted problem faced by our clients and to set goals for achieving com- mon ground (Austin et al., 2008; Van Viet, 2009).

Such professional interactions are an effective way of providing for an integrated community response (Bock and Campbell, 2005; Donoghue et al., 2004).

In our work this meant taking time to meet and ad- vocating for these kinds of expanded roles.

What has been most successful, in our experience, has been our evolving transdisciplinary work. This is when we have collaborated in ways that evolved beyond discipline-specific contributions (Austin et al., 2008). Transdisciplinary collaboration exceeds the level of integration typical in most rural and remote collaborations and in our case has been evolving specifically to a community approach towards mental health and wellness.

It is this level of community psychological practice that resulted in the two pilot programs highlighted in this paper. Our work really started to move to this level as a result of visionary commitment from several community addiction counselors, flexibility in Judi's contract with the federal government, and a commitment from the Health and Wellness Centre that resulted in Darrel being appointed in a full time role to oversee mental health needs in the community. In this capacity we collaborate with each other, our clients, community members, and elders to consider mental, physical, emotional, and spiritual considerations for community wellness. In this way we work with and for the community.

**Policy Considerations for Transdisciplinary Collaboration**

The literature speaks to the benefit and potential of transdisciplinary collaborations (Faqua et al., 2004; Pohl, 2008; Stokols et al., 2008). Policies supporting transdisciplinary community-based collaboration have proven benefits for health promotion, interven- tion, and prevention programming. Further, trans- disciplinary collaboration allows enhanced service delivery and can improve organizational climate for service providers. Such policies not only foster these collaborations but help to maintain focus on the cul- tural and community context, provide a foundation for practice guidelines, and foster better evaluation of initiatives (Faqua et al., 2004; Stokols et al., 2008).

Specifically, it is suggested that transdisciplinary applications serve to inform culturally and con- textually relevant policies for service provision (Pohl, 2008). With ongoing changes to policies and fund- ing structures this becomes progressively more im- portant (Faqua et al., 2004; Stokols et al., 2008).

It is our hope that these case studies, and our experience, serve as phenomenological data to in- form such research and policies. From our perspec- tive, we have learned that community and cross-knit communities benefit more from collaboration, community-side involvement, and shared roles and services than from “cookie-cutter” approaches to programming. When service providers are able to consult Elders and each other they may be, as was the case for us, more able to creatively serve community needs.
### References


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