ABORIGINAL PEOPLES FAMILY ACCORD

THE FIRST STEPS: A NEW JOURNEY TO HEALING

INTERIOR REGION
ABORIGINAL CHILD AND YOUTH MENTAL HEALTH
TRANSITION PLAN

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To the People

It was an honour and privilege to visit the many different communities and to hear your stories, concerns and accomplishments. I feel the responsibility of carrying your voices to the eyes and ears of those who need to see and hear them. I am humbled by this task. My goal is to present your words in a good way; meaning an accurate portrayal of what you have said in a manner that will be heard and respected. This report is my effort to deliver your message.

PREAMBLE

This plan is based on the information collected from speaking with some groups of people and does not reflect the concerns and opinions of all Aboriginal Peoples living in the Interior Region. Many voices were missed. The Aboriginal Peoples Family Accord (APFA) and myself, the Aboriginal Mental Health Planner, acknowledge that not all Aboriginal People will agree with this plan.

We also understand that each Nation and community are distinct and that a generic approach to Aboriginal child and youth mental health services does not account for all of the unique needs and strengths within the individual communities. My perspective, as a Métis woman working with Aboriginal Peoples, also influences the development of this document.

This report provides, at best, a blurry snapshot of the needs within each of the Zones within the Interior. It is not meant to be a prescriptive remedy for all communities but rather a place of beginning that will evolve as the community planning continues.

The framework used to organize this report is based on the teachings of the Medicine Wheel. Some may not agree with the application of the Medicine Wheel or with my interpretation of it as presented in this report. It is important to state that my interpretation is based on the teachings that I have received and that my intention is not to present my personal understanding as truth for all Aboriginal Peoples.

Also of importance is that while this report focuses on the many deep concerns regarding personal and community wellness within Aboriginal communities, the resilience, strength, and survival of Aboriginal Peoples must not be forgotten.

A note on terminology:

In this report, the term Aboriginal is used as inclusive of First Nations, Métis and Inuit peoples.

"Think not forever of yourselves, O Chiefs, nor of your own generation. Think of continuing generations of our families, think of our grandchildren and of those yet unborn, whose faces are coming from beneath."
(Peacemaker 1000 AD, Iroquois)

INTRODUCTION

The mental health of children and youth, in general and in particular, Aboriginal children and youth is of recent concern to the Province of British Columbia. In 2003, the Province produced a general services Child and Youth Mental Health Plan that endorsed a regional approach to service planning and delivery. An identified component of regional planning was the recognition to collaborate with Aboriginal people to develop plans that would enhance services specifically for Aboriginal children and youth with serious mental health concerns.

In order to accomplish this task, the Ministry of Children and Family Development (MCFD) collaborated with the five regional Aboriginal Planning Committees to develop regional Aboriginal Child and Youth Mental Health Plans. The regions and planning committees are: the Fraser Region – The Fraser Region Aboriginal Planning Committee (FRAPC); the North Region – The Northern Aboriginal Authority For Families (NAAFF); Vancouver Coastal Region – Vancouver Coastal Aboriginal Transition Team (VCATT); Vancouver Island Region – Vancouver Island Aboriginal Transition Team (VIATT); and the Interior Region – Aboriginal Peoples Family Accord (APFA).

This report and strategic plan are focused on the Interior Region as defined by the APFA. The purpose of this report is to ultimately present the results of the consultations to the Assistant Deputy Minister (ADM), Provincial Services Division and the Assistant Deputy Minister, Child and Family Development. The ADMs have joint-responsibility for ensuring that Aboriginal child and youth mental health plans are developed and implemented for each region within the province. This plan does not address long-term strategies for providing holistic and integrated services. Instead, it will assist the Ministry of Children and Family Development (MCFD) in delivering Aboriginal child and youth mental health services until the responsibility for these services is transferred to the Aboriginal Peoples Family Accord.

In order to develop this plan the voices of Aboriginal people residing and working throughout the Interior Region were sought. The APFA conducted community consultations as the primary method to identify community needs, strengths, concerns and priorities. Although Elders, youth and other community members participated in the consultations, the majority of participants were service providers. MCFD Aboriginal and Child and Youth Mental Health (CYMH) Teams were also consulted.

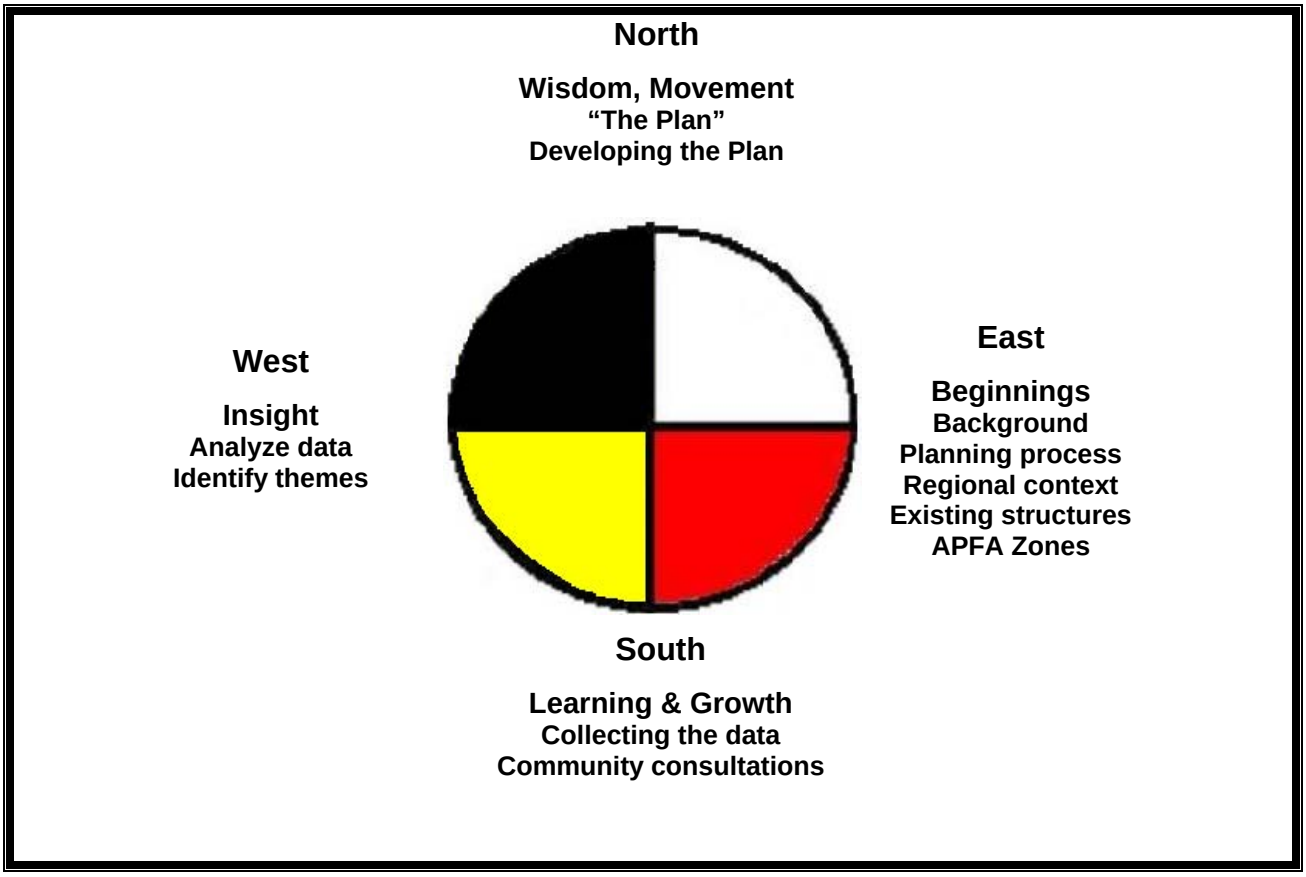
This report describes issues and themes and presents recommendations as identified by the participants of the consultations. It results in an interim strategic plan for the Interior, referred to as a Transition Plan.

The Interior Region Aboriginal CYMH plan is aligned with the *blueprint for change* framework as outlined in the provincial plan. This framework includes: treatment and support, reducing risk, building capacity and improving performance.

This report is structured into four sections that are based on the teachings of the Medicine Wheel. Although the Medicine Wheel has many lessons, this report follows the teachings of the four directions. When one symbolically travels through the four directions the East is the quadrant representing beginnings. The South is the direction of learning. The West represents insight gained from the learning and the North is the place of wisdom. Following these teachings, in this document the East provides a background to the planning process, the South describes the information gathering process, the West provides a discussion of the findings and themes and the North presents the Plan. (See figure 1.0)

The information provided in this document is also viewed as the result of a journey through unknown territory, literally and figuratively. The venture brought me to communities that I had never previously visited. In addition, my travels exposed me to several different points of view, not only of service needs and challenges, but also of the planning process. As with every journey one embarks on, a point of departure is required. As its place of departure, this report begins in the East with a discussion of the background to planning.

Figure 1.0 The Report Framework



1. THE EAST – A Place of Beginnings

According to the teachings of the Medicine Wheel, the East represents new beginnings. This section of the report provides a background to the inception of the planning process. The move to develop an Aboriginal CYMH Plan was directed by MCFD. In order to provide context, brief descriptions of the Provincial Plan, structures of the planning entities involved in the planning and the service Zones are provided. This section concludes with an explanation of the onset to the planning process.

1.1 Background

In recognition of the need to improve services for children and youth at risk of, or suffering from serious mental health concerns, the Province of British Columbia provided new funds toward improving resources and outcomes for this population. In 2003, a provincial general services *Child and Youth Mental Health Plan* (*The Plan)* was developed.

The Plan identifies a multi-faceted approach to promoting improved outcomes. This approach, referred to as a *blueprint for change*, outlines four key components: 1) Providing treatment and support; 2) Reducing risk; 3) Building capacity; 4) Improving performance. These components provide the framework used to guide the development of the general services strategic plan. Treatment and support services are focused on providing specialized clinical interventions for those in most need. Prevention and early intervention programs assist in preventing problems for at-risk children and youth. The healthy development of children, youth and their families is facilitated through capacity building programs. Improving performance is accomplished through providing evidence-based practice and ensuring accountability.

The general services plan identifies Aboriginal children as a priority. *The Plan* acknowledges that the key components must respond to the unique mental health needs and challenges of Aboriginal Peoples. *The Plan* also recognizes that in order to ensure development of appropriate services for this population there is a need to develop partnerships with Aboriginal communities.

In response to *The Plan,* the Ministry of Children and Family Development initiated a collaborative planning process with the province's five Aboriginal regional planning authorities. The aim of the joint-planning was to develop plans to enhance service delivery for Aboriginal children and youth, between the ages of 0-19, with serious mental health concerns. In the Interior Region, the Ministry of Children and Family Development collaborated planning efforts with the Aboriginal Peoples Family Accord (APFA).

1.2 Why the APFA?

The Aboriginal authorities were established under the Province's child welfare community governance initiative. *A Memorandum of Understanding (MOU) for Aboriginal Children,* and the *Tsawwassen Accord* agreements both lay the foundation for a government-to-government partnership and establishment of an Aboriginal Authority in the Interior Region (See Appendix A and B). The MOU guides the planning process for the transition of child and family services to Aboriginal authorities.

Child and youth mental health is one of the categories of child welfare services to be transferred. Additionally, in the year 2007, Aboriginal authorities will begin to assume responsibility for ensuring service delivery for the following programs and services:

- Child Protection, Guardianship and Adoptions
- Family Development
- Early Childhood Development
- Supported Childcare
- Youth Justice
- Special Needs Children and Youth

Because the APFA will eventually assume governance for the delivery of these services, their involvement is critical to the planning process. Since the APFA will continue in their role as a planning committee until 2007, MCFD continues to be responsible for services to Aboriginal children and youth. Thus, in collaboration with the Ministry of Children and Family Development the APFA has begun planning for short and long-term service development and delivery for Aboriginal children and youth with mental health concerns.

The vision, mission statement, and principles established by the APFA guide the development of this plan.

APFA Vision

"Strong, healthy individuals and communities, working together as Nations honouring our positive identity as Aboriginal families and effectively managing our resources for the benefit of our future generations."

APFA Mission Statement

"To provide a framework for Aboriginal People to develop and deliver community based child and family services."

APFA Principles

All work performed by the APFA is based on the core values of respect, honesty, trust, accountability, integrity and common vision. These values are reflected in the following

principles used to guide the development and implementation of this and other APFA service plans:

- A long-term vision of holistic healing and wellness.
- Ensuring Aboriginal values and cultural competency are incorporated in planning, programs and services delivery.
- Strengthening and respecting community and personal responsibility.
- Partnerships, inclusiveness, nurturing innovation and celebrating our common identity.
- Autonomy of individual Aboriginal Nations to develop local service delivery models.
- Capacity development of Aboriginal organizations, workers and citizens.
- Service transition and transformation phased in at a pace set by the community.
- A new beginning allowing for errors and positive learning experiences.
- Equitable service access to all Aboriginal people within the Interior Region, regardless of status or residency.
- Building on existing services and strengthening what works.
- Nation-rebuilding aspirations over the long term.
- Respectful, fair and independent mechanisms for conflict and dispute resolution.
- Transparent and accountable decision-making and governance.

1.3 Approach to Planning

Composition of Planning Teams

The provision of funds to create Aboriginal Planner positions reflects the commitment of the Ministry to plan for services that are developed and delivered in a culturally sensitive manner. Planning in the Interior for Aboriginal service delivery began in April 2005 with the hiring of an Aboriginal Mental Health Planner. The primary responsibility of the Planner is to develop an Aboriginal services plan that is informed by community consultations. The plan is to focus on enhancing current service delivery for Aboriginal children and youth with serious mental health concerns. It is also to be aligned with the goals of the provincial and regional general services plans. Development of the plan is achieved through a collaborative team effort.

The team involved in the planning process includes the Regional CYMH Manager, the Aboriginal Community Services Managers, the Regional Child and Youth Mental Health Team Leaders, the APFA Transition Coordinator, APFA Consultant and the Aboriginal Mental Health Planner. At the provincial level, an Aboriginal Child and Youth Mental Health Planning Committee was established for the purposes of networking and to guide the planning. Membership consists of the Assistant Deputy Minister, the Director of CYMH Policy and Program Support, the Provincial CYMH Consultant, the CYMH Regional Managers and the Aboriginal Mental Health Planners.

In addition, the APFA formed a Reference Group. The role of this Group is to provide

feedback and direction to the overall plan, and to raise awareness of the planning process in their local areas. An Expression of Interest letter was circulated through the Aboriginal communities as a means of attracting Reference Group membership. This method resulted in few responses. Further recruitment occurred through personal invitations to those who appeared interested and through names that were put forward by Directors or members of Aboriginal organizations.

The Reference Group consists of individuals with diverse backgrounds in addictions, mental health, healing, and employment services. Group members are residents of each of the five Zones, within the Interior. The Zones, as defined by the APFA, include the Shuswap, Okanagan, Lillooet-Thompson, Kootenays, and the Cariboo-Chilcotin.

1.4 The Interior Region

The Interior Region is rich in cultural and geographic diversity. It is a vast area with approximately 42,000 or 6% Aboriginal inhabitants. These Aboriginal Peoples are either of First Nations (status and non-status), Métis and/or Inuit descent. Cultural diversity extends beyond Nations to include differences between bands within specific Nations. In addition, there are also differences in the jurisdictional responsibility for service provision to Aboriginal Peoples. Geographic location and historic influences and traditions also contribute to this diversity.

Geographic location of Aboriginal Peoples is also linked to the services they receive. The current trend of more and more people leaving the reserves to live and work in urban centres clearly influences the distribution of dollars. For the people living on a reserve funding falls under the jurisdiction of the federal government. For those residing off reserve or in rural or urban centres, funding is the responsibility of the provincial government. Both of these fiscal responsibilities stem from the Indian Act and are determined through land-based recognition of First Nations Peoples. The Indian Act delegates fiduciary responsibility of First Nations people to the federal government.

Urban Aboriginals are comprised of First Nations status people living off reserve, non-status individuals and Métis people. The Métis, after several years of lobbying for recognition as a Nation, are being recognized by the province for their unique Aboriginal status. This recognition is made evident by the funding targeted specifically for Métis people. The distribution of funds based on the variety of categories of Aboriginal people, such as Métis, Status Indian, on or off reserve, and non-status is a double-edged sword. On the one hand, for example with the Métis, it validates their unique identity, which is empowering and respectful. On the other hand, the separation of funds into the different categories promotes animosity between Aboriginal Nations as they must compete for the limited dollars. This is one of several issues that complicate matters for Aboriginal people and makes it more difficult to present a united front on crucial problems of common concern.

As well as contributing to a division of Nations, the jurisdictional responsibilities of the federal and provincial governments also contributes to a fragmentation of services.

Mental health services on reserves typically occur in the form of contracts with private psychologists or consultants, both of which are expensive and quickly use up the limited federal funds.

Other mental health services available to Aboriginal people are provided off reserve through the general services system. Adult mental health services are delivered through Interior Health and services for children and youth are delivered through the Ministry of Children and Family Development. MCFD services are a combination of direct service delivery and community contracts.

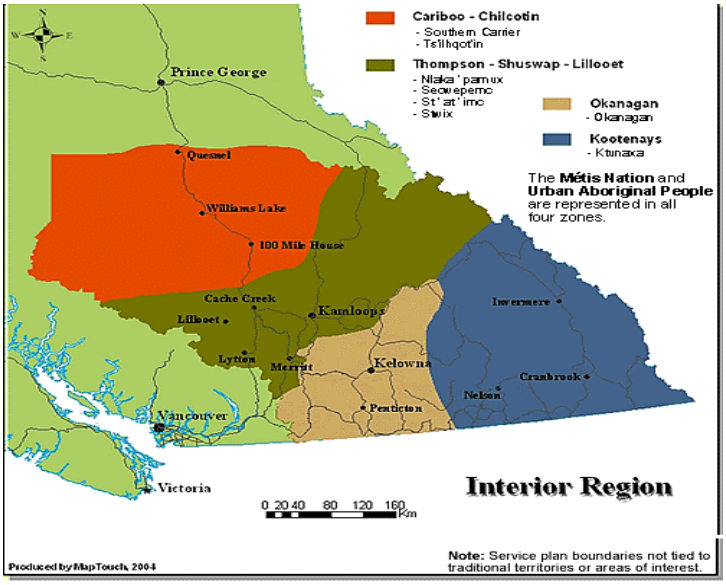
1.5 Structure of MCFD Child and Youth Mental Health

MCFD CYMH treatment services consist of: consultation, clinical based assessment and therapy, home-based and outreach services, family development/support services, day treatment, crisis intervention and stabilization services, and residential services. The mandate covers responsibility for children and youth, with serious mental health challenges, between the ages of 0-19. The Interior Region CYMH has made a commitment to enhance services to all Aboriginal children regardless of their place of residence.

The overall operations of CYMH are the responsibility of the Regional Executive Director (RED). The RED reports directly to the Province. Four regions (the Fraser, the North, Vancouver Coastal and Vancouver Island) have Transition Managers (RTMs). The Interior has a dedicated Regional Manager for CYMH services. The Managers are responsible for the implementation of the service plans. They report directly to the RED. The Regional Manager works closely with the Team Leaders who have the responsibility of ensuring appropriate and consistent service delivery within their network areas. The clinical teams report directly to their Team Leaders. The Regional Manager and Team Leaders work closely with MCFD Community Services Managers (CSMs) to ensure community-based services.

Within the Interior, MCFD CYMH follows seven regional service areas. The areas include the Cariboo, Thompson, South Okanagan/Boundary, Central Okanagan, North Okanagan, East Kootenays and West Kootenays.

The Aboriginal Peoples Family Accord has a different view of the Interior that is based on the traditional territories of the Nations. The Accord has divided the Region into five Zones. The following information describes the geographic boundaries and provides some demographics of each Zone. The information also includes a summary of some Aboriginal centres providing services within each of the areas.



1.6 The APFA Zones

The Shuswap Zone

The Shuswap Zone reaches north to Clinton and from Cache Creek following the Trans-Canada Highway east to Sicamous. The Aboriginal population of the Shuswap Zone is approximately 8,000 persons - with about one-third of the population under the age of 24. Approximately half of the Aboriginal population resides off reserve, with large densities in Kamloops and area.

The Aboriginal population across the Zone is served by a variety of social service agencies (on and off reserve) – the primary ones being:

- Secwepemc Child and Family Services Society (Level 13 delegation) (Kamloops)
- Interior Indian Friendship Centre (Kamloops)
- Interior Métis Child and Family Services (Kamloops)
- The 12 individual bands that comprise the (south) Shuswap Nation
- Q'wemtsin Health Society (QHS)
- White Buffalo Aboriginal Health Society (Kamloops)

The Okanagan Zone

The Okanagan Zone spans from Manning Park in the west to Christina Lake in the east; and from just south of Spallumcheen/Enderby in the north and south to the Canada-US border. Many Okanagan Nation members live in Washington State.

The Aboriginal population within the Okanagan is approximately 11,000. This group of people receive family services from a number of agencies. The following agencies provide a wide variety of prevention service:

- First Nations Friendship Centre (Vernon)
- Ki-Low-Na Friendship Society (Kelowna)
- Ooknakane Friendship Centre (Penticton)
- Lake Country Native Association (Winfield)
- Okanagan Métis Children and Family Services (Kelowna)
- Boundary Individual and Family Services (Grand Forks)
- En'owkin Centre (Penticton)
- Round Lake Treatment Centre (Armstrong)
- The Okanagan Nation Alliance and its seven member bands (Westbank)

The Lillooet –Thompson Zone

The Lillooet – Thompson Zone reaches north to the Ashcroft/Cache Creek area, east through Logan Lake to Merritt, west to Shalath/Bridge River, Lillooet, and south through the Fraser Canyon (Lytton, and Kanaka). The Aboriginal population of the Lillooet – Thompson Zone is approximately 8,500 persons.

The people in this Zone are served by a variety of social service agencies and organizations (on and off reserve) - the primary ones being:

- Nicola Tribal Association (Merritt)
- Lillooet Tribal Council (Lillooet)
- Nlaka'pamux Nation Tribal Council (Lytton)
- The 19 individual bands that comprise these nations
- Scw'exmux Child and Family Services Society (Level 15 delegation) (Merritt)
- Nlha'7kapmx Child and Family Services (Level 15 delegation) (Lytton)
- Conayt Friendship Society (Merritt)
- Lillooet Friendship Society (Lillooet)
- The Interior Métis Family Services (IMFS) serves Merritt and area.
- Lower Nicola Indian Band Health Centre (Merritt)
- The St'at'imc Healing Centre (Lillooet)

The Kootenays Zone

The Kootenays region stretches from Christina Lake east to the Alberta Border, south to the American border, and north to Golden. Forty-four communities encompass the seven natural geographic Zones: Arrow Lakes, Tri City, East Kootenay Lake, Cranbrook, Elk Valley, and Columbia Valley. Cranbrook and Nelson are regional centres for the East and West Kootenays. The Aboriginal population within this zone is estimated at 6,500.

The people residing in this area receive family services from a number of agencies including:

- Ktunaxa Kinbasket Child and Family Services (KKCFS) (Cranbrook)

- Kootenay Region Métis Association (Cranbrook)
- Lower Columbia River All First Nations Council (Castlegar)
- Smum Iem Agency (West Kootenays)

KKCFS works closely with the Kootenay Region Métis Association to provide a variety of on-reserve and off-reserve services in the East Kootenays. Lower Columbia River All First Nations Council and the Smum Iem Agency are developing their capacity to provide family services in the West Kootenays.

The Cariboo-Chilcotin Zone

The Cariboo-Chilcotin Zone spans from the northern Shuswap communities near Clinton to the Southern Carrier communities near Quesnel, going west from Williams Lake to include the Tsilhqot'in communities and the Carrier community of Ulkatcho. This Zone is comprised of three distinct First Nations (15 bands), two Friendship Centres and two Métis Nation organizations.

The Aboriginal population is estimated at 8,000, consisting of Northern Shuswap, Southern Carrier, and Tsilqot'in nations, Métis and urban Aboriginal people - half the population being under the age of 20 years. The residents of this Zone receive family services from a number of agencies. In addition to MCFD, there are two Aboriginal delegated agencies providing statutory (legislated) services:

- Knucwentwecw Society (Level 15 fully delegated) (Williams Lake)
- Desniqi Services Society (Level 12) (Williams Lake)

Also, the following agencies provide a wide variety of prevention services:

- Ts'ilhqot'in National Government and its member bands (Williams Lake)
- Alkali Lake Band
- The Southern Carrier Nation and its member bands
- The Carrier Chilcotin Tribal Council (CCTC) and its member bands (Williams Lake)
- The North Cariboo Aboriginal Family Program Society (The Longname Society) (Quesnel)
- The Cariboo Friendship Society (Williams Lake)
- The Quesnel Tillicum Society Friendship Centre
- The North Cariboo Métis Association (Quesnel)

Given the limited amount of time to conduct community consultations and combined with the huge geographic area in the Interior Region not all communities were consulted. However, in order to develop this plan, efforts were made throughout the five APFA Zones to consult with as many Aboriginal communities, CYMH Teams, and MCFD Aboriginal Teams, as possible.

Section 2, the South – The place of learning and growth, describes the consultation process.

2. THE SOUTH – A Place of Learning and Growth

Following the Medicine Wheel teachings, the South is the place of growth and learning. In order to discover what information to include in the Aboriginal CYMH services plan and the strategies required to implement the plan, the journey entailed visits to many communities.

The methodology used to guide this leg of the journey is a qualitative participatory action research approach (PAR). The PAR approach involves community members as research partners. The goal of this method is to expand beyond producing knowledge to an aim of creating change in structures or situations. PAR focuses on imbalances of power and advocates for community empowerment (Coghlan & Brannick, 2001).

Community Consultations

Consistent with this methodology, input into the strengths, priorities and recommendations were sought through community consultations. The consultations occurred in the form of focus groups, semi-structured individual interviews, discussion meetings and completion of questionnaires. They were conducted from June to November 2005. Two additional focus groups were completed in January and March 2006. Participants were primarily service providers in Aboriginal communities. Elders, youth and other community members participated in some of the gatherings. MCFD Aboriginal Teams, the CYMH Teams and some key representatives of Interior Health were also consulted for their input. There were 358 respondents. Refer to Table 2.1

Table 2.1 Sources of Data Collection – Regional

Location	Focus Groups #	# Participants	Individual Interview	Questionnaire	Total
Shuswap	5	47	1	11	59
Okanagan	12	140	6	14	160
Lillooet - Thompson	4	38	1	2	41
Kootenays	3	37	1	0	38
Cariboo - Chilcotin	6	53	3	4	60
Totals:	**30**	**315**	**12**	**31**	**358**

Focus groups and meetings varied from one and one half hours to four hours and were held in band halls, Aboriginal organizations and MCFD offices. A list of questions (refer to Appendix G) were used to guide the discussions. Frequently, the participants departed from the questions to provide information that they believed to be relevant. In order to gain an in-depth understanding of the needs and concerns, participants were

not discouraged from telling their stories. Based on participant responses, in October, the first question of the service provider questionnaire was revised and was reworded from “what services are available…” to “what services are working well…” (refer to Appendix H)

CYMH Team Leaders, or their designate, attended the majority of the groups. Notes were hand-written by the APFA Aboriginal Mental Health Planner and later transcribed by an administrative support person. For the majority of the focus groups, the APFA provided either a luncheon or snacks. Participants’ names were entered into a draw for prizes.

Questionnaires were distributed to key informants and at community events. There were four surveys designed for service providers, youth, parents or other caregivers, and for Directors of Aboriginal organizations.

Of the first ten surveys left at organizations for completion by Directors, only one was returned. Therefore, the Planner stopped distributing that particular survey (refer to Appendix I) due to an assumption that the organizations may not have the resources necessary to collect the requested statistical information. It is possible that another influencing factor is that face-to-face contact may be the preference for gathering any type of information.

Input was obtained about available services and identified needs. Participants were asked to prioritize what services they perceive are needed to enhance existing programs.

In summary, many of the Aboriginal communities were missed in this round of consultations but will be targeted when the planning resumes in April 2006. The Aboriginal Mental Health Planner recognizes that a deeper level of consultation is needed from community members. Before requesting additional input with the remaining Aboriginal communities, it would be preferable to provide avenues to increase community awareness of the mental health planning process and to work at building relationships.

The West - The place of insight, in Section 3, provides an overview of the process involved in making sense of the information gathered.

3. THE WEST – A Place of Insight

The Medicine Wheel teachings explain the West as the place where insight and understanding take place. Gaining insight, into developing the plan, occurred through harvesting and sifting through the information obtained from the community consultations. The data gained from the consultations were compiled and analyzed. Key components were categorized into themes. This section begins with a discussion of the general findings and is followed by an overview of the Regional themes. It concludes with a brief discussion of the realities, or "situational analysis" regarding the usage of CYMH services within the APFA Zones.

3.1 The Findings – In General

Community consultations revealed a variety of similar concerns and experiences throughout the region. The most prevalent concerns were about the planning process, community ownership, and lack of information and connection with CYMH services and Teams. It is also evident that the concept of mental health holds very different meaning for Aboriginal and general service populations. Of note, there are also varying levels of trust regarding both the Aboriginal Peoples Family Accord and MCFD.

The majority of the participants expressed a strong desire for ownership of not only service implementation but also of the planning process. Many respondents talked of how the communities are the most knowledgeable of their own needs. These needs are unique because they are based on history, culture, tradition, economics and geographical influences. Some participants emphasized that the planning and implementation process was flawed because it could not address the local-level needs. Concern was also expressed that a regional process would result in a "cookie-cutter" approach that would have no relevance to their community.

Many participants said they were "tired of being surveyed" and wondered why the information garnered from previous community consultations could not be used for most planning purposes. They commented that the issues, regardless of the type of service, remain the same.

Further concerns were that the planning process would result in another form of imposed services. Several people expressed that they "were tired of being done to" by the Ministry. Some said they believed that the planning process was a form of "tokenism" and that to be meaningful the money should be given directly to the communities for developing and implementing their own programs and services.

The findings of a study conducted by Chandler and Lalonde (1998) on the correlation between suicide, cultural continuity and identity support these concerns. The researchers found that there were lower rates of suicide in communities that had built stronger cultural continuity through self-determination. This continuity was directly proportional to the level of self-determination in the form of education, self-government,

health, land claims, police/fire services and cultural facilities. These findings indicate that community ownership of programs and services that are built on local culture produce increased mental well-being for the community members.

In addition to revealing doubts regarding the effectiveness of a regional approach to planning, concern of the subsequent strategies to achieve outcomes was expressed. Some participants thought that planning would result in benefiting "a few people" through creation of some positions but that, in the long-run, these positions would not affect long-term change in people's lives.

While the lack of trust was primarily directed at MCFD, some participants spoke of mistrusting the APFA. Some thought that although the APFA is an Aboriginal entity, services and programs delivered under their future governance would fail to support local and distinct needs. In general, there was a lack of knowledge about the APFA structure, the transition process, and of which services and programs are to be involved in the transfer. Despite their concerns and apprehensions, participants contributed answers to the focus group questions.

It is clear that the majority of Aboriginal people consulted have a different understanding of mental health concerns than does the general services CYMH system. CYMH services are believed to be based on the medical model and many Aboriginal Peoples view services from a holistic perspective. The medical model uses terms such as disorder and illness to describe specific behaviours and perceptions. Aboriginal people speak of wellness and healing. The general services system compartmentalizes services. For example, youth addiction is the responsibility of Interior Health. Youth with mental health concerns who are involved with the legal system are seen by forensics rather than CYMH.

In contrast, when Aboriginal people talk about mental health, they mean that mental health encompasses a holistic and integrated view that includes one's physical, mental, emotional and spiritual well-being. Services to increase wellness include whatever it takes to make a person well. For example, most of the Aboriginal people identified Fetal Alcohol Spectrum Disorder (FASD), alcohol and drug abuse/addiction, youth justice involvement and child welfare involvement as all mental health concerns that should be addressed in an integrated way.

Other general findings from the consultations clearly indicate that urban centres have more resources than rural and remote areas. Resources include personnel, written and other resource material, funds to operate programs, and linkages with other providers. All of these resources influence the capacity to access additional funding in order to increase organizational and community capacity. Rural and remote communities have the least amount of contact with CYMH services.

Although most participants of focus groups conducted in urban centres expressed a similar lack of connection with the local CYMH Teams and services, it is evident that some of the teams are building relationships with the Aboriginal communities.

3.2 Emergent Themes

Consistently, across the region there were similar needs, priorities and challenges discussed. Seven significant themes were identified. These themes form the foundation for the strategic direction of the transition plan. The themes are:

- culturally-relevant services
- community-based models
- awareness/education
- accessibility
- collaboration/linkages
- clinical approach
- funding/accountability

Table 3.1 provides a list of the themes, issues and recommendations gained from the consultations. All of these categories represent a summary of the perceived needs, gaps and suggestions for improvement as identified by the participants.

Culturally-Relevant Services

The vast majority of the respondents said that a reconnection with their culture is essential to mental health services for Aboriginal Peoples. The disconnection from culture is the direct result of colonization and residential school effects. An in-depth discussion of the intergenerational trauma, and grief and loss experienced by Aboriginal Peoples resulting from colonization and residential schools is beyond the scope of this report. However, these trauma effects are understood by most of the respondents to be directly linked to contemporary social and parenting problems. These problems manifest through the behavioural and emotional concerns of the children and youth. Intergenerational trauma is understood by most to be the underlying cause of the presenting mental health issues such as suicide, substance abuse/addiction, and sexual abuse. Many of the children's emotional and behavioural problems, for example, were identified as stemming from attachment disorders, parental substance abuse, and parental mental health concerns. There is recognition that children and youth need to learn about the past so they can overcome the legacy, be proud of their ancestry, and become connected to their communities.

Respondents strongly recommend that culture needs to be the foundation for all services and programs. They said that it is essential for "kids to embrace their identity." They recommend that cultural approaches be incorporated in all aspects of treatment, reducing risk and building capacity efforts. In addition to culturally-relevant approaches, it is strongly recommended that Elders, or other Knowledge-Keepers, be routinely utilized as resources in delivering services. It is also recommended that the community decide who is an Elder or Knowledge-Keeper.

Table 3.1 Themes, Issues and Recommendations

Themes	Issues	Recommendations
1.Culturally-relevant Services	-historical context and intergenerational trauma are key issues (seen as core of current MH problems) -historic context makes programming distinct from general services -residential school effects -identity issues -multi-generational grief and loss -addiction, FASD, PTSD, suicide behavioural problems -sexual abuse, family violence, lack of parenting skills	-cultural reconnection is essential to wellness -programs grounded in culture that reconnect and instill pride and belonging of ancestry -Aboriginal service providers -healing practices (sweats, gatherings, healing and talking circles, cultural camps) as part of treatment -knowledge keepers, elders, validated, included and resourced -art therapy - appropriate approach -traditional healers spending time with family may be more appropriate in some instances (ex. spending 4 days with family rather than 1 hour per week) -family-involved -spirituality is essential -holistic (includes FASD, addiction and 4 aspects of self) -healing circles to support families experiencing grief/loss
2.Community-based Models	-youth leaving communities for service - no follow-up plans -workers accessing training outside of community -generic approaches often not relevant to local community -importing workers doesn't work -youth disconnected from community -no services/supports for kids turning 19 -kids expelled from school	-communities want more control in planning and development of services -service must be dynamic and fit with the community -recognize community resources -clinicians that build capacity of local workers and community -provide training in the community -resource the existing Aboriginal programs (AHF,TAC) -local services provided by local Aboriginal people more effective and empowering to community -MH person as defined by the community
3.Awareness/Education	-lack of information on MH services available (what do they do, how to access their service, their location) -lack of connections with local MH teams (urban and reserve) -lack of information on recognizing signs of MH issues -unsure of who is appropriate to receive MH services	-training (concurrent -learning from each other) -MH teams need to build relationships with community -create list of resources -clarity of MH admission criteria -education around MH for community members -cross-cultural training (Métis history, local FN history) -focus training dollars on building the capacity of the community
4.Accessibility	-too many barriers -stigma attached to the language (MH) and with MCFD (trust issues, seen as connected to child protection) -need diagnosis to qualify for service – ignores early problems until they become persistent -MH too clinical - medical model -phone system too technical -many locations inaccessible and not user-friendly -too crisis focused	-change the language -Aboriginal MH clinicians located in Aboriginal organizations -provide outreach to bands and urban centres -Aboriginal community involved in selecting appropriate outreach clinicians -culturally appropriate resource material (brochures, hand-outs, videos) -Aboriginal liaison/coordinators -change phone system -more flexible hours (services in Aboriginal country need to be 24 hours). Create response team -flexibility in length of sessions, location, format, intake, assessment -local Aboriginal MH help line -walk-in services
5.Collaboration/Linkages	-services too fragmented -lack of knowledge of local resources -lack of communication between service providers -mainstream MH clinicians unsure of how to connect with Aboriginal communities	-Aboriginal community coordinator to foster local and national linkages/partnerships -monthly networking with local service providers (FN school advocates, urban, reserve, mainstream MH, health, ECD, youth justice etc.) -involve schools, youth justice, etc.
6.Clinical Approach	-too medical model -services too fragmented -CYMH deals with surface issues -not enough prevention/early intervention programs (cultural reconnection) -general services best practices often not applicable to Aboriginal community -general services don't recognize intergenerational problems -most challenging youth not getting services -not enough assessments (MH & FASD)	-need practice shift to cultural context (mainstream approaches) -incorporate traditional values (community responsible for wellness) -more family treatment programs -school-based Aboriginal MH support worker -dual-disorder clinicians -day programs with wraparound approach -wraparound services training -keep kids out of school-based behavioural program -incorporate mentors (youth, role models, elders, kinship relations) -Aboriginal MH youth support worker –preps kids for counselling -mobile service, focus on life-skills development -in-home service delivery -qualified people to provide early assessment/diagnosis
7.Funding/Accountability	-lack of accountability in general and Aboriginal services -mainstream dollars for urban centres providing services to non-Aboriginal people -short-term funding is problematic	-provide outcomes/evaluation for both general and Aboriginal MH services

Community-Based Models

As seen in Table 3.1, respondents identified that, in order to be relevant, services should be delivered in their local communities. They prefer that local resources, including their own people, be involved in service delivery. Many of the community workers are “already doing the mental health work” and would benefit from an empowerment approach in working with the CYMH Teams. This could be accomplished through becoming part of the team to share knowledge and information with each other. The CYMH clinicians would assume a more supportive than expert role in helping the workers. This approach would recognize the skills and knowledge of the local workers and build on these internal and external resources.

Respondents said that any programming must be adaptable to the distinct community needs. They do not want one-size-fits all approaches whether they are Aboriginal specific or mainstream focused programs. Therefore, the community needs to be involved in making decisions about how the programs and services will be operated within their community. Again, this can be accomplished by working with the community rather than for them.

Of most importance, participants recommend local based programming because they believe that the youth are disconnected from the community. To compound that problem is the fact that youth are frequently removed from the community for “treatment” and then returned with either no follow-up plans or continuing care plans that have no relevance to the local available resources.

It was also recommended that training be provided within the communities. This approach will allow more community workers to access the training and fits with a more holistic view of service delivery. For example, rather than training being targeted for those who work specifically with youth with mental health concerns; employment counsellors, family support workers and others would also benefit from the training. Empowerment approaches such as mentorship, peer mentorship and providing local training are all recommendations from the participants.

Awareness / Education

Training and awareness needs are twofold; the first is to increase awareness of the CYMH services system and the second is to educate community members about signs of different mental health concerns. Most of the respondents said they had little or no connection with the CYMH general services system and Teams. There was confusion about what services are delivered through CYMH, who they serve and how services are accessed. In many instances, people did not know the location of the CYMH offices in their area. Many have never met the clinicians.

There is also a need for educational presentations to help with recognizing signs of serious and persistent mental health concerns and for strategies to address them. Respondents said that awareness of mental health concerns needs to be provided to all community members and not just for service providers.

Since the general CYMH services and Aboriginal communities will be working together to deliver services to Aboriginal children and youth, cross-cultural training at the local community level is also recommended. This approach will educate the CYMH clinicians on the community histories and traditions while increasing the community members' awareness of the general services system. Together they could combine their knowledge to create approaches that best fit with the community needs.

Accessibility

For those respondents who did have experiences with the CYMH system there were mixed reviews. Some had positive experiences they attributed to the relationship with the CYMH clinician. Others, and in fact the majority, said that accessibility was a problem. Many stories were told about encountering long waitlists, difficulty finding "the right person to talk to" and ineffective approaches.

Service providers discussed the difficulty they experienced when trying to refer a youth for services. One worker said that she was told by CYMH that her client was "not eligible because he was chronic." Others said clients did not want to go to CYMH offices due to the stigma attached to mental health services. Clients, for example, did not think they were "crazy."

Of concern is the stigma attached to the Ministry regarding the connection to child protection. There is a fear that children will be apprehended if a family becomes involved in the CYMH system. People thought it would be helpful if the CYMH services were not attached to MCFD offices either through answering the phone or in geographic location.

Respondents also said the locations and offices were not very user-friendly. Workers said that when people did go to the mental health offices they refused to return for subsequent visits. Respondents thought that outreach provided in Aboriginal organizations would be preferable to referring clients to the CYMH offices. However, their first choice is to staff their own positions within the Aboriginal organizations.

Concerns were raised over the one-hour once-per-week treatment approach. Participants said there is a need for CYMH services to be more flexible in the length of sessions, availability, and location. There are also concerns that written and other resource material are not culturally-relevant.

Collaboration / Linkages

Overall, there is an identified need to create networking opportunities that will help to build community knowledge and to strive for more coordinated, integrated and holistic service delivery. Service providers and other community members said there is "a lot of confusion" about what services are available in the communities. They report a lack of communication between service providers and they suspect an overlap of service delivery. They voiced a need for multi-disciplinary teams and for someone to coordinate these teams. Participants think that networking opportunities will help to empower the community to work together to identify community needs and resources.

Some general service providers said they were not sure of how to connect with Aboriginal communities. In comparison to the Aboriginal service providers, they also voiced a need for networking opportunities. Most expressed the desire to learn more about the Aboriginal Peoples residing in their service areas.

Clinical Approach

Most respondents said the current approach to treatment by CYMH is "too clinical and too medical model." They recommend more prevention and early intervention programs that focus on promoting life-skills and cultural reconnection. Some said that often "kids just need someone to be there to listen to them."

Concerns were also raised that youth with the most complex concerns are not getting the services they need. These are youth with behavioural and family problems who are using substances, are involved with youth justice and are either usually expelled from or have quit school. Several people mentioned that CYMH does not address the "core issues" but rather focuses on surface concerns.

In addition, the participants understand the core issues to be linked to cultural disconnection for not only the children and youth but for Aboriginal communities in general. This notion creates further complexity for general services CYMH Teams attempting to deliver clinical services with Aboriginal Peoples. It was discussed, for example, that general services do not account for the historic and intergenerational problems affecting Aboriginal youth. Furthermore, the medical model orientation contrasts with traditional values such as community responsibility for wellness.

Participants recommend that a shift in practice to incorporate a cultural context is necessary when working with Aboriginal Peoples. They suggest more family treatment programs, and mentorship programs that would empower peers, role models, Elders and family members to be partners in supporting children and youth with mental health concerns. They also want more cultural camps and programs where children are learning about their culture through daily activities such as storytelling by Elders and participating in "going back to the land" activities such as gathering berries. Positive Indian parenting programs are also identified as programs that reduce risk.
Art therapy and healing circles are identified as culturally-relevant clinical practices.

Although participants commented that the DSM IV used for diagnosis is not culturally sensitive, they did not discount the need for assessment and accurate diagnosis. In particular, they identified a need for early assessment so that problems can be detected and addressed before they become too complex. They said that conducting assessments in the home or in Aboriginal organizations rather than in a CYMH office would be an improvement. They also note a need for qualified mental health workers and more dual-disorder clinicians. They said that mobile programs and teams would be helpful in bringing services to communities. There was much discussion about gaps in the system for youth who are turning nineteen and have no further support from the current service systems.

Funding / Accountability

The need for consistent and long-term funding was discussed at every focus group. Participants spoke of the problems generated by short-term funding. Service providers said that organizations are continually "scrambling for dollars" to operate programs. These programs tend to be funded for one-year periods allowing just enough time to become established within the community before the program ends. Participants believe this type of programming is detrimental to the people using the services. One person described short-term funding as "contributing to the crisis" situations in communities.

Some youth programs that rely on short-term funding are forced into geographical moves, annually, due to lack of resources to pay the rental fees while they await confirmation of future proposals. This creates inconsistency and contributes to accessibility problems.

Accountability is another gap identified from the community consultations. Some participants spoke of a lack of accountability to the Aboriginal communities by both Aboriginal and general service systems. They believe the Aboriginal communities need to know if services provided to their people are making a difference in their lives.

The request for accountability is congruent with the goal of improving performance as defined by CYMH services. CYMH recommends that any programs delivered for children and youth with mental health concerns must be evidence-based. Some participants said that because these services are not culturally-sensitive, the CYMH evidence-based programs are inappropriate for Aboriginal children and youth.

In addition to common themes identified throughout the Interior, similar strengths of current services were also identified. There were also distinct differences and priorities between communities and Zones that will present challenges in implementing this plan. These differences include variance in current relationships between the Aboriginal communities and CYMH Teams, the theoretical orientations toward service provision and service usage.

3.3 Situational Analysis

The Interior Region

Across the region, participants described the strengths of the programs they perceived to be working well for Aboriginal children and youth. These strengths are identified as being community-based, that is provided within the local community by Aboriginal organizations and/or Aboriginal people. The First Nations Advocates working in the education system, because of their connection to families, are recognized across the Region as a benefit to communities. Programs that are grounded in Aboriginal culture and are geared toward building community capacity are identified as strengths. It was noted that when resources are given for local staff and other community members to receive training, the community greatly benefits because the knowledge remains within the community. Participants identified these types of programs as their preference.

When these community empowerment programs are operational, they are rarely linked with the general services system. Frequently CYMH does not have information on the Aboriginal programs. Additionally, the medical model orientation conflicts with the holistic Indigenous perspective of community healing. The comparison of the most prevalent mental health concerns as perceived by the Aboriginal communities and the general services CYMH system is noteworthy. When asked about the most prevalent mental health concerns among Aboriginal children and youth, the CYMH Teams said they were very similar to the non-Aboriginal clients. Regional statistics, as demonstrated in Table 3.2 support their view. The diagnosis perspective focuses on the individual.

Table: 3.2 Diagnosis – CYMH Perspective

DSM Group	% Non Aboriginal Diagnosis	% Aboriginal Diagnosis
Adjustment disorders	7.97%	9.77%
Anxiety disorders	14.70%	13.26%
Delirium, dementia, amnestic, cognitive disorders	0.05%	0.00%
Dissociate disorders	0.12%	0.23%
Eating disorders	0.81%	0.00%
Factitious disorders	0.02%	0.00%
Impulse control disorders not elsewhere classified	0.57%	0.70%
Infancy, childhood, and adolescence disorders	28.50%	21.40%
Mental disorders due to general condition NOS	13.96%	10.47%
Mood disorders	14.27%	18.14%
Other conditions that may be focus of attention	1.17%	1.86%
Personality disorders	0.05%	0.00%
Schizophrenia and other psychotic disorders	0.14%	0.00%
Sexual and gender identity disorders	0.10%	0.23%
Sleep disorders	1.31%	3.26%
Somatoform disorders	16.09%	20.70%
Substance related disorders	0.07%	0.00%

In contrast, the Aboriginal participants and those who work closely with Aboriginal communities report a broader perspective of prevalent presenting mental health issues. This perspective is unique to Aboriginal children and youth in that it accounts for historic and intergenerational trauma effects. Refer to Table 3.3.

Table: 3.3 Prevalent Presenting Issues - Community Perspective

Perceived Presenting Issue
Historical Trauma – Grief & loss
Unresolved Intergenerational trauma effects (family break down, addiction, residential school effects)
Substance abuse/dual disorders (addictions/MH)
Attachment Issues (no cultural values) (identity issues)
Sexual abuse
Family violence
Suicide/Self-harm
Post Traumatic Stress Disorder
Grief & Loss
FASD
Depression
Drug induced psychosis
Internalized oppression
Sexual Identity – two spirited

These differences can be attributed to the fact that the CYMH perspective is based on the medical model and the community perspective is based on their experiences in the every day realities of their lives, their histories, and their work. Regardless of the orientation, it is crucial to understand that these differences form the theoretical basis that guides their interventions. If the Aboriginal communities and the CYMH services are to work collaboratively, it is necessary to blend both orientations in a way that will benefit the children and youth they are helping.

Community consultations also revealed a perception that the Aboriginal children and youth who are accessing the general CYMH services are doing so because they are involved with child protection. It was thought that many programs are inaccessible for children and youth who are not involved with the child welfare system. Table 3.4 presents a Regional view of the correlation between children and youth who are involved with some type of child protection concerns and accessing mental health services. This data is provided by the Ministry of Children and Family Development and covers the period April 1, 2004 to October 31, 2005.

Table: 3.4 CYMH Aboriginal Case Load

Zone	Total Accessing CYMH Services	Total with Child Protection Involvement	Total Aboriginal Accessing CYMH Services	Total Aboriginal with Child Protection Involvement	Total % Aboriginal Accessing with Child Protection
Shuswap	534	92	38	16	42.1
Okanagan	2061	290	138	36	26.0
Lillooet - Thompson	178	45	71	22	30.9
Kootenays	1509	206	105	32	30.5
Cariboo - Chilcotin	338	70	78	43	55.1
Total	**4620**	**703**	**430**	**149**	**36.9**

As demonstrated in Table 3.4, almost 37% of Aboriginal children and youth who access the general services system are involved with some type of child protection concern. This high percentage appears to support the participants' views. Table 3.4 does not account for the numbers of children and youth who are referred to the general system through youth justice or other service sectors.

Additional differences including service usage and current relationships with CYMH Teams are discussed in the following situational analyses of the APFA Zones.

Shuswap Zone

Since April 2005, the Kamloops CYMH office has demonstrated their commitment to improving services for Aboriginal children and families. An Aboriginal Community and Development Clinician position was created with the designated responsibility of building relationships and networks within the Aboriginal communities. One goal of this position is to gain a clearer understanding of Aboriginal community needs with the intent of improving the quality of services delivered to Aboriginal children and their families. This clinician is currently working toward building relationships within the Aboriginal communities.

Additionally, the Team Leader has conducted a focus group with youth and Elders from the Kamloops area with the aim of gathering information to improve current service delivery. The Team Leader is also developing a local Mental Health Advisory group composed of Aboriginal service providers within the area.

The Aboriginal communities consulted in the Shuswap were very clear they would prefer to receive direct funds to staff their own mental health positions. Some organizations want to hire or contract psychologists and others would prefer a youth mental health worker. However, most communities are agreeable to outreach services provided by CYMH, with the condition that the community is involved in all stages of planning for this approach.

Okanagan Zone

Throughout the Okanagan Zone there are varying levels of usage and connections with CYMH services and Teams. The Ki-Low-Na Friendship Society employs an Aboriginal Mental Health Liaison position funded through Interior Health. Although this service and CYMH are potentially working with some of the same families, they are poorly linked. Also, Kelowna CYMH has recently hired a Mètis clinician who is building relationships with the local Mètis community. There is an additional Mètis clinician working in Grand Forks who is well connected with the Aboriginal communities in the area.

In Penticton, the CYMH Team has been working with the Penticton Indian Band (PIB) to address the needs of their community. CYMH has provided the FRIENDS school-based program for the PIB. FRIENDS is an early intervention program specific to childhood anxiety and depression. The program builds self-esteem, problem-solving skills, and relationships skills.

To increase accessibility for the Aboriginal population, the Penticton CYMH Team also adapted their intake procedures. The clinician, for example, conducted face-to-face intakes at a location on reserve rather than by telephone.

In both the Westbank and North Okanagan areas, there is less connection with the CYMH system. In Vernon and area, many of the service providers do not know who the clinicians are or where their offices are located. The Team Leader position for the North Okanagan is currently vacant. Both CYMH clinicians and Aboriginal service providers in these areas have expressed an interest in working together.

Lillooet – Thompson Zone

This Zone has the benefit of two CYMH clinicians of Aboriginal ancestry. In Lillooet, the worker is a First Nations person and in Merritt the worker is of Métis ancestry. Both workers provide outreach services and work with predominantly Aboriginal caseloads. It is evident that these clinicians are well connected with, and trusted by the Aboriginal population and organizations in their service areas.

Both clinicians understand the impacts of the historical oppression of Aboriginal Peoples and are working with their Team Leaders to develop more culturally-sensitive treatment and support interventions and reducing risk activities. These approaches include community involvement.

In addition to employing Aboriginal clinicians in this Zone, the CYMH Team Leader held a meeting with the Aboriginal communities in the Lillooet area with the aim of soliciting community input on the needs and gaps of services in the area. This information will be used to improve services for Aboriginal children and youth. The meeting also provided a venue to raise awareness of services provided by the CYMH system and is a first step toward building relationships with the Aboriginal communities.

Kootenays Zone

The participants of the Kootenay Zone divide the area into East and West. The East is typically referred to as the Cranbrook area and the West as the Castlegar area. Connections to CYMH services are varied in these areas. Most of the community members in the Cranbrook area access services from the Ktunaxa Kinbasket Child and Family Services rather than from CYMH.

In the West Kootenays, some members of the CYMH team have more contact with the Aboriginal communities than do other Team members. Most of the Team are aware of, or have worked with, the Aboriginal Family Support Worker and the First Nations Advocate from the schools in the area.

The Kootenays are also attempting to create “a hub of services” to increase accessibility for Aboriginal people. They have formed a community table with representatives from both the East and West areas. The CYMH Teams are invited to attend the planning meetings. These meetings provide a forum for relationship building between the CYMH Teams and the Aboriginal service providers and other community members.

Cariboo-Chilcotin Zone

Although, in general, most of the Zones have transportation challenges, the Cariboo has distinct challenges based on geography. Throughout the area, transportation for workers to get to communities and for clients to access services is problematic. Accessing communities requires several hours of driving.

Most participants identify that the local Child and Youth Mental health offices are rarely accessed due to long waitlists. Several members of the Aboriginal organizations said they had no previous contact with CYMH services. As with other Zones, there was a strong identification that people were not clear on what services were provided by CYMH, who the clinicians are, and where the offices are located. Private psychologists and counsellors were identified as the primary providers of mental health treatment for people living on a reserve.

In urban centres, specifically the Williams Lake area, the hospital, the RCMP and MCFD Aboriginal Teams were identified as the services most involved in providing interventions for children and youth with serious mental health concerns. One person said the “police are more involved than mental health to manage the problems” of the youth who present with multi-level issues. Children and youth are routinely admitted to the emergency room at the hospital and then referred to Kamloops for assessment and treatment. The youth are then returned to the community with “no real support plans.” It is recommended that the CYMH Team work more closely with the hospital.

Some CYMH clinicians working in the Cariboo noted that building capacity within the Aboriginal communities, specifically Canim Lake, seemed to be making a difference as their Aboriginal CYMH caseload has decreased from previous years. The clinicians attributed this reduction to increased services provided directly in the Aboriginal communities.

In summary, due to the vast diversity within the Interior Region, it is necessary to consider the strengths and challenges that will influence the development and implementation of an Aboriginal child and youth mental health plan.

3.4 Strengths, Challenges, Opportunities, Threats

The following information does not provide an exhaustive list of the strengths and challenges but does identify the areas with the most potential to influence implementation of the plan.

Strengths

- *Commitment of CYMH System* - There is an openness and desire by employees of the Ministry of Children and Family Development CYMH network to provide more culturally relevant services to Aboriginal children and their families.

- *Clinical Team Leaders highly motivated* – The Teams Leaders are open to providing outreach and working toward the empowerment of Aboriginal communities. They want to work together with communities to share their experiences and knowledge base with the aim of developing services that will be a good fit for the communities within their service areas.

- *CYMH collaboration with Aboriginal communities* – In some Zones CYMH have already initiated relationship building opportunities with the Aboriginal communities. This will help with establishing trust and breaking down barriers to service.

- *Aboriginal organizations agree to work with CYMH* – Many of the Aboriginal organizations are willing to work with CYMH to plan for a collaborative approach to serve children and youth and their families.

Challenges

The following information presents challenges in implementing the Aboriginal Child and Youth Mental Health Plan

- *Different perspectives on Mental Health* – The Aboriginal communities do not always accept the medical model approach and the holistic approach is not always accepted by the CYMH system.

- *Geography* – Providing outreach services and reducing risk programs will be difficult to achieve in outlying areas as will coordinating planning and networking meetings. Geography also impacts the recruitment and retention of new employees.

- *Poverty* – The social and economic conditions of many Aboriginal people contribute to their well-being. Services focused only on their cognitive, behavioural and/or physical concerns will not address their lack of basic needs.

- *Trust* – There is a historic mistrust issue of Aboriginal Peoples with the Ministry of Children and Family Development. There is a fear that involvement with any Ministry service could result in the removal of their children. There is also mistrust of the Aboriginal Peoples Family Accord and of the transition process.

- *Family involvement* - Many parents and other caregivers are struggling with their own issues, which prevent them from becoming involved in their children's healing.

- *Scarce resources* – There is a lack of people and money available in both the Aboriginal communities and the CYMH system to meet the demand for services.

- *Lack of training in mental health and local cultural sensitivity* - Many Aboriginal service providers have not received training about serious and persistent mental health disorders. Many CYMH clinicians have not received training about the history, values, and culture of the local Aboriginal people in their service areas.

- *Funding (on / off reserve)* – Jurisdictional responsibilities will impede the delivery of services provided on reserve.

- *Internal Aboriginal politics and other issues* – The diversity between Aboriginal Nations and communities creates challenges in reaching consensus on service provision and in developing partnerships.

Opportunities

While there are several challenges to implementing the plan, there are some opportunities to facilitate the process.

- *CYMH reform more congruent with Aboriginal perspective* – The Province's move toward more community-based models of service delivery is a good fit with Aboriginal community perspectives. In particular, the Interior Region's CYMH general services plan fosters a bio-psycho-social-spiritual approach to guide mental health interventions. This model is congruent with the holistic perspective held by many Aboriginal people.

- *Political will in the province* - The Province has put forward a commitment to keep the concerns of Aboriginal Peoples at the forefront of their agenda.

Threats

Threats to implementation include:

- *Stigma* – The language and labelling attached to mental health services poses a threat. Many people view these services as only for crazy or insane people. Many are also concerned that once a label is attached to a child or youth it is very difficult to overcome.

- *Communities want ownership of plan development* - Most communities want direct funds to develop and implement their own child and youth mental health plans. They may perceive this Regional plan as irrelevant and imposed which will make it difficult for communities to adopt this plan.

In summary, the findings from the consultations indicate that fostering community empowerment, through Aboriginal Peoples involvement in planning and local service implementation is essential to consider in developing this plan. It is also evident that culture must be the foundation from which to build the plan. Additionally, communities want their children to have access to qualified service providers. Qualifications are identified as including cultural, community, and/or academic knowledge.

Communities, despite their differences in theoretical perspectives toward wellness, are also willing to work with the general services system to ensure quality of services and to increase both their knowledge bases through information sharing. However, according to the community consultation results, Aboriginal Peoples, in general, have had difficulty in either accessing the general services system or in receiving services that they perceive to be irrelevant.

It is in consideration of these, and the other findings of the community consultations, that the Aboriginal Child and Youth Mental Health plan is formulated. The Plan, as presented in Section 4, the North, includes a discussion of the rationale for the identified strategies. All of the strategies are designed to facilitate community empowerment and capacity building.

Figure 3.0 provides a visual overview of the themes identified from the community consultations. The framework to build the plan is organized using the format of the Medicine Wheel. Culture is at the centre of the circle, representing the core, or foundation of the plan.

Each component within the *blueprint for change* framework of providing treatment and support, reducing risk, building capacity and improving performance, includes relevant themes and strategies included in the plan.

Figure 3.1 presents an integrated approach to implementing the plan.

Figure 3.0 Blue Print for Change Framework for the Transition Plan

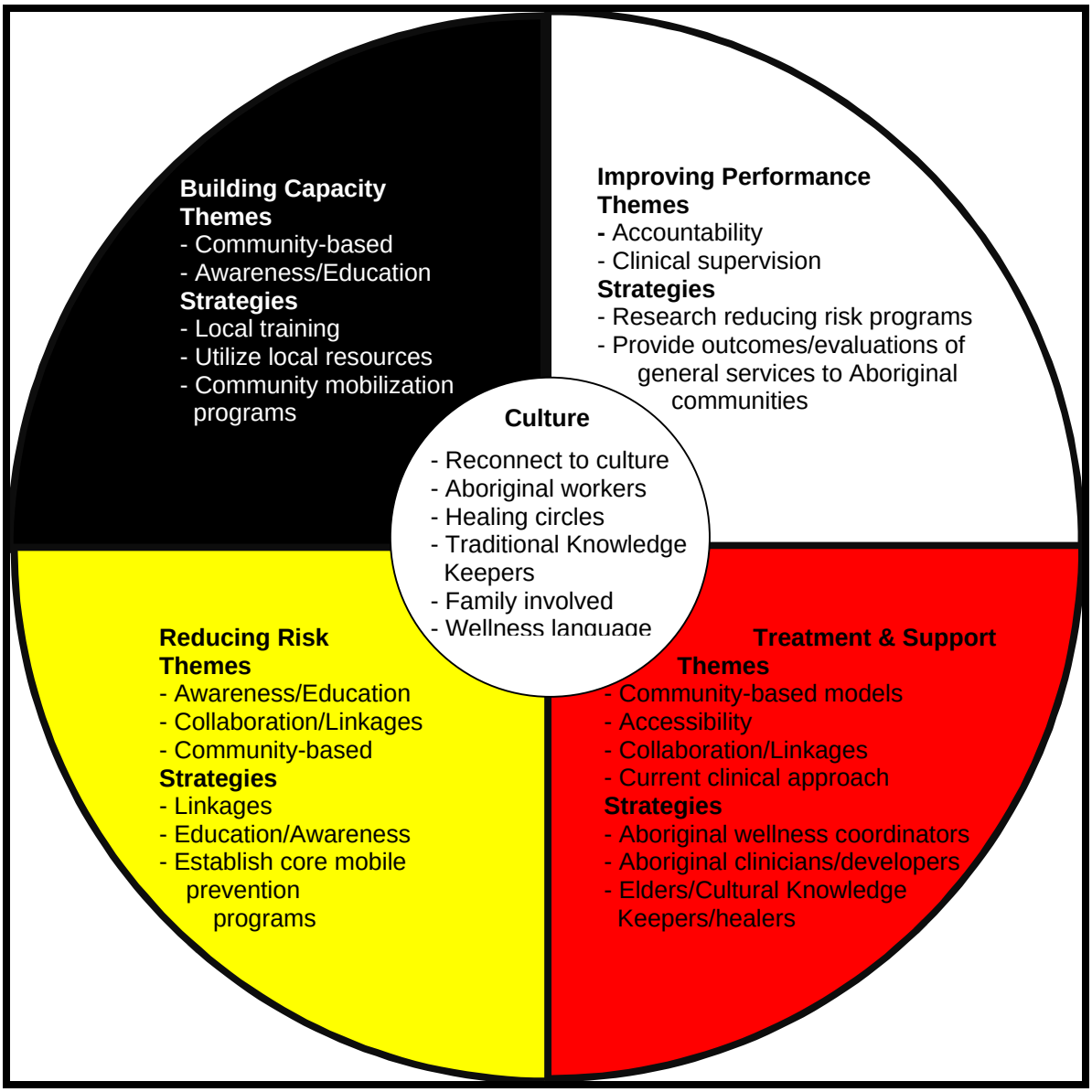
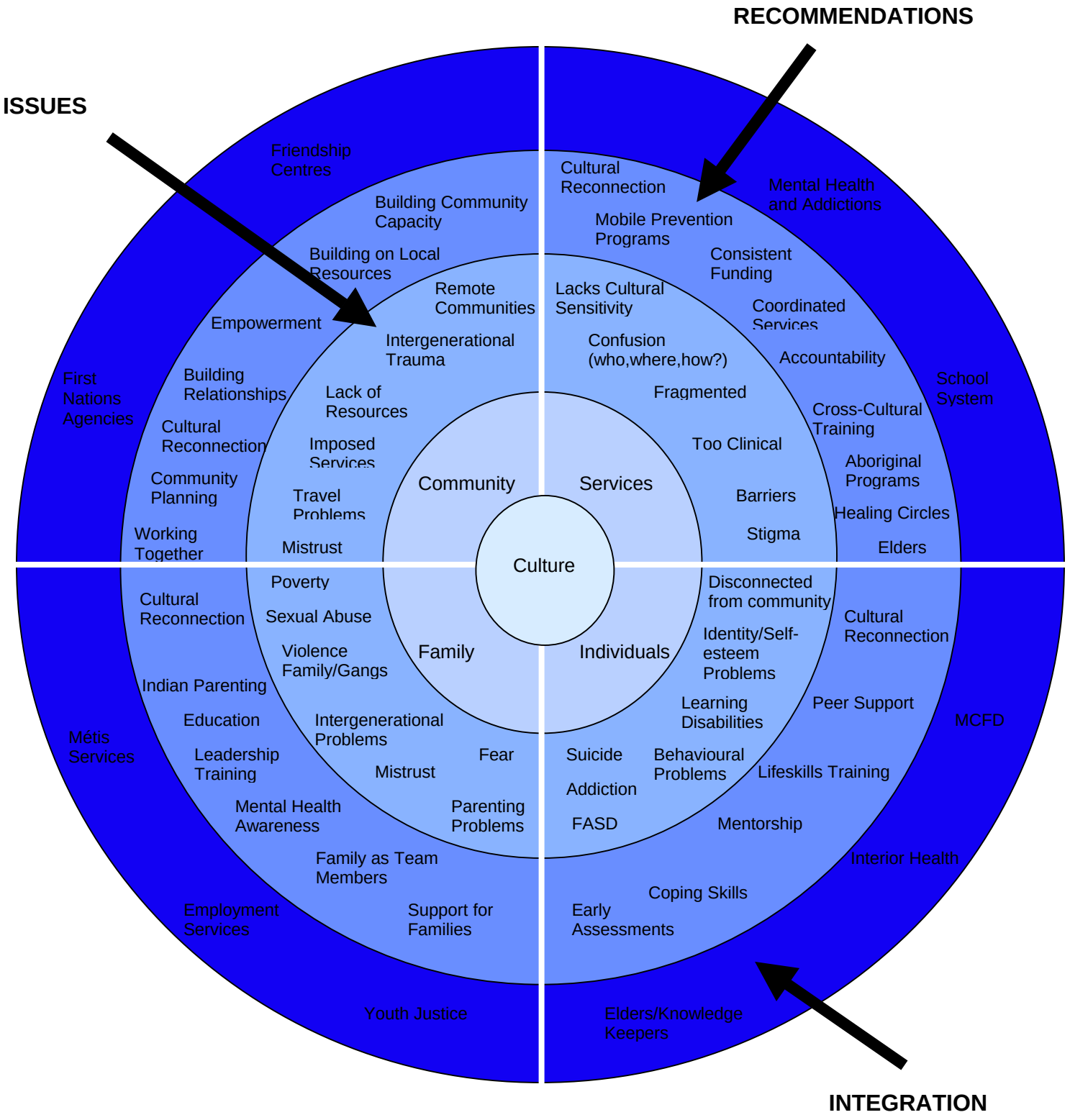


Figure 3.1 Integrated Approach to Aboriginal CYMH Services



4. THE NORTH – A Place of Wisdom

When journeying through the Medicine Wheel, the North is the place of wisdom. According to the Microsoft Encarta Reference Library (2003), wisdom is defined as "good sense: the knowledge and experience needed to make sensible decisions and judgments, or the good sense shown by the decisions and judgments made." In regards to developing this plan, sensible decisions and judgements are influenced by three critical factors: 1) the recommendations of the people consulted; 2) the knowledge that MCFD is responsible for the delivery of services and programs; and 3) a consideration of the available funds. A balanced view of these factors is essential to creating this plan.

4.1 Goals, Objectives and Strategies

The seven themes that emerged from the data were further categorized into the four key components of the blueprint for change framework. Refer to Figure 3.0. This framework includes:

- Treatment and Support
- Reducing Risk
- Building Capacity
- Improving Performance

The goals, objectives and strategies of this plan are developed within this framework.

1. Treatment and Support

Goal Statement:
Aboriginal children and youth will have equitable and timely access to meaningful and appropriate mental health services.

Objective:

To increase the accessibility of culturally-relevant services.

Strategy # 1. Aboriginal Wellness Coordinators:

- Five Aboriginal Wellness Coordinator programs will be created; one in each Zone. These positions will guide and assist workers to navigate families through the general services mental health system. They will also help to link families and workers with necessary resources. They will act as a support to CYMH clinicians.

- The coordinators will work closely with the Team Leaders to provide a bridge between the clinical teams and the Aboriginal communities within their Zone.

- Coordinators will organize networking meetings with Aboriginal front-line workers and Team Leaders to facilitate the building of strong working relationships. This will also help to build capacity on both sides as Aboriginal workers and clinical teams learn from each other.

- Coordinators will work with Team Leaders and Aboriginal communities to identify key individuals to create local multi-disciplinary teams including Traditional Helpers or approaches. These teams will ensure service coordination from intake to aftercare.

- Coordinators will work with Aboriginal communities to identify the local cultural Knowledge-Keepers, Elders and Healers who are willing to provide cultural training and to help provide services with families at the local community level.

- The coordinators will work with Team Leaders to establish criteria for referrals to the CYMH system.

- The coordinators will contribute to the development of a Regional Aboriginal information management system by collecting statistical data and resource information within their Zones. They will collect statistics on the numbers of cases and types of presenting issues. The coordinators will also compile a resource list of programs and services delivered within the Aboriginal communities. The resource list will have the dual purpose of providing important resource information to the communities and the CYMH Teams and will help with the long-term planning for the APFA.

- Coordinators will receive support and supervision from the Regional Aboriginal Program Leader and the Team Leaders. They will receive ongoing training that will include trauma, grief and loss, and critical incident stress debriefing.

Rationale

This strategy will increase accessibility. Participants said that families did not access services through CYMH due to many barriers including stigma attached to mental health and MCFD. Both families and workers identified a lack of knowledge of the CYMH Teams, the services they provide and the system in general. They also mentioned that it would be helpful to have someone to navigate them through the system when necessary. This would include receiving assistance beginning with initial access of services and includes mechanisms for ongoing support. It was also recommended that the navigation people be from the communities. The incorporation of Elders and traditional healing approaches will also increase accessibility and provide meaningful services.

Strategy # 2. Aboriginal Development Clinicians.

- Three Aboriginal Development Clinician positions will be created. These positions will be added in the Region.

- The positions will provide clinical consultation and development of community linkages/networks.

- These clinicians will provide assessment, treatment and ongoing case management.

- The positions will work closely with the Team Leaders, the Aboriginal Program Leader and the Aboriginal Wellness Coordinators to build the capacity of communities. This entails coordination and development of local case management teams. Additionally, coordinating community forums to further identify distinct community needs will be a focus of the position.

- Community Tables will be supported.

- These positions will work closely with the Aboriginal Program Leader to identify and implement "more holistic" and culturally-informed practice.

- These positions will receive clinical supervision from the Team Leaders.

- Preference will be given to qualified Aboriginal people.

Rationale

This strategy is directed toward building community capacity and creating local teams. Participants said they wanted services to be delivered by people qualified to work with Aboriginal children presenting with serious mental health concerns. The Development Clinicians will have the academic credentials to provide the clinical services. The clinicians will also help to build multi-disciplinary teams.

Regional Level

Strategy #1. Aboriginal Program Leader

- A Regional Aboriginal Program Leader position will be created to provide supervision and support to the 5 Aboriginal Wellness Coordinators for 2006-2007. Additional responsibilities of this position include; researching culturally competent assessments and models of care; research and identify culturally competent benchmarks for evaluation; research standards – present findings to communities for input; joint-development of policy and practice; and ensuring quality improvement. This position will be provided through a contract.

Strategy #2. Elders and other Knowledge-Keepers are accessed and resourced

- Services of Elders and/or other community Knowledge-Keepers to provide consultation or assist in training will be provided through honoraria. Three percent of

the funds for each Zone will be allocated and held at the Regional level for this resource.

2. Reducing Risk

Goal Statement:

Consistent and sustainable culturally-relevant prevention programs to facilitate personal and community wellness are available for Aboriginal children, youth and their families

Objective:

To increase access to prevention and early intervention programs for Aboriginal children, youth and their families.

Strategy # 1. Implement mobile prevention programs that have the potential to evolve based on community feedback.

- Five Aboriginal-developed prevention programs will be implemented in the five Zones.
- The Aboriginal Suicide Critical Incident Response Team is a community mobilization program that will be implemented in the Shuswap and Thompson – Lillooet Zones.
- The Okanagan Zone will implement the R'N8IveVoice "Mental Health and Well Being: The Importance of cultural identity to Aboriginal youth."
- The Kootenay Zone will implement the Métis Mentorship Program.
- The Cariboo-Chilcotin will implement the Restoring Balance Program.
- All of the prevention programs will be managed through the APFA.
- Programs will include provisions for supervision and support of facilitators.
- This is a regional responsibility for the APFA and CYMH.

Rationale

The prevention programs identified are selected based on their ability to provide services to as many people as possible. The criteria used to select the programs include: 1) mobile and adaptable to community needs; 2) grounded in culture; 3) developed by Aboriginal Peoples; and 4) evidence of promising and/or field recognized practices. The criteria were formulated directly from the results of the community consultations.

Strategy # 2. Utilize APFA community tables to identify needs and develop goals to direct types of early intervention and prevention programs that are based on local community needs.

- Aboriginal Development Clinicians, Team Leaders and Aboriginal Wellness Coordinators are responsible for working with the communities to develop and implement the programs at the local levels.

Strategy # 3. Increase efforts to provide public awareness of mental health and to provide resources and education.

- Coordinate community gatherings and other venues to provide information. Topics, at a minimum, will include:
    a) Children and youth – cultural identity, addiction, family violence, life skills.
    b) Family – parenting skills, mental illness, grief and loss, FASD.
    c) Individuals – coping skills, self-esteem, high-risk behaviours, suicide attempts/ideation, warning signs.

- Aboriginal Development Clinicians and Wellness Coordinators work together to achieve this strategy.

Rationale

All of the above strategies will increase awareness of mental health concerns while providing sustainable and consistent programming. By providing culturally-relevant prevention and early intervention programs that utilize local community resources, Aboriginal youth will be encouraged to reconnect with their communities.

The strategies will also provide more local prevention programs that address historical trauma and present-day violence. The programs all have components of family involvement and building life skills, both of which are identified, in research, as effective strategies when working with Aboriginal children and youth (Cross, Earle, Echo-Hawk Solie, & Manness, 2000).

3. Building Capacity

Goal Statement:

Aboriginal communities will acquire the knowledge base needed to identify and develop local mental health/wellness services and programs.

Objective:

To implement programs and educational activities that empower community members and workers to deliver mental health/wellness services.

Strategy # 1. Provide training to workers in their local community using local facilitators.

- Develop user-friendly local cultural awareness training curriculum to provide ongoing training to CYMH clinicians and during orientation for new staff.

- Develop curriculum on basic counselling skills and historical trauma effects (similar to the human services worker program) for Aboriginal front-line workers and/or paraprofessionals or those in need of the training.

- All cultural awareness training will include a component on the distinct historical context of all Aboriginal Peoples, including Métis history.

- These are Regional responsibilities of the APFA and CYMH.

Strategy # 2. Provide training to interested support workers to act as navigators to assist families through the systems.

- Provide local forums to attract interest.

- Develop criteria for acceptance into training.

- Develop curriculum for lay counselling program.

- Provide regional forum for support and networking.

- These are Regional responsibilities of the APFA and CYMH.

Strategy # 3. Continue to research programs that have a community mobilization component and are culturally-relevant.

- Identify mobilization programs.

- Research feasibility (human resources, culture, financial) in delivering the programs to the local communities.

- This is the responsibility of the APFA.

Rationale

The implementation of reducing risk programs will also contribute to building community capacity. Building the capacity of the community members is an important area identified by the consultations. Many respondents expressed that there is a wealth of resources already existing in the communities. They also discussed the importance of

community healing. This healing will continue through involving as many community members as possible in receiving education and training on personal, family and community wellness.

4. Improving Performance

Goal Statement:

Improved results are reported for Aboriginal children, youth and their families who have received services through contracted and direct services.

Objective:

To establish outcome measured practice and reporting systems to the Aboriginal communities.

Strategy # 1. Provide Aboriginal organizations within the five Zones with educational opportunities on outcome measured practices.

- Compile statistical information of Aboriginal clients receiving services.
- Establish baseline information on persons served accessing programs and compare with discharge information.
- Provide an annual outcomes report to Aboriginal communities of the effectiveness of programs and services provided.
- Provide support to evaluate the five prevention programs implemented in the Zones.
- This is a Regional responsibility for the APFA and CYMH.

Rationale

These strategies will help to ensure the accountability required by the Province and requested by the Aboriginal communities. Some community members commented on a need for more accountability for programs whether delivered directly by MCFD or through contracted agencies. Resources need to be allocated in order to assist Aboriginal organizations in developing outcomes management systems. Providing training in outcomes management is a first step in preparing organizations to incorporate these measures into their information management systems. There were varied opinions of evidence-based practice that emerged during the consultations. The consensus is that current evidence-based mental health programs for children and youth are not applicable to Aboriginal Peoples because the research regarding these programs is based in the general population.

Providing evaluation on programs developed specifically for Aboriginal children and youth provides an innovative opportunity to produce evidence-based Aboriginal programs that could become models for other Regions and/or provinces.

Regional Priorities

- Human Resources - Create teams, including Aboriginal members to interview psychiatrists, clinicians and support people.

- Create a hiring selection process that is acceptable to and involves Aboriginal communities.

- Establish protocols between MCFD and Aboriginal organizations holding contracts to ensure coordination and implementation of the plan.

- Establish protocols with community partners to ensure the coordination of services for children and families. These include, First Nations Advocates, Youth Justice, Community Health Departments, Child Welfare, Youth Addictions and Interior Health.

- Regional protocol will be developed to ensure that services are provided within the context of socio-economic factors and historic context, which affect the wellness of Aboriginal peoples.

- Train clinical teams and front-line workers of the Aboriginal communities in Indian wraparound principles in order to provide a consistent philosophical approach to culturally-relevant clinical practice.

- Provide training for Aboriginal front-line workers and CYMH teams in Aboriginal approaches such as the Gathering of Native Americans (GONA) method to team building and community empowerment with the goal of providing a framework to build community tables and multi-disciplinary teams.

- Use Aboriginal people to develop resource materials (pamphlets, brochures and handouts).

- These are all responsibilities of the APFA and CYMH.

The next step to achieving the regional priorities is to develop implementation plans for both the APFA and CYMH.

Beyond the Scope of this Plan

Community consultations identified other areas of importance that are not addressed in this plan. These areas include:

- Developing standards of practice.
- Support the educational advancement for Aboriginal workers – towards earning degrees.
- Integrate funds – federal, provincial, youth justice, child welfare, and other funding sources – to provide holistic and integrated services for children and youth.
- Developing ways and means of continuing support services for youth, once they turn 19 years of age.

Although addressing these areas is beyond the scope of this plan, it is recommended that they be considered for future development of a holistic and integrated plan for service delivery to Aboriginal children, youth and their families.

CONCLUSION

This document has attempted to formulate an Aboriginal Child and Youth Mental Health Transition Plan for the Interior Region that is based on the findings from the community consultations. True to the cyclical teachings of the Medicine Wheel, as this journey ends it also paves the way for new beginnings. This plan is an evolving document that will continuously transform with evaluation and community input.

The consultations have identified a variety of themes and recommendations to inform the development of this initial plan. The themes, recommendations and strategies are all based on the information garnered from the focus groups, individual interviews, questionnaires and community meetings.

This plan is also formulated using the Province's *blueprint for change* framework of providing treatment and support, reducing risk, building capacity and improving performance. It is clear from the community consultations that the needs of the Aboriginal communities are aligned with the Province's framework.

It is also clear that Aboriginal communities have participated in a myriad of consultations. They have voiced similar needs, concerns and recommendations all relating to culture as the foundation to any programming and community involvement in any planning and implementation. They continue to advocate for recognition of local community resources.

While this plan does not provide for local ownership of planning and implementation, it is developed in the spirit of partnership. The complexities that will be involved in implementing this plan cannot be understated. However, the sharing of knowledge and resources between the Aboriginal communities and the general CYMH services provides an opportunity toward creating a new way of healing that may benefit both worlds.

APPENDICES

Appendix A Tsawwassen Accord

Tsawwassen Accord

Re: Provincial Proposal for Regionalization of Aboriginal Child Welfare Services.

A. Whereas Aboriginal People as defined under Section 35 of the Constitution of Canada recognize that our children and families are the cornerstone of our Nations futures.
B. Whereas the Aboriginal Nations have an inherent right of self determination including jurisdiction relating to the children and families of those Nations;
C. Whereas the rights of self determination and jurisdiction are not respected by the federal and provincial governments;
D. Whereas the federal government is acting in a manner not consistent with its fiduciary obligations to our Nations to act in the best interests of our children and families;
E. Whereas the Province is proposing a process of regionalization for child welfare, which is in keeping with the trend toward institutionalization which, is a further derogation of our rights.
F. Whereas the regionalization proposal imposes an unrealistic timeline, includes a threat that failure to participate in this process within the timeframe allotted will preclude future involvement or participation; the lack of clarity around Aboriginal Governance structure as used in Hon. Hogg's correspondence of June 10 2202;
G. Whereas the Province has dictated the planning and design of the governance of Regional Authorities of Child and Family Services without adequate and appropriate consultation to ensure the needs of Aboriginal Nations are met, including the superimposition of a proposed blended Regional Authority;
H. Whereas the proposed blended authority model reinforces the province's assimilative policies.

Therefore be it resolved

A. That the Interior Region reject unequivocally the concept of a blended Aboriginal Regional Authority;
B. That the Interior Region accepts in principle the concept of an Aboriginal Regional Authority;

Declaration

- Our children and our families are the cornerstone of our futures, and we recognize that Our Children are Our Future.

- The provincial assertion of jurisdiction in the area of child and family services, and the delegated models, which the province is urging upon our communities, has resulted in a situation where our children are not being properly cared for.
- Our inherent right of self-determination will only be achieved through the recognition of our inherent jurisdiction for our children and families, and has a

strong and lasting commitment to ensuring that this right is recognized and fully implemented.

- The federal government has the over arching fiduciary duty to protect and support our jurisdiction in this area, and must be pressured to take up these responsibilities by fully funding and supporting our assertion of jurisdiction in the area of child and family services.
- The Interior Region is directed to plan ways for Aboriginal Nations, as a unified force, to work towards asserting our inherent jurisdiction in the area of child and family services.

Source: Aboriginal Peoples Family Accord Website:

http://www.apfabc.org/mou.htm

Appendix B Memorandum of Understanding

Between: **The Union of British Columbia Indian Chiefs, The First Nations Summit, The Métis Provincial Council of British Columbia, The United Native Nations,** and **The Province of British Columbia** *(as represented by the Premier of British Columbia, the Minister of Children and Family Development and the Minister of Community, Aboriginal and Women's Services)*.

And in Support of this Memorandum of Understanding and as participants in the process: **Assembly of First Nations (BC Region), BC Aboriginal Network on Disabilities Society, BC Association of Aboriginal Friendship Centres, Federation of Aboriginal Foster Parents, Métis Commission for Children and Family Services, Native Courtworker and Counseling Association of BC, First Nations Agency Directors Forum, Aboriginal Health Association of BC, and Healing Our Spirit - BC Aboriginal HIV/AIDS Society.**

WHEREAS

A. The Parties agree that there is a disproportionate number of Aboriginal children in care in British Columbia. They agree that this number must be reduced and the children should be returned to their communities where it is appropriate to do so.

B. The Parties recognize that First Nations, the Métis Nation, Inuit and other Aboriginal Peoples assert an inherent right with respect to and jurisdiction over the safety and well being of their children and families.

C. The Parties agree on the need for a respectful and ongoing government-to-government relationship and dialogue on all issues relating to the safety and well being of all Aboriginal children and families.

D. The Parties agree that this relationship is based on mutual trust and mutual respect and must be consistent with existing protocols, agreements and memoranda of understanding.

E. The Parties acknowledge a new and collaborative relationship made possible through the mutual agreement among the Aboriginal Leadership of British Columbia, as expressed through the historic Tsawwassen Accord.

F. The Parties acknowledge and agree that First Nations, the Métis Nation, Inuit and other Aboriginal communities require support, including the necessary capacity and resources, to enable them to develop and deliver a full range of child and family services.

G. The Parties acknowledge that planning, policy and program development, implementation evaluation and decision-making must be undertaken jointly between the provincial government and First Nations, the Métis Nation, Inuit and other Aboriginal communities.

H. *The Child, Family and Community Service Act* provides that:

a) Aboriginal people and communities need to be involved in the planning and delivery of services to their families and their children through the Regional Aboriginal Authorities;

b) A child's cultural identity, kinship ties and attachment to his or her extended family and community should be preserved; and

c) First Nations, the Métis Nation, Inuit and other Aboriginal communities are recognized as independent entities that have a right to party status in all legal proceedings involving their children.

I. The Ministry of Children and Family Development is committed to ensuring that its legislation, policies and services are culturally sensitive and responsive to the needs of Aboriginal governments and communities.

Therefore the Parties agree as follows:

1.0 PURPOSES

1.1 The purpose of this Memorandum of Understanding ("MOU") is to establish a joint dialogue and decision making process regarding general and systemic issues relating to the safety and well-being of Aboriginal children and families that:

a) is on a government-to-government basis;

b) recognizes that First Nations, the Métis Nation, Inuit and other Aboriginal Peoples assert jurisdiction over their children and families, regardless of residency;

c) recognizes the importance of transferring the delivery of services to Aboriginal communities; and

d) draws on the expertise of Aboriginal service delivery agencies and research institutions.

e) reflects the historic and new relationship established at Tsawwassen on June 11, 2002.

1.2 The joint dialogue and decision-making process will focus on:

a) reducing the number of Aboriginal children in care and returning Aboriginal children to their communities where it is appropriate to do so; and

b) other topics or issues agreed to by the Parties.

1.3 The joint dialogue and decision making process will be carried out through the Minister's Joint Aboriginal Management Committee, which is established in section 2.0 and is comprised of representatives of the Parties, Aboriginal service delivery agencies, and co-chaired by the Minister of Children and Family Development and an Aboriginal representative.

2.0 JOINT ABORIGINAL MANAGEMENT COMMITTEE

2.1 The Minister of Children and Family Development will establish a Joint Aboriginal Management Committee (the "Committee") comprised of one representative appointed by each of the following organizations:

a) the Union of BC Indian Chiefs;

b) the First Nations Summit;

c) the Métis Provincial Council of BC;

d) the United Native Nations;

e) the Assembly of First Nations (BC Region);

f) the Ministry of Children and Family Development;

g) the BC Aboriginal Network on Disabilities Society;

h) the BC Association of Aboriginal Friendship Centres;

i) the Federation of Aboriginal Foster Parents;

j) the Métis Commission of Children and Families;

k) the Native Courtworkers and Counseling Association;

l) the First Nations Agency Directors Forum;

m) the Aboriginal Health Association of BC; and

n) The Healing Our Spirit - BC Aboriginal HIV/AIDS Society

2.2 Each of the organizations referred to in section 2.1 will appoint one alternate representative who will attend meetings of the Committee in the absence of the representative appointed in that section.

2.3 The role of the Committee will be to:

a) establish priorities and monitor progress on reducing the number of Aboriginal children ii care and returning Aboriginal children to their communities where it is appropriate to do so;

b) provide advice to the Minister of Children and Family Development regarding the efficient and effective allocation of resources within the Ministry of Children and Family Development to address issues affecting Aboriginal children, families and communities;

c) serve as a forum for dialogue and exchange of information among the participating

organizations and once established, the Regional Aboriginal Authorities;

d) enable the participating organizations and once established, the Regional Aboriginal Authorities to keep their respective constituencies informed regarding the dialogue process; and

e) ensure that the full range of perspectives is examined.

2.4 The Committee will strive to seek consensus among the members of the Committee with respect to the advice it provides to the Minister of Children and Family Development.

2.5 The Minister of Children and Family Development, or the Minister's representative and an Aboriginal representative appointed by the organizations referred to in section 2.1, will co-chair the meeting of the Committee.

2.6 The Executive Director, Provincial Aboriginal Secretariat, will act as secretary for the committee, and will provide support services for the Committee by:

a) preparing and distributing meeting notices and other relevant information to the members of the committee; and

b) the logistics for the meetings.

2.7 Agendas for meetings of the Committee will be developed jointly by the secretary and the members of the Committee. The agendas, together with any supporting material, will be distributed at least one week in advance of meetings to enable the members of the Committee to be prepared.

2.8 The Committee will meet at least 4 times per year and will establish a schedule of meeting dates. Committee meetings may also be held as needed or at the call of the Minister of Children and Family Development.

2.9 The Committee will establish a technical working group(s) as needed to address issues or matters identified by the Committee. The technical working group(s) will be responsible for developing options and recommendations and providing them to the Committee.

3.0 FUNDING

3.1 The Ministry of Children and Family Development will, subject to annual allocations by Treasury Board, provide adequate funding to support all of the activities of the Joint Aboriginal Management Committee and its technical working groups(s), including the establishment of an independent Provincial Aboriginal Secretariat and reimbursement for expenses in accordance with government financial policy.

3.2 The Ministry of Children and Family Development will provide adequate funding for the implementation of activities and action plans intended to achieve the purposes of this memorandum, subject to annual allocations by Treasury Board.

4.0 SPECIAL CLAUSES

4.1 The Parties wish to maintain an ongoing government-to-government relationship that does not derogate from or displace the bilateral nation-to-nation relationship between Aboriginal Peoples and the Government of Canada or from the Crown's fiduciary obligation to Aboriginal Peoples.

4.2 This MOU is not intended to limit or replace any treaty, interim measures or other negotiations that any of the Parties may be involved in.

4.3 Nothing in this MOU shall be interpreted in a manner, which extinguishes, abrogates or diminishes Aboriginal or treaty rights, including Aboriginal title, which are protected under section 35 of the *Constitution Act, 1982*.

4.4 Nothing in the MOU shall be interpreted in a manner which diminishes or fetters the statutory responsibilities of the Minister of Children and Family Development or which conflicts with the Minister's duties as a member of the Executive Council of the Province of British Columbia.

4.5 Nothing in this MOU shall be interpreted in a manner that undermines or limits the rights and responsibilities of the participating Aboriginal governments and organizations and their respective Aboriginal Policy Tables to address issues of urgent concern with any level of government.

4.6 The dialogue process under this MOU is not intended to displace the obligation of the Crown to consult with Aboriginal governments, nor an Aboriginal government's right to dialogue with the Crown.

4.7 Nothing in this MOU shall be interpreted in a manner that implies endorsement or acceptance of provincial legislation and policies by the participating Aboriginal governments and organizations.

5.0 TERM AND REVIEW

5.1 This MOU shall come into effect as of the date of the Minister's signature, and will remain in effect for a (5) five-year period from that date (the "Term").

5.2 This MOU and activities associated with it will be reviewed annually by the Parties during the Term.

IN WITNESS WHEREOF the parties have agreed to this Memorandum of Understanding on the dates noted below:

Stewart Phillip, President of the Union of British Columbia Indian Chiefs

Edward John, Task Group Member of the First Nations Summit

Lydia Hwitsum, Task Group Member of the First Nations Summit

Herb George, Task Group Member of the First Nations Summit

Harley Desjarlais, President of the Métis Provincial Council of British Columbia

Scott Clark, President of the United Native Nations

Gordon Campbell, Premier of the Province of British Columbia

Gordon Hogg, Minister of Children and Family Development of the Province of British Columbia

George Abbott, Minister of Community, Aboriginal and Women's Services of the Province of British Columbia

The following agencies support this Memorandum of Understanding as members of the Aboriginal Advisory Committee:

Herb George, Vice Chief of the Assembly of First Nations (BC Region)

Lillian Allison, President of the BC Aboriginal Network on Disabilities Society

Grace Neilsen, President of the BC Association of Aboriginal Friendship Centres

Faye Poirier, Chair of the Federation of Aboriginal Foster Parents

Robert Simonds, President of the Métis Commission

Lynn Lydberg, President of the Native Courtworker and Counseling Association of BC

Paul Saim, Chair of the First Nations Agency Directors Forum

Grace Neilsen, Chair of the Aboriginal Health Association of BC

Florence Hackett, President of the Healing Our Spirit - BC Aboriginal HIV/AIDS Society

Source: Aboriginal Peoples Family Accord website

http://www.apfabc.org/mou.htm

Appendix C Terms of Reference

DRAFT

Aboriginal Child and Youth Mental Health Planning Reference Group
Terms Of Reference

Background

A Provincial Child and Youth Mental Health (CYMH) Plan aimed at improving resources and outcomes for children with mental health concerns was developed in 2003. Each region, within BC, was given the task of creating a CYMH Plan that was aligned with the Provincial Plan and based on the unique needs of the area. The Interior Region has developed a Plan for the general population. The Aboriginal Peoples Family Accord (APFA) has received funding to develop, in collaboration with the Ministry of Children and Family Development CYMH, an Aboriginal CYMH Plan that is aligned with the Interior Region's Plan.

Purpose:

The Reference Group will assist in planning for the achievement of high quality culturally-relevant services for Aboriginal children and youth with mental health concerns and their families.

Membership

- 4 Elders and 4 subject matter representatives from each of the 4 areas within the Interior Region and at least one youth, to ensure diversity and sensitivity to the broad spectrum of needs. The subject matter representatives will have work related experience with mental health and/or addictions.

Reports to: The Board of Directors for the Aboriginal Peoples Family Accord

Logistics

- 4 Meetings per year
- Travel costs covered by Aboriginal Peoples Family Accord CYMH Mental Health Planning
- Term ends in March 2006 and may be extended dependent on future planning agreements with the Province

Tasks

- Identify barriers to planning and service improvements
- Coordinate and guide planning process for developing the Aboriginal CYMH Plan
- Review drafts and provide input for revisions to the Plan
- Act as liaisons to the broader community to raise awareness of the Plan
- Make recommendations to the Board, as necessary, on any area where action or improvement is needed
- Make recommendations on matters regarding planning and priorities for the Plan
- Compile a report on Reference Group's activities for the APFA Annual Report

Appendix D Expression of Interest

Expression of Interest

The Aboriginal Peoples Family Accord is seeking interested Aboriginal individuals to form a reference group representative of the Interior Region.

The reference group will work with the Aboriginal Mental Health Planner in developing the **Aboriginal Child & Youth Mental Health Plan** for the Interior Region.

Group members will be expected to meet at least 4 times per year, sometimes by teleconference. Transportation costs and reasonable expenses will be provided as may be required.

A background working in mental health and/or addictions will be helpful.

Please submit your letter stating your interest and background of working with mental health and/or addictions and including references by **August 5, 2005**.

Send by fax, email or regular mail to:

Aboriginal Peoples Family Accord

3255 C Shannon Lake Road
Westbank, BC V4T 1V4

Phone: (250) 707- 0095; Fax: (250) 707- 0166
Email: jmurphy@syilx.org

Appendix E Reference Group Invitation

November 12, 2005

Name of person invited
Address

Dear

The Aboriginal Peoples Family Accord would like to invite you to become a member of the Aboriginal Child and Youth Mental Health Planning Reference Group. With the new funding targeted for developing and improving mental health/wellness services for Aboriginal children and youth and their families, we recognize the need to establish a group that is representative of the service areas within the Interior Region. The reference group will work with the Aboriginal Mental Health Planner in developing the Aboriginal Child and Youth Mental Health Plan for the Interior Region.

In your capacity as an at the and combined with your working experience in the area of mental health you are in a position to well represent the area.

The group will meet four times per year and sometimes by teleconference. The first meeting is planned for November 29, 2005 in Kelowna at the Ki-Low-Na Friendship Centre. The Aboriginal Peoples Family Accord will cover the cost of your travel and accommodations, details of which Sandra Young will forward to you.

Please confirm your attendance with Sandra Young @ (250) 707-0095. I look forward to meeting you and welcoming you to the Group.

In the Spirit of Collaboration,

Janice Murphy
Aboriginal Mental Health Planner
Aboriginal Peoples Family Accord
Phone: (250) 707-0095
Cell: (250) 215-9055
Email: jmurphy@syilx.org

Appendix F Focus Group Handout

The Aboriginal Peoples Family Accord

Aboriginal Child and Youth Mental Health Planning

Background

The province has allocated $10 million toward the development of new services for Aboriginal children and youth presenting with serious mental health concerns. The Aboriginal Peoples Family Accord (APFA) together with the Ministry of Children and Family Development (MCFD) is developing a Child and Youth Mental Health (CYMH) Plan for Aboriginal people living in the Interior Region. APFA is consulting with communities to ensure that their needs are represented within the planning process.

Purpose of Planning Sessions

- To ensure that communities have an opportunity to voice cultural appropriateness in regional service planning and development of system changes.
- To identify and support current service delivery within your communities for Aboriginal children and youth with mental health concerns.
- To identify your community's needs and priorities regarding children and youth with mental health concerns.

Overall Goal:

With input from the communities, a regional Aboriginal CYMH plan will be developed for implementation of new programs and services for April 1, 2006. Longer-range planning will continue to 2007/2008.

Components of the Plan:

- Providing treatment and support
- Reducing risk
- Building capacity
- Improving performance

For more information, please call Janice Murphy, Aboriginal Mental Health Planner (250) 707-0095 or (250) 215-9055

Appendix G Community Consultations Focus Group Questions

Aboriginal Peoples Family Accord

Aboriginal Child and Youth Mental Health

The Aboriginal Peoples Family Accord (APFA) together with Interior Ministry of Children and Family Development (MCFD) is developing a Child and Youth Mental Health (CYMH) Plan for Aboriginal people living in the Interior Region. The following survey is designed to help us gather information about the services provided, in your geographic area, to this population. This information will be used to help us in our planning to improve mental health/wellness service systems for Aboriginal children and youth and their families. Your point of view, as a service provider who interacts with the community, is of particular importance to us. Please help us out by answering the following questions. Thank you.

1. What services/supports are available for Aboriginal children and youth with mental health concerns (serious emotional/behavioural disturbances)?

2. What are the strengths of these supports/services?

3. What is the most prevalent presenting mental health issue that you encounter in your work with this population?

4. What are some of the challenges in serving this population?

5. What is needed to overcome these challenges?

6. What are the top 3 priorities in your community that would help to improve services to this population? (Specific recommendations)

Appendix H Community Consultations Focus Group Questions (revised)

Aboriginal Peoples Family Accord

Aboriginal Child and Youth Mental Health

The Aboriginal Peoples Family Accord (APFA) together with the Ministry of Children and Family Development (MCFD) is developing a Child and Youth Mental Health (CYMH) Plan for Aboriginal people living in the Interior Region. The following questions are designed to gather information about the services provided, in your geographic area, to this population. This information will be used to help us in our planning to improve mental health/wellness services for Aboriginal children and youth and their families. Your point of view, as a service provider who interacts with the community, is of particular importance to us. Please help us out by answering the following questions. Thank you.

1. What services/supports are working well for Aboriginal children and youth with mental health concerns (serious emotional/behavioural disturbances)?

2. What are the strengths of these supports/services?

3. What is the most prevalent presenting mental health issue that you encounter in your work with this population?

4. What are some of the challenges in serving this population?

5. What changes are needed in order to overcome these challenges?

6. What are the top 3 priorities in your community that would help to improve services to this population? (Specific recommendations)

Revised Oct 13/05

Appendix I Community Consultations Directors Questions

Aboriginal Peoples Family Accord
Aboriginal Child and Youth Mental Health

The Aboriginal Peoples Family Accord (APFA) together with the Ministry of Children and Family Development (MCFD) is developing a Child and Youth Mental Health (CYMH) Plan for Aboriginal people living in the Interior Region. The following survey is designed to help us gather information about the services provided to this population by your organization. This information will be used to help us in our planning to improve mental health/wellness service systems for Aboriginal children and youth and their families. As a service provider administrator, your viewpoint is of particular importance to us. Please help us out by answering the following questions.

Type of agency/program: _____

Position/Title of person completing the survey: _____

1. What suggestions do you have to improve mental health/wellness services for Aboriginal children and youth and their families?

2. What are 3 areas that need immediate attention for serving this population?

Description of Population Served:

3. What are the key reasons that lead the population to seek out your services? (Examples, substance misuse, abuse, etc.)

4. What percentage best describes the intensity of problems among clients you serve for each of the following categories?

_____ % of very low intensity of problems

_____ % of moderate intensity of problems

_____ % of very intense level of problems

5. What is an estimate of the percentage of young people served by your organization in the last year?

_____ % under 12 years old

_____ % 12 years old to 19 years old

_____ % 20 years old to 30 years old

6. What are the 3 most common presenting problems?

7. What is the typical length of service provided to clients? (Example: day, week, month, year).

Services Provided:

8. Please describe the type of services your organization provides. (check applicable).

_____ individual counselling

_____ self help/support groups

_____ family counselling

_____ group counselling/therapy. Please list types of groups offered: _____

_____

_____

_____ parent education. Please list topics: _____

_____

_____

_____ community education/information. Please list topics: _____

_____

_____ individual life skills

_____ home visits

_____ case management

_____ traditional healing services

_____ spiritual assistance

_____ nutritional/ physical health counselling

_____ inpatient/residential services

_____ crisis response

_____ volunteer helpers

_____ alcohol/drug treatment _____ inpatient _____ outpatient

_____ other services offered: _____

_____

_____

9. How often does your organization involve the family in service provision?

_____ no routine services with families

_____ when child/youth initially begins services with the organization

_____ at the beginning and end of service provision

_____ at each contact with the child/youth

_____ when the family requests help with problems and concerns

_____ other:_____

_____

Budget/Personnel

10. What percentage of your budget is committed to the following types of services?

_____ % of universal prevention (targets general population)

_____ % of indicated prevention (targets groups exhibiting early signs of problem

(behaviour)

_____ % of treatment and support (direct interventions)

11. How many people work in your organization?

# of _____ administrators

# of _____ service managers

# of _____ direct service providers

# of _____ support staff

# of _____ others: _____

Referrals

12. Which of the agencies listed below referred families to your organization during the past year? (check all that apply).

_____ Family self-referral

_____ Schools

_____ Intensive residential treatment programs

_____ Substance abuse treatment programs

_____ Mental Health

_____ Physicians

_____ Street nurse

_____ Juvenile justice

_____ Health services

_____ Child protection

_____ Other: _____

_____

13. For what specific reason(s) would a person be denied services by your organization?

14. Do you have a waiting list? Yes □ No □

15. What is the average length of the waiting list?_____

16. When services are required that are beyond the scope of your organization/program to which other community services do you most often refer children and their families?

Relationships With Other Service Providers

17. Please rate the relationship between the group/organization you represent and other groups/organizations by placing a 1, 2, 3, or 4 in each of the blanks:

1= we have a very strong, cooperative relationship with this group/organization
2= we have somewhat of a relationship, but not very strong
3= we have a poor relationship because of past history and other issues
4= we are basically unaware of the services provided by this organization/group

_____ Schools

_____ Health services, specify_____

_____ Mental Health

_____ Juvenile justice

_____ Child protection services

_____ Law enforcement/police

_____ Women's transition houses

_____ Other, specify

18. What prevention services do you think, that are not currently or readily available, are needed for Aboriginal children and youth and their families?

19. What treatment/intervention services for Aboriginal children and youth and their families do you think are needed that are not currently or readily available?

Thank you for your help!

Appendix J Goals, Objectives and Strategies Matrix

TREATMENT AND SUPPORT	*Goal Statement:* *Aboriginal children and youth will have equitable and timely access to meaningful and appropriate mental health services.*

Objectives	Strategies to reach objectives	Key responsibilities and linkages	Measures
To increase the accessibility of culturally-relevant services	• Create new FTE's for Aboriginal Wellness Coordinators in the five APFA Zones in the region	APFA Regional CYMH Manager	Aboriginal Wellness coordinators are established within the five APFA Zones
	• Create 3.0 FTE Aboriginal Development Clinician positions in the APFA Zones	APFA Regional CYMH Manager	FTE's are situation in the Region
	• Research culturally appropriate assessment tools	APFA	Culturally appropriate assessment tools are utilized in treatment and support interventions
	• Utilize Elders and other Knowledge Keepers in intervention strategies and in multi-disciplinary teams • Regional Aboriginal Program Leader Position	Aboriginal Wellness Coordinators Aboriginal Development Clinicians APFA Regional CYMH Manager	Documentation of Elder/Knowledge Keeper participation is evident Position is operational

REDUCING RISK	*Goal Statement:* *Consistent and sustainable culturally-relevant prevention programs to facilitate personal and community wellness are available for Aboriginal children, youth and their families*

Objectives	**Strategies to reach objectives**	**Key responsibilities and linkages**	**Measures**

To increase access to prevention programs for Aboriginal children, youth and their families.	• Implement mobile prevention programs that have the potential to evolve based on community feedback.
	  • Shuswap/Thompson and Lillooett zones will implement an Aboriginal Suicide Critical Incident Response Team
	  • Okanagan zone will implement the R'N8Ive Voice
	  • Kootenay zone will implement a Mètis Mentorship Program
	  • Cariboo-Chilcotin zone will implement a Restoring Balance Program
		APFA
		
		Regional CYMH Manager
			Prevention programs are operational in the five zones

	• Utilize APFA community tables to identify needs and develop goals to direct types of early intervention and prevention programs that are based on local community needs	Aboriginal Development Clinicians Aboriginal Wellness Coordinators CYMH Team Leaders	Community tables are established. Programs are identified and documented.
	• Increase efforts to provide public awareness of mental health	Aboriginal Development Clinicians Aboriginal Wellness Coordinators	Evidence of community gathering to provide information Aboriginal produced written and other resources are available.

BUILDING CAPACITY	*Goal Statement:* *Aboriginal communities will acquire the knowledge base needed to identify and develop local mental health/wellness services and programs.*

Objectives	**Strategies to reach objectives**	**Key responsibilities and linkages**	**Measures**
To implement programs and educational activities that expand the capacity of the community members and workers to deliver mental health/wellness services	• Provide training to workers in their local community using local facilitators	APFA Regional CYMH Manager Regional Training Manager	User-friendly local cultural awareness training curriculum is development and includes: basic counselling skills, intergenerational trauma effects, and distinct historical context of all Aboriginal Peoples including Mètis history.
	• Provide training to interested support workers to act as navigators to assist families throughout the systems	APFA Regional CYMH Manager Regional Training Manager	Local forums to attract interest are provided. Criteria for acceptance into training is developed Curriculum for lay counselling program is developed Regional forums for support and networking are provided
	• Continue to research programs that have a community mobilization component and are culturally-relevant	APFA	Programs will be identified and documented and will include a feasibility analysis

IMPROVING PERFORMANCE	*Goal Statement:* *Improved results are reported for Aboriginal children, youth and their families who have received services through contracted and direct services*

Objectives	**Strategies to reach objectives**	**Key responsibilities and linkages**	**Measures**
To establish outcome measured practice and reporting systems to the Aboriginal communities	• Provide Aboriginal organizations within the five Zones with educational opportunities on outcome measured practice	APFA Regional CYMH Manager Regional Training Manager Regional Aboriginal Program Leader	Statistical information of Aboriginal clients receiving services are compiled Baseline information on persons served accessing programs are compared with discharge information Aboriginal communities receive annual outcomes report on the effectiveness of programs and services provided The five prevention programs implemented in the Zones are evaluated

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REFERENCE GROUP BIOGRAPHIES

Gilly Alook

My name is Spotted Wolf (The symbol of "united family and togetherness"). I acknowledge the creator in my daily prayer and at work I have my daughters' prayers on the wall, which I read every day. There has been a lot of personal heartache and loss in my life. There has been a lot of mental health issues and addictions to alcohol and drugs issues in my family. Having the spirit of the Spotted Wolf within me I continue to thrive in encouraging my family and my community to unite and work together in every thing they do. Also for the well being of our future generation.

I am a member of this focus group because I am employed by the Ministry of Employment and Income Assistance as a financial assistance worker. I spend a lot of time looking for ways to help my people take care of the day to day struggles in making ends meet. I am committed to encouraging my employers to be forthcoming with ideas and plans to help aboriginal people recover their lost heritage and not to add to our pain.

I am a volunteer with Kelowna Metis Society. I spend my Sundays serving breakfast for the homeless in Kelowna. I am committed to working hard to make sure that C&YMH services to Aboriginal people are managed and monitored by aboriginal people. I am committed to help my employer understand the needs and aspirations of Aboriginal people and their communities. I continue to make positive changes in my life and working hand in hand with the creator to help me understand the positive steps I make in my personal life.

Kim Montgomery-Waardenburg

My name is Singing Red Woman. Singing, my prayers, the sweat lodge, dancing, and just being out in nature hiking are ways for me to connect with the creator. My family heritage is Okanagan and Shuswap. I am a Similkameen woman raised in white community but my strong spirit kept my soul at home.

I thank the creator for blessing me with powerful personal tools to integrate ancient wisdom with contemporary experience and as a Similkameen Woman to call each spiritual warrior to my own true place in the song and dance of life. I have a passion for singing and telling traditional stories to children and am involved in this reference group because I believe that as Similkameen Woman I am here for very spiritual and symbolic reasons. The survival of our nation depend upon the survival of the women. It is us who gave birth to the nation's succeeding generation. The creator gave life to the nation through women.

I have a Masters of Social Work with a background in clinical counselling. I have compassion for people, children, and families. My objective is to assist children and families. I want to provide a safe home for other kids in the community to come to. I have been sober since 1990 and I think that is an illustration of the life I lead. Other illustrations are my family and friends and the amount of cultural strength we have. The other illustration is that I have systemic lupus arithmatosis, a chronic illness I have had

for twelve years yet it has not shattered my belief that the creator provides me with these challenges to strengthen my resolve to have better outcomes for our children and our families in our communities.

Audrey Ward

My name C'ik'wsxn which means sunlight or sunshine. I am of mixed heritage. My grandfather, Billy McLeod was from Vernon and grandmother Lizzette Saddleman was from Quilchena - I am a member of the Upper Nicola Band, I am also Scottish, from the "MacDonald Clan". As a person of mixed heritage it was never easy being "not white enough" or not "brown enough". However it was my grandfather who gave me the best advice of my life. He told me to be like the wind and the water, not to let anything stop me, but to go around obstacles. I acknowledge the creator through ongoing prayer, smudge, and by using the drum. Furthermore, I acknowledge my spirit, the spirit of others and the spirit of all living things. I give thanks to those that have gone before us and for those yet to be born. I am a second generation survivor of the Indian Residential School.

I am a member of this reference group because as a registered Canadian Art Therapist, I deal with issues relating to C&YMH everyday of my working life. As a native woman I am convinced that the only way for us to have a healthy community is to encourage those of us who are living in our community now to create safe and welcoming infrastructure for those who are spiritually lost, and accommodation for those who need to stay home in our villages and be taken care of at home. I am tenacious, courageous, loving, friendly, a teacher, and an advocate. I have learned to take responsibility for myself, my health, and my behaviour. My sons come first in my life. I am married with three sons and have three close friends.

Lisa Armstrong

My name is Elizabeth Armstrong, but I go by Lisa. In my younger years, I went through and experienced an identity cultural crisis but have identified my rich cultural heritage through my journey and embraced both cultures/Russian/Cree. I acknowledge the creator through playing the flute and drumming. My spiritual life is guided by the spirit of the Raven ("the creator of the sun, the moon and stars"). I have a degree in social work and am registered in BC as a registered social worker. I am a member of this reference group because I am employed with White Buffalo Aboriginal Health Society as a wellness and employment counsellor. For nearly four and a half years I have worked with people on the streets, in drug houses, and entrenched in the sex trade. I am committed to the health and well being of our children and youth on the street. I am here to make sure that those children and youth with mental illness issues are provided support in their own communities and to avoid having them end up lost on the streets of our cities.

Jeanie Cardinal

My name is Jeanie Cardinal. I am a Métis Woman (my great grandfather was English, and my great grandmother was Cree). Members of my family spent their early years

denying our heritage. I am the first in my family generation to declare pride in being Métis, which has created a domino effect within my family to take pride in personally claiming and taking pride in their rightful heritage. In being a proud Métis Woman, I acknowledge the creator by practicing private prayers and participating in the sweat lodges and sharing creator's wisdom with others around me. I also celebrate my wellness through having a clearer spiritual relationship with my creator and my connection with the spirit of grizzly bear.

I am a member of this reference group for several purposes; because I have been working with Interior Metis Child & Family Services under the Human Resources Development of Canada - Homelessness Initiative funding. I work with at risk youth and individuals who are the most vulnerable in our community, and have advocated and assisted children, youth and adults with mental wellness and health issues to reach their highest potential. I bring the background of nursing and special needs worker with clinical practice and several years of experience advocating for marginalized individuals within the community.

I am passionate about personal wellness. The belief and experience of overcoming the challenges developed out of childhood abuse and neglect assist me in my passionate approach and belief in others finding and reaching their own wellness and healing in life. My past has a positive influence in the way I live; I am stronger, easy going, confident and powerful. I believe in who I am, where I am going, and I believe that each individual is able to reach their own inner healing and journey and should have the same rights and opportunities to access services and resources to reach their own highest potential in life.

Sheena Rogers

I am Sheena Rogers. The spirits of Chilcotin people adopted me and I am here to say that they have not been disappointed. I acknowledge the creator by taking part in sweat lodges and smudging. I am member of this reference group because I have been employed with the Cariboo Friendship Society in Williams Lake. I have been a program coordinator of Children Who Witness Abuse. I know I have some heritage, but no one acknowledges it so it is confusing to not know what I am.

I am committed to helping aboriginal people take responsibilities in developing C&YMH services in their own communities. I am tenacious and courageous but always willing to be flexible when required. I teach my children to value and understand peoples' cultural differences.

Laurie Peters

My name is Laurie Peters. I am Okanagon Woman. ("Old-One or Chief, made the earth out of a woman, and she said she would be the mother of all of the people. Thus the earth was once a human being, and she is alive yet; but she has been transformed and we cannot see her in the same way we can see a person. Nevertheless, she has legs, arms, head, heart, flesh, bones and blood. The soil is her flesh; the trees and vegetation are her hair; the rocks, her bones; and the wind is her breath. She lies spread out, and we live on her. She shivers and contracts when cold, and expands and perspires when

hot. When she moves, we have an earthquake. Old-One, after transforming her, took some of the flesh and rolled it into balls, as people do with mud or clay. These he transformed into the beings of the ancient world").

The above quotation describes Okanagon Nation's description of "THE MOTHER OF ALL OF THE PEOPLE". My struggles are similar to what mother earth goes through daily. I do a lot of prayer and soul searching, smudging, drumming, and I use my rattle. I also go to church and the sweat lodge. I do meditation on my own and talk to others about their beliefs and how it works for them. I am still trying to figure out where I am at. I consider myself Okanagan but have mixed ancestry. I also have Cree, Scottish, Irish, and English ancestry.

I am a member of this reference group because I now work as an Aboriginal Mental Health Liaison at the Ki-low-na Friendship Society. I have worked as an aboriginal infant development consultant. I am loving, full of faith, funny, and wear my heart on my sleeve. I encourage Aboriginal parents to teach their children cultural values such as integrity, self-respect and respect for elders. I continue to hope that the Aboriginal people will take on the responsibility for managing C&YMH services in our own communities. If that happens then I believe my participation in this project would have been worth it.

Sharon Brown

My name is Pilpinek ("togetherness"). I acknowledge the creator by valuing and embracing the beauty of spirituality and connectedness. I am NIha'7kapmz woman who is always exploring and researching the traditional tools ways we used in past, such as talking circles, sweat lodges, healing circles and family to help families connect to their heritage. I am with this reference group because I am a residential school survivor and I think that is where I am a huge strength. I use it as a way to connect to families out there. I have training as a social worker and have my Bachelor of Social Work, as well as training in art and play therapy. I am an Aboriginal outreach child and youth health worker. My family has worked through their addictions and we are reclaiming our cultural and traditional connections. Just being in a place to say I will explore it and find out what it is about; I really believe I could be in a process that reinforces the future of our children.

Leon Louis

My ancestral name, Cwelna (with a backwards "e"), is my great great grandfather's name handed down for thousands of years. My father is Similkameen and my mother is Thompson. I acknowledge the creator by thanking before I go to bed for the good and for the morning sun. I use the sweat lodge and I go to the mountain and fast to become one with the mountain and animals and rocks.

I pray daily for me, for our nation, and our children. I am with this reference group because I am a cultural coordinator for our Nation. My great grandfather was the last hereditary chief of our tribe and I am proud of that. I do my best to carry on where my

great grandfather has left off. He witnessed the end of our way of life. I am a witness to bringing it back to our people and I am honoured to be a part of it. I do my best to bring back ceremonies and traditions to our nation. I dedicate a healing to the children of the world that are living in war, living in the streets and are starving.

We in the Okanagan are beginning to teach our children who they are, without the classroom. I believe that we should keep our children until they learn their identity and before letting them go through rights of passage and to school. We need to find our own way for what is normal. Culture is my everyday life and I believe that aboriginal children must be taught their own language in order to help them with acknowledging their heritage.

Janice Murphy

My name is Janice Mercredi and I am a member of the Métis Nation. My father was Cree, Dene (Chipewyan) and French, and my mother is Dene (Chipewyan) and Irish. When I was growing up there were many negative stereotypes about Native people and some of my family members, including myself internalized these beliefs. This created internal struggles for me and left me feeling caught between two worlds. It was a confusing and often painful place to be. My personal healing journey helped me to find a place of balance through an internal acceptance and embracing of my mixed-blood. I can now honour both sides of my ancestry. My past challenges have transformed into strengths that now help me to walk in both worlds. I connect with the creator through prayer, smudging and tobacco offerings and I give thanks daily. I feel connected to nature and sometimes am moved to tears by the beauty of the lakes, mountains and forests. At those times, I am especially grateful. My personal and professional experience has taught me to work at seeing beyond what people present to who they are in spirit.

I am a member of the Reference Group as an Mental Health Planner for the Aboriginal Peoples Family Accord. I hold a Masters Degree in Social Work and am a registered Social Worker. I am doing this work because I think that for Aboriginal people, good health is a balance of physical, mental, emotional, and spiritual elements. I also believe in the empowerment of Aboriginal Peoples. I believe it is essential for Aboriginal children to know and accept who they are and that this happens by authentically knowing their ancestry and culture. Additionally, I believe that if the environment encourages and supports their sense of self, the children will grow up with a strong identity that will increase their health and wellness.

George Johnston

My name Oguttu Omungu Odhiambo. I am native of Luo tribe (Kenya East Africa). I acknowledge the creator through prayer, and a belief in touching my drum on a regular basis. I was brought up with a strong belief spirituality and also strong belief in Christianity in boarding schools. I have often struggled with spiritual conflict and this conflict has resulted in my ability to understand cultural differences.

I am with this reference group as a cultural respect consultant. I have Masters Degree in Clinical Psychology. I am a retired Public Servant after 32 years of service to the B.C. Government where I worked as: childcare worker, probation officer, clinician, social

worker, community development officer, discrimination and harassment trainer, diversity trainer, cultural awareness trainer and Interior Regional Cultural Consultant.

My passion in supporting indigenous people in discovering their heritage comes from having been uprooted from my village in Kenya to a boarding school in England for four years. Even though I began to go home to my village after four years for visits, my families continued to see me as a lost soul /spirit.

Sandra Young

My name is Sandra Young. I acknowledge my creator by recognizing my mixed heritage and thanking the creator for little daily things that have encouraged me to have a brave heart.

Upon this life's path of mine, I ask the creator to help me walk a straight line, to let me be gentle on my feet, let me breathe the air so sweet, especially when I am out hiking and enjoying nature around me. I am resourceful, caring, and empathetic.

I am a member of the Musqueam People on my mother's side, but also have some Scottish background. I also have English heritage on my father's side. I am with this reference group because of my background in anthropology (the teachings about origins, nature and people's relationships to their creator).

Although I was raised off reserve, I still consider myself a Musqueam woman and I genuinely believe that Aboriginal People must be able to not only have input, but also be able to be in charge of Aboriginal CYMH itself.