A Shared Mental Health Care Model at Whitehorse Hospital, Yukon: A First Nations and Medical Perspective

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Thesis Submitted in Partial Fulfillment Of

The Requirements For The Degree Of

Master of Social Work

The University of Northern British Columbia

October 2008

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Your file Votre référence
ISBN: 978-0-494-48774-7
Our file Notre référence
ISBN: 978-0-494-48774-7

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ABSTRACT

This research presents a Shared Mental Health Care model for Whitehorse General Hospital that successfully merges medical and Aboriginal health and healing practices within the mental health program. This blended model encourages a collaborative approach that supports the key concepts and principles of the national Shared Care model. This research explores the Whitehorse Hospital mental health program from employee participant views, perspectives, and experiences. A significant number of strengths are identified within the mental health program, along with suggestions for change and improvement. Results are descriptive in nature and positively reflect on program components. The research reveals that a collaborative Shared Care model does operate successfully at Whitehorse Hospital, and complements the medical and First Nations programs, as the way forward.

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CHAPTER ONE

INTRODUCTION

Shared Mental Health Care is a progressive mental health care concept that has changed how mental health services are delivered to clients across Canada, and around the world. This collaborative and consultative approach brings together family physicians, psychiatrists, and mental health professionals to provide a more accessible, effective, comprehensive, and quality mental health service. The College of Family Physicians of Canada and the Canadian Psychiatric Association described this collaborative approach in a joint position paper, *Shared Mental Health Care in Canada* (Kates, Craven, Bishop, Clinton, Kraftcheck, LeClair, et al., 1997). Shared Mental Health Care is defined as follows:

> *"... a process of collaboration between the family physician and the psychiatrist that enables responsibilities of care to be apportioned according to the treatment needs of the patient at different points in time in the course of a mental health problem and the respective skills of the family physician and the psychiatrist"* (p. 10).

The goal of the Shared Mental Health Care (or Shared Care) approach is to improve the working relationship of health care professionals who work in the area of mental health. This is achieved through improved communication and shared responsibility of mutual mental health clients. Collaboration is considered to be a critical key concept of Shared Care, as is support and education. The sharing of information and educational opportunities were also promoted to improve the knowledge, skill level, and confidence of family physicians. Maximizing available resources is another key concept of Shared Care, especially important for smaller and rural communities. There is strong support for communities to implement a Shared Mental Health Care model, in terms of

its effectiveness, and better use of available mental health resources. This approach provides for a more coordinated and comprehensive mental health program that would improve access, quality of care, and service delivery. The key concepts, of collaboration, support and education, maximizing resources, and case management are considered to be essential components to implementing a successful Shared Care model.

At Whitehorse General Hospital, Yukon, a model of Shared Care exists. This mental health program consists of two separate, but parallel components. First, the medical mental health program involves the family physician, nurses, mental health nurses, and a consulting psychiatrist. The second component is a First Nations health program that delivers a holistic health and cultural component to Aboriginal patients, while in hospital. These two distinct programs operate independently of each other, and at the same time deliver excellent patient care.

Purpose and Objectives of Research Study

The purpose of this research is to determine if a Shared Mental Health Care model for Whitehorse General Hospital operates, and if so would it continue to be reflective of both medical and First Nations culture and values. The objectives of this research are:

1. To describe the mental health care program, in relation to the Shared Care and Aboriginal health models
2. To increase awareness and understanding of the First Nations and Medical components of the mental health program, and how they collaborate, complement, and support one another
3. To explore how the Shared Care model works, and the degree to which it is complementary to the First Nations practices of the mental health program

4. To present an improved Shared Mental Health Care program for Whitehorse General Hospital, Yukon, one that uniquely incorporates First Nations philosophical, cultural and traditional healing practices

The Personal Context

My purpose and vision to see a successful Shared Care model at Whitehorse Hospital comes from a strong personal interest and commitment to mental health clients, , a passion for the concept of Shared Care, and a desire to share this information with others who work in the field of mental health. In my previous role as Whitehorse Hospital mental health nurse, I was acutely aware that there was a lack of information among staff as to what the two programs did, and a need for role clarification.

My personal involvement with this mental health program created some minor challenges for me in my role as both a researcher and co-worker. This relationship was unique, as I had professional and some personal relationships with participants. There were benefits to my dual role. My intimate knowledge of the mental health program, my social work and nursing background and experiences, and my theoretical constructs were all elements that I believe contributed to the high quality of data and the positive results for this project. To address the possibility of an ethical dilemma, every attempt was made to acknowledge and minimize potential bias, during the planning, preparation, data collection, and data analysis phases. It was critical to me that I maintain an objective stance, be vigilant, and very aware of possible ethical dilemmas that could arise. To differentiate, in my role as researcher, I was very clear that this study was based on participant perspectives, and not my own personal views.

Role of Whitehorse General Hospital

As a researcher I was given permission and formal approval (see Appendix 1) to conduct research on site at Whitehorse Hospital with access to hospital staff, and during their regularly scheduled work hours. The role of Whitehorse Hospital administration was very positive, and with strong support for my studies, and my thesis project, they encouraged me to proceed, even though my Masters degree was in social work, and I had been working at the hospital as a registered nurse. I believe there was relevance to the hospital in my capacity as a nurse, or as a social worker. Politics was not a major issue in this study, given that the study itself was an internal one, and did not involve any external agencies. My proposal was submitted and approved by senior administration, and also reviewed informally, and accepted by the newly formed Whitehorse General Hospital Ethics Committee (2003). Another formal submission for this research project was to the Yukon Scientists and Explorers Permit (see Appendix 2). Approvals were granted by this Yukon agency, and also the University of Northern British Columbia Ethics Review Committee.

Chapter Outlines

A brief description of the contents of this thesis report is outlined here. Chapter One provides the introduction, and an overview of this document. Chapter Two follows, with an extensive literature review of the Shared Care and Aboriginal health models. Historical information, key concepts, and relevant Canadian and international literature is also discussed for these two models, as well as the emerging acceptance and integration of holistic health into mainstream medical programs and facilities, such as Whitehorse Hospital. Considerable support for these models extends to an integration of holistic health concepts within a medical model framework. Chapter Three provides a brief

summary of the services Whitehorse Hospital currently provides. Chapter Four presents the research methodology. This study will use a descriptive thematic method of inquiry, and a content and comparative analysis approach. Key concepts of the Shared Care and Aboriginal models frame the methodological process. They include: collaboration; support and education; maximizing resources; case management; collaboration and consensus; holistic health and healing; and Aboriginal healing methods. The focus of inquiry was the mental health program, specifically an examination of the strengths, areas to improve, and solutions for change. Participants' views and perspectives were critical in exploring these areas. Participants, who were also employees, were from a variety of professional disciplines, health care services, and all directly or indirectly involved with mental health clients. It should be mentioned the term discipline, in this research paper, refers to employees who work in a specific professional occupation, with the exception of the support group who consist of health professionals and providers. Also, the term 'medical' refers to all disciplines, other than First Nations health, and who work within the medical system.

The research also explored participants' vision or ideas for a future model of Shared Care. A three step process was used in this research. The first step was to gather support for my Shared Care project. In the second step, participants attended an information education session, followed by a third step where participants completed interview questionnaires. Data collection was done using focus groups and individual interviews, and with strong participation evident in this study. Chapter Five presents the results of this research study with data summarized and analyzed by model, participant discipline, key concepts, and vision statements. Comparisons and contrasts explored

similarities and variations across the data, and among discipline groups. All data results point to a participant driven vision of a Shared Mental Health Care model for Whitehorse Hospital. Chapter Six discusses the implications for social work practice, and presents research conclusions, common themes in the study, and a collaborative and holistic health approach to social work. The impact of this research is explored in personal and professional terms, as well, as the relevance of this study for future research initiatives.

CHAPTER TWO

A REVIEW OF THE LITERATURE

Introduction

This chapter will examine key concepts and relevant Canadian, and international literature regarding Shared Mental Health Care and Aboriginal health. A historical overview of both models is presented in this chapter, and discussion on the emerging acceptance, and integration of holistic health into mainstream medical programs and facilities.

Shared Mental Health Care

Historical Background

The Shared Mental Health Care model was created in 1997, by members of the Canadian General Practitioners Association, and the Canadian Psychiatric Association. A critical need and definitive gap was identified in the way mental health services were delivered to clients in Canada. As a result of collaborative efforts of both professional associations, a 'National Conjoint Committee on Mental Health Care' was formed, and a solution proposed to address these issues, and was called Shared Mental Health Care. This concept was promoted as a new model for mental health service delivery. The *Shared Mental Health Care in Canada – Position Paper*, described the mental health situation at that time (Kates, Craven, Bishop, et al., 1997). Issues and concerns were also expressed in this document with clear resolutions. The need to establish and strengthen the working relationship between the family physician and psychiatrist was considered to be an important component of Shared Care. This collaborative approach would be expected to encourage and support a Shared Care model, improve the mental health

services and systems, and contribute to a more comprehensive and coordinated mental health delivery system. These positive changes would assist health care professionals to better navigate the mental health system to access mental health services for their clients. A national *Collaborative Working Group on Shared Mental Health Care* (Canadian Psychiatric Association and College of Family Physicians of Canada, 2002) was then created to further develop and expand the Shared Care model. The Working Group's objectives included: to share information on Shared Care projects with other health professionals across Canada; integrate and incorporate Shared Care into university academic residency programs; encourage continuing educational opportunities for family physicians; develop strategies for underserved and rural populations; lobby for Shared Care funding; and develop a national implementation research strategy for Shared Care projects. Results of these initiatives were published in the *Shared Mental Health Care in Canada Current Status, Commentary, and Recommendation* (Canadian Psychiatric Association and College of Family Physicians of Canada, 2000). This report provided background information and suggestions to plan, develop, and implement a Shared Care model. A key informant survey of 350 health care professionals suggested that a majority of participants had increased awareness, interest, and an acceptance of the Shared Care model. An inquiry into Shared Care initiatives and projects was also conducted. This study showed strong support for this approach, which was clearly evident in the reported number of Shared Care projects already in existence. Updates from the Collaborative Working Group provided additional recommendations (Canadian Psychiatric Association and College of Family Physicians of Canada, 2002, 2003). They included: training practitioners in the Shared Care model, and integrating Shared Care

principles into mental health policy and reform. Guidance and assistance on the implementation of Shared Care initiatives was also presented for practitioners and policy makers. Definite support and a desire to share information among Canadian health care professionals were also clear objectives of the Working Group. Two valuable reports show this commitment and their achievements. The document *Shared Mental Health Care in Canada: A Compendium of Current Projects* (Kates & Ackerman, 2002) report provided a compilation of Shared Care projects across Canada with over 100 initiatives documented in the first five years of Shared Care. Numerous project descriptions assisted others to implement Shared Care models. The second report, *Shared Mental Health Care: A Bibliography and Overview* (Craven & Bland, 2002) summarized critical issues regarding the Shared Care model. This document showed a strong need for collaboration between family physicians, and psychiatrists. Also presented are different theoretical perspectives, models, and educational training initiatives. Challenges, barriers, and evaluation research methods were also presented. This comprehensive overview is an excellent document that encourages others to understand the value, and the challenges of implementing a Shared Care model.

Communication is critical for psychiatrists, family physicians, and mental health professionals to exchange and update information on Shared Care. The annual national conference on Shared Care has been in existence since 2000. This event is strongly supported by health care professionals across Canada. Yukon is represented at this conference with various Whitehorse Hospital and community representatives attending, including myself. A Shared Care Newsletter (2007) and Shared Mental Health Care Website (2008) keep members up to date. The Shared Care website provides information

on Shared Care, background history, current resources, and publications from Canada, and around the world. Also showcased, are excerpts from the national Shared Care conferences.

Collaborative Mental Health Care

Shared Care continued to evolve, and in 2003 expanded to include not only psychiatrists and family physicians, but other professional disciplines (Kates, 2006). Representatives from twelve Canadian associations came together to form partnerships and created a working committee to further the work of Shared Care. Professionals included: social work, psychology, nursing, occupational therapy, pharmacy, dietetics, national mental health organizations, and continued participation from members of the College of Family Physicians of Canada, and the Canadian Psychiatric Association (Canadian Collaborative Mental Health Initiative, 2006). This consortium received funding from the Health Care Transition Fund (Health Canada, 2007) to develop the Canadian Collaborative Mental Health Initiative. Their objectives included: to improve the overall mental health of Canadians; increase collaboration among health care professionals; and the inclusion of consumers, families and caregivers within the Shared Care model. This successful group of health care professionals achieved many of their objectives. These include: a published research series on collaborative health; a charter mandate that was created, based on consultations with health care professionals, caregivers, and Aboriginal groups across Canada; and toolkits developed for specific target groups to assist with the planning, and implementation of collaborative community initiatives (Canadian Collaborative Mental Health Initiative, 2006, May; Kates, Ackerman, Crustola, & Mach, 2006). Also published was a second compendium, the

Resource Guide II, which is an updated status report of nearly 100 Shared Care and collaborative projects across Canada (Canadian Collaborative Mental Health Initiative, 2005, December). As a result of the excellent work of the Canadian Collaborative Mental Health consortium, Shared Care has now been widely recognized and acknowledged among health care professionals across the country. In addition, considerable financial support was received from the federal Primary Health Care Transition Fund, which produced hundreds of provincial and territorial Shared Care initiatives (Health Canada, 2007). The concept of Shared Care evolved to a new level, and included a name change. The term Shared Mental Health Care was replaced by Collaborative Mental Health Care. This created some confusion. For example, the Shared Care website (2008) clearly identified 'Shared Mental Health Care in Canada' at the top of the web page, and just below was an announcement for the '2008 Collaborative Mental Health Care Conference'. Despite the desire by some to change the name, many community initiatives in the *Resource Guide II* (Canadian Collaborative Mental Health Initiative, 2005, December) are titled Shared Care.

Other Shared Mental Health Care Models

Shared care has been associated with other names. Historically, Craven and Bland (2002) trace the origins of shared and collaborative care to the United Kingdom. This older term is called 'shifted out-client', and was used when discharged hospital clients are shifted to community care with virtually no significant difference in client service delivery. In the United States there is a mental health concept called, 'carve-out to collaboration'. The American Academy of Family Physicians endorsed this model, which supports mental health professionals working within family physician clinics

(White, 1997). The community consultation-liaison program (CLIPP) is another version of Shared Care that is now widely accepted in Australia, and the United Kingdom. This integrated and consultative model is where mental health professionals provide support and education to family physicians, and to their mental health clients (Bower & Sibbald, 2000; Meadows, 1998; Willis, Condon, & Litt, 2000). Craven and Bland (2002) and Ungar and Hoffman (1998) describe the concept of split-care, as a mental health approach. This concept refers to a consultation process where the client visits the family physician and psychiatrist separately, and with no verbal communication between disciplines. The Shared Care model is now slowly replacing the split-care model.

Shared Mental Health Care Reform

The Canadian federal government now strongly supports an integrated and collaborative practice with mental health professionals, as part of an interdisciplinary team (Canadian Mental Health Commission, n.d.; Health Canada, 2002; Health Council of Canada, 2006; Kirby & Keon, 2006; Romanow, 2002). Interdisciplinary is one term that defines different health care professionals working together in partnership, as they apply methods of their respective disciplines to their practices. They can include: social workers, psychologists, nurses, family physicians, and psychiatrists (Chisholm, 2001; Craven & Bland, 2002; Gagné, 2005; Kates, Crustola, Farrar, & Nikolaou, 2002). Gagné (2005) and Hoekstra (2001) also included the client as part of the interdisciplinary team. Primary health care reforms are becoming more common. Health Canada (2007, March) supports primary care initiatives in the area of mental health. The term 'primary health care' is defined as the first contact by a consumer to a health care service, institution, or professional. A family physician, nurse, pharmacist, dietician, for example, would be

considered first contact, as well as a clinic, hospital, or telephone health help line (Canadian Collaborative Mental Health Initiative, 2006; Gagné, 2005; National Primary Health Care Awareness Strategy, 2005). This concept of primary health care is based on shared responsibilities among health care professionals, who provide flexible and varied services, and use a client centered or consumer approach (Gagné, 2005). A multidisciplinary team based approach is the stated goal for primary health care in Canada (Health Council of Canada, 2006).

Canadian provinces have also initiated mental health reforms with progressive changes in the area of mental health and addictions, and with a shift towards a collaborative systems framework. There is now strong support for coordinated and integrated partnerships within the health system. This collaborative and client centered approach is supportive of a Shared Care model (Alberta Alcohol and Drug Abuse Commission, 2005; Alberta Provincial Mental Health Planning Project, 2004). Graham-Walker (2000, March 7, March 28) states that Nova Scotia has made similar progress in the area of mental health reform by restructuring a fragmented and inaccessible mental health system in Halifax. Ontario has implemented mental health reforms. The Ontario Ministry of Health and Long Term Care published two reports on mental health reform, *Mental Health: 2000 and Beyond. Strengthening Ontario's Mental Health System* (Newman, 1998), and *Making it Happen. Operational Framework for the Delivery of Mental Health Services and Supports* (Ontario Ministry of Health, 1999). This province also supports a collaborative and coordinated mental health care system, and is one that supports a holistic concept within mental health.

Strong support also exists for a shifting paradigm towards a more collaborative and consultative model, by the World Health Organization, and United Nations General Assembly. Clear recommendations include an integration of psychiatry and mental health within primary health care settings, and an established need for a multisectoral and interdisciplinary approach across organizations. Increased knowledge for mental health professionals, and university curriculum changes in the area of mental health are also supported (World Health Organization, 2001b). This highly respected international organization now provides their endorsement for a Shared Care model. The World Health Organization (1990, 1999, 2001b, 2002a) is a strong advocate for mental health, as is evident in their many publications. In 1991, the United Nations General Assembly (as cited in WHO, 2001b) adopted and endorsed similar principles to improve and protect mental health service delivery with an emphasis on community care.

Barriers to Implementation of Shared Mental Health Care

Support definitely exists for a Shared Care model. There are, however, potential barriers and obstacles that could impact on the implementation of Shared Care initiatives. Positive change towards mental health reform can be challenging. Issues include: a fragmented mental health system; fee-for-service issues for psychiatrists and family physicians, where joint consultations are not allowed; negative attitudes towards Shared Care; confidentiality among disciplines; and decreasing numbers of health care professionals (Kates, Craven, Bishop, et al., 1997; Romanow, 2002). Indications show that despite the barriers, the acceptance of the Shared Care model is moving forward, resulting in positive change (Canadian Psychiatric Association and College of Family Physicians of Canada, 2003).

Shared Mental Health Care Key Concepts

The key themes of Shared Mental Health Care are critical to the foundation of this model. These concepts of 'collaboration', 'support and education', and 'maximizing resources' are recommended when planning and implementing Shared Care initiatives.

Collaboration

The most important key concept necessary to the success of a Shared Care approach is collaboration. This term is defined in the literature as a collaborative process, where family physicians and psychiatrists, through improved communication and consultation, share responsibility for the care of mental health clients. This occurs within a collaborative and coordinated mental health system (Canadian Psychiatric Association and College of Family Physicians of Canada, 2000; Kates, Craven, Bishop, et al., 1997). Gagné (2005) states that collaboration is defined from a primary health care perspective, as "two or more primary health care providers working together with consumer, family, and caregiver for purposes of improving health outcomes and system capacity" (p. 61). Collaboration between family physicians and psychiatrists is the critical component required for Shared Care success. Typically, the first contact for clients into the mental health system is with the family physician, as 35% to 50% of clients seek help for their mental health problems (British Columbia Provincial Government, 1998; Chisholm, 2001; Gagné, 2005; Health Canada, 2002; Hill, Levitt, Chambers, Cohen & Underwood, 2001; Kates, 2002; Kates, Craven, Bishop, et al., 1997; Kates, Craven, Crustola, et al., 1997). Other studies suggest a higher figure of 60% to 84% (Arboleda-Flórez & Saraceno, 2001; Canadian Collaborative Mental Health Initiative, 2006). A report from Health Canada (2002) suggests that mental health affects all Canadians in some way with

20% of Canadians experiencing a mental illness in their life, and 90% impacted indirectly through a family member or significant other. Considering that family physicians are most often the first contact for clients accessing mental health care services, there is a critical need to strengthen the working relationship between family physicians and psychiatrists (Canadian Psychiatric Association and College of Family Physicians of Canada,, 2000, 2003; Kates, Crustola, et al., 2002). Communication is encouraged between these two disciplines to encourage and support this collaborative relationship (British Columbia Provincial Government, 1998; Canadian Psychiatric Association and College of Family Physicians of Canada, 2000; Kates, 2002; Kates, Craven, & Bishop, et al., 1997). The literature strongly supports the collaborative concept, where the psychiatrist provides consultative services within the family physicians office (Canadian Psychiatric Association and College of Family Physicians of Canada, 2000; Ungar & Hoffman, 1998). As a result, this mutual relationship shifts to a stronger and more consultative arrangement. The family physician would then have improved mental health knowledge and skills to better manage mental health clients, and access the needed and available resources (Canadian Psychiatric Association and College of Family Physicians of Canada, 2000; Kates, Craven, Bishop, et al., 1997; Ungar and Hoffman, 1998). There is substantial support for a collaborative model, especially one that includes not only family physicians and psychiatrists, but mental health professionals, especially within primary care clinics. It is suggested that social workers, nurses, psychiatrists, and family physicians be included as part of the interdisciplinary mental health team, and work in collaborative partnership together (Borsellino, 1999; Chisholm, 2001; College of Family Physicians & Royal College of Physicians and Surgeons of Canada, 2006; Gagné, 2005;

Kates, Crustola, et al., 2002; Manzer, 2001; McCann & Baker, 2002; Webber & Wills, 1997). Kates (2002) suggests that there is a "continuum of care that flows with other specialized services" (pg. 1). This is important, as 40% of clients access services through mental health professionals (Kates, 2002). Gagné (2005) presents detailed statistics and percentages on client access. This author suggests clients consult their family physician (45%), psychiatrist (25%), psychologist (23%), social worker (21%), religious advisors (8%), and nurses (6%). A coordinated and comprehensive mental health care system involves strong relationships, and the commitment of all mental health care professionals to support a collaborative approach. This is critical to the success of a Shared Care program (Canadian Psychiatric Association and College of Family Physicians of Canada, 2000; Helm, 2000; Kates, 2002; Kates, Craven, Bishop, et. al., 1997; Romanow, 2002; Ungar & Hoffman, 1998).

Support and education

'Support and education' is one of the key concepts and founding principles of the Shared Mental Health Care model. This concept is identified in the literature as 'support and education', and in this paper I will use this term as one phrase. This collaborative approach presents unique opportunities when knowledge is shared between the family physicians and psychiatrists (Canadian Psychiatric Association and College of Family Physicians of Canada, 2000; Kates, 2002; Ungar & Hoffman, 1998; Wysong, 1999). Kates, Craven, Bishop, et al. (1997), Manzer (2001), and Ungar and Jarmain (1999) suggest collaborative, joint clinical consultations with the psychiatrist, family physician, and the client. This exchange of mental health information within the primary care clinic improves the family physician's knowledge and expertise with mental health clients

(Kates, Craven, Bishop, et al., 1997; Leverette & Parker, 1999). Continuing medical education is available for family physicians, and is strongly encouraged. Theory based mental health modules, practical placements in psychiatric areas, and specialist psychiatric training are now widely available to family physicians (Canadian Psychiatric Association and College of Family Physicians of Canada, 2000; Kates, Craven, Bishop, et. al., 1997; Meadows, 1998). Collaborative educational outreach programs are also available. The national *ACCESS* program provides psychiatric support and education through clinical case reviews, interactive workshops, and telephone support with psychiatrists (Ungar, 1996). The *Enhanced Mental Health Skills Program* is a mentorship program where psychiatrists provide support and education to family physicians in British Columbia. This initiative is aimed at increasing the competency and skill level of family physicians, especially those in rural and remote settings, and where there is a lack of mental health services (Kates & Ackerman, 2002). A major shift has occurred with the integration of Shared Care approaches into university residency training, and curriculum programs. Psychiatric residents now train in primary care clinics and family physicians train in psychiatric settings (Bland & Galarneau, 2001; Canadian Psychiatric Association and College of Family Physicians of Canada, 2000; Graham-Walker, 2000, April; Leverette & Parker, 1999; Ungar & Hoffman, 1998; World Health Organization, 2001b). An increasing number of mental health educational resources are available across Canada, such as clinical case conferences, educational programs, and mental health workshops, and many are offered through telehealth (Canadian Psychiatric Association and College of Family Physicians of Canada, 2000, 2002; Gagné, 2005; Kates & Ackerman, 2002). Federal reports have encouraged telehealth initiatives (Health

Canada, 2002; House of Commons Canada, 1995). The British Columbia Provincial Government (2007) has recently published the *Family Physician Guide*. This booklet focuses on mental health and addictions, and includes one chapter dedicated to Shared Care. This guide strongly encourages collaborative relationships between family physicians and psychiatry. The Shared Care concept has been endorsed by the federal government. The British Columbia Medical Association and the College of Family Physicians of British Columbia also extend support to Shared Mental Health Care models (British Columbia Provincial Government, 2007). An innovative mentoring program, the *Collaborative Mental Health Care Network*, extends support and education to Ontario family physicians via telephone and email. This new concept has received overwhelming support from physicians with approvals from the Ontario College of Family Physicians Association (Hunter, Gingrich, Rochman, Silveira, & Salach, 2007). Other resources are available world wide on the internet. A mental health educational series, *Practice Essentials*, is available to assist Australian family physicians to treat and manage mental health clients (Medical Journal Australia, 1998). This program is also available to Canadian health care professionals on the Shared Care Website (2008).

Maximizing resources in underserved populations

The Shared Care model clearly benefits and supports mental health services within small, remote, and rural communities. These services are often underserved due to a lack of psychiatrists and mental health professionals. Consulting psychiatrists from tertiary centers provide mentorship, education, and support to family physicians, thereby maximizing existing resources effectively. University psychiatric residency placements also support rural communities (Canadian Psychiatric Association and College of Family

Physicians of Canada, 2000; Hodges, 2001; Kates, Craven, Bishop, et al., 1997; Romanow, 2002; Ungar; 1996). Borsellino (1999), the Canadian Psychiatric Association and College of Family Physicians of Canada, (2000), and Webber and Wills (1997) suggest greater collaboration between mental health professionals and nurses to improve skills and mental health knowledge. Allied professionals, such as social workers, are also encouraged to support interdisciplinary collaboration within a Shared Care framework (Canadian Psychiatric Association and College of Family Physicians of Canada, 2000; Hodges, 2001; Kates, Craven, Bishop, et al., 1997; Romanow, 2002; Ungar, 1996). Implementing Shared Care initiatives and strategies in rural and remote areas in Canada ensures that communities maintain acceptable standards of care, and maximize available mental health services and resources. This results in a cost effective, efficient, and effective mental health service (British Columbia Provincial Government, 1998; Canadian Psychiatric Association and College of Family Physicians of Canada, 2000; Kates, Craven, Bishop et al., 1997; Romanow, 2002; Ungar & Hoffman, 1998).

Case management

Another key concept of Shared Care is case management, but for reasons unknown, this component was not included in the literature. Considering the importance of using a collaborative or interdisciplinary approach in case management, I have included this as a Shared Care key concept in this research study. Baldwin and Woods (1994) state that there is no clear definition for case management, but there is discussion on case managers, their roles, and components of this concept. There is an identified need for case management for clients and their families, as they navigate the mental health care system. Words to describe this system include: a 'fragmented', 'confusing', a

'maze', a 'duplication of services', and 'fend for themselves', as explained by clients and consumers (Baldwin & Woods, 1994; Durban, Goering, Wasylenki & Roth, 1997; Helm, 2000; Romanow, 2002). The need for a case manager is crucial, and is where one person is responsible for the coordination of client care. Helm (2000) considers case management as a critical component of community care, but is concerned, because 50% of mental health professionals are transient. This author suggests the family physician be delegated as case manager to conduct assessments, provide counselling and support, and coordinate client programs. Social workers are also considered as case managers within primary care settings (Canadian Association of Social Workers, 2003). Meadows (1998) reports on the successful Australian CLIPP program, where mental health nurses are used in a similar capacity. Romanow (2002) suggests the case manager "guides individual clients through the various aspects of the health care system and co-ordinates all aspects of their care" (p. 122). One case management initiative that is supported by the federal government is a national electronic record (Health Canada, 2002; House of Commons Canada, 1995), which collaboratively connects health care professionals who share a mutual client.

Implementation of Shared Mental Health Care Projects and Initiatives

There have been a variety of Shared Mental Health Care initiatives and projects implemented in the majority of Canadian provinces, since its inception in 1997. The Collaborative Working Group provided suggestions for implementing Shared Care initiatives (Canadian Psychiatric Association and College of Family Physicians of Canada, 2000). They include: a review of existing mental health services, support for a collaborative approach among mental health professionals, and identifying effective

strategies for underserved and Aboriginal communities. All are considered to be essential components of a Shared Care model. Prior to implementation, a review of similar Canadian projects is recommended and beneficial (Canadian Collaborative Mental Health Initiative, 2005, December; Kates & Ackerman, 2002). A significant number of Shared Care initiatives have been integrated into mental health services within family physician clinics. The most common practice is for mental health professionals and psychiatrists to regularly visit primary care clinics to conduct client mental health assessments, and follow up. In these programs, the psychiatrist typically has a consulting role with the mental health clinician, and joint consultations with the family physician. Support and education is also provided in these meetings (Graham-Walker, 2000, March 7, March 28; Kates & Ackerman, 2002; Kates, Craven, Crustola, et al., 1997; McMaster University, 2007). Many clinics have hired mental health professionals and integrated this collaborative mental health service within their primary care clinics (Graham-Walker, 2000, March 7, March 28; Wysong, 1999). The Hamilton-Wentworth, Ontario, HSO mental health program (Kates, Craven, Crustola, et al., 1997) was one of the first to successfully integrate Shared Care into two primary care clinics. A family physician, psychiatrist, and mental health counselor work in collaboration together in the community clinic, and with telephone support. Mental health professionals conduct preliminary assessments on site, and a consulting psychiatrist regularly visits the clinic, depending on need. McMaster University (2007) reports that the HSO Shared Care program continues to expand and integrate mental health services within 145 primary care clinics, and is strongly supported by all health professionals.

Shared care has been implemented with success using an interdisciplinary and collaborative approach in hospitals. The North York General Hospital in Ontario set the precedent as one of the first hospitals to implement a Shared Care model. The major focus for this program is the collaborative relationship between family physicians and the mental health system. As well, this hospital changed recruitment policies to ensure that those hired support a Shared Care model (Ungar & Jarmain, 1999). Manzer (2001) reports on the success of the St. Joseph's Hospital in Toronto, Ontario. This program focused on a collaborative approach with client pre-assessments by the mental health clinician, then joint consultations with the clinician, psychiatrist, and client. The family physician is supported by the team and initiates client treatment plans (Manzer, 2001). Successful Shared Care approaches have also been implemented in hospital emergency departments. In these institutions, mental health nurses collaborate and coordinate with hospital health care providers to facilitate admissions, and follow up with discharge planning. Successful programs are in existence in New Brunswick and Yukon (Canadian Collaborative Mental Health Initiative, 2005, December). Hospitals are also providing outreach mental health services to community clinics. The Ottawa Hospital, in Ontario established two community outreach clinics for client discharge follow up, and for other students who access university campus services (Kates & Ackerman, 2002). Outreach psychiatric services extend to hospitals in rural and remote Ontario communities, through university affiliations. For example, a University of Toronto Shared Care initiative provides mental health services to Sault Ste. Marie, Ontario. University psychiatrists assist hospital and community psychiatrists with client consultations, and provide support and education (Kates & Ackerman, 2002). Kates and Ackerman (2002), Kates, Craven,

Crustola, et al. (1997), and McMaster (2007) suggest rural outreach programs have been found to decrease the workload of the resident psychiatrist, and improve knowledge and skill levels of the family physician. As a result, family physicians' report they are more prepared to manage severely mentally ill clients in a clinic setting.

Shared Care in Aboriginal and Northern Territorial Communities

First Nations communities have begun to incorporate and integrate Shared Care models into their mental health programs. A collaborative mental health program, in Calgary, Alberta is a well organized community based First Nations program (Pace, 2007). This collaborative model consists of twelve family physicians, two First Nations physicians, and one resident First Nation psychiatrist. Telephone consultation and telehealth is also available. Collaboration between elders, a psychologist, clients, and their families also occurs. The *Ohsweken Mental Health* program in Northern Ontario is another example. This community based program integrates concepts of the Shared Care model within their service (Wieman, 2001). This program has a crisis response team that includes: a social worker, nurses, a consulting psychiatrist, and a resident First Nations psychiatrist. Culturally sensitive Aboriginal holistic health and healing methods, and traditional beliefs and practices are all key components of this mental health program. This interdisciplinary model supports consultations with traditional healers and social workers. There is acknowledgement that there are few Aboriginal Shared Care programs. Kamil (2004) suggests First Nations communities have yet to ‘experience’ Shared Care. There is the potential, however, to encourage and advocate to First Nations communities about the tremendous benefits of Shared Mental Health Care programs (Canadian Collaborative Mental Health Initiative, 2005, May; Kamil, 2004; Wiemen, 2001). The

northern territories are beginning to explore Shared Care initiatives. Four collaborative First Nations community initiatives are identified in the *Resource Guide II.* One of these programs is the 'Yukon First Nations Health Program', which is integrated within the Whitehorse Hospital mental health program (Canadian Collaborative Mental Health Initiative, 2005, December).

Aboriginal Health and Healing

Historical Background

Federal initiatives, historically, have focused on policy and process aspects of Aboriginal health. There has now been a shift and a move forward, as the federal government has taken a leading role in Aboriginal reform. Critical Aboriginal health issues have been explored, and there is strong support with identified solutions, from all levels of government. This involves: First Nations; Inuit; Métis; federal, provincial, and territorial governments; and Aboriginal organizations. This collaborative effort is evident in the many reports and documents on issues of Aboriginal health. The Royal Commission on Aboriginal Peoples (1991, 1993, 1996) was created to examine these concerns. National roundtable discussions, presentations, and public consultations took place in many cities across Canada, resulting in two critical documents. The first report, *Gathering Strength* (1991) identified inequities in health standards between Aboriginal and non Aboriginal Canadians. Recommendations in this report include a shift in strategy from a 'piecemeal to holistic' approach to Aboriginal health and healing, and an acknowledgement of the importance of cultural and traditional health and healing methods. The *Path to Healing* report (1993) followed, with recommendations to address Aboriginal inequalities using a holistic health approach within an integrated health and

social service system. Expectations were that positive change would result and relationships would improve between Canadian and Aboriginal communities. More importantly the health and social status of Aboriginal people would be enhanced. Four commissioned reports were published, based on the *Path to Healing* (1993) roundtable consultations. Holistic health and healing was a common theme throughout these discussions. Clear definitions of healing within a holistic health framework model are presented, specifically in two of these reports. Healing processes for the individual, family, and community are also considered important within a well integrated holistic system (Krawll, 1999; Lane, Bopp, Bopp, & Norris, 2002). The House of Commons (1995) created a federal committee to conduct further consultations among Aboriginal and federal health organizations, and communities. This committee published a report called, *Towards Holistic Wellness: Aboriginal People's. Report of the Standing Committee on Health, 31.* As a result of this document, Aboriginal people were given the opportunity to define health, healing, and wellness from their perspectives and views. This report also recommended the need for a holistic health approach with an integration of traditional healing methods into western practices of medicine. A collaborative approach to health is one that is acknowledged in the *Future of Health Care in Canada* report, as one that reflects community needs (Romanow, 2002). Holistic health was also an accepted theme for the future of health care. As a result of the collaborative efforts among all levels of government and Aboriginal communities, the national *Blueprint on Aboriginal Health. A 10 Year Transformative Plan* (2005) was created to address Aboriginal health issues. This document defines Aboriginal health, as the "collective vision for First Nations people is to be served by their own distinct yet coordinated health

system, which ensures a full continuum of services, a wholistic approach to health, and the integrity of traditional healing practices" (p. 9). Several reports that contributed to the development of this *Blueprint on Aboriginal Health* (2005) focused specifically on holistic health and healing, and the need to address and improve Aboriginal health services, and systems. These documents included: the *First Nations Health Report Card* (Gideon, 2005), the *First Nations Health Action Plan* (Assembly of First Nations, 2004), and the *First Nations Holistic Policy and Planning Model, Draft 4* (Assembly of First Nations, 2005). Federal first ministers who participated in these meetings (2004, 2005), not only acknowledged this *Blueprint on Aboriginal Health* (2005), but committed 700 million dollars for initiatives. Health Canada (2007-2008) was committed to work in partnership with First Nations and Inuit communities and leaders to develop a strategic plan to improve Aboriginal health outcomes. This process would ensure availability and access to quality health care services, and provide a 'coordinated continuum' of service delivery (First Nations Inuit Health, 2007). The Aboriginal Healing Foundation (n.d.) was also actively involved in the promotion and support of Aboriginal healing initiatives and strategies. This federally funded organization focused on impacts of residential school system traumas and abuses, rebuilding health processes, and 'intergenerational separation'. Funding is available for community awareness and educational initiatives on the impacts of residential schools, traditional cultural and heritage projects, and a variety of holistic health and healing initiatives, which have been published in a three volume report (Aboriginal Healing Foundation, 2006). The Institute of Aboriginal People's Health is one of the thirteen Canadian Institutes of Health Research (2006) that strongly supports research initiatives to address immediate and long term health issues, and

improves the overall health of Aboriginal people. Partnerships and the sharing of research activities are also important (Canadian Institutes of Health Research, 2006; Health Canada, 2007-2008). The National Network for Aboriginal Mental Health Research (2006) works in partnership with Aboriginal people and groups, and provides research opportunities, and training. Health research is critical in addressing Aboriginal health issues, and improving health outcomes.

Barriers to First Nations Health Practices

Despite the fact that great progress has been made by First Nations and federal government leaders and community members on holistic models of health and practice, there remain a number of barriers that can impact on successful program outcomes. Credibility of First Nations healers and a lack of acceptance by society are two such concerns (House of Commons, 1995; Waldram, Herring, & Young, 1995). Social issues, such as substandard housing and unemployment are still evident with gaps and systemic issues identified (Schmidt, 2000). There are also decreasing numbers of available Aboriginal healers and resources, and financial concerns in funding these Aboriginal healing practices (House of Commons, 1995). Efficacy and validity issues, a lack of definition and standards, and poor funding for traditional medicines are serious concerns (Waldram, et al., 1995). The House of Commons (1995), *Report of the Standing Committee on Health* suggests that effective solutions for change focus on promoting health and wellness in Aboriginal communities. Consultative and collaborative models of practice, community partnerships, and the development of a national action plan among all levels of governments are all approaches that could potentially reduce the barriers. The development of the national *Blueprint on Aboriginal Health 10 Year Plan*

(2005) is also a step forward. Results are not yet known as to whether there are successful outcomes from this action plan.

Key Concepts of the Aboriginal Model

Holistic health and healing

Holistic health is consistently defined in the literature as an 'interconnectiveness' or 'interdependence' that involves the 'whole' person. This holistic concept includes the physical, mental, emotional, and spiritual components of the individual. According to some Aboriginal concepts, these key elements are required to maintain balance and harmony to achieve optimum health and well being for individuals, families, and communities. This definition of holistic health also includes social, cultural, economic, political, geographical, and environmental factors (Bopp & Bopp, 1997; Canadian Association of Social Workers, 2003; Cross, Earle, Echo-Hawke Solie, & Manness, 2000; Hart, 2000; Hollow Water First Nations, 1999; Kassi & Walker, 2002; Krawll, 1999; Lane, Bopp, et. al., 2002; Smye & Mussell, 2001). The holistic health concept is strongly supported by all levels of government (Assembly of First Nations, 2005; Blueprint on Aboriginal Health, 2005; Canadian Institute Health Research, 2006; House of Commons Canada, 1995; Royal Commission on Aboriginal Peoples, 1991, 1993, 1996). Holistic health is an accepted concept in Yukon First Nations communities (Jensen & Johnson, 1998). The Government of Yukon (2003) also supports holistic health as the "physical, mental, emotional, social, and spiritual well being of residents of Yukon in harmony with their physical social, economic, and cultural environments" (p. 2). Council of Yukon First Nations (2001) describes health as "a wholistic view that promotes and recognizes all aspects related to the wellbeing of nation, communities,

family and individuals" (p. 1). Kenny (2004) supports the holistic health definition, and includes the past, present, and future within the healing process. A New Zealand Maori holistic health model, *Te Whare Tapa Wha health*, was developed in 1994 by Dr. Mason Durie (as cited in New Zealand Childcare Association, n.d.). He described the holistic model as the four walls of a house, which includes: taha tinana (the physical side), taha hinengaro (thoughts and feelings), taha wairua (the spiritual side), and taha whanau (family). Each dimension is then necessary for the individual's overall health and well-being. Family is also included as a holistic concept by the Yukon Registered Nurses Association (2005).

Aboriginal world view

It is important to note in the literature, reference is made to an Aboriginal world view. This concept is viewed as a set of beliefs and value systems, which explains the essence of a culture, while connecting people and communities (Government of Yukon, 1998; Jensen & Johnson, 1998). Dr. Brant Castellano (2004), a highly respected Mohawk woman, and retired Professor Emeritus of Trent University, defines the concept of 'world view' as a tree rooted and supported in the earth, and is shared to community members through language, ceremony, and family. Kenny (2004) defines Aboriginal world view principles as: cultural practices, holistic health, spirituality, and an "interconnected web of life" with a "belief in adaptability and change" (pg. 8). The Government of Yukon (1998) describes elders as respected and important to Yukon First Nations culture, as they share world views through oral history, and storytelling. An elder is defined as "someone who has lived a good life, has acquired wisdom, displays qualities of kindness, patience, and fairness" (p.27).

Collaboration and consensus

Aboriginal people and communities have used ancient methods of collaboration and consensus for centuries, especially for community decision making (Aboriginal Healing and Wellness Strategy, 2001; Simpson, 2000a). The Canadian government supports collaboration and partnerships, as is evident in the many roundtable discussions and consultations on Aboriginal health (Royal Commission, 1991, 1993). These collaborative efforts resulted in progressive Aboriginal health reforms (Blueprint on Aboriginal Health, 2005; House of Commons Canada, 1995; Kenny, 2004; Lane, Bopp, et al., 2002; Royal Commission Aboriginal Peoples, 1991, 1993). A collaborative and participatory healing approach is crucial to create the structures necessary for healing that strengthen the capacity of a community to support its people (Aboriginal Healing and Wellness Strategy, 2001). Lane, Bopp, et al. (2002) agree, and suggest that collaborative partnerships are critical among Aboriginal communities and leaders. These essential support systems indicate a shared common vision towards an integrated holistic system. Collaborative efforts improve access to more available resources, so individuals, families, and communities are able to heal (Aboriginal Healing Foundation, 2006). Cross, et al. (2000) support this collaboration, and extend this concept to include agencies and professionals. A collaborative model of alternative dispute resolution, or circle sentencing, is a common practice used within the Yukon justice system (Government of Yukon, 2001).

Aboriginal healing methods and practices

Aboriginal or 'traditional' knowledge is defined as a process that is understood to be an accumulation of knowledge, information, social values and attitudes, experiences,

teachings, and storytelling. Individuals, communities, and their environments are actively involved in this process, as traditional knowledge is collected over time, and passed on from generation to generation (Emery, 2000; Jalan, 1993; Petch, 2000; Simpson, 2000a). Brant Castellano (2004) believes in the concept of traditional teachings using music, stories, and ceremonies to share this information. Castellano (2004) cites elder Peter Waskahat who strongly supports the "connections between land, family, spirituality, values, and every day living" (p. 100). Bopp and Bopp (1997) suggest using symbolism with traditional healing, and say for every illness there is a 'blessing' and a 'message' to learn by, with the focus on health. Aboriginal healing methods and practices are part of the healing process to promote health and well being. The medicine wheel is one tool that is used, by some First Nations, for individual healing (Assembly of First Nations, 2005; Bopp & Bopp, 1997; Bopp, Bopp, Brown, Lane, 1985; Cross, et al., 2000; Hart, 2001; Hollow Water First Nation, 1999; Royal Commission, 1993). The *Sacred Tree* booklet defines the medicine wheel as an ancient north and south American symbol that is used in a variety of ways to 'interrelate' with the four elements of holistic health, and to promote an individual's ability to heal, grow, and change (Bopp, Bopp, et al., 1985). Bopp and Bopp (1997) describe the medicine wheel as a tool that is based on the holistic concepts that represents balance leading to wholeness, meaning healing of the whole person, family, and the community. The *Sacred Tree* (Bopp, Bopp, Brown, et al., 1985) and medicine wheel tool are used as healing approaches, by the Yukon First Nations Health program at Whitehorse Hospital.

Sharing and healing circles have been a part of Aboriginal culture for many years, and they continue to be a popular healing method (Government of Yukon, 2001; Hart,

2000; Hollow Water, 1999; Simpson, 2000a). Aboriginal medicine is another healing approach that is an integral part of indigenous cultures, and used for social, religious, and medicinal reasons (Waldram, et al., 1995; World Health Organization, 2001a). Aboriginal healers administer these traditional medicines, and also specialize in different areas of practice. Involvement of elders, the community, and the environment are considered to be necessary and critical components in Aboriginal healing methods (Bopp & Bopp, 1997; Government of Yukon, 1998; Hollow Water, 1999; House of Commons Canada, 1995; Lane, Bopp, et al., 2002; Native Law Centre Canada, 1996; Simpson, 2000a). The World Health Organization (2000, 2001a, 2002b, 2004) defines standards, guidelines, and strategies on proper uses of traditional medicines, and healing methods. Issues of standards of safety, efficacy, quality control, and traditional and herbal products are addressed in these reports.

Holistic Health and Wellness Frameworks

It is important at this point to present an overview of Aboriginal health and healing frameworks. The literature suggests healing first begins within the individual (Bopp & Bopp, 1997; Krawll, 1999; Lane, Bopp, et al., 2002). The Alberta Mental Health Board (2006), Assembly of First Nations (2005), and Bopp and Bopp (1997) suggest that the individual's healing journey extends to family relationships, and links to their community, social networks, and resources. Community based holistic healing models suggest collaborative and integrated systems begin with the individual, and then expands to others, resulting in a positive healing effect for the community (Aboriginal Healing Foundation, 2006; Bopp & Bopp, 1997; Lane, Bopp, et al., 2002). Cross, et al. (2000) describes a 'relational model' of healing that involves the mind-body-spirit

connection, the family, and the social and cultural context of their community. Traditional knowledge and past wisdoms are also critical (Bopp & Bopp, 1997), as well as traditional healers, and Aboriginal healing practices within community based programs (Cross, et al., 2000; Hollow Water First Nations, 1999). The Aboriginal Healing Foundation (2006) presents an excellent description of a 'community based healing journey' model for survivors of residential schools. This program includes: increased awareness and educational programs; knowledge of residential schools, and the related impacts; increased support of available resources; and collaboration with community leaders and organizations.

Integration of Aboriginal and Medical Models

There has been a significant shift in attitude within the federal government and the medical community, towards an acceptance and integration of the concept of holistic health and wellness. The medical definition of 'health' has been revised from illness and absence of disease to a more positive and broader view of holistic health and wellness. The *Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health* (Miller & Keane, 1997), states that 'health' is a "relative state in which one is able to function well physically, mentally, socially, and spiritually"… and "within the environment in which one is living" (p. 697). Individual responsibility and preventative care are also considered components of health. This expanded definition of holistic health has been used by the World Health Organization (1946), for over 50 years.

The federal government is very supportive of an integrative approach, shifting towards a more culturally appropriate holistic health model of service delivery. Federal documents strongly support the need to reorganize existing health and social service

delivery systems, and incorporate and integrate traditional Aboriginal healing approaches and practices within mainstream medical systems (Aboriginal Healing and Wellness Strategy, 2001; House of Commons, 1995; Royal Commission on Aboriginal Peoples, 1991). Community based traditional holistic healing frameworks include integrated healing methods into cultural wilderness camps (Hollow Water First Nations, 1999; Lane, Bopp, et al., 2002), and long term residential treatment (Hill, 2003; Royal Commission on Aboriginal Peoples, 1991, 1996; Smye & Mussell, 2001). Rural Canadian nursing stations have successfully integrated Aboriginal health and healing practices into medical models of treatment with 76 remote and rural nursing stations, providing a holistic and integrated service (Aboriginal Wellness Strategy, 2001; Health Canada, 2007-2008). Health Canada (2007, March) also extends considerable support for First Nations and Inuit community programs that incorporate traditional methods of practice. For example, funding is provided for transportation to the nearest approved traditional healer.

Professional associations from the social work, nursing, and family physician disciplines have progressed towards an acceptance and integration of holistic health concepts into their professional practices (Canadian Association Social Workers, 1998; Patterson, 1998). The *Guidelines for Ethical Practice* for social workers' includes 'social well-being' in the definition of health (Canadian Association of Social Workers (2005b). Hart (2001) stresses the importance of awareness of Aboriginal culture within a social worker's practice. Two position papers on Aboriginal health provide recommendations for professionals. The Canadian Medical Association (2002) supports the document *Health of Aboriginal Peoples*, and encourages physicians to have an improved acceptance

and understanding of Aboriginal health concepts, and to integrate these concepts into their medical practice. The *Guide for Health Professionals Working with Aboriginal Peoples* (Smylie, 2001) is another position paper that provides a series of guidelines and recommendations. Community based health care and prevention based programming are some initiatives suggested. This guide was endorsed by the College of Family Physicians, Assembly of First Nations, and the Aboriginal Health Issues Committee, which consisted of a group of health care professionals, established for this report. It is important to note that representatives on this committee consisted of physicians and nurses from Ontario, Quebec, Nunavut, and Northwest Territory.

There are also an increasing number of successful Aboriginal health programs integrated and positioned within acute care hospital settings across Canada that provide holistic health and healing services to Aboriginal clients. Other community based programs have collaborative affiliations with hospitals, and provide direct in-client services. A number of hospitals in Canada offer Aboriginal health programs as part of their service. They include: Calgary Health Region (n.d.); Nanaimo Regional General Hospital (Vancouver Island Health Authority, n.d.); Prince George Regional Hospital (Northern Health, n.d.); Regina Qu'Appelle Health Region (n.d.); Royal Jubilee Hospital (Vancouver Island Health Authority, n.d.); Whitehorse Hospital (Hogan, 2002); and the Winnipeg Regional Health Authority (n.d.). These hospital programs offer access to a wide range of services, such as, health promotion; advocacy; support to clients and families while in hospital; language and interpreters; supportive counselling; Aboriginal healing methods; liaison among client, hospital staff, community, and other health care professionals; referrals; and coordination of discharge planning. A number of Aboriginal

health programs also provide cross cultural workshops to health care professionals, community outreach services, and act as resource centers to rural communities. Aboriginal ceremonies within hospitals in Saskatchewan and Manitoba are an accepted practice, where administrators compromise on the no smoking policy, by allowing ceremonial sweetgrass within the hospital (Jalan, 1993; Waldram, et al., 1995).

The federal government has made a very clear and strong commitment to endorse comprehensive holistic health and wellness practices integrated into mainstream medical systems (Browne, Fiske, & Thomas, 2000; House of Commons Canada, 1995; Royal Commission of Aboriginal Peoples, 1991, 1996; Waldram, et al., 1995). Lane, Bopp, et al. (2002) state that "what is needed is the creation of an integrated holistic system that provides critical pathways for healing, personal growth and learning, leading to a significant improvement in social, economic, and political life of the person, family and community" (p. 57). The Assembly of First Nations (2005) and Lane, Bopp, et al. (2002) suggest a blending of traditional and medical models into existing medical programs. Commissioned reports suggest positive outcomes result when the two models are merged, especially in the planning, development, and implementation phases of community health programs (Helin, 1993; Jalan, 1993; O'Neil, 1993; Proctor, 1993). Petch (2000), Procter (2000), and Simpson (2000a) identify components of Aboriginal and medical or western models, and compare and contrast these views. Procter (2000) suggests the need to continue to legitimize and verify traditional knowledge. Petch (2000) and Procter (1993) support a new framework using the strengths of both models to 'blend' and integrate both cultures of the Aboriginal and medical model. This new approach is described as a 'superholistic model' (Petch, 2000).

Summary

This comprehensive literature review has presented a historical overview, and a brief summary of the key concepts of both the Aboriginal and Shared Care models. There is clearly strong support for a collaborative approach that integrates holistic health within medical models of care. This information provides critical information needed to move forward and fully understand this research project, and the impacts on the Whitehorse General Hospital.

CHAPTER THREE

WHITEHORSE GENERAL HOSPITAL

Whitehorse General Hospital in the Yukon Territory is a 49 bed community hospital that provides acute care services to a Yukon population of 32,714 (Government of Yukon, 2007), and parts of northern British Columbia, and Alaska. The majority of Yukon residents live in the city of Whitehorse, and within fourteen rural, and First Nations communities. In 1992, the Canadian government transferred responsibility for all Yukon health and social services to the Government of Yukon (1998, 2002). The Whitehorse General Hospital was the one exception. As part of this devolution process, the hospital became a private corporation, governed by a board of directors. A First Nations health program was created shortly thereafter. A committee was formed to monitor and provide direction to this new program with the Council of Yukon First Nations appointing four hospital trustees to this board. An elder working group was later appointed in 1995 to discuss traditional medicines, and consult on the development of a First Nations healing room, which opened in 1999. The First Nations health program incorporates holistic health values and beliefs that are reflective of Yukon First Nations cultural and healing practices (Hogan, 2002). The Whitehorse General Hospital (2002) describes the First Nations health program mission as follows:

> "W*e advocate for First Nations people at Whitehorse Hospital to ensure quality and culturally sensitive holistic health care"* (p. 1).

This comprehensive program provides services to all Aboriginal clients at Whitehorse Hospital, as well as providing outreach to rural Yukon First Nations communities.

First Nations health and social liaison workers (7 FTE) offer a range of services, and in many areas of the hospital and community. They include: information and education; health promotion; interpretive services; support and advocacy; liaison with the client, medical staff, and communities; mental health; child life work; and discharge plans (Hogan, 2000). A popular First Nations cross cultural workshop is available for family physicians, and medical staff. Aboriginal healing methods are an accepted practice at Whitehorse Hospital with variations depending on the specific beliefs and practices of the fourteen Yukon First Nations. Ceremonies, prayers, traditional foods and medicines, and use of the First Nations healing room are all a part of a client's overall hospital experience, and care. Collaboration, communication, consensus, relationships, and a sense of community are not only principles of the Aboriginal model, but are critical components of the mental health program at Whitehorse Hospital.

The second component of the mental health program at Whitehorse Hospital involves the medical system. The family physician is the first contact for clients who are in crisis, and require assessment, and treatment. Mental health clients are cared for in the hospital emergency department, or admitted to the west (or medical) unit, where there are 17 acute care beds with seven identified as mental health. Consultations also occur with family physicians, regarding direct admission from one of the four family practice clinics. It is not common for mental health clients to be admitted to the east (or surgical) unit. The family physician is often the case manager for their clients', as they assume primary care responsibility, and coordinate care. A consulting psychiatrist (.25 FTE) visits Whitehorse Hospital weekdays to see referred mental health clients for individual consultation, as well as offering education, guidance, and support to family physicians

and mental health nurses, both in person, and via telephone. Clients can also be referred for consultation to the psychiatrist's office within the community. Joint consultations are not conducted with the psychiatrist, family physician, and client in Yukon, due to billing regulations. Visiting specialists, such as a child psychiatrist, have occasionally provided consultative services to clients admitted to Whitehorse Hospital, on request. Family physicians also consult regularly with psychiatric specialists in Alberta and British Columbia, especially when caring for youth, or if a client is being transferred out of the Yukon for long term assessment and treatment. Whitehorse Hospital is considered to be an acute care center with mental health clients admitted for short term duration. Two mental health registered nurses (2 FTE), work as part of the west unit team. They cover 12 hour days, and 7 days per week, caring for mental health clients within the Hospital. Their role includes: conducting of mental health assessments, crisis intervention work, counseling and support, case management, and discharge planning for all referred mental health clients. Another role of the mental health nurse is to ensure the legal process is followed for all committed clients under the *Yukon Mental Health Act* (Government of Yukon, 2002). The mental health nurse works collaboratively and in consultation with all health and social service professionals who work directly and indirectly with mental health clients at Whitehorse Hospital. They also provide consultative services to health professionals in the rural communities. Registered nurses in the emergency department, and registered nurses and licensed practical nurses on the west unit are responsible for the physical, mental, emotional, and spiritual care of mental health clients, when the mental health nurses or First Nations liaison workers are not available.

There are two qualified social workers who work with clients at Whitehorse Hospital. The First Nations social worker is responsible for liaison with hospital and community supports, and the coordination of discharge planning for all Aboriginal hospital clients, including mental health. A second social worker is responsible for all other hospital clients with the exception of mental health, as this is primarily the responsibility of the mental health nurses. However, on occasion, this social worker has assisted and supported the mental health nurse, as needed.

Several critical reports helped to improve and strengthen the Whitehorse Hospital mental health program. The *Final Report of the Task Force on Hospital and Community Based Mental Health Services* (Whitehorse General Hospital, 1999) showed that the mental health program met its objectives of assessment, crisis management, stabilization, and discharge planning. This Task Force report recommended increased collaboration, and a sharing of information among stakeholders. The first suggestion identified by the Task Force was to implement Whitehorse Hospital's version of Shared Care plans. These case management plans (Pasquali, 1998) were developed based on mutual mental health clients who accessed both community and hospital mental health services. This plan was coordinated by either the family physician or community mental health clinician. The client Shared Care plans consisted of a brief summary of diagnosis, issues of concern, and likely presentation to the emergency department. Clinical interventions, medications, community supports, and other relevant information were also included in this plan. It is unclear as to whether the hospital Shared Care plan is associated with the national Shared Mental Health Care model, as the name is the same. I was not able to find out where the Shared Care name originated. Another consideration is that the Shared Care model does

not include client care plans or case management within the key concepts of this approach. The second Task Force recommendation was the community mental health *Next Working Day Service* (Government of Yukon, 1999). This initiative was implemented for clients who present to the emergency department in crisis, but not requiring admission. Both initiatives were successful, however, the Shared Care plans were considered to be outdated and inconsistent.

Whitehorse Hospital continues to be progressive in its vision to improve mental health service delivery. A second formal assessment and review of the mental health program was conducted by the *Mental Health Evaluation and Community Consultation Unit* (MHECCU) from the University of British Columbia (Chan & Noone, 2001). This critical evaluation report resulted in significant changes to the Whitehorse program. The first implemented recommendation was the expanded role of the mental health nurse to include assessment, consultation, and crisis intervention services to clients in the emergency department. A preliminary evaluation of this service was conducted (Scott, 2001), and results showed overwhelming support for this initiative. This expanded mental health nurse role, and the use of emergency department Shared Care plans, are but two components of the Shared Mental Health Care model that fit with the national Shared Care philosophies of collaboration, and maximizing resources in underserved areas.

The *Whitehorse General Hospital Accreditation Survey Report* (Canadian Council on Health Services Accreditation, 2004) acknowledged significant progress in the area of mental health following the MHECCU review, and provided further recommendations. They included progressive policy and practice initiatives that were implemented to address safety issues, and other client and staff concerns. These improvements include:

the creation of an ethics committee; the hiring of a consulting then a part time psychiatrist (.25 FTE) was hired; and renovations to the seclusion room were completed to ensure client safety. Several areas to be addressed in the immediate future include: another safety issue, for example, when confused and mentally ill clients are mixed with acute care clients on the west unit, and in the emergency department. A timely service is also acknowledged as an issue in the emergency department, with a suggestion to assess the effectiveness of this service holistically. There has been considerable progress in the positive changes to the mental health program at Whitehorse Hospital with ongoing improvements in service delivery. Administrators continue to assess the effectiveness of mental health services with the goal of ensuring a comprehensive and successful mental health program.

The next step in this research process is the focus of participant views and perspectives for a Shared Care model.

CHAPTER FOUR

METHODS

Introduction

This research explored how a Shared Mental Health Care model operates within the Whitehorse General Hospital mental health program. The focus of inquiry was on participants' observations, perspectives, viewpoints, and experiences as they examined the mental health program. A descriptive thematic qualitative approach was used in this study. Patton (1990) defines a thematic strategy as "common themes and relationships emerging from and related to the context within which it exists" (p. 51). Themes are also determined as data is reduced to specific categories (Coleman & Unrau, 1996; Krueger & Casey, 2000; Seidman, 1998). Thematic tools were created to structure this process. Matrix tables framed the critical key concepts of the Aboriginal and Shared Care models (Coleman & Unrau, 1996; Miles & Huberman, 1994; Patton, 1990; Rubin & Babbie, 1997). The participant interview guide questionnaire was structured in this same format, and found to be invaluable during data collection, and analysis. The participant information education package presented relevant information on the Shared Care and Aboriginal models, as well as provided a step by step format that guided participants through the methodological process (Rubin & Babbie, 1993, 1997). Data collection involved three methods, which consisted of focus groups, individual interviews, and participants completing questionnaires themselves. This qualitative research design also included a holistic component that examined the 'whole' context of the research to better reflect First Nations concepts, perspectives, and practices (Janesick, 1998; Kenny, 2004; Patton, 1990).

Purpose and Objectives of Research Study

The purpose of this research is to determine if a Shared Mental Health Care model for Whitehorse General Hospital operates, and if so would it continue to be reflective of both medical and First Nations culture and values. This study has four objectives:

1. To describe the mental health care program, in relation to the Shared Care and Aboriginal health models
2. To increase awareness and understanding of the First Nations and Medical components of the mental health program, and how they collaborate, complement, and support one another
3. To explore how the Shared Care model works, and the degree to which it is complementary to the First Nations practices of the mental health program
4. To present an improved Shared Mental Health Care program for Whitehorse General Hospital, Yukon, one that uniquely incorporates First Nations philosophical, cultural and traditional healing practices

Participant Sample

The participant sample in this study consisted of all employees who were directly or indirectly involved with mental health clients at Whitehorse Hospital. Participant discipline groups included: senior administration; middle management; clinical case managers; family physicians, and the psychiatrist; First Nations health, including one First Nations social worker; west unit registered nurses, and licensed practical nurses; emergency department registered nurses; a mental health nurse; and an east unit registered nurse. Support staff included: a dietician; pharmacist; physical therapist; housekeeping; security; dietary aids; maintenance; administrative assistants, and one

social worker who support but are not responsible to the mental health program. Unfortunately, the laboratory and radiology departments were not represented in this sample, due to availability, and time constraints.

A 'Participant Summary Sheet and Consent Form' (see Appendix 3) was reviewed and completed by all participants prior to data collection. This form provided participants with an overview of the research questions, explanation of the use of the results, informed consent, confidentiality, and care and disposal of research materials (Patton, 1990; Rothery, 1996; Rubin & Babbie, 1997). No names were revealed with data categorically coded, and analyzed according to discipline group. Consent forms were completed by all participants.

Considerable thought was given whether to include clients as a participant group. Although, this would have added an interesting dimension to the study, it was decided not to involve clients and their families, because this research focused specifically on Whitehorse Hospital employees and their views, perspectives, and involvement within the mental health program. As well, the focus of inquiry was predominantly on issues related to the areas of collaboration, support and education, maximizing resources, case management, and holistic health and healing, and an exploration of the First Nations health program and practices.

Interview Sites

Focus groups and individual interviews were conducted on site at Whitehorse Hospital, so as to provide easier access, increased comfort, and maximum participant involvement. Various site locations were used in and around the hospital. The majority of interviews were conducted in the report room on the west unit. This area is where the

largest concentration of staff works. Staff rest areas in their respective work place were also popular venues. Middle management and senior administration preferred their own offices as interview sites. The First Nations boardroom was used for two focus groups. The hospital cafeteria, a bench outside on hospital grounds, the local coffee shop, and another work place were alternative sites. Senior administrators supported my request to conduct all interviews at Whitehorse Hospital, when units were not busy. Participants were informed of this approval and authorization, but were consciously aware of taking time away from their work. Many participants completed interviews on their meal breaks, or on their own time.

Data Interview Process

Step 1 Gathering support

This process occurred in three phases. These steps included: 1) gathering support and inviting participants to take part in my research project; 2) attending an information education session; and 3) the completion of an interview questionnaire. The first step in this interview process was the gathering of support for my project with recruitment selection within specific identified discipline groups (Janesick, 1998). In the preparation phase of this study, all staff who worked directly and indirectly with mental health clients in various areas of Whitehorse Hospital were approached. A brief informal overview of the study and research process was provided to potential participants, and if interested, they were asked to attend an information education session, followed by the completion of an interview questionnaire. Flexible times and days were offered for these meetings at respective work sites. It was not known which participants would be involved, as this would depend on level of interest, workload, and whoever was on shift on any given day.

Expressions of support were received from potential participants with only three declining to participate, with thanks. Discussions were highly effective, and gathered not only support for the research study, but also for the Shared Care model.

Step 2 Information education session

The information education session was the second component of the data collection process. An overview of the Shared Care and Aboriginal models was provided to participants. Historical background and key concepts of each model were reviewed, and how they are integrated within the acute care setting of Whitehorse Hospital. Collaborative practice and the possibilities of a Shared Care model at Whitehorse Hospital were also discussed. A 'Participant Information Education Package' (see Appendix 4) was made available to all those who attended the information education sessions to assist in completion of the participant questionnaire. This package was identical to the information presented, and was well received by participants. Only those participants who attended the information education sessions could complete the interview questionnaire. As a result of gathering support for this thesis project, the participant recruitment and attendance at the information education sessions was considered a success. Results were impressive with 63% of participants' having completed questionnaires. Table 1 shows that strong support exists for this project.

Table 1

Participant Recruitment

Gathering Support	Attended Information Education Sessions	Number Participant Responses
Over 100	85	54

Step 3 Participant interview questionnaires

The third step in this data interview process was completion of the 'Participant Interview Guide Questionnaire' (see Appendix 5). This tool was based on an interview guide format, using a thematic method of inquiry (Coleman & Unrau, 1996; Huberman & Miles, 1998; Rubin & Babbie, 1997; Seidman, 1998). This framework was developed using a structured, step by step interview format with a specific list of topics and questions to guide the interview. This process encouraged sufficient detail and allowed participants to express their own views and in their own words. The interview guide allowed the researcher the flexibility to informally gather the information, and ensured all participants received the same inquiry process, and were asked the same questions, in essentially the same sequence, and with adequate information (Rubin & Babbie, 1993). Questions were clear, easy to understand, and open ended, allowing for description and quality data (Coleman & Unrau, 1996; Rubin & Babbie, 1997; Seidman, 1998). The expectation was that the participant interview questionnaire would explore and achieve the objectives of this research study. A one page summary started the interview process with specific instructions to assist participants with completion of the interview tool. Handouts in this package (see in Appendix 5) provided background information on the specific questions and topics for participants to refer to. The participant package

consisted of three parts. The first inquiry was the 'description of the Whitehorse Hospital mental health program'. One of the handouts summarized the different disciplines, their roles, and the services they provide to mental health clients. Participants were given the opportunity to comment and update. The second inquiry, 'what are we doing now?' allowed participants to discuss possible elements of Shared Mental Health Care within the existing mental health care program. A handout was provided on this question also, summarizing Shared Care at Whitehorse Hospital. The next set of questions focused specifically on the key concepts of the Shared Mental Health Care and Aboriginal models, in relation to the Whitehorse Hospital mental health program. A thematic matrix style approach (see Table 2) organized and framed the key concepts of both models, which helped to structure participant responses (Coleman & Unrau, 1996; Miles & Huberman, 1994; Rubin & Babbie, 1997).

Table 2

Thematic Matrix

Shared Mental Health Care Model

Key Concepts	*Strengths*	*What Would You Like to See Different*	*Solutions & Suggestions for Change*
Collaboration			
Support/Education			
Maximizing Use of Resources			
Case Management			

Aboriginal Health Model

Key Concepts	*Strengths*	*What Would You Like to See Different*	*Solutions & Suggestions for change*
Collaboration and Consensus			
Holistic Health and Healing			
Aboriginal Healing Methods/ Practices			

This matrix table presents the Shared Care and Aboriginal model key concepts, as described in Table 1. This thematic interview format used a modified version of the SWOT analysis to answer the third part of the questionnaire, 'how are we doing now?' Idaho State University Pocatello (2006) defines SWOT as "a strategic planning tool, useful for planning and decision making at multiple levels within an institution, organization or business" (p. 1). This model is appropriate for this study, but somewhat restrictive and negative, as it addresses, 'strengths, weaknesses, opportunities, and threats' (Danca, n.d.; Krueger 1988; Westhues, Lafrance, & Schmidt, 2001). This SWOT analysis was adapted for this study with the focus on 'strengths', 'what would you like to

see different', and 'suggestions and solutions for change'. Using this thematic technique encouraged positive data results for changes in the mental health program, and reflected a strengths perspective (DeJong & Miller, 2000), and a solution focused approach (DeJong & Berg, 2002). There are intentional overlaps placed in the key concept thematic format. The two questions, 'what would you like to see different?', and 'suggestions and solutions for change' were similar, but different, and presented a more positive approach to the data results. Participants would describe what they would like to see different, rather than focus negatively on the mental health program. The third component of the participant interview guide questionnaire consisted of three vision questions. They were: 'what would a Shared Mental Health Care model at Whitehorse Hospital look like in the future?'; 'what Shared Mental Health Care components would you like to see implemented?', 'what is your vision?', and all rated in terms of priority. A 'questions, comments, suggestions' page, was also included in this package. All participants received the same information and instructions either individually or in focus groups. This ensured the consistency of the data across disciplines and methods. The interview guide was piloted with a registered nurse colleague, who was not involved in the study (Janesick, 1998). No major revisions were required at that time.

Data Collection

The data collection process took place over a period of four months, and with the majority of participant questionnaires received within the first six weeks of the study.

Demographics

Table 3

Demographics

Years Worked at Whitehorse Hospital	Age	Gender	Race
1 - 4 = 7	< 29 = 3	M = 15	Caucasian = 46
5 – 10 = 16	30 – 44 = 15		Aboriginal = 6
11– 15 = 31	45 - 55 = 23	F = 38	Aboriginal/ Caucasian = 1
16 – 20 = 0			
21 – 25 = 6	> 55 = 10		Aboriginal/ Black = 1
> 30 = 2			

Note. Respondents = 54 with 2 not completing the age category

The majority of participants, 71% (38) were between the ages of 30 and 55 with approximately two thirds female, and one third male. All but eight participants are Caucasian. It is expected the majority would have a relatively good working knowledge of the Whitehorse Hospital mental health program, as 90% (47) of participants worked at the hospital between 5 and 20 years, and two had over 30 years service. Only seven participants had less than 4 years service.

A 'Participant Data Summary Tool' was created (see Table 4) to assist in the organization of participant information. This non specific data was categorized according to participant number, discipline, interview method, and site. This form also included: data quality, appropriateness, gaps, variables, specific quotes, and important comments.

Table 4

Participant Data Summary Tool

Participant # and Discipline	Interview Method and Location Site	Data Quality	Appropriate / Relevant of the Data	Gaps/ Incomplete	Variables, Quotes, Journal Notes, Comments

This summary data form was found to be invaluable, and referred to frequently throughout the methodological process. Quantitative numbers were easily extrapolated when analyzing demographics, disciplines groups, site locations, and interview methods.

Focus groups and individual interview methods

Participant interviews were conducted at Whitehorse Hospital to gather the necessary information required for this study. Participants were offered a choice of interview method, and whether to attend a focus group, an individual interview with the researcher, or complete the questionnaire themselves. The focus group approach consisted of a specific group of two to six persons coming together to discuss and explore their thoughts, views and perspectives on a common topic (Krueger & Casey, 2000; Patton, 1990). Individual interviews followed a very similar process with the same standardized interview guide format, but with just the participant, and the researcher. There was consistency, and little variation occurred across methods. Participants were also given the opportunity to attend the focus groups or an individual interview either in two separate sessions, a combination of both methods, or they could complete the questionnaire themselves. These sessions did not have to run concurrently or on the same

day. This design change was effective in allowing for maximum participation in this study. Participant focus groups and individual interviews were conducted with each session taking approximately 30 to 45 minutes, followed by a question and answer period. The time frame was the same for the presentation of the information education sessions, and the completion of the questionnaires. Participants' respective worksites were visited on average three to five times per week to make arrangements, conduct individual interviews and focus groups, and follow up inquiry as to the completion of the questionnaires. Some of these visits were during my regularly scheduled workday as a nurse at the hospital, but during my scheduled meal breaks. A variety of dates and times, and various interview locations, were made available. The flexibility and availability of myself, as the researcher, was crucial in conducting the focus groups and individual interview process. I endeavoured to establish rapport and an element of trust with participants. As a result, relationships were able to develop within a supportive and respectful environment (Fontana & Frey, 1998; Janesick, 1998). Every effort was made to ensure maximum participation, and as little disruption as possible. At no time was client care compromised in any way. All of these factors contributed to high respondent numbers, critical to the success of this project.

The senior administrators at Whitehorse Hospital were the first discipline group to receive the information education focus group session. Discussion followed the presentation. Verification was provided that the participant sample would be inclusive only of Whitehorse Hospital personnel. Also discussed, an inquiry as to the name for this project, whether it was to be Shared Mental Health Care or collaborative care. A unanimous decision supported a Shared Mental Health Care model at Whitehorse

Hospital. It was suggested this concept "fits in nicely with the future direction of the hospital". Positive feedback and support was extended, with an endorsement from senior administrators to proceed with staff focus groups and individual interviews.

The west unit was the second focus group to receive the information education session. This group was multidisciplinary in nature, and included west unit registered nurses and licensed practical nurses, and the hospital support staff discipline. This focus group was important, as it was the first employee interviews. Informal evaluation discussions were conducted following the information education session. Feedback was requested, and received. The focus group process was considered to be a good experience. Participants reported positively on the information they were given in the presentation and summary handouts, which they described as comprehensive and appropriate. Participants did say they needed time to process the information received, and preferred to complete their questionnaires at a later date. They also requested additional information to assist with completion of their questionnaires, specifically, the detailed information education package I referred to in my presentation notes. I subsequently provided this more detailed package (see Appendix 4) to all participants, including the senior administration group, to ensure all received the same information. No revisions or changes were required from the feedback.

Multidisciplinary focus groups continued on the west unit. During these sessions participants were presented with the information education sessions. Focus groups were a preferred method of choice by these participants with six being conducted at the beginning of data collection. Single discipline focus groups were also conducted at the same time in other areas of the hospital with several groups preferring to complete the

information education session followed by the questionnaires in one session. Mid way through data collection, there was a notable shift in research method. Participant preference was then for individual interviews for both the information education sessions, and the questionnaire interviews. Almost all of the individual interview participants preferred to complete their questionnaires themselves, returning them sporadically, depending on hospital activity. Towards the end of data collection, gentle reminders were provided to the remaining participants with the offer of support and assistance, or the option of attending a focus group. As a result, this method was again popular with four focus groups arranged towards the end of the study. Data collection was complete when all disciplines were represented with sufficient numbers in all categories, and 54 respondents in this survey (Rubin & Babbie, 1993, 1997). Table 5 summarizes the interview methods and represents participants who completed questionnaires.

Table 5

Interview Method

Discipline	Information Education Sessions			Questionnaires		
	Focus Group	Individual Interview		Focus Group	Individual Interview	Participant Complete
Senior Administration	3				2	1
Middle Management		2				2
Clinical Care Managers		3				3
Physicians	5	2		5	1	1
First Nations Health	4			4		
Emergency Room Registered Nurses	2	3		2	2	1
West Unit Registered Nurses	5	5				10
Mental Health Nurses		1				1
East Unit Registered Nurses		1				1
Licensed Practical Nurses	6			4		2
Support staff	6	6		2	3	7
Participant Numbers	31	23		17	8	29

Note. Total respondents = 54; The physician group, includes psychiatrist

Table 5 clearly shows the majority of participants (48), preferred attending focus groups to receive the information education sessions. A smaller number of participants, (17), attended focus groups to complete their questionnaires. A large number (29), preferred to complete the questionnaire component individually, and a small number completed with the researcher. Most participants attended separate focus group sessions for the information education session, and questionnaire. Although, some participants, (18), preferred to complete both components in the same session, either in focus groups or individual interviews. This complete approach was preferred by specific discipline groups, such as family physicians, First Nations, and senior administration, possibly as they were more available during the day. Strong support for this study was received by all participant discipline groups.

Methodological Design Changes

It should be mentioned that decisions had been made to change the methodological design in this research study, prior to data collection. The original participant sample included only those employees who provided direct services to mental health clients. There were four specific focus groups that would have included: family physicians, and the psychiatrist; First Nations health workers; the staff on the west unit, which included registered nurses, licensed practical nurses, and the mental health nurses; and management. I had become aware that the shared Care model had expanded to include other health care professionals, such as social workers. There was also considerable interest to attend in this study. As a result, the participant sample was expanded to all staff that provided direct and indirect care and services to mental health clients. Methodological design changes in the interview method were then necessary to

reflect increased numbers in the participant sample. Also, the need for a more flexible approach was evident. A shift from the original design plan of four centralized focus group locations to varied participant locations of work was required. A decision was made to allow participants a choice in method between focus groups or individual interviews. The interview method was then changed. Participants were given the choice whether to attend a focus group, have an individual interview with the researcher, or complete the questionnaire themselves. The participant interview questionnaire guide was also revised slightly to present a more structured and simplified approach to accommodate participants who would complete the questionnaire themselves, and ensure a standard is maintained across disciplines, and methods. All methodological changes were reviewed and supported by Whitehorse Hospital senior administration.

Data Analysis Process

In preparation for data analysis, activities were conducted to organize and manage the data, supporting this process. A systematic and structured data management and analysis framework was created for this study. This format clearly guides this rigorous and disciplined process (Coleman & Unrau, 1996; Patton, 1990). Huberman and Miles (1998) provided an excellent framework used in this study. They describe three 'sub processes' that include data reduction (manage the data), data displays (organize and structure the data), and verification of conclusions (interpretation from data displays). The first step in the data management process was to gather, organize, and manage all relevant data (Coleman & Unrau, 1996; Patton, 1990). A physical and electronic filing system was created with a back up data system (Huberman & Miles, 1998; Patton, 1990). All participant interview responses were transcribed, and typed into data display

documents that were created to organize and reduce the data (Miles & Huberman, 1994). These data sets were grouped according to discipline, location of work, key concepts, and vision statement categories. A process of content analysis was used to identify patterns, and key themes within the data, and define categories within a 'conceptual framework' (Krippendorff, 1980; Patton, 1990). Thematic results were then put into matrices (Huberman & Miles, 1998; Patton, 1990; Seidman, 1998). Vision statement data was categorized in the same way using a similar process. The next analytical step was to interpret the data, and verify conclusions. Observation of regularities, similarities, differences, relationships, connections, and theoretical constructs was used. These tactics were central to the identification and summarizing of the key themes in the matrix charts (Coleman & Unrau, 1996; Mertens, 2005; Miles & Huberman, 1994; Patton, 1990; Rubin & Babbie, 1997). A colour coded marking system was used with each colour delegated to one of the seven vision statement categories, including subgroups. Counting techniques were utilized to then determine priority vision statements (Krippendorff, 1980; Patton, 1990). Comparisons and contrasts of key concept and vision statement data were conducted, including counting tactics to verify participant vision statements. This data was entered into matrix tables. Analysis of all data was important to present an improved Shared Care model for Whitehorse Hospital.

Trustworthiness of Results and Conclusions

Judging the quality of the data was essential in this research project with credibility as the most important and critical indicator (Coleman & Unrau, 1996; Mertens, 2005; Patton, 1990). There are a number of elements that are required to ensure a credible study. A thoroughly researched methodological plan was necessary, as well as

the development of a structured data management and analysis framework, both adding to the credibility of this research. Comparing and contrasting themes, and using different methods of thematic inquiry, resulted in the presentation of appropriate and accurate quality data results. Specific thematic matrix tools also structured, and validated the data. The participant information education package (Appendix 4), and the participant interview questionnaire package (see Appendix 5), and participant guided participants through the data collection process, especially the key concept forms. The participant data summary form (Table 4), and matrix # 1, # 2, #3, graphs (Appendix 6, 7, 8 respectively) summarized the key concept data into structured themes, and guided the data management and analysis process.

A number of strategies and tactics to validate the credibility of this research study were used in this paper. Sufficient and 'thick' detailed description of thoughts, feelings, relationships, experiences, and context are balanced with credible explanation, and participant summary responses. Perspectives and views of participants are clearly presented within the thematic matrix results (Denzin, 1998; Patton, 1990). Audit trails, via hard copy, and electronically were an integral part of the methodological process (Coleman & Unrau, 1996; Patton, 1990). The data management and analysis plan is a perfect example of an audit trail. Quotes, metaphors, and tests for completion have also added to the credibility of this research (Coleman & Unrau, 1996; Patton, 1990). Member checks (Janesick, 1998; Mertens, 2005; Patton, 1990) were completed with participants who provided emails for results on their consent form. Prolonged and substantial time at the interview site with participants (Coleman & Unrau, 1996; Janesick, 1998; Mertens, 2005) was another strategy used. I had purposefully visited the research

site during data collection, until I had sufficient representation in all discipline areas. This process over time with the use of journal notations was consistently transparent in tracking methodological changes. Results of this study are beneficial to other small community based hospitals that have mental health programs that include both medical and Aboriginal components. Authentic and fair representation (Mertens, 2005; Patton, 1990) of participant responses is presented as a balanced view of their perspectives, values, and beliefs. This is crucial in ensuring an accurate description of this research study, which is presented in this report. Mertens (2005) cites Guba and Lincoln (1989) who describes the concept of 'ontological authenticity' or the "degree to which participant's conscious experience of the world becomes more informed" (p. 256). Participants not only became more informed about Shared Care, but strongly supported this model at Whitehorse Hospital. Maintaining objectivity in this study was critical. This ensured the research represents participant perspectives, and not my own assumptions or viewpoints (Mertens, 2005; Patton, 1990). Distance from participants during data collection was a key theme adhered to throughout the entire methodological process (Coleman & Unrau, 1996; Guba & Lincoln, 1994). The rigorous and structured methodological process of this research study presents credible and trustworthy results and conclusions. Analytical strategies and techniques used an adequate and consistent level of appropriate data, and the variety of interview methods used supports and confirmed the research findings (Coleman & Unrau, 1996; Mertens, 2005; Patton, 1990). A 'logical chain of evidence' was utilized in this study, and presented in this methodical report (Guba and Lincoln, 1994; Mertens, 2005; Miles & Huberman; 1994).

Ethical Considerations

Ethical processes were followed during preparation, data collection, analysis, and the writing of this report. An ongoing and conscious awareness of the potential for bias and researcher effects was an integral and essential part of the research process. Every effort was made to minimize these possibilities. An open and honest approach, the sharing of my personal information, qualifications, and experiences is presented in this report, which ensured credibility, and validated myself as a researcher. Considering, I had personal and professional relationships with participants it was important to ensure an accurate portrayal of the participant data is represented in an objective, neutral, and unbiased way. It was essential that my position or standpoint, as a researcher to participants, be reciprocal, and based on an equal position during data collection (Mertens, 2005). These ethical considerations were integrated throughout the research process, which ensured the research data and conclusions to be representative of participant viewpoints in a fair and objective way. Anonymity, confidentiality, and safe keeping of participant interview materials processes were also ethical issues adhered to. Ethical conduct and research principles were an integral part of this study, and guided this research project during preparation, data collection, data management, and the analysis phases. A number of ethical research documents were reviewed concerning the protection of indigenous knowledge, traditional medicines, and traditional practices (Aboriginal Healing Foundation, 2000; Brascoupe' & Mann, 2001; Canadian Institutes Health Research, 2002, 2007; Emery, 2000; Hill, 2003). Also critical to this academic study, a review of ethical research guidelines was conducted, and referred to during the research process. Publications include: the Canadian Association of Social Workers,

'Code of Ethics' (2005); the *Association of Canadian Universities for Northern Studies* (2003); *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (Canadian Institutes of Health Research, 1998, 2000, 2002, 2005); and University of Northern British Columbia's *Policies and Procedures General Research Ethics* (1995, 2005). It is important to note this research project was reviewed by the ethics committees of the University Northern British Columbia, and informally by Whitehorse General Hospital.

Summary

The research method used for this study has been outlined in this chapter. The results of this study will show if a Shared Mental Health Care model would be successful, and this discussed in the next chapter.

CHAPTER FIVE

RESULTS

Introduction

This research examines the Whitehorse Hospital mental health program, and specifically the medical and First Nations health programs. Key concepts of the Aboriginal and Shared Care models are presented from participant perspectives, in terms of strengths, areas to improve, and solutions for change. Results are descriptive, and reflect a vision for change, towards a Shared Care model. A thematic content analysis strategy identifies important themes within the data, which was entered into matrix tables (Krippendorff, 1980; Patton, 1990). Themes were categorized by Shared Care and Aboriginal models, participant discipline groups, and locations. Vision statement data was analyzed with critical themes emerging. A comparative analysis was conducted with key concept themes, models, disciplines, and vision statement data. Thematic comments were counted and framed within vision statements. These strategies assisted to verify, and confirm data results. A Shared Mental Health Care vision for Whitehorse Hospital emerged from the data, based on participant perspectives.

Matrix # 1: Key Concept Themes by Model

Matrix # 1 (see Appendix 6) clearly identifies support for major concepts within the data, based on identified themes of the Shared Care and Aboriginal health models. Matrix results present a majority of comments with equal representation of participant responses in all key concept areas. Critical information identifies strengths, what participants would like to see different, and solutions and suggestions for change. Table 6 presents a brief summary of key themes by model.

Table 6

Summary Key Concept Themes by Model

Shared Mental Health Care

Key Concepts	Strengths	What Would You Like See Different	Solutions/ Suggestions for Change
Collaboration	- Collaboration - Communication among mental health team and family physicians	- Improve communication - Increase psychiatric services	- Separate mental health unit - Mental health nurse 24/7 in emergency and west units
Support and Education	- Mental health workshops, and training - Telehealth	- Improve educational opportunities for: all staff and new nurses	- Mandatory mental health in bi-annual hospital days - Psychiatrist and mental health nurse in-services - Record telehealth - Peer support
Maximizing Use of Resources	- Utilization of existing mental health resources - Psychiatrist support and consultation to family physicians - Expanded role of mental health nurse to emergency department	- Expanded mental health program and staffing - Mental health education sessions to improve staff knowledge and skills	- Mental health nurse 24/7 - Second psychiatrist - Separate mental health unit with trained staff - Mental health clinic with addiction/detox - Mental health multidisciplinary rounds and clinical case presentations
Case Management	- Shared care plans - Client history - Mental health and First Nations client record notations	- Training in Shared Care plans - Communicate Shared Care plans exist - Improve, update, and maintain plans	- Multi-disciplinary approach to develop Shared Care plans - Meditech care plans - Review/ update at 3-6 months by case manager - Cultural component - Psychiatrist and physician – eligible for fee for service

Note. MH team consists of Mental Health Nurses and Psychiatrist; Meditech is Whitehorse Hospital electronic client record

Aboriginal Health

Key Concepts	Strengths	What Would You Like To See Different	Solutions/ Suggestions for Change
Collaboration and Consensus	- Collaboration - First Nations health program - First Nations health workers - First Nations health health have excellent communication, and emotional support to clients and families - Adolescent mental health - Discharge planning - Knowledge of available resources	- Improve collaboration - Improve communication, specifically reports of client information - Expand First Nations staffing service, so more available and accessible - Improve mental health skills of First Nations workers - Need increased First Nation cultural information - Focus on residential school and related social issues	- First Nations and mental health staff work collaboratively together to: communicate and report both verbal and written client assessments and information - Expand First Nations coverage to weekends and nights - First Nations health information, tours, and pamphlets - Integrate residential school component into mental health intake assessment
Holistic Health and Healing	- Strong personal belief in 'whole person', holistic health approach to healing	- Increased education in all areas first nations health program	- Educational training - Holistic health pamphlets on First Nations culture
Aboriginal Healing Methods and Practices	- Traditional practices, such as spiritual, traditional medicine and foods, elder support - Healing room	- Improved understanding Aboriginal healing methods, including access and utilization	- Educational sessions in First Nations healing methods, for all staff - First Nations holistic health and healing pamphlets and tours - Integrated holistic health center

Note. Meditech refers to Whitehorse Hospital electronic client record.

Matrix # 2 shows that participant data results overwhelmingly support a Shared Care model for Whitehorse Hospital, one that incorporates components of Aboriginal health. Considerable strengths are identified within the data, indicating a well supported mental health program. These strengths show success, but there is also an acknowledgment and desire for positive change. This is clearly evident in the excellent suggestions and solutions identified for change. Matrix 1 presents a general and overall summary of the participant data based on key concept themes. This approach not only supports the key concept themes revealed, but presents additional specific information on the participant data, reflective of the discipline, and triangulating the data. Further analysis of the data by discipline and model was then conducted.

Matrix # 2: Key Themes by Model and Discipline

The second matrix (see Appendix 7) looks at participant discipline data from differing viewpoints and perspectives. Key themes were explored within the Shared Care and Aboriginal health models, and categorized by discipline group. Clear patterns and views became evident with different priorities emerging with respect to strengths, what participants would like to see different, and suggestions for change in the Whitehorse Hospital mental health program. Table 7 presents a summarized version of Matrix # 2. It is important when reading this table to note specific variations in discipline groups. Middle management and west unit registered nurses, include other related health care professionals clustered together to ensure confidentiality and anonymity. Family physicians and the psychiatrist are referred to separately in other sections of this paper, but in this chapter, both discipline groups are classified as 'physicians'. This allows for confidentiality of the psychiatrist, and is appropriate as they attended the family

physician focus group. The First Nations health discipline group consists of staff from the Yukon First Nations health program. Also, refer to Table 7, '*Note*', for further details. Questions may arise, as to why the east unit (surgical) was not included in this study. A decision was made by the east unit clinical care manager that this area would not participate in this survey, due to the new bed allocation system, and very few mental health clients admitted to that unit. Table 7 presents key theme data, by model and discipline for both the Shared Care and Aboriginal health models.

Table 7

Summary Key Themes by Model and Discipline

Discipline	Shared Care	Aboriginal Health
Senior Admin-istration	- Collaboration is a strength, but acknowledged a need to do more - Support and education identified as strength, as well as need for increased training, and staff development	- Strong well accepted First Nations health program - Improve collaboration - provide more support, no "road blocks" - Educational programs for all staff in holistic health, healing, methods - Explore traditional medicines fit with medical system - Integrated holistic health center
Middle Management	- Support and education critical in area of staff development	- Well accepted program - Need for supportive counselling training for First Nations staff
First Nations	- Strength is collaboration between First Nations, and mental health - Need improved communication between First Nations and west unit regarding client charting - Expand First Nations health staff - Coordinated, well staffed mental health clinic using Shared Care	- Strong Aboriginal health and healing methods, especially healing room, spiritual practices - Need for education and access to resources - Revise mental health intake form to reflect residential school survivor issues
Physicians	- Overwhelming support for collaborative effort of mental health nurses - Increased psychiatrist services - 24/7 mental health nurse - Critical issue - mixed mental health unit solution a separate mental health unit and day clinic - Mental health education – topics include: Mental Health Act; disorders, improve telehealth - Local family physician funding opportunities in mental health - Develop Shared Care plans, be more available & fee for service	- Excellent First Nations health program - Aboriginal holistic health and healing practice component supported with interest and a desire to learn more

Emergency Department Registered Nurses	- Strong support for mental health nurse in emergency department - Need to expand mental health nurse to 24/7, and be available full time emergency department - Mental health education – high risk issues, and for new nurses - Drop in clinic to decrease emergency department workload - Existing Shared Care plans good but require consistent updating	- Very positive comments for first nations health program, - Strong support for First Nations healing methods, especially traditional medicines and meals, elder participation, and residential school healing initiatives.
West Unit Registered Nurses	- Strong support for Shared Care - Multidisciplinary cooperation with family physicians, and mental health nurses - Mental health nurse is resource - Need additional mental health education and training sessions - Mandatory biennial hospital education days - incorporate mental health - Formal relationships with university psychiatric resident - Expand mental health program- increased psychiatrist; and mental health nurse 24/7	- Strong personal belief and acceptance of holistic health and healing concepts - Aboriginal healing methods strongly supported by majority - Need to improve verbal communication in area of client assessment and reporting - Positive comments for First Nations child support worker, and discharge planning social worker
West Unit Licensed Practical Nurses	- Need for full time psychiatrist, specific to Whitehorse Hospital, for clients, and staff training - Limited client Shared Care plans - Need to communicate plan to staff and update regularly - Educational mental health conferences, workshops, training, and repeat them	- Strong support for collaboration with disciplines working together, and sharing information - Holistic health concept of healing is an excellent strength - Desire for increased awareness, and education on First Nations health program

Support	- Strong support for collaborative and multidisciplinary approach with mental health nurses, family physicians, psychiatrist, and support staff - Expand mental health program with additional psychiatrist, and mental health nurses - Explore psychiatrist resident - Multidisciplinary client meetings with flexible dates, times - Improve communication – due to potential safety issues - Excellent workshops in mental health - need training expanded	- Strong support for First Nations health program, specifically the sharing of information, and the healing room - Request for more information on First Nations healing practices and healing room tours

Note. Middle management includes clinical care managers, education, quality assurance; west unit registered nurse includes: mental health nurse and east unit registered nurse; physician group, includes the psychiatrist

Matrix # 2 presents similar themes, as in matrix # 1. Results in Table 7 show considerable strengths in the key concept data. These strengths are balanced with areas to improve. Collaboration among all disciplines is considered to be a strong focus of the mental health program, as is support and education. Expanding the mental health program to include increased psychiatric and mental health nurse services are identified as a priority for many discipline groups. Also, very important is a separate mental health area for clients, as well as educational opportunities that improve the knowledge and skill level of all hospital employees. The First Nations health program is described as being well accepted, by many participants, and this result is strongly reflected in participant responses. There is also a definite and clear need for additional information about the First Nations health program. The important issue for senior administration and middle management is staff education and development, but from a broader perspective, and reflective of their supervisory roles. The support discipline identified the need for

education for all staff involved or associated with mental health clients in their work and duties. They identify specific issues related to collaboration, communication, support and education, and staff safety. Numerous solutions are suggested by this group. The next step in this research process is to examine participants' shared visions.

Matrix # 3: Vision Statement Results

The results of vision statement data present clearly defined themes that emerge from three specific vision questions. They include: "what would a shared mental health care model at Whitehorse Hospital look like in the future?", "what is your vision?", and "if the mental health program were to be expanded, what would your priority be?" Participants identified one to four vision statements, with several including two comments within one vision statement. Results show a high number of participants, (43 or 79%) responding to the vision category section of the questionnaire. Matrix # 3 was then created to present a vision for Shared Mental Health Care at Whitehorse General Hospital (see Appendix 8 for details). All participant vision statements were numerically ranked, according to priority and vision. Four vision statements identify five critical themes in the data. They include: separate mental health unit; expanded mental health service; outpatient clinic; day and hospital based program; separate addictions and medical detoxification area; support and education; and Shared Care plans. An 'other' category includes comments important to mention, but did not rank high enough to score on the matrix. A decision was made to separate vision statements from matrix data results. This was done to ensure vision statements were prioritized to present the future direction of the mental health program at Whitehorse Hospital. Table 8 presents a

simplified version of Appendix 8 with participant vision statement priorities that are calculated in percentages.

Table 8

Matrix # 3 Simplified

Vision	Vision Statement	Participant Response %
Vision One	Separate mental health unit	53
	Expanded mental health program	
	First Nations health program	39
	Mental health nurse	32
	Other disciplines	25
	Psychiatrist	18
Vision Two	Day hospital	27
	Expanded mental health program	
	Mental health nurse	25
	Other disciplines	13
	Support and education	13
Vision Three	Support and education	20
Vision Four	Mental health nurses	35

Note. Percentages are based on Matrix # 3; Less than 10 comments are not included in this table, except for vision # 4; in vision statement # 4 this number is rated six out of 17 respondents.

Table 8 clearly presents all vision statements. The majority of participants (80%, or 156 out of 193) completed vision statements # 1 and # 2 categories. The analysis of matrix # 3 posed several questions. These include: whether to use only the priority # 1

vision statements; a combination of vision statements # 1 and # 2; or the total number of the four vision statements. The most appropriate conclusion that represents participant views is to use vision statement # 1, with variations. My decision was based on prioritized participant responses that present a clear shared vision for the Whitehorse Hospital mental health program. Table 9 reflects these six vision statement priorities.

Table 9

Vision Statement Priorities

Priority				Vision Numbers
# 1	Separate Mental Health Unit			25*
# 2	Expand Mental Health program			
		Mental health nurse	27	
		First Nations health	18	
		Other disciplines	17	
		Psychiatrist	11	
		Recreation activity	5	
# 3	Outpatient clinic and day hospital			22
# 4	Support and education			10
# 5	Case management and Shared Care plans			8
# 6	Separate medical detoxification and addictions area			7

Note. Percentages include combined vision statements # 1 and # 2 and 80% of all respondents; separate mental health unit is vision statement # 1, as identified by 25 of 53 respondents; support and education includes vision statements # 1, # 2, # 3.

Vision Statement Priorities

Clustering of this data was relatively simple, as vision statements were clear, and presented in six general categories. An 'other' category was created for statements that were important, but did not fit. Also notable, vision statement data was analyzed after key concept data, so as not to influence vision priorities. The first vision statement priority in this study was clearly identified, as a separate mental health facility. Results show overwhelming support for this concept with the majority (53%) of participants identifying this as their first vision. This statement is also listed as the first priority, because of the high participant numbers (23) in vision statement # 1. The expanded mental health program for Whitehorse Hospital is identified as the second priority. Participants suggest improvements and changes in all areas of the mental health program. The majority of comments focused on increasing staffing levels for the mental health program. Participant support is listed in percentages for this expanded model. This includes: the First Nations health program (39%); mental health nurses (37%); other disciplines (25%); and the psychiatrist (18%). This priority is listed as the second vision statement, as participant support is strong with nearly half (45%) of vision # 1 and # 2 comments included in this section. I decided not to separate the specific elements of this expanded mental health program, as numbers were consistently high across all vision statements, as represented in the final totals. The third priority for a Shared Care vision for Whitehorse Hospital consisted of strong support for a hospital based outpatient and day clinic. This priority, when vision statement # 1 (23%) and vision statement # 2 (27%) are merged is rated by participants as being important. Support and education is identified as the fourth priority, as the majority of participants identify this concept in

vision statement # 3 (20%), and numbers are consistent in vision # 2 (13%), and vision # 1 (9%). Case management or Shared Care plan is the fifth priority acknowledged by participants. This area did not rate as high as others, but deserves to be mentioned. The sixth priority, also did not rate high in the numbers, and includes a separate medical detoxification, and addictions area. Several references were made for this separate unit to be located within the hospital, and follow a 'best practices' detoxification protocol.

Matrix # 4: Comparison of Key Concept and Vision Statement Data

Participants clearly stated and prioritized vision statements. The question is, whether priority visions are rated consistently across all data results. A comparison of vision statement priorities with key concept themes by model (Matrix # 1), key concept themes by discipline (Matrix # 2), and vision statement data (Matrix # 3) was then conducted. The first step in this analytical process was to numerically count comments within the data display summaries, with respect to strengths, what participants would like to see different, and suggestions or solutions for change, taking into consideration concept overlaps. The seven vision statement categories were delegated using a colour coded system, which assisted in the data analysis process. All participant responses in the data display summaries and vision statement categories were counted. This technique helped to visualize key themes in both sets of data, which further validated the findings (Patton, 1990; Miles & Huberman, 1994). Matrix # 4 presents this information, and displays the results framed by the vision statement priorities.

A 'Key Concept and Vision Statement Analysis Verification' tool was created in Matrix # 4 (see Appendix 9). This table verifies the key concept data, and also provides a comprehensive overview of the identified vision statements within the key concepts

framework. It should be noted, the theme collaboration, which includes both Shared Care and Aboriginal health programs, is not evident in the vision statement priorities (Matrix # 3). The key concepts of holistic health and healing, and Aboriginal healing methods are not listed either. Considering these key concepts are identified in high numbers within the Matrix # 1 and # 2 data displays, they are included in this comparative analysis. The results in Matrix # 4, show there are a considerable number of comments in the strengths category (239), what participants would like to see different (470), and solutions and suggestions for change (296) categories. This indicates sufficient detailed responses and shows strong support for all identified key concepts, and vision statement results. Key concepts are identified in this matrix, as collaboration, holistic health and healing, Aboriginal healing methods, support and education, and case management concepts. There is also an expectation for positive change, as participants identify what they would like to see different. These areas include: collaboration, holistic health and healing, Aboriginal healing methods, support and education, and an expanded mental health program, specifically mental health nurses, and the psychiatrist. A number of excellent solutions and suggestions for change are presented in this matrix, especially in the area of collaboration, holistic health and healing, Aboriginal methods, support and education; and expanding the mental health nurse program.

Results clearly show collaboration is the most important concept to participants, which is evident not only in the number of comments (205) that is indicated consistently in the data, with the exception of the vision statements. Holistic health and healing, and Aboriginal methods also received a consistently high number of responses (201). This concept is identified as a major strength, and there is a clear need and desire to learn more

about these Aboriginal key concepts. The concept of support and education (189) received considerable discussion with a substantial number of comments on this issue. Mental health nurses (88) are identified as the next priority. Shared Care plans (73), the psychiatrist (59), and the First Nations health program (42) followed. A separate mental health unit (42), as well as an expanded mental health program that includes other disciplines (39), are also identified priorities. An outpatient clinic and day hospital, also received notable mention. Recreational activities, and a separate medical detoxification and addictions area, received the fewest comments.

Analysis of Matrix # 4, presents a separate mental health unit as priority # 1. This concept is clearly identified in vision statement data, but is not consistently represented in the key concept data, as only 42 comments were reported. Priority # 2 is presented as an expanded mental health program. This area was consistently presented across matrix tables, with the mental health nurse as the priority. The psychiatrist holds a higher rank in the matrix data compared to vision statements, and numbers are relatively consistent for First Nations health, and other disciplines. An outpatient clinic day hospital is ranked as vision statement priority # 3, whereas in the data it is ranked considerably lower. Support and education is ranked exceptionally high in terms of participant comments, yet in vision statements, it is rated priority #4. There is a definite need to continue existing educational programs, but expand in this area. A considerable number of comments on case management and Shared Care plans are provided in the data, whereas this is rated as priority # 5 in the vision statements. A separate medical detoxification and addictions area, and recreational activities are ranked lower, at six and seven. Matrix # 4 clearly shows what is important to participants, especially in the improvements for change

category. Vision statements should be respected, as this is a vision for the future of mental health care at Whitehorse Hospital.

Comparison of Discipline Groups

Critical and common themes are identified within the data, specific to discipline groups. Matrix # 2 was examined and data display summaries of the nine discipline groups were analyzed. Relationships, comparisons, similarities, and differences were explored (Coleman & Unrau, 1996; Miles & Huberman, 1994; Patton, 1990; Rubin & Babbie, 1997). Different priorities and mental health issues were revealed for the discipline groups, with respect to strengths, what they would like to see different, and suggestions for change. Issues include: collaboration and communication; expanding the mental health program; support and education; and safety issues, which supports the need for a mental health area, which is separate from acute care services.

Collaboration and communication

All discipline groups expressed overwhelming support for collaboration. This key concept is considered to be a strength, and by all disciplines, especially among the mental health nurse and psychiatrist. Collaboration is also suggested as an improvement with the majority of discipline groups. Another important suggestion is to expand the mental health program. Communication is an identified area to improve for several discipline groups. One example noted was some misunderstanding between the west unit, and First Nations health staff about client reporting issues. The west unit registered nurses and licensed practical nurses prefer to use verbal reports and updates, whereas First Nations health workers utilize chart records for their communication. An awareness and discussion of reporting preferences could be all that is needed to not only improve

communication, but the relationship between the two discipline groups. There were no major differences between west unit registered nurses, and west unit licensed practical nurses. The same is also noted for the physician group, which includes the psychiatrist and family physicians. The psychiatrist arrived at the focus group a little late, and this allowed family physicians an opportunity to discuss specific issues related to their discipline. There were no differences in physician comments before or after the psychiatrist attended. Comments appeared to be open and honest throughout. A large number of participants in the support discipline group expressed serious concern in the area of communication, relating to personal safety. Strong statements were cited in the 'what would you like to see different' section, followed by excellent solutions and suggestions for change, which are detailed further on in this chapter.

Expanded mental health program

An expanded mental health program is presented in the data results. The majority of disciplines overwhelmingly suggest increased services of the mental health nurse with a 24 hour service, and an expanded role to the emergency department. Psychiatric services would also be more available, with an increase to full time staffing. It is also recommended the First Nations health program expand their coverage and services to also provide 24 hours per day, and 7 day per week coverage.

Support and education

All discipline groups present positive comments for existing support and educational programs offered at Whitehorse Hospital. Participants also provide excellent suggestions to improve and expand training and education. In addition, west unit registered nurses, licensed practical nurses, and physicians agree that the psychiatrist

should be more available for consultation, and provide educational sessions to west unit staff. Senior administrators are supportive of hospital educational programs, and suggest additional opportunities for the mental health nurses. Emergency nurses provide solutions of peer mentoring and skills training to improve confidence levels in the area of mental health. The support group, on the other hand, address educational issues in terms of hospital security and client safety.

Safety issues

The majority of participant discipline groups identify safety concerns with specific reference to mental health clients admitted to the acute care service on the west unit. A separate mental health unit is identified as a solution by the majority of disciplines to address this concern. The issue of safety was strongly identified by the support group with one key difference. The majority of the support discipline group expressed concern for their own personal safety. A lack of communication, and not being aware of potentially high risk mental health clients in this groups' workplace are the specific issues.

Participant comments were usually related to their specific work location, their clients' needs, and the services they provide. For example, the majority of nurses on the west unit suggest a separate mental health unit, as they work in a mixed (acute care and mental health) unit setting, whereas the emergency department registered nurses prefer an outpatient clinic, and day hospital based program. Also, the west unit registered nurses and licensed practical nurses are not as clear on the role of the First Nations workers, and request clarification. In contrast, the emergency department registered nurses had greater awareness and knowledge about the role of the First Nations health program. This

reflects on relationships, as the First Nations health workers work more closely with emergency staff than the west unit, especially in arranging follow up, and referral services for their clients. Physicians also had very positive remarks about the First Nations health program, especially in reference to their clients in the emergency department. Physicians also identified an issue of compensation for their time involved in the development and updating of client Shared Care plans. This is the only group that is not paid for their participation, whereas other disciplines attend on their regularly scheduled work day. Residential school issues were raised by two disciplines. The emergency department registered nurses say residential school healing initiatives are an identified strength. The First Nations group suggests training of staff in this area, and recommends that residential school assessments are conducted with the inclusion of attendance, intergenerational histories, social concerns, and emotional issues. One solution identified by the First Nations group is to integrate this residential assessment, and incorporate a cultural component into a mental health intake and assessment form (see Appendix 10).

Possible Limitations of the Data Results

Several issues, considered as possible limitations, emerged in this research study. The first consideration was that the participant interview questionnaire was presented in two different formats. The structured key concept thematic tool was one type used, where participants commented specifically on the strengths, what they would like to see different, and suggestions for change about the mental health program. The other format was a descriptive inquiry as to participant vision statements about the future of the mental health program. The two different interview formats, as well as three different

questionnaire methods could present possible limitations. On the other hand, the methodology was used consistently across all methods. Another possible issue was electronic recording of the focus groups, which was not done in this study. This could have added additional background information that could have possibly influenced the results. Considering individual interviews were not taped, this was the reason why this was not done. A third possibility is that too much information was provided in the participant interview guide questionnaire package. The concern is that the handout could possibly lead the participant in the direction to support a Shared Care model. This was not considered likely, as the more informed participants were the better they understood the information, and the expectations required to complete the questionnaires. The inclusion of clients in the participant sample was seriously considered, and clearly the client perspective is missing from this study. This was a serious concern for one participant from the support discipline group. This issue was discussed at length. The concern was summarized as follows: it is critical that the client be a part of the collaborative process, especially if the mental health program were to be expanded. I agreed with this statement. After considerable thought however, I stood by my decision not to include clients in this study. My reasons remained the same. The focus of the study would have shifted from a descriptive to evaluation approach, and also 0data collection was already in progress. Another issue was the three questionnaires, of which two were missing, and one was partially complete. All three participants had received information education sessions, followed by an individual interview. This is where my very detailed journal notes were helpful, and their comments were included in the data, and considered to be an important part of the methodological process. Language was a

possible issue to four participants, for whom English was a second language. These participants were approached (as all were), and I inquired if assistance or clarification of the questions was required. Two participants admitted they might have trouble putting their thoughts into words. One received clarification and completed the questionnaire themself, and the second received an individual interview. Responses from all four participants were excellent with rich descriptive data presented. There were no apparent differences in the quality of their data responses compared to their respective discipline groups. There was one exception, as one participant provided limited data, but the responses received were of good quality. I did question later, whether there could have been more information had I interviewed participants themselves or conducted focus groups. Reflecting on this, I do not think I would have done anything different.

Shared Mental Health Care Vision at Whitehorse Hospital

A future vision for a Shared Mental Health Care model at Whitehorse Hospital is strongly supported by an overwhelming majority of participants with results consistent across the data. The final step in this data analysis process is to identify participants' vision of a Shared Care model from their perspective. Table 10 presents an outline of the key summary points in this Shared Care vision.

Table 10

A Shared Mental Health Care Vision for Whitehorse General Hospital

# 1	Collaboration
# 2	Holistic health, and healing, including Aboriginal methods
# 3	Separate mental health unit with day hospital and outpatient clinic
# 4	Expand mental health program
	Mental health nurse
	First Nations health
	Psychiatrist
# 5	Support and education
# 6	Case management and Shared Care plans
# 7	Separate medical detoxification and addictions area

 # 1: Collaboration

The key concept of collaboration is listed in the data as a significant strength to the mental health program. Participant comments overwhelmingly state there is collaboration, cooperation, and good communication among mental health nurses, family physicians, the psychiatrist, and the First Nations health program. The mental health nurses and psychiatrist are also seen as excellent supports to family physicians, and nurses in the emergency department, and west unit. Collaboration is identified as a strength, but this concept is also considered to be an area to improve, specifically the communication of mental health clients who are potentially presenting safety concerns, and reporting verbal and written client record notations. Suggestions clearly support a

separate mental health unit, and that mental health nurses be available to the emergency department and the west unit 24 hours per day, and 7 days per week. Considerable support is extended by participants in the area of Aboriginal collaboration and consensus. There is also strong support extended to First Nations health workers. Data clearly identifies this discipline group has excellent communication skills, as they interact and provide emotional support with clients and their families. Other collaborative strengths within the First Nations health program include: adolescent mental health care, discharge planning, and knowledge of available resources. Participants provide clear direction on solutions and suggestions to improve communication and collaboration. It is suggested First Nations and mental health work more collaboratively together with improved communication, specifically in the area of sharing and reporting of client assessments, issues of concern, treatment and discharge planning, and other relevant information. Another recommendation is the integration of a First Nations component into the mental health intake process, which begins with the client's point of entry to the hospital. This assessment (see Appendix 10) would determine First Nations status, and whether a client is a residential school survivor. Also included would be incorporation of social concerns and stressors, abuse issues, and these elements are also important in the discharge planning process for clients.

In the area of collaboration, participant responses identify similar issues in this category that overlap with other key concepts of support and education, and maximizing resources. A collaborative effort is required for the maximization of existing and available resources. This concept is critical to rural and remote Canadian communities. The utilization of existing mental health services and resources at Whitehorse Hospital is

strongly presented in the data, as a strength. Support is strong for the collaborative approach. This includes: improved communication, and supportive consultations between the psychiatrist and family physician. Other collaborative strategies to maximize resources include: an expanded mental health program, specifically extending the mental health nurse role to the emergency department; and a second psychiatrist would also improve the service. Another strategy to maximize resources is to have a separate mental health unit, and a mental health clinic is also suggested.

 # 2: Holistic health, healing, and methods

All participant disciplines consider the First Nations health program a strong, well supported, and accepted program at Whitehorse Hospital. Participants do suggest the need for increased understanding of the role and responsibilities of First Nations workers, especially by west unit participants. Strong links to the community are considered to be strengths, especially in arranging follow up, and referral services for emergency department clients. First Nations and holistic health and healing methods are also considered strengths, and this is consistently supported by participants across the data. This concept is suggested as an integral part of the health and well being of First Nations clients. Participants comment on personal preferences. Many state they have a "strong belief in the whole person", and that holistic health and healing is a "wonderful approach for treating the whole person". There is also strong support among participants for the holistic health concept of the physical, mental, emotional, and spiritual healing, and extending this concept to all hospital clients. The healing room, spiritual practices, traditional foods, the medicines program, and elder support are considered strengths within the First Nations health program. Tours of the healing room, and holistic First

Nations pamphlets, are some of suggestions for change. Participants have a strong desire and interest to learn more about the First Nations health program. They suggest additional educational opportunities for hospital staff in all areas of the First Nations health program, but especially access and utilization, and Aboriginal healing practices. Another important recommendation is to integrate a residential school component into the mental health intake and assessment form. This would highlight residential school attendance, and resulting social problems, as well as family and intergenerational issues.

 # 3: Separate mental health unit with day hospital and outpatient clinic

The next priority in this study is a separate mental health facility. Participants envision this unit to be an area separate from acute care clients, and the current mixed ward. They suggest this mental health program is a separate unit, but in association with Whitehorse Hospital, and one that includes an addictions and detoxification service. A number of participants suggest the 'Thompson Center', which is an existing and vacant structure adjacent to the hospital, and accessible via a locked hallway. Participants provide very specific details for this separate mental health area. This unit would be a multidisciplinary, well staffed, and properly trained unit that would operate seven days per week, and 24 hours per day. This unit would include a consulting psychiatrist, First Nations health, and mental health nurses. Other disciplines included are social work, occupational therapy, and physical therapy. Structured activities and recreational programs are also included. Participants' envision a strong First Nations presence within this separate mental health facility. Support also exists to incorporate other programs within this mental health unit. They include: a day clinic; day programs; a drop in; a medical detoxification unit; a separate smoking area; activities; elder participation; and

access to other hospital services. Numerous participant comments refer to a multidisciplinary and integrated medical and First Nations mental health unit. This center would provide a comprehensive, and all inclusive holistic mental health service.

 # 4: Expanded mental health program

An expanded mental health program for Whitehorse Hospital is identified as the next priority, and rated as high by the majority of participants. The most important component in expanding this program was the need to increase the staffing for mental health nurse services to a minimum of 12, but preferably 24 hour day coverage, and 7 days per week. Participants suggest this would ensure weekends, sickness days, and statutory holidays were covered. This improved service would ensure all clients and staff have access to a consistent, and available, mental health nurse service. Other suggestions by participants for the expanded role of the mental health nurse include: to work in the emergency department on a permanent basis; operate a mental health clinic; and conduct regular staff training. Also, identified by a significant majority is to expand the role and services of the First Nations health program. Participants clearly support this program with a need for additional First Nations health workers to be trained in mental health, and staff levels be increased, so this service could be more available and accessible to the hospital with a weekend, and night coverage. It was suggested this expanded First Nations service could be integrated into an outpatient clinic, or a separate mental health unit. A First Nations holistic health and healing center was also suggested, where traditional health and healing methods would be offered with ceremonies, spiritual work, and workshops on First Nations concepts. A number of disciplines identified the need to increase the psychiatrist services for hospital client consultations, and family physician

support. This expanded role would also enable the psychiatrist to provide staff education to ensure all disciplines associated with the mental health program are adequately trained. Participant comments in this category, also suggest expanding the mental health program to include other disciplines, such as a social worker, and a mental health family physician. These professionals would work in partnership with other disciplines, already involved in the mental health program, including the First Nations, and mental health workers.

 # 5: Support and education

Expanding on the existing educational mental health programming is a key suggestion by a high majority of participants. The goal for many is to have educated, well trained staff, who are specialized in the area of mental health. There are a number of strengths presented in the data that support the existing educational workshops and training. Non violent crisis intervention, CPR, telehealth, and First Nations cross cultural training are some of the programs identified as excellent, and available to staff. There is also a clear need to improve educational opportunities, and have workshops available for all staff, including the support discipline. Participant solutions include: incorporating the mental health and First Nations health program into the bi-annual mandatory hospital education days; recording and taping of telehealth programs; a peer support and mentoring program; and a variety of mental health in-services provided by the mental health nurse, and psychiatrist. Educational modules and online self study are alternative ideas. Specific suggestions for these topics include: psychiatric disorders, identification of symptoms, medications and treatments; practical ways to deal with high risk mental health clients; mental health and safety issues; and addictions. Other suggestions are for

the mental health nurses and the psychiatrist to present clinical case presentations, in-services, and conduct multidisciplinary mental health rounds. This would improve the knowledge, education, skill level, and provide support to general duty staff. Also listed as priorities, are the orientation of new staff to mental health, and a workshop on the *Yukon Mental Health Act* (Government of Yukon, 2002). Another priority is to expand mental health education to all First Nations health workers to improve knowledge and skills in the area of mental health.

 # 6: Case management and Shared Care plans

Shared care plans or case management are acknowledged in the data by participants. This area did not rate as high as others, but considering this concept was consistently presented in the data display summaries, it deserves to be mentioned. Support definitely exists for mental health client Shared Care plans. There is an acknowledgement these plans exist, and suggestions are clear. There is a need for training on how Shared Care plans are developed to ensure effectiveness. Also important to participants is to share and communicate that there is a client plan in place. Shared care plans are described by several respondents as 'ancient'. Strong support exists for client care plans to be regularly updated and maintained by the mental health nurses, and on all clients who regularly access mental health services. Also suggested: multidisciplinary rounds, which would involve the client in the development of their Shared Care plan; a case manager responsible for an update review of the client plans quarterly, or every six months; place the plan on the hospital electronic meditech client system, so all staff involved are aware of the plan; and incorporate a cultural component into the Shared Care plan. Historical and current client records, mental health nurse, and

First Nations health staff notations are all identified as case management strengths. An important recommendation is to include in the mental health intake assessment First Nations components of status, residential school abuses, and associated issues.

 # 7: Other priorities

Several priority themes did not rate high in number, but were consistently mentioned in the data. A separate medical detoxification and addictions area were identified in this category. A majority of participant comments suggested that addictions services be included as part of the separate mental health unit with some saying an addictions unit should be located within the hospital. This would accommodate mental health clients with addiction problems. The remaining priority themes include: collaboration, consensus, and partnership; holistic health; client focused collaborative consultations with a steering committee; safety policy; in and out-client therapy; discharge planning; and a female counsellor to address women's emotional and mental health issues, such as abuse and rape. One participant suggested "one holistic health vision for all with a First Nations and medical approach to healing". I am confident the summary of the Shared Mental Health Care visions that I have presented here will encourage future discussion among participants.

Summary

Results presented in this chapter clearly support a Shared Mental Health Care model, and vision for Whitehorse Hospital. Data analyzed represents participant data that contributed to this vision. A Shared Care model is supported with an integration of both medical and First Nations health models, and is incorporated throughout the entire mental health program. Participant priorities clearly envision a future Shared Care model with a

strong collaborative and holistic approach to health and healing. A separate mental health unit with a day hospital, and outpatient clinic, is the highest priority. An expanded mental health program, specifically the services of the mental health nurse, First Nations health, and the psychiatrist are described as critical to the future success of the mental health program. Support and education, and case management or Shared Care plans are also of high importance, followed by a separate medical and detoxification area. This vision positively reflects on the future of the mental health program at Whitehorse Hospital, and also impacts on implications for social work practice.

CHAPTER SIX

IMPLICATIONS FOR SOCIAL WORK PRACTICE

Research Conclusions

The Whitehorse Hospital Shared Mental Health Care model is one that is strongly supported by research participants from all disciplines, and at all levels. This vision clearly shows support for a collaborative mental health model, complementing the medical and First Nations holistic health components. The primary focus for participants in this study is a separate mental health unit with a day hospital and clinic. Strong support also exists for a second vision for an expanded mental health program with increased services and staffing, specifically, the mental health nurse, First Nations health workers, and the psychiatrist. The strengths of the mental health program showed overwhelming support for the concepts and themes of collaboration, holistic health, and Aboriginal healing methods. Support and education, client Shared Care plans or case management, and a separate addictions area were also identified as clear priority areas for participants. Results in this study show a definite commitment to the Whitehorse Hospital mental health program by participants. This is evident in the participant numbers with 53 completed interview guide questionnaires. The data was descriptive and detailed with clear representation by all disciplines with sufficient data in all categories. The collective shared and common experiences (Patton, 1990; Schwandt, 1997) among participants involved with the mental health program were forthcoming, and with tremendous support. This reflected on a commitment of the staff at Whitehorse Hospital to work together to create a Shared Care vision for the mental health program. Participants identified a great number of strengths within the program. This is balanced

by a need to improve this service. Many suggestions and solutions were identified to address these issues. A Shared Care model is definitely supported in the data results. The purpose and objectives of this research study have been achieved. It has been determined there is a Shared Mental Health Care model in existence at Whitehorse Hospital. This is clearly a successful collaborative program that supports both the First Nations and medical approaches within a Shared Care perspective. This is evident in the matrix key concept data. Some inconsistencies around communication and safety concerns do need to be addressed, but the results from this report will likely initiate positive change. There is a clear need for program description of Whitehorse Hospital's existing services, and this is presented in Chapter Three, and throughout the data. It is important for all involved to be aware of the different program components, the staff involved, and their roles. It is evident from participant responses that there is an increased awareness, and a greater understanding of the components of the Aboriginal and Shared Care models, and how they fit within the Whitehorse Hospital medical and First Nations health programs. Research statements definitely address the question, as to whether a Shared Care model exists at Whitehorse Hospital, and it clearly does. A vision for a new and improved Shared Mental Health Care model for Whitehorse General Hospital, Yukon is one that uniquely incorporates both medical and, First Nations cultural and holistic health and traditional healing practices.

Common Themes in the Research

Key themes in this research were explored. Collaboration is a recurrent theme in this research study. A collaborative model is described in the Shared Care literature as, encouragement and support for the working relationship between the family physician,

psychiatrist, and mental health professionals. This partnership works towards improved communication and consultation. This collaborative model is one that, if all professionals are in agreement, can successfully coordinate a multidisciplinary group of health and social service professionals, and as a result effectively maximize mental health service delivery. A shared responsibility is critical for the caring of mutual mental health clients, leading towards a more comprehensive approach to mental health service care (Canadian Psychiatric Association and College of Family Physicians of Canada, 2000; Kates, Craven, Bishop, et al., 1997). Another critical theme that is strongly supported in the literature and throughout this research study is the concept of the holistic health model. Collaboration, consensus, and partnerships are also strong component of Aboriginal principles, as well as relationships, and a sense of community. The focus on an acknowledgement and acceptance of the Aboriginal holistic health and healing concept is considered to be the cornerstone for change, and is supported by all levels of governments. This is a positive shift towards an integration of holistic health beliefs and practices into all aspects of the medical model (Aboriginal Healing and Wellness Strategy, 2001; Lane, Bopp, et al., 2002). Yukon Territory is no exception. There is strong support for the concept of Aboriginal health and healing from this territorial government, the Whitehorse Hospital board of directors, and senior administration. This is evident in the creation of the Whitehorse Hospital First Nations health program. There is a successful integration of Aboriginal health and healing, cultural approaches, philosophies, and traditional healing methods into all aspects of the Whitehorse mental health program, which is clearly supported in the research results. This type of collaborative model has shown a recent increase in Shared Care initiatives across Canada,

including the northern territories (Canadian Collaborative Mental Health Initiative, 2005, December). A Shared Care model is in existence at Whitehorse General Hospital, and according to participants, is a successful collaborative effort (Scott, 2002).

Collaborative and Holistic Health Approach to Social Work

Collaboration is a key social work principle and value, where stakeholders work together to develop partnerships, and collectively share resources and responsibilities of mutual clients (Barter, 1996; Hart, 2001). Barter (1996) also suggests that a collaborative framework is a 'critical theme' for social work practice, and there needs to be a commitment by stakeholders to work together. Collaboration was also a key theme among social workers at a Canadian Association of Social Workers (2001) forum in Montreal, Quebec. This conference was considered to be a historic event, where social workers from the areas of practice, education, and regulation came together for the first time. The document, *Toward Sector Collaboration*, presented a summary of discussions that took place at this conference. Many identified issues that impact on the social work profession include: financial constraints, changes in the delivery of social programs and services, world events, and globalization. This collaborative sector approach charted a new path forward for the profession and addressed priorities and strategies for the three areas of social work. MacKenzie Davies (2005) describes the possibilities of an interprofessional approach to social work practice, education, and research. This author is editor of the *Journal of the Ontario Association of Social Workers Newsmagazine*. This magazine devoted an entire issue to the theme of interprofessional collaboration, which is now suggested to be the preferred term, rather than interdisciplinary. Shekter-Wolfson (2005) defines the term interprofessional practice as "occasions when two or

more professions learn from and about each other to improve collaboration and the quality of care" (p.1). Shekter-Wolfson (2005) suggests that as social workers 'move forward' in the profession we are positioned as a 'natural fit' to collaborate with other health care professionals, and their mutual clients.

Collaborative practice is a key component in a joint position paper by the Alberta Association of Registered Nurses (n.d.), which involves the provincial registered nurses association, licensed practical nurses association, and the registered psychiatric nurses association. Collaborative practice is a working relationship and environment, for the benefit of clients and workers. Two former, Toronto, Ontario, nursing college programs, Centennial and George Brown Colleges, have merged and work collaboratively, and in partnership with Ryerson University (2006-2007) to offer undergraduate degrees in nursing. These programs utilize resources and share classes of both colleges. This program initiative is a relatively new concept across Canada. A note of interest is that Centennial College is where I received my nursing college diploma, and my social work undergraduate degree was with Ryerson University. As of 2005, this university now offers a collaborative nursing program. The University of Toronto (n.d.), faculty of social work, offers interdisciplinary collaborative graduate degree programs. The University of Northern British Columbia (n.d.) school of social work program is quite unique, as collaboration is promoted, especially in remote areas, northern, and in Aboriginal communities. This is evident in the commitment by this university to support a collaborative, interdisciplinary, and holistic approach within social work education, and practice. Holistic health is a critical component of social work practice. Medical definitions of health now include a holistic component, which involves all parts of the

individual, including their family, social, and environmental aspects (Miller & Keane, 1997). Saleebey (1992) suggests social workers' reflect on a client's issue from a 'strengths' perspective, which is to focus on the concept of health and wellness, rather than disease. This approach also looks at a holistic view of the client in the bigger context of the individual's life, and their community support systems.

Highly respected Aboriginal scholars (Brant Castellano, 2004; Hart, 2001; Simpson, 2000b) write about the importance of understanding, accepting, and integrating holistic health concepts into medical systems. New frameworks are now being created that represent the strengths of both cultures and models (Petch, 2000). It is clear, in the data, there is strong support for an integration of the holistic health model within Whitehorse Hospital mental health program, and there is also a definite need and desire of all participant disciplines to learn more about the First Nations holistic health program and practices. A critical concept of the Whitehorse Hospital's Shared Care model is that the two distinct First Nations and medical components complement one another. The utilization of the strengths of both programs with an integration of the Aboriginal and medical components, form the foundations for a strong, and sustainable mental health program.

Personal and Professional Impact of Research

The common themes of collaboration and holistic health have major implications for social work practice. Incorporating themes of collaboration, partnerships, and principles of holistic health and healing should be an integral part of a social worker's practice. Janesick (1998) suggests a researcher explore how their ideology fits within their practice framework. This research study has challenged my principles and beliefs,

and caused me to examine my personal and professional practices. My methodological ideology has strong roots in the medical model, as I have been a registered nurse for many years. As I moved into the social work profession, with an undergraduate degree in 1996, my philosophical views shifted to a more social and environmental approach with a strong interest in holistic health. A personal learning objective began, over ten years ago, when I started working with Yukon First Nations communities. My understanding of holistic health and healing concepts from a First Nations perspective improved, and I was able to put the theory I had learned into practice. I also explored my theoretical constructs taking University of Northern British Columbia, Masters level social work courses, which again challenged my personal values and beliefs, as a registered social worker, and a nurse. An awareness of this in my role as researcher, as well as my intimate knowledge of the mental health program, my social work and nursing background and experiences, and my theoretical constructs were all elements of consideration in this report.

The Shared Mental Health Care collaborative model seemed a natural fit with my social work and nursing background. Having been introduced to the Shared Care model by a Whitehorse family physician, and attending the national Shared Care conferences, I was committed to examining how this approach would fit within Whitehorse Hospital. I was inspired by one Canadian psychiatrist, Dr. Nick Kates, who led the initiative for Shared Mental Health Care. His participation and contribution to the comprehensive *Shared Mental Health Care in Canada,* joint position paper (Kates, Craven, Bishop, et al., 1997), and continued work with the Collaborative Working Group has been admirable. Dr. Kates is a strong advocate for Shared Mental Health Care, and continues

his work today through the Canadian Collaborative Mental Health Initiative (2006). As a result of Dr. Kate's unwavering dedication and commitment to Shared Mental Health Care he has inspired many health care professionals, including myself. In Yukon, there is considerable support now for the collaborative Shared Care approach from within the medical community, government, Whitehorse Hospital, and the participants in this study who now strongly support this concept. Northern territorial Shared Care initiatives have now begun with Whitehorse Hospital being one such program (Canadian Collaborative Mental Health Initiative, 2005, December).

The holistic health principles and practices are an integral and critical part of my professional practice as a social worker. Hart (2001) suggests social workers incorporate holistic health into their own practices, especially if working with Aboriginal clients. This author also suggests social workers personally explore their own physical, mental, emotional, and spiritual aspects of themselves. Strategies such as these, would not only create a better understanding of Aboriginal beliefs and values, but also improve the relationship between social worker, and client. Mr. Hart speaks from a personal viewpoint, as he is of First Nations ancestry, and a social worker. I agree with Hart's approach. I myself have examined holistic health concepts in relation to my social work practice. I believe in the holistic model of health that considers the different parts of the individual, including the physical, mental, emotional, spiritual, social, and their environment, and the family and community in which the client lives. You must have all these elements in order to be healthy, whole, and in balance. Hart (2000) describes the 'helping process', as stages of development. They include: healthy relationships; the sharing of knowledge and information; and using specific techniques, such as the

medicine wheel, ceremonies, rituals, and elder advice and participation, in healing approaches. I concur with Hart, and suggest these stages are critical to optimum health. I have benefited personally and professionally, and felt honoured to have been asked to participate in a number of First Nations ceremonies within Whitehorse hospital, in my role as mental health nurse. Professional associations are suggesting their members integrate holistic health into professional practice (Hart, 2001; Smylie, 2001). It is the strength and commitment of all health care professionals involved in these processes, to move positively forward, and towards equality of health among Canadians. This approach would then support the integration of holistic health principles into mainstream medical systems, and social work practices. An integrated medical and holistic health model of social work practice is achievable, desirable, and beneficial for both health care professionals, and clients in any cross cultural setting. I believe an integrated model begins with having a better understanding, and acceptance of Aboriginal cultural and healing methods working with Yukon First Nations communities, and the Whitehorse Hospital First Nations health program. I challenge all social workers to examine their holistic health beliefs, and integrate this concept into their professional practice. My personal, professional, and academic experiences, as well as analyzing the results of this research study have contributed to my now unique collaborative and holistic health approach to social work practice.

Research Implications for Social Work Practice

Another journey that I have taken, as a result of this research study, is a methodological one. Patton (1990) states "critical and creative thinking" (p. 434) is addressed through qualitative inquiry. In my pursuit for a step by step qualitative

process, I came to the realization I had to be creative, as there were no clear, concrete, or systematic social work frameworks that would assist me to manage and analyze the research data for this study. Tutty, Rothery, and Grinnell (1996) provide descriptive explanations as to what to do, but no specific information on how to conduct data management and analysis, from a social work perspective.

Rubin & Babbie (1997) calls the methodological process, (as cited by Lofland & Lofland, 1995), a 'terminological jungle' (p. 6). This very accurate term, (as cited by Rubin & Babbie, 1997) described my thoughts, as I reviewed the many different approaches, models, theories, and texts. A descriptive phenomenological approach (Patton, 1990) was considered for this research study, but a more structured and systematic approach was what I was looking for. This personal preference was likely due to my medical background. The grounded theory model (Huberman & Miles, 1998; Miles & Huberman, 1994; Strauss & Corbin, 1998) was also considered for this study, as it provided a detailed and clear 'how to' approach to data management and analysis, but this model was not appropriate for this study. This methodological detour of mine was beneficial in that a number of approaches were reviewed for consideration in this research study, and may be useful in future studies. The concern remains however, that there is no clear, step by step social work model from which researchers like myself, would benefit. Harrison (1994) suggests there is no specific social work model, but there is an integration of other research models that reflect social work perspectives, and approaches. I realized I needed to put my social work hat on, and reevaluate the purpose of the study and my research question, and have a more conscious awareness of my social work and nursing theoretical constructs. As I continued to review the literature, I began

to get a clearer picture of the analytical process I would use in this study. The first challenge for me was develop a framework, which I could work within, so a personalized data management and analysis framework was developed. My decision in the end was to incorporate parts of the social work and medical models using a descriptive thematic inquiry and comparative analysis process. The different theoretical perspectives and views assisted me to frame and structure an individual approach that contributed to the methodological process. This framework incorporates, integrates, and blends together different theoretical approaches and strategies from a variety of disciplines, and is supportive of my medical and social work background, as well my interest in psychology and education. The lack of a clearly defined social work model of practice could be considered beneficial, as social workers do have the flexibility and creativity to develop a critical model appropriate for their specific practice. This personal approach could assist their clients by using an all encompassing, collaborative, and more holistic model of service delivery. Concerns do exist, however that with no clearly defined social work model, there is a lack of credibility, and validation from other professions. Perhaps, the standardization of social work practice, verification of credentials, strong provincial and territorial social work organizations, and a more involved and powerful Canadian Association of Social Workers lobby group would give credibility to a well deserved profession.

Relevance for Future Social Work Research

The impact of this research study clearly shows an accepted and well integrated medical and Aboriginal model within a small community hospital. This Shared Mental Health Care model in Yukon was one of the first precedent setting programs of its kind

that involved a community hospital in the Northern territories, and a model for other hospitals to follow in similar settings.

This research study explores and describes the existing mental health programs, and outlines strengths, areas to improve, and solutions and suggestions for change by employees. A vision for a future mental health program is also presented, based on participant perspectives. The next phase of this research project is to give clients an opportunity to do the same. This would result in a more comprehensive vision for the mental health program at Whitehorse Hospital, and be representative of all those involved from a consumer, community, or a professional capacity. Vision statement priorities would then be the basis for program changes and policy development. Proposals submitted and a detailed implementation plan would be the next steps. Future change is inevitable, and a true vision, based on participants' views and ideals, would strengthen the mental health program, maximize available services, and promote a comprehensive and complete medical and holistic mental health service, one that is beneficial to, and supported by clients, staff, management, and hospital board of directors, and Yukon communities.

Summary Conclusion

It is the reality of a vision for a Shared Mental Health Care model at Whitehorse General Hospital that started this methodological journey. It is also my passion for the mental health clients, and the mental health program that has propelled and energized me throughout this methodological journey to the completion of this thesis report. This research provides participants and employees of the Whitehorse Hospital with an increased awareness and understanding of the two major components of the mental health

program. This knowledge brings together medical and First Nations cultural concepts, and principles of holistic health and healing. The collective descriptive experiences, and comments among participants involved with the mental health program clearly show that the strengths of the mental health program are considerable, and reflect the desire and commitment of all staff to work together towards positive change, supportive of the many identified solutions for change. This research paper positively describes the collaboration of the First Nations and medical programs of the Whitehorse Hospital mental health program. This successful blended model integrates and incorporates First Nations cultural traditions and beliefs, and a holistic approach to health and healing, thus being complementary and supportive of a unique Shared Care model. The results of this study confirm this is a strong and well supported mental health program, and is one that reflects on the health care professionals who deliver this service. There is obvious commitment, enthusiasm, dedication, and support by the Whitehorse Hospital staff participants for an improved mental health program with an identified vision for the future. There is a unique Shared Mental Health Care model at Whitehorse General Hospital, Yukon.

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APPENDIX 3

PARTICIPANT SUMMARY SHEET & CONSENT FORM

A Shared Mental Health Care Model at Whitehorse General Hospital

My name is Lynn Scott and I am a graduate student at the University of Northern British Columbia working on my thesis towards a Masters degree in social work. I currently work casual as a registered nurse on the West unit, and if you recall, have previously worked as mental health nurse. I continue to have a personal interest in the field of mental health and the success of the mental health program at Whitehorse Hospital. So, I am asking you to participate in this study.

Shared Mental Health Care (Shared Care) is a relatively new and innovative health care concept bringing together family physicians, psychiatrists, mental health nurses, and nurses. This new approach brings a collaborative and comprehensive approach to mental health care. I believe Whitehorse Hospital has a Shared Mental Health Care program, what with the expanded role of the mental health nurses seeing mental health clients in the emergency department, and the continued use of 'Shared Care plans in the emergency department. These components of the Whitehorse mental health program fit nicely into the national strategy of the Shared Care model.

The purpose of this research project is as follows: to present a general description of the mental health program from participant perspectives; show how the First Nations and medical models collaborate, complement and support one another, incorporating national Shared Care principles; and finally, based on participant responses, present a new and improved Shared Mental Health Care model, reflective of First Nations cultural and healing practices, for Whitehorse Hospital.

In this descriptive and thematic qualitative study I will personally select participants, depending on their interest in the mental health program, and availability. Participants will be assigned to specific focus groups depending on profession and occupation. The four groups will include the: First Nations health program; medical staff; Physicians; and Administration. Participation will be voluntary and you may withdraw at any time without a reason, and without penalty. Information received during focus group interviews will be kept confidential specifying no names, and will be coded according to group, allowing for candid expression of thoughts and feelings. The information you provide will be used toward my Masters of social work thesis, and it may also be used in scholarly papers or journals. Tapes will be transcribed then erased. All written interview materials and notes will be shredded within two years following acceptance of the thesis. Common themes shared in the focus groups and interviews will be summarized, and inserted as tables in the paper. Authorization will be requested if specific quotes are used. The attached consents will be reviewed prior to the interview.

If you have any problems or concerns with this process, please contact myself at the numbers listed below. You can also contact my supervisor, Dr. Glen Schmidt, 250-960-6519, or Dr. Max Blouw, Vice President Research, University of Northern British Columbia, 250-960-5820).

So, I am asking you to participate in this study and I encourage you to ask questions and share comments during the focus group interviews. Should you have any additional comments following the interviews, please feel free to call or email. I would be very interested in what you have to say. Thank you very much for your time.

Sincerely, Lynn Scott Tel: 867-634-2138 (home); 393-8722 (west unit); Scotts@northwest.net

CONSENT

Focus Group Interview Participant

Interview Group:_______
Participant #: _______

1. I understand that *Lynn Scott* is conducting a study for thesis completion towards a Masters of social work degree at the University of Northern British Columbia. The topic of research project is:

A Shared Mental Health Care Model at Whitehorse General Hospital

2. I understand that I have been asked to participate in focus groups and interviews to discuss the mental health program at Whitehorse Hospital. This interview will last for approximately 1 ½ hours, and my participation is voluntary. I may withdraw at any time.

3. I understand and agree that the information I will provide to *Lynn Scott* during the focus groups will be respected, and remain confidential and private at all times. I understand this information will be recorded, kept under lock and key, and deleted and shredded within two years of the completion of this thesis project.

I agree to participate in this study and have received and read the Participant Summary Sheet

Print name: ______________________

Signature: ______________________ Date: ______________________

Please complete if you would you like to receive a copy or email of the results of this paper?

Yes _______ Telephone number and/or Email address: ____________________

APPENDIX 4

PARTICIPANT INFORMATION EDUCATION PACKAGE

SHARED MENTAL HEALTH CARE at WHITEHORSE GENERAL HOSPITAL

1. OUTLINE FOCUS GROUP/INDIVIDUAL INTERVIEW PROCESS

   - HELLOS/ INTRODUCTIONS/ PASTRIES
   - PARTICPANT PACKAGE – Consent

2. PURPOSE – GOALS -- OBJECTIVES

PURPOSE: OF MY THESIS

- Present a Shared Mental Health Care Model for Whitehorse General Hospital
- Incorporate national Shared Mental Health Care principles and key concepts
- Reflects First Nations principles and values, and
- Represent a territorial and northern perspective (northern territories)

MY GOALS: FOR THIS STUDY

- Increase awareness and understanding of the Aboriginal model, the Shared Mental Health Care model, and integrated medical and Aboriginal models of health care
- Present an overall description of the mental health program at Whitehorse Hospital from participant perspectives
- Explore how the Whitehorse Hospital's First Nations and medical programs operate independently, as well as collaborate, complement, and support one another, using principles of the national Shared Mental Health Care model.
- Present a vision for a new and improved Shared Mental Health Care model for Whitehorse General Hospital, Yukon, which uniquely incorporates First Nations philosophical, cultural and traditional healing practices.

MY OBJECTIVES – for this study

- When this study is complete, I will proceed with writing up the research report, to complete my thesis for my Masters degree in social work
- Present a proposal to the Collaborative Working group, so as to apply for funding to implement the vision of a Shared Mental Health Care program at Whitehorse Hospital

3. INFORMATION and EDUCATION
   - Shared Mental Health Care healing Model
   - Aboriginal health and healing health Model
   - Integrated medical and Aboriginal Models in health care

I NEED YOUR INPUT-HOW CAN WE MAKE OUR MENTAL HEALTH PROGRAM BETTER?

1. SHARED MENTAL HEALTH CARE MODEL

Question
Have you heard about Shared Mental Health Care-also known as Shared Care/Collaborative care?

Definition
"A 'process of collaboration', where family physicians and psychiatrists, through improved communication and consultation, share responsibility for the care of mental health clients, ultimately providing a collaborative and comprehensive approach to mental health care" (Kates, Craven, et al.,1997).

Historical Background

- Many reports have been published by family physicians expressing frustration and concern when accessing mental health care services for their clients - communication issues; access mental health services; lack of respect and support
- In 1997, the Canadian Psychiatric Association and the Canadian General Practitioners association identified a need and a very definite gap in the services provided to mental health clients.
- In 2000, representatives from both associations published a Joint Task Force Position Paper Report, (Kates, Craven, Bishop, et al, 2000), and proposed a solution they called 'Shared Mental Health Care', bringing together family physicians, psychiatrists, and mental health professionals to provide a more comprehensive delivery of service, thereby improving access and quality of care to mental health clients (Kates & Craven, 2000). Collaborative Working Group (2000) outlined Shared Care principles and key concepts … <u>Suggestions for Implementation</u>
    - A review of existing mental health services
    - support for a collaborative approach among mental health professionals
    - The need to define effective strategies dealing with underserved, rural and isolated communities, including Aboriginal populations.

- Shared Care has now expanded further to involve groups other than family physicians and psychiatrists. A national collaborative Shared Mental Health Care Project (2002) working group has been established and represents many Canadian associations including social workers, occupational Therapists, mental health nurses, mental health, psychologists, nurses, psychiatrists, family physicians.

- World Health Organization
    - 'Health Systems: Principled Integrated Care' (2003) – Report suggests:
        - health systems be based on core principles of primary health care
    - Mental health: New Understanding, New Hope. (2001)
        - This report suggests a shift towards a Shared Mental Health Care model
        - Recommendations include:
            - A consultative approach
            - Integration of psychiatry and mental health within primary care health care settings
            - Increasing the knowledge base of professionals
            - Changing university curriculum to reflect mental health services
            - Improved access to mental health services with decreased stigma.

Key Concepts of Shared Mental Health Care (Shared Care):

1. *Collaborative/Consultative Approaches*

   - Original goal - of Shared Care is to improve the working relationship between family physicians and psychiatrists; and mental health professionals
   - Objective - to do this it is suggested professionals meet in the family physicians' office, thereby increasing client's access to mental health services
   - Professionals working with mental health clients work in collaboration with one another
   - Communication
   - Relationships
   - Integrate primary care and mental health services

2. *Education and support*

   - In-services, workshops
   - Education modules
   - Telehealth, online modules
   - Clinical training
   - Peer mentoring

3. *Maximizing Use of resources/Underserved Populations*

   - Effective and better use of available mental health resources.
   - This approach provides for a more comprehensive program that is better coordinated and improves access and service delivery
   - Result is better cost effective measures and a much more efficient health care system.

4. *Case Management (client care plans)* – not defined as a key concept by the Joint Task Force, but included in this thesis report

5. *Client/ Client Centered focus* - Recent key concept of Shared Mental Health Care

IMPLEMENTATION of Shared Mental Health Care projects –

A Compendium of Current Projects (Kates & Ackerman, 2002), describes over 100 Shared Care projects across Canada,

Suggestions to implement a Shared Care model (Collaborative Working Group, 2000):

- A visiting psychiatrist consult, mentor, and provide advice and supervision to family physicians working in smaller and rural communities
- Greater collaboration between mental health nurses and general duty nurses
- Encourage professionals such as social workers, psychiatrists, nurses, and family physicians collaborate and work in partnership together

1. COLLABORATIVE MODELS

- Hamilton-Wentworth HSO, Mental Health program in Ontario – (Kates, Craven, et.al. 1997).
  - One of the first in implementing a collaborative Shared Care model
  - Successful integration of mental health and primary care. program consists of:
    - Mental health counsellors in each of the Family Practice clinics with a psychiatrist visiting the clinics every 1 – 3 weeks, depending on need
    - The family physician, mental health counselor, & psychiatrist work collaboratively together by telephone, with the physician supported by the psychiatrist in person.

- North York General Hospital in Ontario (Ungar & Jarmain, 1999)
  - One of the first – a community hospital that implemented Shared Care concepts:
    - A collaborative relationship between family physicians and mental health system
    - Systemic changes, within hospital, include a change in their mission statement and recruiting strategy. For example, when a vacancy became available for a psychiatrist, they hired one that would support the new Shared Care model.

2. PSYCHIATRIC OUTREACH

- Psychiatric Outreach, mental health Evaluation and Community Consultation Unit (MHECCU), Department of Psychiatry, University of British Columbia
  - Psychiatrist services – if none available in community or "need to augment their available psychiatric care. By providing:
    - Direct consultation to clients
    - Indirect – discussion/consultation with referring family physician
    - education models
    - Clinical case reviews
    - Client group – children, youth, their families, adults, and elderly

3. MENTAL HEALTH CLINICS

- Adult Outpatient Psychiatric Clinic, Mental Health program, Sault Area Hospitals
  - Goal – to improve access and predictability of specialized psychiatric care for remote and underserved northern Ontario communities
    - reduce inappropriate admissions
  - Plan – visiting psychiatrist – consultation, support, and education
    - community nurse specialist
  - Results – family physician is "willing" and able to manage severely mentally ill clients in an outpatient setting

- Urgent Consultation Clinics, Ottawa Hospital (General Campus, Civic Campus)
  - Referrals for in clients, and by family physician clinics/offices
  - Urgent consultation clinics to provide rapid access to psychiatric care for clients, and following discharge
  - Converted long term day treatment program (4-6 months) to an acute day hospital program (4 weeks)

4. CASE MANAGEMENT (SHARED CARE PLANS

- ACCESS - a national program of education and consultation in psychiatry, North York Hospital, ON, that focuses on developing client care plans for psychiatric clients.

- NDCL (New Dimensions in Community Living) program - provides intensive case management services to clients with severe and persistent mental illness who have experienced difficulty using services in the past. Program provides emotional and medical support and activities of daily living programs.

5. EDUCATION
  - Universities: British Columbia, Alberta, Toronto, Queens and Dalhousie Universities have encouraged psychiatry and family medicine departments to take the lead in developing Shared Care models
  - A major shift is the approach to training and education where psychiatric residents train in primary care clinics and practices, and vise versa.
  - Curriculum changes to integrate the Shared Care model.
  - Focus on improvement of communication skills and collaboration between the two disciplines.
  - One Shared Care project involved a component of education and training for child care providers to improve their ability to identify child care issues, treatment options, and interviewing techniques

6. OTHER INITIATIVES ACROSS CANADA – Calgary, Edmonton, Vancouver

7. World - Around the world, Australia, UK, US, the model of Shared Care has been implemented in a variety of ways

ABORIGINAL MODEL
<u>*Historical*</u>

Federal Government Reports/ Documents – policy, procedure, process oriented

- *Royal Commission on Aboriginal Peoples*
  - 'Gathering Strength' (1991)
    - Defines Aboriginal concept of holistic health
    - Discusses inequities in health standards of Aboriginals
    - Acknowledges Aboriginal cultural and traditional healing practices
  - 'Path to Healing' (1993)
    - Goal of Royal Commission – to integrate the holistic health approach into health and social areas

- *House of Commons of Canada (1995) – Towards Holistic Wellness: Aboriginal People's*
  - Components of Aboriginal wellness – mental, physical, spiritual, environmental
  - *Towards Holistic Wellness* document
    - Role of Community; Wellness approach – incorporates traditional with western approaches; and consider integration of Aboriginal and Western models of wellness

- *Institute of Aboriginal People's Health Research* – 1 of11 Institutes that are part of the Canadian Institutes of Health Research

Aboriginal Reports/ Documents

- *Aboriginal Healing Movement*
  - Started in early 1980's with the focus on alcohol and an awareness of much larger problems – addictions, parenting, anger issues, residential school syndrome
  - Viewed as a movement and also as healing initiatives and Aboriginal programs and activities
  - Foundations of healing
    - Holistic health principles as physical, mental, spiritual, and environmental components of wellness but also include political, economical, social, and cultural elements
    - Healing comes from within
    - Healing of the individual and community interrelated
    - Overcoming past oppressions, abuses
  - Towards holistic wellness
    - Role of Community – the community defines the problem and solutions
    - Wellness – need to incorporate traditional and western approaches to healing
    - Integration of Aboriginal and Western practices
  - Funding of community projects

- *Aboriginal Healing and Wellness Strategy (2001)*
  - Funds projects for Aboriginals by Aboriginals and must include Aboriginal health and healing practices when planning primary health programs
  - Royal Commission recommends 'Strengthening the Journey' as a service delivery model to address Aboriginal health and healing issues

- *National Network for Aboriginal Mental Health Research (NNAMHR)*
  - Assists Aboriginal people with Aboriginal research opportunities

Key Concepts of the Model

1. *Holistic Health and Healing*

Definition of the holistic concept of health is consistent across the literature – and includes
- Body, Mind, and Spirit, and
- Physical, Emotional, Mental, Spiritual, supported by:
    - *Royal Commission on Aboriginal Peoples*
    - *House of Commons of Canada – Towards holistic Wellness: the Aboriginal People*
    - *Aboriginal Healing Movement*
    - *Aboriginal world view*

Other Terms
- "Whole health"….."interconnectedness" …"interdependence"
- Inclusion of the social and cultural components
- Maintain balance and harmony within the individual, family and community

Council of Yukon First Nations
- "The approach and vision of health is a wholistic view that promotes and recognizes all aspects related to the wellbeing of nation, communities, family and individuals".

2. *Collaboration, consensus, and Partnerships*
- Historically, Aboriginal people and communities have used a collaborative or consensus approach for centuries, decisions made with all in agreement
- Federal government supports concepts of collaboration and partnerships when conducting national consultations with Aboriginal communities and groups
- The Institute of Aboriginal People's Health strategic plan (2006) suggests partnerships and the sharing of Aboriginal knowledge when conducting research

3. *Aboriginal Healing Methods and Practices*
- Holistic health and healing
- Sharing and/or healing circles
- Environment
- Wilderness camp
- Traditional or Aboriginal healers and medicines
- Elder involvement necessary for healings
- Healing Process - Restoring balance
- Medicine wheel based on holistic health
- Community involvement

World Health Organization support for Aboriginal medicines and traditional healing
- *Proper Use of Traditional, Complementary and Alternative* Medicine (2004)
- *Traditional Medicine Strategy 2002-2005* (2002) – definitions of traditional medicine: suggest integration traditional medicine with national health care systems
- *Traditional Medicine & Complementary/Alternative Medicines* (2001)
- *Training Traditional health Practitioners in Primary Health Care Guidelines* (1995)

4) Community Wellness Framework Models

'Strengthening the Journey Model - called *Aboriginal Circle of Care* (Aboriginal Healing and Wellness Strategy, 2001)

- An *Aboriginal Circle of Care* – is a supportive, safe, inclusive, accessible environment; staff as role models; and relationships
- Balance – emphasis on physical, mental, emotional and spiritual balance; cultural teaching and spiritual development; strong and positive sense of identity
- Integrated interventions that incorporate interventions from the 'two worlds' an ethic of choice and self responsibility
- Community development and empowerment with centers
- Recommended by the Royal Commission Aboriginal Peoples
- Holistic model uses sharing Aboriginal knowledge and integrated into community nursing stations

'Circle of Life' Yukon Model of Health and Healing (Kassie, 2002)

- A health promotion booklet on cancer prevention (Kassi & Walker, 2002). This holistic tool is used so as to reduce the risk of cancer by looking positively at the spirit, mind, body, heart. The *Circle of Life* tool was developed using First Nations beliefs of holistic health, focusing on the mind, body, heart, and spirit in order to maintain harmony and balance for good health.
- This book is one of the few that have been published for Yukoners by Yukoners.
- This model could easily be implemented into western or medical models.
- The *Circle of Life* tool would provide an excellent opportunity for social workers and other professionals to encourage their clients or clients to explore strengths and solutions to mend their mind, body, heart, or spirit.

The Medicine Wheel – *The Sacred Tree* booklet (Bopp, Bopp, Brown, Lane, 1985)

- Funding for booklet provided by: national Native Alcohol and Drug Abuse program of Health and Welfare Canada
- Ancient symbol of the universe and individual journeys around the medicine wheel
- Used by many native people of North and South American as teachings about the life of the sacred tree, including the life of the people, including Yukon
- Principles – Four Aspects of our nature – physical, mental spiritual, emotional; Four Great Meanings of the *Sacred Tree* – wholeness, protection, nourishment, growth; Four seasons; Four races; Four directions; Four elements;

Aboriginal Healing Foundation (May, 2000)

- Supports Aboriginals in building/reinforcing sustainable healing processes for the legacy of physical abuse and sexual abuse in residential schools, including intergenerational
- Facilitate the healing process by helping Aboriginal people help Ethical Guidelines: published for Aboriginal communities doing healing work

Active Yukon Projects - (10) funded by the Aboriginal Healing Foundation

- *Intensive Therapeutic Community Healing Project* - Kwanlin Dun First Nations: therapeutic program, blend of Western and First Nations philosophies for a holistic
- *Teslin Tlingit Council's Healing Strategy* - Conference on residential schools Jan 05. Healing strategy - 4 healing workshops (anger management, family violence, addictions awareness, and spirituality.

INTEGRATION of ABORIGINAL and MEDICAL MODELS of HEALTH CARE

Key concepts

1) *Holistic health – New Definitions of Health*

- *'Encyclopedia and Dictionary of Medicine, nursing, and Allied health' (1997)*
  - "a relative state in which one is able to function well physically, mentally, socially, and spiritually" and "within the environment in which one is living" (Miller & Keane, 1997)

- *World Health Organization (1946)*
  - "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.....". This definition has not been amended since 1948

- *Yukon Health Act* – supports the principles of holistic health as a state of "physical, mental, emotional, social and spiritual well being of residents of Yukon in harmony with their physical social, economic and cultural environments".

2) *Acceptance of Aboriginal Health and Healing Practices*

- Shift within the federal government and the medical community towards
- Royal Commission (1991) and House of Commons Canada (1995)
- Associations – Canadian Medical Association, Canadian Association of Social Workers, British Nursing Association
  - A shift in attitude towards an acceptance of the holistic health model of practice
  - Committed to acceptance and to encourage integration of Aboriginal holistic practices incorporated into medical, social work, and nursing practices.

3). *Integration of Aboriginal Health and Healing methods with the Medical Model*

- Rural and Remote nursing stations have integrated Aboriginal health and healing practices into medical models of treatment in the north
- Health programs within hospitals – they operate within acute care centers using a holistic health care approach to care and provide a variety of services to First Nations clients.
  - Aboriginal Health Program, Calgary Health Region, AB
  - Fort Qu'Appelle Indian Hospital (Health Canada)
  - Aboriginal Liaison program. Tillicum Haus', Nanaimo Regional Hospital, BC
  - Aboriginal Health program, Prince George Regional Hospital, BC
  - Aboriginal Health Services program', Winnipeg, MN
  - First Nations health program, Whitehorse General Hospital, Whitehorse
- Winnipeg, Nanaimo, Calgary and Whitehorse programs provide support, access, information and education, referrals and discharge planning
- Whitehorse and Calgary programs also providing cross cultural workshops to hospital staff
- Regina Fort Qu'Appelle Hospital also provides services to non Aboriginals. .

<u>COLLABORATIVE/ SHARED CARE/ INTERDISCIPLINARY PRACTICE</u> – new buzz word

- Collaborative Nursing Practice in Alberta. Joint document supports nursing associations
    - Working together, mutual respect, a collaborative working environment for nurses/clients

- Collaborative Nursing Degree program – Ryerson University - starting in 2005
    - Two Toronto Colleges merged with University, and developed partnerships

- Collaborative Graduate/Masters Social Work programs - University of Toronto, Interdisciplinary programs 1.Addictions, 2.Ethics and Pluralism, 3.Womens Studies

- University of Northern British Columbia – Social Work program - Mission statement
    - Collaboration - supporting Northern/remote areas, Aboriginal and cultural issues
    - Acknowledgment of a holistic, interdisciplinary and activist nature of social work

- Canadian Association of Social Workers
    - Purpose and objective – (1/8) Collaborate, strengthen and unify the SW profession

- Health Council of Canada. Annual Report. (2006). Health Care Renewal in Canada.
    - Team based multidisciplinary care for primary health care in Canada
    - *National Electronic Patient Record*

COLLABORATIVE - <u>Projects in Yukon</u>

- Collaborative Wound Conference – Sept 2004 - Multidisciplinary approach - wound care
- Collaborative Palliative care Project - Home care, Cont care, Therapies, WGH pharmacist
- Collaborative Chronic Disease – (diabetes.....) - - Telehealth with communities

<u>Collaborative BC/YT Initiative</u>

– Mental health/addictions - funded by Primary Health Care Transition Fund'

- Multidisciplinary approach – collaboration and ability to work together
- Improve Access
- Decrease burden on family physician
- strengthen community links, including Rural and Urban
- Improve Best Practices
- Maximize resources to ensure sustainability (caveat)

PHASE I - Completed:

- *Yukon Drug Strategy Assessment Community Resources* – (Kramer, Oct 04)- Benchmark
- Provide education, information, training – WGH Mental Health Nurses attended
    - Mental health screening workshop – Nov 04; Motivation counseling – Jan 05
- Stakeholders Steering Committee meeting – (Hospital spokesperson attended)
- Planned: Peer mentoring; distance education and consultation with experts; client based case conferencing – meetings and common record called 'continuous record of care'
- Participating YT Communities – WH, HJ, WL, DC, Old Crow

Collaborative Community Health Centre proposal by Yukon Registered Nursing Association

- Registered nurse Practitioners provide health care as they do in the Yukon communities
- Other services suggested - Therapies, mental health

APPENDIX 5

PARTICIPANT INTERVIEW GUIDE QUESTIONNAIRE PACKAGE

WHAT ABOUT *OUR* SHARED MENTAL HEALTH CARE MODEL
for WHITEHORSE GENERAL HOSPITAL
- DESCRIPTION OF WGH MENTAL HEALTH PROGRAM – See Handout #1
  - Overview Current Whitehorse Hospital's mental health program
  - What is your job? Any corrections, additions

____

____

2. WHAT ARE WE DOING NOW??? – See Handout #2
   - ❑ Shared Care and Aboriginal models of health care

3. HOW ARE WE DOING NOW??? – See Handout #3
   - ❑ Strengths?
   - ❑ What Would You Like to See Different?
   - ❑ Solutions and suggestions for change?

QUESTIONS:

4. WHAT WOULD A SHARED MENTAL HEALTH CARE MODEL at WGH LOOK LIKE IN FUTURE??? - See Handout #4
   - ❑ What Would You Like To See???
   - ❑ What is YOUR vision???

____

____

5. IF OUR MENTAL HEALTH PROGRAM WERE TO BE EXPANDED???
   - ❑ What Would Your Priority Be? Number please
   - ❑ What SMHC components would you like to see implemented?

   1. ____
   2. ____
   3. ____

QUESTIONS????? PLEASE ASK! COMMENTS SUGGESTIONS – Handout #5

Handout # 1 – CURRENT DESCRIPTION WGH MENTAL HEALTH PROGRAM

– a descriptive inquiry – any changes, corrections, additions???

- First Nations Health Program liaison workers
  - Program developed……by elders
  - First Nations liaison workers are all Aboriginal clients
  - Program incorporates Aboriginal holistic health values and taking into consideration, physical, emotional, cultural, spiritual needs of the client
  - Provides information, support, education, advocacy, discharge planning, liaise between client and medical staff
  - Aboriginal healing methods – traditional medicines, traditional diets
  - First Nations healing room – open to all

- Medical program – mental health nurses – two
  - Assessment, crisis intervention, discharge planning for all referred (physician or nurse), and suicidal in-client and emergency department mental health clients
  - Mental health screening tools used (depression, alcohol, suicide)
  - Work collaboratively with consulting psychiatrist, family physicians, First Nations liaison workers, nurses, and support staff
  - Provide support and education to staff
  - Shared Care plans or case management plans
  - Yukon Mental Health Act – ensuring process is followed for all committed clients

- Family physicians
  - Key contact, and often first contact for client in crisis or requiring treatment
  - Case manager
  - Co-ordinates client care

- Nurses
  - Physical care
  - Emotional care when mental health nurse not available or off duty

- Consulting psychiatrist
  - Assessment and consultation of mental health clients within hospital
  - Support to family physicians and mental health nurses

Medical supports – direct and regular contact with mental health clients

- Administrative assistants – main contact for mental health clients
- Dietary – deliver dietary trays to all mental health clients
- Housekeeping – of client rooms, hallways, seclusion room as required
- Clinical care managers – administration
- Pharmacy – dispenses drugs and client information
- Dietician – discusses dietary issues with special diet clients
- Admission / discharge – admit mental health clients to emergency, observation of lobby
- Security – Respond to code yellow; accompanying clients for smokes
- Social worker – collaborative support and advice to mental health nurses, First Nations Health program, and hospital staff
- Quality assurance – risk management
- Mental health care team (former) – now part of acute care quality assurance team

Handout # 2 *Shared Mental Health Care & First Nations Models*
WHAT ARE WE DOING NOW? In terms of OUR Shared Care model

Collaboration

- Communication, relationships
- Collaboratively work together (family physician, psychiatrist, mental health nurse, First Nations, emergency department registered nurses, occupation and physical therapies, administrative assistants, admission and discharge, housekeeping, dietary, pharmacy, lab, senior admin
- Interdisciplinary team meetings – weekly rounds
- *National Ambulatory Care Reporting System* –analysis admission and emergency visits/classification of diseases
- Quality Assurance Teams
- Collaborative Initiatives Whitehorse Hospital involved in
  - *PARTY* – youth alcohol prevention program, involves education, ambulance, and RCMP; and Safe Grad
  - Palliative/Home Care project
  - BC/YT collaborative initiative – Addictions/Mental health
  - Substance Abuse Prevention Coalition (SAPC) WGH major partner outreach van – sharps, equipment

Support/ education

- Tele health sessions
- Hospital education sessions
  - Non violent crisis intervention
  - Mental health risk management assessment
  - First Nations cross cultural workshop

Maximizing use of resources

- Mental health nurse expanded role to see mental health clients in Emergency department
  - Decrease workload on family physician
  - Increase access and continuity of client care

Case management

- Interdisciplinary team meetings – discharge planning
  - Client Shared Care plans in emergency
  - Expanded Shared Mental Health Care plans – piloted, and supported by medical staff, and family physicians and clients

Holistic health and healing

- Principles of wholeness and balance
  - Physical, mental, emotional, and spiritual
- Acceptance – by medical community

Collaboration and consensus

- Communication
- Relationships
- Sense of community

Aboriginal healing methods

- Integration of First Nations practices at WGH
  - Traditional medicines/foods
  - Ceremonies on ward and in First Nations healing room
- Healing room open to all
- Healing methods vary among First Nations

Handout # 3 SHARED MENTAL HEALTH CARE HOW ARE WE DOING?

	Strengths	*What Would You Like To See Different?*	*Solutions and /Suggestions for Change*
Collaboration			
Support/Education			
Maximizing Use of Resources			
Case Management			

Handout # 3 FIRST NATIONS MODEL HOW ARE WE DOING?

	Strengths	*What Would You Like To See Different?*	*Solutions /Suggestions for Change*
Collaboration and consensus			
Holistic health and healing			
Aboriginal healing methods/ practices			

Handout #4 ....possibilities A SHARED CARE MODEL FOR WGH ......suggestions based on implementation projects across Canada

1. COLLABORATION
   - Continue to communicate, consult, and work collaboratively together, sharing information and knowledge among all health professionals who provide physical, emotional, mental, spiritual, social, and environmental care to our mental health clients
   - Encourage mental health team professionals, such as social workers, First Nations workers, nurses, psychiatrists, family physicians to collaborate and work in partnership with client s

2. MENTAL HEALTH OUT PATIENT CLINIC
   - 0900 – 1100 hours daily, including weekends
   - A private Emergency department mental health office for consultation
   - Urgent Drop in Clinic/Urgent Consultation
   - Day Hospital program
   - Possibility of: Groups
   - The mental health outpatient clinic would be an excellent follow up for physicians, especially when it is evenings or weekends.
   - This should decrease repeat visits to the emergency department, and decrease admissions, and improve safety concerns with mental health clients in Emergency department

3. MEDICAL DETOXIFICATION
   - Medical management for client care for withdrawal to alcohol and/or drugs
   - Client support and education
   - Referrals to appropriate community resources

4. EXPAND MENTAL HEALTH NURSE ROLE
   - Continue to see all mental health clients presenting in emergency in collaboration with Emergency Physician and nurses
   - Responsibility for new mental health out client clinic. This service would provide assessment, crisis intervention, counseling support, discharge planning for referred mental health clients, for:
     - Clients seen in emergency department overnight and requiring follow up but not admission
     - Referred from family physician's office – to prevent admission
     - Clients requiring 1-3 follow up sessions to prevent admission

5. EXPAND ROLE OF PSYCHIATRIST, OR SECOND ½ TIME PSYCHIATRIST
   - Augment existing psychiatric services
   - Continue to support the primary psychiatrist for client consultation
   - Continue to support and educate family physicians, mental health nurses, and hospital staff working with mental health clients

6. EXPAND ROLE OF MENTAL HEALTH PROFESSIONALS:
   - Mental health professionals – social workers, First Nations Liaison Workers, nurses, to care for the physical, emotional, mental, spiritual needs of the mental health clients; and participate in inpatient and outpatient programming.
   - Some hospitals have added a Community nurse Practitioner to assist the Emergency department with assessments mental health clients

7. SHARED CARE PLANS
   - Develop Expanded Shared Care plans for all identified clients who access Whitehorse Hospital mental health and emergency department services on a regular basis
   - Emergency Admission form could be flagged by the Admissions & Discharge staff using the confidential Meditech computer system, so all staff would be aware of a SCP on file
   - The full document would remain confidential in Meditech computer system, and in hard copy in a specifically coded envelope on the Clients Chart with access would be to Emergency Physicians, family physicians, emergency department and west unit nurses, other staff deemed appropriate
   - Family physician directives included
   - Client involvement and support

8. SUPPORT AND EDUCATION OPPORTUNITIES
   - Tele health – make more accessible and available (i.e. Onsite WGH)
   - Training modules (Mheccu) – "Enhanced Skills program" for Family Physicians', UBC
   - ACCESS – Canadian psychiatric education modules for family physicians
   - Education – expand knowledge base of professionals working with mental health clients.
     - Provide educational sessions to staff, workshops, inservices, and mental health days on Topics such as: Psychiatric diseases, treatments, risk assessments, crisis intervention techniques, Anger management techniques, conflict resolution, solution focused supportive counselling, etc...by mental health nurse, psychiatrist, mental health experts
   - Consultation via telephone with experts
   - Clinical Training
   - Orientation of new staff to mental health (i.e. mental health Act)
   - Peer Mentoring - for example – nurses, mental health nurses and First Nations Liaison Workers spend time in each others work areas
   - Solution Focused Crisis Intervention supportive Counselling
   - Residency programs – Family Practice, Psychiatric residency

9. COORDINATOR FOR EXPANDING SHARED CARE PROGRAM AT WGH
   - Coordinate and implement Shared Mental Health Care Model initiatives for the at WGH mental health program
   - Work collaboratively with other relevant Yukon projects and initiatives, for example –the collaborative BC/Yukon mental health/addictions initiative
   - Develop specific process to evaluate the changes as they are implemented, to determine effectiveness and whether or not changes to process or implementation need to be revised.

10. STEERING COMMITTEE
    - Provide support and direction to Coordinator of Shared mental health program
    - Monitor progress of initiative and target dates are followed
    - Report to, gather information, update progress, and advise on Shared Care initiatives to senior administration and WGH Hospital Board of Directors

Handout # 5 -

QUESTIONS?????......PLEASE ASK!!!!! … COMMENTS….. SUGGESTIONS

APPENDIX 6

MATRIX # 1: KEY CONCEPT THEMES BY KEY CONCEPT AND MODEL

Shared Mental Health Care	STRENGTHS	WHAT WOULD YOU LIKE TO SEE DIFFERENTLY	SOLUTIONS & SUGGESTIONS FOR CHANGE
COLLABOR-ATION	▪ Collaboration is a significant strength to mental health program ▪ Cooperation and good communication among mental health nurse, physicians, psychiatrist ▪ Mental health nurse/ psychiatrist seen as excellent supports to family physicians and nurses in west unit & emergency department. They provide knowledge, expertise, and share information to both client and staff ▪ Acknowledgement and strong support there is collaboration & cooperation among all staff who work within a multidimensional system ▪ Very good to excellent collaboration with physicians, mental health nurses, and psychiatrist ▪ Experienced family physicians ▪ Mental health nurse assessing clients and sharing information in emergency department ▪ Very good to excellent communication system ▪ "Staff development is almost always collaborative approach"	▪ Could be more. Need improved collaboration, and improved communication ▪ Need for increase in psychiatric services, so clients are seen without delays, "in a timely fashion", and not kept in hospital longer than necessary ▪ Increase availability of mental health nurse services, for nights, and when mental health nurse if vacation, ill, etc. ▪ Separate mental health clients from acute care settings, as well as palliative, maternity, pediatrics, and intensive care	▪ Separate mental health unit ▪ Mental health nurses staffed and available 24/7 ▪ A second psychiatrist attached to the hospital ▪ A separate mental health unit, with secure area, at Thompson Centre, "that will incorporate addictions, detox and mental health clients under one umbrella"

SUPPORT AND EDUCATION	▪ Support of existing educational workshops, training, telehealth sessions on mental health ▪ Training is available, specifically the non violent crisis intervention workshop, and First Nations health cross cultural training ▪ Telehealth is available ▪ Mental health nurse provides support and guidance to all staff and Family Physicians ▪ Case histories well documented	▪ Clear need identified to improve educational opportunities, especially to nurses and new nurses ▪ Telehealth – times not preferable ▪ Lack of Inservices, workshops and proper training in mental health issues for all nurses, but especially for new nurses to Territory. ▪ Areas identified – mental health risk assessments, illnesses, medications, out of control emergency clients, and mental health Act ▪ Not being paid for educational sessions	▪ Telehealth – Record sessions, and prefer University British Columbia sessions ▪ Orienting new staff ▪ Peer support and mentoring ▪ Incorporate mental health into bi-annual hospital staff educational days ▪ Variety mental health in-services from psychiatrist and mental health nurse ▪ Lunch/Learn mental health in-services ▪ Conduct a mental health Day conference/ symposium – for hospital, and community ▪ Mental health rounds with mental health nurse participation
MAXIMIZING RESOURCES	▪ Very good utilization of existing mental health resources, specifically psychiatrist and mental health nurses ▪ Psychiatrist provides client consultation and support to family physician, and mental health nurses Services ▪ Mental health nurse expanded role to assess and assist clients in crisis in Emergency department ▪ Appropriate use of staff skills	▪ Expanded mental health program – Additional mental health nurses would provide coverage 24 hour per day, and 7 days per week ▪ Psychiatrist services - increase from current 25% ▪ 2nd psychiatrist to improve service ▪ Ensure mental health nurse available to west unit and Emergency department so adequate coverage and will fit with First Nations and Shared	▪ Mental health nurse position - 24/7, or 12 hour days, 7 days per week, and on call at night ▪ Hire 3rd part time mental health nurse or Psychiatric social worker to cover ▪ 2nd psychiatrist - for Interdisciplinary rounds, clinical case presentations quarterly, case rounds by psychiatrist, mental health nurses, and Physicians ▪ In-services by mental health

		Care models ▪ Fewer admissions if seen by mental health nurse in emergency department ▪ Improve and increase knowledge, education, and skills of mental health workers, if separate unit, will be critical ▪ Develop a more formal relationship with a university ▪ Separate mental health from acute care – "mix of acute and psychiatric clients is not working"	nurse, psychiatrist, social worker ▪ A separate mental health unit with trained staff, activities and elder participation ▪ Mental health clinic separate but in association with Whitehorse Hospital and include: detoxification, addictions, and mental health ▪ Psychiatric resident ▪ Mental health clinic separate from the hospital, reference to Thompson Centre, with mental health, addictions, and detox under one umbrella. ▪ A common room with arts, crafts, and activities, and elder participation ▪ A mental health consumer driven steering committee with accountability
CASE MAN-AGEMENT	▪ An acknowledgement and strength that some client care plans are in use ▪ Support definitely exists for existing Shared Care plans for mental health clients" ▪ Mental health nurse records, history, and old chart ▪ Interdisciplinary team meetings for client rounds, case	▪ Education and training on how to do case management plans to ensure effectiveness ▪ Need to regularly update, improve, and maintain, what several participants call "ancient" Shared Care plans ▪ Need to share and communicate there is a specific client plan in place. Not always communicated	▪ Multidisciplinary rounds, which involve the client in the development of the Shared Care plan ▪ Mental health weekly rounds, perhaps following west unit client rounds ▪ Determine who is responsible as case manager ▪ Case manager is responsible for

	conferences ▪ Historical charts, current client records, and mental health nurses and First Nations health staff notations, are identified as case management strengths.	that there is a plan ▪ Request medical plan of care and Discharge plan be written down ▪ Involve all relevant staff, client, and their family in case management ▪ Mental health weekly rounds, perhaps with west unit client rounds, and at a better time where all disciplines can attend ▪ Staff could include cultural component – is not evident in staff reports on client records	an update review of client plans quarterly or every six months ▪ Input plan on the hospital electronic Meditech client system, so all staff involved are aware of the plan ▪ Include a cultural component to the plan ▪ Payment to family physicians and psychiatrist for their time commitment for initiation and review of all client Shared Care plans ▪ Training in case management so that it is done effectively Shared Care plans

Aboriginal	STRENGTHS	WHAT WOULD YOU LIKE TO SEE DIFFERENTLY	SOLUTIONS & SUGGESTIONS FOR CHANGE
COLLABORATION AND CONSENSUS	▪ "Aboriginal Model is collaboration" ▪ Considerable support is extended to concept of Aboriginal collaboration and consensus. ▪ Strong support extended by participants to First Nations health Workers ▪ Data clearly identifies the First Nations health program discipline group has very good to excellent communication skills, as they provide emotional support and interact with clients, and their families. ▪ "Child support worker excellent with First Nations adolescents with mental health issues"; Very good social worker Discharge planning, ▪ Knowledgeable of resources ▪ "Excellent bridge between hospital and community"	▪ Could be more collaboration, and communication ▪ First Nations and mental health working together on client Shared Care plans, and discharge planning ▪ First Nations liaison workers need to be more available and accessible, especially on weekends, and nights ▪ More of the First Nations health workers educated in mental health issues, and counselling, and not one specializing in mental health ▪ Residential school history for the client with their family history integrated into the mental health system	▪ First Nations mental health work more collaboratively together with improved communication, specifically in the area of client assessments, reporting of information, treatment and discharge planning ▪ Communicate/report assessment and valuable information of "clients health and what is necessary for healing" "Everyone sit down and share info" ▪ First Nations staff levels are increased, so service is more available/ accessible / expanded weekend/ night coverage ▪ Education appears to be a priority ▪ All First Nations health workers improve knowledge and skills in mental health ▪ Increased First Nations cultural information, pamphlets, and tours ▪ Integrate residential school component into mental health intake/assessment form. This highlights attending residential school, resulting social issues, family, intergenerational history

HOLISTIC HEALTH AND HEALING	▪ Strong support for holistic health concept of the physical, mental, emotional, and spiritual healing ▪ Participants state, they have a "strong belief in the whole person", and holistic health and healing is a "wonderful approach for treating the whole person". ▪ Healing room, traditional foods, residential school assessments	▪ More information and education on First Nations culture, traditional healing, and holistic health and healing concepts, including residential school survivors ▪ Clarification of First Nations health Worker role with regards to holistic health and healing program, and in general ▪ Encourages increased education for hospital staff in all areas of First Nations health programs, specifically cultural information and understanding First Nations healing practices.	▪ First Nations health educational programs on holistic health and healing for all staff ▪ Integrated holistic health center
HEALING METHODS AND PRACTICES	▪ Participants express strong support and an interest in this program ▪ Strong support for the healing room ▪ Traditional spiritual practices ▪ Traditional foods and medicines ▪ Elder support and supply medications	▪ Request educational sessions, so participants will have a better understanding of First Nations healing methods, including access and utilization. ▪ Use of the healing room more often ▪ Acknowledgement and concern expressed what can and should be Shared, in terms of Aboriginal practices	▪ Tours of the healing room, holistic First Nations pamphlets, and educational programs on holistic health and healing for all staff ▪ An integrated holistic health center, educate and increase understanding of access and utilization of healing room ▪ Educational sessions on traditional healing methods and First Nations medications ▪ Increase staffing for First Nations health program

APPENDIX 7

MATRIX # 2: KEY THEMES BY MODEL AND DISCIPLINE

PARTICIPANT GROUP	SHARED CARE	ABORIGINAL HEALTH
SENIOR ADMIN	▪ The most important strength for this group is collaboration. They acknowledge collaboration has improved, but admit the need to do more ▪ "Some do some don't, there are those people who collaborate, they work together, but others just give the info". ▪ Collaboration, education, and knowledge should be shared among disciplines, so more staff are educated in mental health ▪ Support and education identified as a strength, but need for increased staff development training ▪ Specific training topics include: mental health issues and disorders; assessment skills, how to deal with clients in crisis; client care/ treatment in hospital; case management; team building skills ▪ Solutions identify need - interdisciplinary mental health rounds, clinical case presentations by mental health nurse, psychiatrist, family physician	▪ First Nations health program is considered a strength, and well accepted by staff and community ▪ Improve collaboration - provide more support for the First Nations program with "no road blocks" ▪ support is strong for educational programs on First Nations holistic health and traditional practices and suggest education in this area be provided to all staff ▪ Holistic healing methods - need to improve, saying "it happens and accepted by some, not all staff". ▪ Need to explore how traditional medicines fit with western medications and within the medical model. ▪ Strong support exists for an integrated holistic health center.
MIDDLE MANAGEMENT	▪ Major strength identified - support and education, specifically staff development education ▪ Supportive of collaborative approach ▪ Suggest increased collaboration, and a greater role for communication ▪ Expand mental health nurse staffing to 24/7 and to be more available in emergency department ▪ Safety concerns for clients on integrated west unit ▪ Expand mental health program - Thomson Center	▪ First Nations health is a strong program - "well accepted by all" ▪ More training to "better understand the gaps they are bridging" ▪ There is an identified need for supportive counselling training for all First Nations workers

FIRST NATIONS	▪ Collaboration is a strength between First Nations health workers and mental health team, but this could improve regarding a clients admission, discharge, and therapeutic support plan ▪ Suggestion the mental health team, incorporate into the mental health assessment tool, (starting in the emergency department), issues of residential school survivor, generational abuse issues, and the resulting trauma and abuses suffered ▪ One area of concern was the need for improved communication between First Nations health and west unit health workers. First Nations health workers say they feel "devalued", as medical staff do not read their client records ▪ There is a need for a mental health clinic, with a well staffed unit with a coordinator and psychiatrist. This mental health clinic would work "within a Shared Care model", and be willing to encourage further collaboration between First Nations health program and the mental health staff. Activities, a recreation program, a living area, and visiting elders would be components of this new program - "like it used to be"	▪ Strong support for the Aboriginal model ▪ Strong support for healing room to conduct "traditional spiritual practices to facilitate supportive counselling healing with the client and family" ▪ Cross cultural workshop not enough for hospital staff, need for further education and access to available resources – healing room, residential school survivor videos, Aboriginal magazines ▪ Education and information to hospital staff on First Nations residential school survivor and how to support this client population is also considered to be important ▪ Suggestions for a revised mental health intake form that would reflect and integrate residential school survivor issues, intergenerational concerns, and traumas associated with attendance at residential schools. For example, include: First Nations status, identification of Residential school survivor abuses, current social stressors, such as poverty, housing, alcohol, and plan of action for discharge and referrals (see Appendix 10). Training was also suggested to implement this new intake process.
PHYSICIANS	▪ Collaboration exists, especially between family physicians, psychiatrist, and mental health nurses ▪ Overwhelming support for collaborative approach in Shared Care model. Comments: collaborative model include: "excellent", and "the fact is there is collaboration, especially with the psychiatrist, mental health nurses, and nursing staff" ▪ Suggestions for an expanded mental health program. Psychiatrist considered a valuable	▪ Very strong support exists by the physician group for the First Nations health program, which they describe as "outstanding" ▪ Strong support for First Nations interventions ▪ First Nations healing methods and practices are also strongly supported with a definite interest and desire to learn more on the many aspects of holistic health and healing that are delivered by the First Nations health program.

	resource, but there is a need to increase psychiatric services up from the current .25% staffing. Suggest expand mental health nurse to 24 hour/7 day coverage. It "can't work any better when available" ▪ Important to all physicians is Shared Care and client discharge planning. Suggest these plans "need to be more available, especially in the ER" [Emergency department], and this department should be involved ▪ Concern regarding the current billing system in Yukon, as the psychiatrist, and family physician cannot bill for the same client meeting. ▪ A critical issue identified as a priority by all members of this discipline group, is having a mixed unit with mental health and acute care clients on the same west unit. ▪ Solution identified is a day clinic area with recreation services for mental health clients. Suggesting a day area with recreational services - like "how it used to be" ▪ Support and education are clearly important to this group. suggestions include : training nurses on the *Yukon mental health Act*, changes in how telehealth services are delivered – improve times and record sessions ▪ Local mental health education available for family physicians ▪ Funding available for case management and educational opportunities as it is for salaried employees. Suggest "salary as possible alternative for case management", or payment for developing and updating client Shared Care plans	▪ Desire/interest to learn more about First Nations program and methods, but understand limits of reporting, and sensitivity of sharing this information

EMERGENCY DEPARTMENT REGISTERED NURSES	▪ The emergency department registered nurses discipline group, identify one clear strength as the mental health nurse role in the emergency unit. ▪ Strong support to expand the mental health program. Specifically, there is a need to increase services of the psychiatrist ▪ Need to increase mental health coverage to 24 hour, 7 days per week, to respond to emergency department needs as required, which they are "currently not able to do". Suggest increase staffing of mental health nurses so they would be available to respond to client needs in emergency department, as sometimes clients are "lost in the system", as mental health nurse is not available ▪ Considerable support for a "drop in clinic", which would decrease the emergency department workload ▪ Support for separate mental health unit with reference to this unit being located at the Thompson Centre. ▪ Need for support and education. Topics suggested include: mental health practice issues, "what to say" to mental health clients if they are "suicidal", and a better understanding of the Mental Health Act. Suggest peer mentoring with mental health nurse ▪ Finally, existing Shared Care plans for clients in the emergency department are described as "good", but require regular and consistent updating. As well there needs to be a determination of who is responsible for this	▪ First Nations health program and mental health nurses "share the workload" and "both are very helpful" ▪ Strong support for the holistic concept, and suggest using this concept for all clients ▪ Strong support for the First Nations program, including positive comments on elder participation and traditional medications and meals ▪ An identified strength is the residential school healing initiatives

WEST UNIT REGISTERD NURSES, includes mental health registered nurse, & east unit registered nurse	▪ All participants in this group express strong support for the Shared Care collaborative model. Comments include: there is "multidimensional cooperation", "mental health nurses seen as strong resource", and "our strongest strength is our GP [family physician] with nursing staff, and mental health nurse – respect, trust and communication" ▪ Strong support for relationship between family physicians, nursing staff, and mental health nurses ▪ Key theme with this discipline group is expansion of mental health program. Specifically, - Increase the psychiatrist services from existing .25% to 50%, preferably full time - Expanding coverage of the mental health nurse to minimum 12, preferable 24 hours per day, seven days per week, including vacation, stat holidays, and illness or education ▪ Support and education is another key concept with considerable attention. Numerous remarks from this group suggest additional staff education and training sessions. Topics identified are listed as: the *Yukon Mental Health Act*; mental health disorders; therapeutic management; Alcohol, drugs, and withdrawal; how to deal with out of control clients; case management techniques; ▪ Peer mentoring and cross training in mental health services and First Nations program– a number of comments received. ▪ Mental health nurse and psychiatrist provide inservices. ▪ Mental health educational seminars, a mental health day, a symposium, with some suggesting inclusion of the community.	▪ Strong support exists for the First Nations health program. Comments such as "quite unique the program we have up here", and Whitehorse Hospital is "tolerant and welcoming" in terms of Aboriginal practices, express their support. The concept of holistic health and healing and Aboriginal healing methods was strongly supported by a number of participants. Many expressed personal beliefs and an acceptance of the holistic health concept, using terms, "whole person", "interconnectedness", and a healing of the emotional, mental, spiritual aspects of an individual, as well as the physical. ▪ Some comments on good communication, but others express concern of a lack of communication, specifically in the area of reporting client assessments and their health and healing ▪ Need to expand the First Nations program, so service is more available on days, weekends, and nights ▪ Suggestion the First Nations health program be actively involved in the healing methods in the areas of Detox, Addictions, and mental health ▪ Need for role clarification of First Nations health Workers ▪ Positive comments by this group were extended to the First Nations child support worker and First Nations discharge planning social worker ▪ Strong need expressed for increased staff education and information sessions on First Nations traditional healing, medicines, and methods ▪ Suggest increased mental health education programs for First Nations staff ▪ Use/ accessibility of the healing room is considered a great strength for clients, there is desire to know more

	▪ Strong support for mandatory mental health educational days be incorporated into the regular hospital educational days "just like we have CPR day" (cardiopulmonary resuscitation). ▪ Several suggestions for the hospital to maximize resources and "develop a formal relationship with a university", so psychiatric residents can do practical placements at Whitehorse Hospital, and in northern and rural settings. ▪ Yukon registered nurses association provide educational funding; and Whitehorse Hospital has been very supportive of continuing education, and suggest education should include case management ▪ Strong support for case management, which is viewed in the well documented chart case notes and mental health assessment records ▪ Strong support for Shared Care plans that are in existence, but need to be updated regularly ▪ mental health assessment tools – considered an educational strength	

LICENSED PRACTICAL NURSES WEST UNIT	▪ Very strong focus on working together, sharing of information and working collaboratively with family physicians and mental health nurse ▪ The major issues for this licensed practical nurse discipline group are the need for a full time psychiatrist, and case management ▪ The first need is for a full time psychiatrist who is more available for in hospital clients, and also available for staff in-services and workshops ▪ The second need identified by this group is for a full time psychiatrist, specifically for Whitehorse Hospital. This position would not only increase access to psychiatric services for clients, but educational opportunities would be more readily available to staff. ▪ Another major issue for this group is Shared Care plans. There is acknowledgement of a limited number of Shared Care plans for those clients who regularly access mental health services at Whitehorse hospital. Suggestions for change were clear. They include: Shared Care plans should be noted or displayed on the meditech system; note on the hospital outpatient form; review quarterly; use these plans for clients frequenting the emergency department; increase the number of Shared Care plans in existence. ▪ Education is also an issue. Topics suggested include: psychiatric medications, street drugs, mental health issues. Suggestions also include: mental health clinical rounds, workshops, conferences. It was also mentioned educational sessions be repeated so more staff can attend, and the conference be open to the community	▪ Strong support for collaboration and consensus, specifically the sharing of information ▪ There is very strong support for the First Nations health program by the licensed practical nurse group ▪ Strengths were identified that focus on collaboration and consensus. For example, there is a very strong belief within this participant group that everyone should "focus on working together and sharing information". ▪ The holistic health concept of healing was also identified as an excellent strength and a strong belief in the "Circle of Life" tool, used by the First Nations health program, and considered a strength in healing of the "spirit, mind, heart". One suggestion to improve, and Shared by a number of participants, is to increase awareness as to what the First Nations program is all about. ▪ The First Nations program is described as "invaluable", but there is still a desire by this group for more information. ▪ Suggestion for cross training with First Nations program ▪ Desire for increasing awareness of what the role clarification, and to increase their awareness and role clarification and unsure what First Nations health program is all about

SUPPORT	▪ Strong support exists for collaboration, specifically the collaborative approach with physicians, the psychiatrist, mental health nurses, and support staff ▪ In this support discipline category, there were numerous solutions and suggestions for change from this group, especially around collaboration, communication, support and education, and safety issues. ▪ Strong support for using the multidisciplinary team approach, especially for mental health rounds, with mental health nurse present, and client discharges discussed at that time. suggestions include: accommodate all disciplines in client rounds by being "time flexible", and include notification and "liaise with retail pharmacist on discharge planning, so they know medication changes and why"; include "Pastors involved in discharge planning", as they are often the community support counselors; and strong support for medical plans of care, as "discharge planning very valuable to staff" ▪ Explore psychiatric residency programs ▪ There are many suggestions to expand the mental health program and provide additional mental health nurse and psychiatrist services. ▪ There were two major issues identified by this group, the need for improved communication with regards to safety concerns, and the need for increased education and support. The first issue was consistent throughout the support data responses, and identified by many participants, is the issue of poor communication resulting in	▪ Strong support for First Nations health program, especially the sharing of information ▪ A strength of this program is First Nations healing practices and methods, and the First Nations healing room ▪ Request from many in this group, for a description as to what the First Nations program is all about, and role clarification, as to "what they are doing and why", and about First Nations healing practices used. ▪ Suggestions for more information on the First Nations health program, in the form of pamphlets, and tours of the healing Room. . ▪ Suggest asking for the smoke detector to be removed prior to smudging or sweetgrass ceremonies

	potentially unsafe working situations. ▪ This disciplines primary concern is a lack of information about possible safety issue, as a result of poor communication not Shared by nursing Staff to support Workers. This leads to concern due to their client contact in their everyday work activities. Concern is staff are interacting with mental health clients, and do not know the client is or may be unpredictable or aggressive in their behaviour. As a result, they may be at risk of harm or injury. ▪ Specific comments include: the "only indication of mental health concerns with client is no sharps or in seclusion room – over time may figure it out for self"; "not knowing that client is mental health"; "not getting enough about client"; and being "misinformed or not informed at all". ▪ The support discipline group, provide numerous positive solutions For change to improve safety in the workplace. Some of these excellent suggestions include: "communicate client issues that potentially present safety concerns"; "if client a concern or unpredictable – meditech"; "ask to remove smoke detectors for smudging or when using sweet grass"; a specific "client gown to prevent mistaken identify"; a "high guard rail by river"; install "panic buttons", and have a "secure area for mental health", and a "mental health facility". Suggest every support staff person should go through training ▪ The second major issue for the support discipline group is education and training. Participants strongly support and identify, as a strength, the	-

	educational training and workshops available ▪ They provide a number of solutions to improve their knowledge and skill level. They include: "the need for mental health information on at risk clients", "improve knowledge and skill level of workers", "training specific for difficult situations", such as "when a client grabs you", and what to say and "how to talk to mental health clients". They also suggest "ALL" support staff, including security have opportunity to take these courses and are replaced so are able to do so", and regular mental health educational sessions with mental health nurse and psychiatrist during "lunch and learns". ▪ Many positive comments and strong support for mental health education and support, specifically, non violent crisis intervention, cross cultural course are mandatory programs with annual paid Hospital education days. Conflict Resolution courses are now available and completed by some staff.	

APPENDIX 8

MATRIX # 3: VISION FOR SHARED CARE AT WHITEHORSE HOSPITAL

	VISION # 1	VISION # 2	VISION # 3	VISION # 4	TOTAL
SEPARATE MENTAL HEALTH UNIT	23	2			25
EXPAND Mental health program services					
- MENTAL HEALTH NURSES	16	11	1	6	34
- FIRST NATIONS HEALTH PROGRAM	17	1		1	19
--OTHER DISCIPLINES (social worker, Family Physician, Therapies)	11	6		3	20
- PSYCHIATRIST	8			3	11
-RECREATION ACTIVITY	3	2		1	6
OUTPATIENT CLINIC & DAY HOSPITAL BASED PROGRAM	10	12	2	3	27
SUPPORT & EDUCATION	4	6	9	1	20
CASE MANAGEMENT/ SHARED CARE PLANS	4	4	3		11
SEPARATE MEDICAL DETOX/ADDICTIONS AREA	6	1	2		9
OTHER (see details below)	4	2	3	2	11
TOTALS*	106	50	20	17	193

Note. Totals do not reflect the total number of respondents, as some participants included 2 items in their vision # 1, with one exception 23 respondents clearly identified separate mental health unit under vision # 1; vision # 1, # 2, # 3, # 4 are actually vision statements ranked as priorities.

APPENDIX 9 MATRIX # 4: KEY CONCEPT AND VISION STATEMENT ANALYSIS VERIFICATION

	STRENGTHS				SEE DIFFERENT				SOLUTIONS				TOTAL
KEY CONCEPTS	COL	S/E	M/R	CM	COL	S/E	M/R	CM	COL	S/E	M/R	CM	
COLLABORATION (Shared Care and Aboriginal Health)	39	2	13	12	83	9		14	12	4	6	11	205
HOLISTIC HEALTH, HEALING	50	14	2	12	32	11	15	23	9	16	6	11	201
SUPPORT & EDUCATION		47	2		3	62	4	1	8	52	8	2	189
EXPAND MENTAL HEALTH prog - MENTAL HEALTH NURSES			7	2	29	3	18	3	14	2	8	2	88
- FIRST NATIONS HEALTH	1			2	10		11	4	2	10	3		42
- PSYCHIATRIST			2		20	2	18	1	5	3	7	1	59
- OTHER DISCIPLINES			1		10		8	2	5		8	5	39
- RECREATION/ACTIVITIES			1		1		13		2		2		19
CASE MANAGEMENT/SHARED CARE PLANS	1	2		26	19	2			2			21	73
SEPARATE MENTAL HEALTH UNIT				1	4	0	10	1	9		17	2	45
OUTPATIENT CLINIC & DAY HOSPITAL BASED PROGRAM					9		9		10		7		35
SEPARATE MEDICAL DETOX/ ADDICTIONS AREA					2	1	3		3	1			10
TOTALS	91	65	28	55	222	90	109	49	81	88	72	55	1005
	STRENGTHS - 239				SEE DIFFERENT 470				SOLUTIONS - 296				

Note. Other disciplines includes: social worker, family physician, physical and occupational therapy; COL – Collaborative; S/E – Support and education; M/R – Maximizing resources; CM – Case management; See Different – What would you like to see different; Solutions – Solutions/suggestions for change

APPENDIX 10

GENERAL MENTAL HEALTH INTAKE FORM DRAFT: FIRST NATIONS

A. STATUS
- First Nations
- Inuit
- Métis

B. RESIDENTIAL SCHOOL SURVIVOR ABUSE
- Emotional Trauma
- Sexual Abuse
- Physical Abuse
- Starvation
- Racism

C. CURRENT SOCIAL STRESSORS
- Poverty
- Sexual Abuse
- Physical/Emotional Abuse
- Alcohol/Drugs
- Family Violence
- Inadequate Housing
- FASD
- Unresolved trauma
- Intergenerational Survivor

D. PLAN OF ACTION/REFERRALS FOR FIRST NATION AND MENTAL HEALTH STAFF
- Admit and plan
- Discharge Referrals

Note. This is a suggested Intake form by one participant in this study