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Mental Health Wellness Coordination Initiative

Final Engagement Report

Worker Report | Youth & Chief Workshop Summary | Statistics

Prepared by:

Manitoba Keewatinowi Okimakanak Inc.

MANITOBA FIRST NATIONS MENTAL HEALTH NETWORK

Manitoba Keewatinowi Okimakanak Inc. Mental Health Wellness Coordination Initiative *is supported by Health Canada's First Nations and Inuit Health Branch (FNIHB) and Partner First Nations*

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Part 1:

Manitoba Keewatinowi Okimakanak Mental Health Wellness Coordination Initiative

Frontline Workers Engagement Report

October 17-18, 2016
Thompson, Manitoba

October 24-25, 2016
Winnipeg, Manitoba

1.1 Background

Introduction

In response to the alarming rates of suicide amongst Manitoba First Nations, the Manitoba Keewatinowi Okimakanak (MKO) Chiefs passed a number of resolutions over the past 12 years, including but not limited to securing government funding, to provide crisis intervention services and full time mental health services at the First Nation community level, building capacity that creates a critical debriefing mobile team and establishing a regional suicide intervention strategy in the MKO region.

In June 2016, the Prime Minister announced new federal funding of approximately $69 million over three years. The funding is to support a number of initiatives across the country including 4 crisis response teams, an increase in Mental Health Wellness Teams from 11 to 43, capacity development and training and a 24-hour culturally safe crisis line.

The Manitoba region, especially the north, was identified as an area of greatest need and was provided $10 million over a 3-year period (2016/17, 2017/18 and 2018/19) for one crisis response team, 3 Wellness teams for 2016/17 with an additional 3 Wellness teams to be funded for the next 2 years and capacity development funds for these teams.

With an Executive Council motion to create an MKO coordinated services model for the north, the decision was made to have MKO create a crisis team and lead the development and coordination of Wellness teams.

MKO undertook an engagement process that involved a series of gatherings. The first gathering was held with community-based resources over a four-day period. The second gathering was held with the Chiefs and youth representatives of Manitoba First Nations.

The 4-day engagement sessions with community-based resources was held in two locations: October 17-18, 2016 in Thompson and October 24-25, 2016 in Winnipeg. A total of 80 community-based resources representing 30 First Nations participated in these engagement sessions. The focus of the engagement sessions involved a review of a draft work plan, proposed budget, existing best practices, culturally appropriate alternative healing models, service gaps and key elements in a program design. The Incident Command System (ICS) framework was used a guide for discussions for the establishment of a Mental Health Crisis Response Team, Mental Health Wellness Teams and crisis response plans. The participants found the engagement meaningful as it helped strengthen, renew and establish relationships with other First Nation communities.

Participant discussions were recorded by several different facilitators and the data was collected, analyzed and organized into themes, strategic directions and desired program design elements. The data analysis resulted in a report of six major themes, unanswered questions and challenges that provides strategic direction for the Mental Health Wellness Coordination Initiative.

The engagement sessions with the Chiefs and youth representatives were held as a two-day conference in Winnipeg at the Canad Inns Destination Center – Club Regent on March 29-30, 2017. Approximately 180 people participated in this gathering. Community-based resources were encouraged and invited to attend this gathering. The focus of the engagement session was the six major themes, unanswered questions and challenges as outlined in Part 1 of this report. A series of 17 related questions to the major themes and challenges were put into a handbook handed out to the conference participants. The conference participants' responses are provided Part 2 of this report.

1.2 Mental Health Wellness Continuum of Care Framework

This mental health wellness continuum of care framework was used as a basis for the implementation of the Crisis Response team and Wellness teams. This model involves:

- **Committing to community-based decision making** and an engagement process which builds on level of community capacity and competency;
- **Delivering culturally-relevant programs** and services which are founded in the language, spirituality and customs of each First Nations communities;
- **Strengthening and building service networks**;
- **Providing training opportunities** for local service providers as ways to develop and implement community-based response plans; and
- **Harmonizing services and advocacy work** to address legislative, policy, fiscal challenges and limitations to ensure the coordination of responsibility and actions at all levels.

The deliverables with the new federal funding of approximately $10 million over a three-year period is for:

One mobile crisis response team
Which consists of 7 clinical staff (professionals and cultural experts) which can be deployed at a moment's notice to respond to crises as identified by communities. Four members of the team would be located in the North and three in the South.

Three complementary Mental Wellness Teams for 2016/17 with an additional 3 Wellness teams to be funded for the next 2 years with extensive backgrounds in both Indigenous practices and clinical approaches to mental health therapy.

Capacity development for the Mental Health Wellness Teams and the Mobile Crisis Response Team

1.3 Major Themes

Six major themes emerged from the engagement process with the key stakeholders. The themes focused on the development of mental health wellness and crisis intervention teams as well as community-based crisis response plans.

TRAINING OF LOCAL CRISIS RESPONSE TEAMS IS IMPERATIVE

The need to train community-based service providers in best practice prevention and intervention models as a way to promote the rapid mobilization of resources and to support increased stability within the community. Community-based service providers know and understand their cultural and social contexts; they are best positioned to meet the complex needs of community members in times of crises.

It is imperative the Mental Health Wellness Teams pay significant attention to support communities through training and mentorship to develop local crisis response teams including the identification of key people and the development of community-based protocols consistent with the Mental Health Wellness Continuum of Care Framework. Training that was identified included *Applied Suicide Intervention Skills Training*, *Mental Health First Aid, Critical Incident Stress Management and Debriefing*.

The Mental Health Wellness Initiative must clearly identify the system for follow up and aftercare services; this may include referrals to FNIHB therapist, establishing grief support groups, peer support incentives and home visits.

The use of community-based models to address crisis is consistent with the research around best practice models. Wesley-Equimaux and Smolenski (2007) note “community-based approaches address the need to reach the widest range of individuals and to have impact on the community as a whole with respect to social structures, collective self-esteem and shared visions. McCaslin and Boyer (2009) assert, “Models of success cannot be transplanted without deep and thoughtful consideration given to the unique culture and circumstances of the community with community input.”

The need to develop promotional material to create awareness and support prevention is essential. These promotional materials may include but not be limited to pamphlets, radio advertisements, YouTube, Twitter and Facebook as well as a providing a magnetic emergency contact/phone list to each household.

Key Themes/Points

- *Locals know the community/context*
- *Self-Care should be taught*
- *Retrain and refresher training*
- *MKO to take lead in training teams to better respond to crisis*
- *Community-based response teams*
- *Mental health first aid*
- *Applied suicide intervention skills training*
- *Mentorship*
- *Community driven*
- *Enhance skills*
- *Provide support to local teams that already exist*

TEAMS SHOULD BE INTERDISCIPLINARY AND RESPECT THE CULTURAL NORMS AND VALUES OF EACH COMMUNITY

The need to develop collaborative and multidisciplinary wellness teams and crisis response teams at the local, regional and provincial level are important to providing crisis response. Key representatives identified for these teams were R.C.M.P., FNIHB therapist, Elders, Youth Peer Mentors, BHC/BFI workers, CFS workers, Nurses and Teachers. Representing several different, but interrelated fields of work, these teams should be aware and respectful of the specific cultural context of each community including spiritual practices and belief systems. Cultural proficiency and holistic healing training were identified as a way to ensure team members are aware of how their own worldviews impact their practice.

In addition to western approaches, Indigenous practices were identified including sweat lodges, sharing circles, pipe ceremonies and the use of Christian and traditional elders and spiritual leaders.

Using holistic approaches to address the high rates of suicide, homicide and other trauma is supported by research. Rod McCormick (2004), for example, notes that the goal of healing for Aboriginal people is related to attaining and maintaining balance between the four dimensions of a person (physical, mental, emotional and spiritual). Further, he asserts that effective healing in Aboriginal communities focuses on inter-connectedness of family, community, culture, and nature. He strongly emphasizes that balance, inter-connectedness, intra-connectedness, and transcendence are the most important goals of the healing process and should be a starting point in an exploration of possible healing strategies for Aboriginal people (McCormick as quoted in Wesley-Equimaux, Smolenski pg.8-2004).

Key Themes/Points

- *Being open minded and nonjudgmental*
- *Using a holistic approach (mind, body, emotions and spirit)*
- *Creating awareness and education on wellness and well-being*
- *Developing advertisements using pamphlets, radio, TV, YouTube, Twitter and Facebook*
- *Including sharing circles, sweatlodge and other ceremonial practices*
- *Respecting other community's denominations (respecting the practices and belief systems in the community [i.e. if communities do not believe in sharing circle or smudging])*
- *Key people identified were R.C.M.P., therapists, elders, youth and all resources within the community and community people*

RELATIONSHIPS MATTER

Positive and healthy relationships with the community and community members were seen as the foundation for the implementation of the Mental Health Wellness Continuum of Care Framework. Ensuring MKO builds trust with the community and community-based service providers relates to providing a continuum of care services from crisis response to mentorship to aftercare. This trust building will support community-based service providers in developing their own best practice models, as they will be responsible to provide ongoing services once the crisis has subsided.

These relationships and social connections within the communities must be based on mutual trust, respect, and understanding. Far too often services have been short-term, often leaving the community on its own to deal with complicated mental health and wellness issues.

Key Themes/Points

- *Community resource people are accessible*
- *People need to stay in the community*
- *Communities have their professionals and community workers who are trusted and fully engaged in their services*
- *Community-based approaches seen most effective, talk about safety and spiritual balance*
- *Getting people to trust the services*
- *Networking*
- *Secondments or "loans" of services providers*
- *Follow-up and aftercare services*

PROTOCOLS, PROCEDURES AND COMMUNICATION STRATEGIES NEED TO BE CLEARLY DELINEATED

While specific practices were not identified, clear communication of the protocols and procedures for engaging the Mental Health Wellness Teams and Mental Health Crisis team is imperative. Key ideas identified include:

- Ensuring relevant information is provided in a timely manner to support good decisions;
- Using collaborative decision-making practices on an ongoing basis to promote the development of community-based crisis response plans and mental health teams;
- Clearly defining the roles and responsibilities of the MKO Crisis Response and Mental Wellness Teams as well as those of community-based crisis response teams.

The advisory council structure of the MKO initiative should include individuals who have knowledge of both western and Indigenous healing practices including elders, psychologists, therapists and youth.

Concerns were raised about the scope of responsibility and the authority of this council to make binding project decisions. As a result, using effective and meaningful communication to ensure the ongoing support of Chiefs in the North and South was seen as being very important to the successful implementation of the Initiative.

SELF-CARE IS IMPORTANT

Because the access to community-based resources is limited and underfunded, community-based service providers are often left on their own to deal with the vicarious trauma they experience in their work. Caring for the caregivers, and building self-care into practice for the community workers and aftercare services will help avoid burnout and keep the community-based service providers effective in their work.

Caring for caregivers is supported by research, which highlights the importance of self-care to reduce burnout. Cook-Shonkoff (2016), for example, argues that to avoid burnout and "… remain effective and balanced as therapists it is critical to manage stress and explore the impact that the work has on us." As a result, part of the planning by the Community Wellness teams should include training on managing triggers, signs of burnout, and stress as well as on building self-esteem and self-confidence.

Key Themes/Points

- *People talked about burnout and the need to learn how to look after themselves*
- *Vicarious trauma*
- *MKO health wellness team to provide debriefing sessions with local crisis response teams*
- *Staff retreats-caring for caregiver*

AN ENVIRONMENTAL SCAN OF COMMUNITY-BASED PROGRAMS AND SERVICES IS REQUIRED TO FOCUS THE WORK OF THE MENTAL WELLNESS TEAMS

First Nations are at different stages in their ability to offer holistic crisis response and aftercare services. These differences are often related to geography and the size of the community. In order to build on the strengths and address the needs of each First Nation, an environmental scan of community-based assets and challenges (human, financial and infrastructure) be completed is essential to providing a network of services. This scan would allow for the Mental Wellness Teams to customize resource development and training to meet the needs of each community or group of communities.

Ensuring members of the Mental Wellness Teams participate in "train the trainer" skills courses would enable team members to facilitate training in First Nation communities.

Key Themes/Points

- *Where are the teams going to be located?*
- *Will they have access to specialist (psychological/therapist) to their community teams?*
- *Lack of facility space to hold debriefing sessions*
- *Community-based funding does not allow for professionals in their communities*
- *How to compensate people using alternative healing approaches (how is the community paying for Elders when using in debriefings, and aftercare services?)*
- *Looking at symptoms not root cause*
- *Who covers the after hour services for workers, limited human resources/ support workers?*

Unanswered Questions and Key Challenges

While not a theme, a number of key challenges were identified which should be addressed prior to full implementation of the Mental Health Wellness Coordination Initiative.

1. **Location for Crisis Response Teams**
   This is significant given the geography of Manitoba and the isolation of many First Nation communities. The issue of travel and geography could become a significant challenge if more than one community is experiencing a crisis at the same time. It will be important to ensure communities are aware of what crises MKO will respond to and how critical incidences will be prioritized. What will be the response times to provide these services onsite?

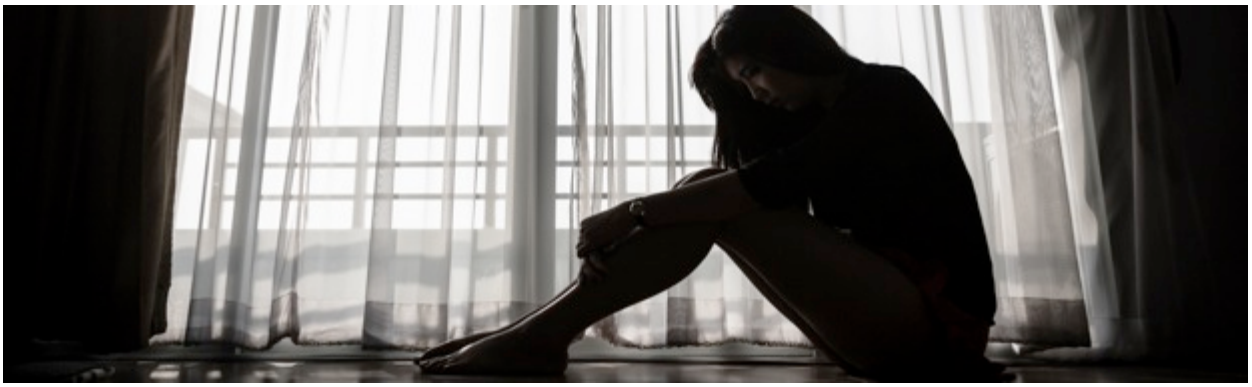
2. **Access to Specialized Services**
   Service providers questioned whether this Initiative would increase access to specialized services (e.g., psychologists, therapists) at the community level to provide direct service as well as to support the development of community-based teams. A concern was raised about how access to specialized services under this Initiative would impact current access to the FNIHB therapists.

3. **Funding Models and Its Challenges**
   Community-based resources are extremely limited and do not allow for engaging specialized services such as psychologists and traditional practitioners. The current funding model makes it difficult to compensate elders and traditional practitioners who use Indigenous-healing approaches. The question of how elders and specialized services will be paid when called upon during critical incidence stress debriefing and/or aftercare services. This needs to be addressed at the onset to avoid future misunderstanding.

4. **Lack of Facilities in First Nation Communities**
   The lack of facilities or spaces to hold debriefing sessions and host teams was identified as an issue in some communities.

5. **Increased awareness on the impact of colonization and historical trauma**
   A key weakness of the Initiative is the focus on the symptoms rather than the root causes of the high rates of suicide, homicide, and other traumatic events in the communities. It is imperative that any training initiative increase understanding of and awareness about the impact of colonization and historical trauma on First Nation's people.

6. **Aftercare Services**
   Aftercare services are extremely important in preventing crisis. What types of aftercare support will be available in the community and outside the community?



Conclusion

The National Health Organization of Canada (2009) argues that change to current models of service delivery "requires us to focus on empowering the healing process of First Nations communities. We can do this by always asking ourselves what moves us away from colonization and steps us closer to decolonization." Approaches designed to mitigate the impacts of historical trauma and address the suicide and homicide crisis must be founded in the cultural context and practices of each community and focused on building the capacity of local resource people to provide care. This is not an easy task, as it requires both the immediate action of the community-based response team and longer-term foundational training by the Community Mental Wellness Teams. It requires extensive knowledge of the unique cultural context of each community and the implementation of customized, culturally appropriate service delivery models.

It is an indisputable fact we have survived every challenge thrown at us as a people. We will continue to survive these challenges too. It is imperative this initiative be viewed as one more tool added to our resources to ensure we prevail. In the wisdom of our people, the answers to these current challenges lie in our people.

1.4 Training Initiatives

Living Works offers training in Applied Suicide Intervention Skills Training, as well as other suicide awareness and prevention training programs. *www.livingworks.net*
Suicide Prevention Resource Centre provides prevention support, training, and resources to assist organizations and individuals to develop suicide prevention programs, interventions and policies. *www.sprc.org*

Working Minds provides tools and networks to organizations to help them with suicide prevention, intervention and post-vention. *www.workingminds.org*

Klinic Community Health Centre has developed a tool kit designed to help service providers and organizations deliver services that are trauma informed. *www.sprc.org www.trauma-informed.ca*

The Canadian Association for Suicide Prevention works toward reducing suicide and its impact in Canada, through advocacy, support and education. *www.suicideprevention.ca*

The Community is The Medicine Dr. Darien Thira, Reg. Psych. Darien Thira Consulting Incorporated. *www.thira.ca – darien@thira.ca*
Dr. Darien Thira is a registered psychologist who serves as a community development/mental health consultant for many Aboriginal communities across Canada and offers training workshops and clinical consultation related to personal and community wellness, grief and trauma healing, "addictions," suicide pre-/inter-/post-vention, and related fields. He is also an adjunct faculty member at the Adler School of Professional Psychology.

International Critical Incident Stress Foundation
CISF's Academy of Crisis Intervention aims to promote and maintain standards of training in the specific field of crisis intervention and is in the forefront of delivering quality Critical Incident Stress Management (CISM) training.

ICISF offers high-quality courses in comprehensive crisis intervention and disaster behavioural health. You may use these courses to fulfill program requirements for ICISF's Certificate of Specialized Training and Continuing Education may be available.

Patty Stewart McCord Critical Stress Management usually does most of the training with First Nation Communities and she will also help develop your own Crisis Response Manual that is suitable for a culturally specific First Nation Community.

Trauma Informed Care – Klinic a resource for service organizations and providers to deliver services that trauma-informed. Trauma-Informed; the Trauma Toolkit, Second Edition, 2013.

Mental Health First Aid Canadian Mental Health Association teaches Mental Health First Aid skills, not necessarily to become therapist or counselors. It is a basic 12-hour training course delivered in four modules of mental health. Participants will learn how to provide initial help to people who are showing signs of a mental health problem or experiencing a mental health crisis.

Attachment Trauma Treatment Centre for Healing (ATTCH)-Trauma Integration Training and Certification Training Program and Certificated Program.

Nonviolent Crisis Intervention Training
It is a prevention training program that teaches participants with proven strategies for safely defusing anxious, hostile, or violent behaviour at the earliest possible stage. It's been setting the standard for crisis prevention and intervention training. http://www.crisisprevention.com

Part 2:

Manitoba Keewatinowi Okimakanak Mental Health Wellness Coordination Initiative

Chief and Youth Engagement Report

March 29 and 30, 2017
Canad Inns Destination Centre – Club Regent
Winnipeg, Manitoba

2.1 Background

Introduction

The Chiefs and youth representatives of the 63 Manitoba First Nations gathered in Winnipeg on March 29-30, 2017 to provide input on the MKO Mental Health Wellness Coordination Initiative. The two-day conference sought to gather input from the Chiefs and youth representatives on how the Mental Health Wellness Coordination Initiative (MHWCI) can best address suicide in and amongst Manitoba First Nations. This Winnipeg gathering was the second of two MKO led engagement sessions on the MHWCI. To realize the intent of this conference, Ms. Theresa Yetman, Coordinator of the MKO MHWCI provided the delegates a Powerpoint backgrounder on the major six themes, unanswered questions and challenges on the mental health services to the communities deriving from the first engagement session outlined in Part 1 of this report. Participants learned Part 1 of the engagement process involved community-based resources.

MC and facilitator Katherine Whitecloud at Manitoba Keewatinowi Okimakanak (MKO) "Healthy Life, Healthy Mind: Manitoba Youth and Leadership Conference on Mental Health."

Following Ms. Yetman's presentation, conference delegates received additional presentations on current insights, strategies and responses to suicide, suicide prevention, intervention and post-intervention. Presenters also included: MKO Grand Chief Sheila North-Wilson; Dr. Martin Brokenleg PhD Psych; Dr. Darion Thira, PhD. Reg. Psych; First Nations scholars – Ms. Shaunessy Mckay and Mr. Pytor Hodgson. Finally, Ms. Jan DeWar-Catagas – WRTC and Sargent Alex Bear, Aboriginal Policing Services – R.C.M.P. gave potent presentations.

Following the presentations, conference participants spent the afternoon in small groups working from handbooks containing seventeen questions and a comments section on pertinent aspects of the MHWCI and the six themes of the community-based resources engagement report. Questions posed of the participants included: What is a crisis? What does self-care look like in your community? How can the Mobile Crisis Response Team help caregivers debrief after a crisis? How do communities pay people who use alternative healing processes? What local resources do you use to provide crisis response and healing? What local resources should be on the local crisis response team?

Mobile Crisis Response Team

Does your community have a local Mental Health Wellness Team? Who is on it? If not, who should be on your Mental Health Wellness Team? What training is needed for your workers in your community? Who should be receiving the training in crisis response in your community? How can a trust be built with communities? What suggestions or recommendations do you have for the Mobile Crisis Response Team to ensure an ongoing relationship with First Nations communities? What would a community-based

protocol entail in responding to crisis? How can Mobile Crisis Response Team develop and maintain support for independent First Nations? What kinds of supports (aftercare) are needed to stop another crisis from happening? What do you think is priority when it comes to a crisis? Besides the therapist and the psychologist, what other resources would you recommend? How do you know if a crisis has been stabilized? What does stabilized look like? Finally, the participants were asked to provide "other comments" to the conference organizers that future conferences might be improved.

The participants' responses taken directly from the small group handbook (Appendix) have been grouped thematically and summarized into three major sections: Crisis Response, Mental Health Wellness, Capacity Development and Training. Each section is comprised of questions and responses specific to that section.

For example, all crisis specific queries and responses are reported under the Crisis Response section. The same is true for the Mental Health Wellness and Capacity Development and Training. The questions for each section have been converted into statements. The participants' responses to each question were then grouped into themes as outlined in the table of contents. The themes are provided in a numbered snapshot at the beginning of each statement. Each theme is followed with a summary of the participants' responses.

Delegate's phraseology has been honoured in this report but the occasional grammatical error did require some editing. It is the intent of the Conference organizers to have a hardcopy of this Summary Report available for distribution. A downloadable version will be made available on the MKO website at *www.mkonation.com.*

2.2 Crisis Response: What is a Crisis?

Conference delegates listed a number of situations and circumstances as key defining attributes of a crisis. To summarize these attributes, a crisis can be defined as a traumatic event(s) that adversely impacts one or more individuals, family, community or Nation and is characterized by the loss of life or well-being. A crisis may be natural or unnatural, planned or unplanned, but it compels the victim(s) and those impacted to seek immediate and appropriate help. The following situations and circumstances are listed in the order most noted to the least noted by delegates:

1. Alcohol and Drug Abuse in the Community
2. The Loss of Life Through Suicide, Homicide and Accidents
3. Criminal Activity – Gangs, Bootlegging, Violence, and Incarceration
4. Lack of Community Infrastructure and Housing
5. Unemployment
6. Colonization as the Root Cause of Crisis
7. Poor Health Conditions

Alcohol and Drug Abuse in the Community. This was the most significant crisis-related problem for conference delegates. Describing the situation as out of control, alcohol and drugs (including fentanyl, marijuana) are often used to numb the pain of grief and loss. It was also stated that parents [negatively] influence the young ones; if parents are not in the right state of mind due to substance abuse.

The Loss of Life Through Suicide, Homicide and Accidents. There are many types of crises, but the main crisis is suicide amongst young people. A crisis in the community is when one or more people are thinking about harming themselves, having a mental breakdown or contemplating suicide and needs immediate help. Most respondents identified a crisis as *entailing the loss of life or lives* by suicide, homicide or accidents. One respondent noted,
"A crisis is when a child loses both of his/her parents in a car accident" and it is an issue that is overwhelming to frontline workers, community members, and the community and the crisis may be life changing if not dealt with in an appropriate manner.

Criminal Activity – Gangs, Bootlegging, Violence and Incarceration. These problems were the third most referenced form of crisis in the community. For many respondents, any form of abuse [can] leads to crisis and these include, bullying, gossip, discrimination (human rights violations). Alcohol-fueled illegal and violent activities such as family gangs and gang affiliations, knifings, Murdered and Missing First Nation Women, bootlegging, favouritism [employment/education/training opportunities], elder and family violence, aggressive behaviour and assault are activities that are implicated in a crisis.

Lack of Community Infrastructure and Housing. Infrastructure and housing issues are viewed as contributing to the crises in First Nation communities. Put simply, the crisis of the lack of housing, infrastructure and fire-fighting equipment in our communities is made worse by arson and vandalism.

Unemployment. For many respondents, a crisis is unemployment and the high cost of food made worse by the lack of training, education and employment opportunities.

Colonization as The Root Cause of Crisis. The root cause of problems [crises] on our reserves is Colonization. Colonization is the most pressing as it resulted in family problems, the loss of culture, resources, stability, language, leadership, priorities and [broken] treaties, loss of tradition and loss of roles in family.

Poor Health Conditions. A crisis is the poor health conditions, such as children with disabilities, illness outbreak, and notably diabetes. High food costs, child neglect, children in care, loss of control and times of tough decision-making (due to harsh circumstances) add to stress and can cause health concerns.

2.3 Crisis Response: Crisis Stabilization

Conference participants identified four main indicators of *how the community would look once* the crisis has been stabilized. These indicators include:

1. Calm, Stable , Safe and Happy
2. An Organized Crisis Response With Support Services to all Those Impacted
3. Suicide Rate and Alcohol and Drug Activity Declines
4. Sense of Belonging and Connectedness

Calm, Stable, Safe and Happy. People feel safe and calm and can go back to their normal daily living activities. They are at peace with themselves and the world around them. People are happy, smiling, laughing, having fun and feeling good.

Chief Karen Batson and Pine Creek Elder at Manitoba Keewatinowi Okimakanak (MKO) "Healthy Life, Healthy Mind: Manitoba Youth and Leadership Conference on Mental Health

An organized Crisis Response with support services to all those impacted. Parents and caregivers would have a sense of relief when steps are taken at a time of crisis and when aftercare supports are in place.

Suicide rate and alcohol and drug activity declines. People are not being buried weekly in the community. Communities have less alcohol and drug use and trafficking, people are healing and working on themselves and showing a positive behaviour and attitude and have a sense of peace and harmony.

Sense of belonging and connectedness. People will have a sense of belonging and connectedness within their families and community. The land and culture is alive and well. People are reconnected with the land and taking care of the land and have a sense of community spirit and pride. People take part in cultural events and work together as a community to make sure everyone is okay.

2.4 Crisis Response: Community-Based Protocol for Crisis Intervention

Written crisis response protocols or procedures are not too common in First Nation communities. It would be useful to have a hands-on manual with practical guidelines. The Conference delegates have responded with common community-based protocol practices. Depending on the complexity of the crisis, the initial response is to make the first phone calls for emergency services followed by crisis response activities. Through this whole process, it is important the service provider remains calm, non-judgmental, culturally sensitive and listens with respect and compassion. The crisis response activities include:

1. Emergency Services
2. A Crisis Line
3. Community Leadership or Mental Health Wellness Workers
4. Crisis Response Team
5. Assess, Prioritize and Develop a Plan
6. Capacity Development and Training
7. Protocol and Procedures Manual

Emergency Services. Emergency services including ambulance, fire department, police, band constables, first response team, and/or amber alert would be contacted for medical reasons, fire or someone's life is at risk.

Crisis Line. A crisis line operated 24-hours-a-day, 7-days-a-week can also be called if someone is struggling with suicidal thoughts or feels concerned about a friend, family member or co-worker or is impacted by a suicide or suicide attempt. Crisis lines are usually operated by trained Counsellors.

Community Leadership or Mental Health Wellness Workers. A member of Chief and Council or Mental Health Wellness is also a part of the first phone calls made for help in a crisis. They can request the services of the mobile crisis team and invite the team into the community to assist with the crisis. Crisis response activities will involve a number of things to support and build on the community' strengths to address the crisis. It is important that the response activities are supported by the community's cultural practices. Knowledge of the community's customs and traditions is therefore important.

Crisis Response Team. Establishing a local Community Crisis Response Team is critical. The size of the Community Crisis Response Team will depend on the complexity of the incident. The roles and responsibilities (public and private) will need to be specified such as communication to the leadership and community, the person assuming the supervisory role who can activate the community response team and specifying who will be visiting impacted families and homes to provide support and comfort. One-on-one sessions and home visits are common practices in the community. It is important to the youth that they are a part of the Crisis Response Team; otherwise they would like to have their own Youth Crisis Response Team.

Assess, Prioritize and Develop a Plan. A critical part of the Crisis Response team is debriefing and assessing the crisis to develop a plan of action in the communities. A part of assessing a crisis is to identify affected community members and special target groups including the youth, families and school all the while respecting local practices. The team is to have a series of meetings and discussions to prioritize and establish a plan of action. Appropriate personal protective measures are to be taken to ensure safety in planning a response.

Capacity Development and Training. A key element of the crisis response is the provision of training or access to training for teachers, counsellors and managers to build capacity. Of note was the message to train and mentor the youth; ongoing training may be required including peer mentorship. The Mobile Crisis Response Team can play a role in providing capacity development and training in crisis response. Conference participants appreciate that a certified professional working under an oath of confidentiality could help debrief the crisis.

Protocol and Procedures Manual. It is necessary to develop a Protocol and Procedures Manual in collaboration with the community resources and the community. The community schools need protocols and procedures in place to deal with immediate risk situations and threats. The conference participants identified bullying in the schoolyards and classrooms as a huge concern that needs to be addressed. The manual for community caregivers is to include roles and responsibilities and a guide on how to respond to a crisis if it were to happen again.

2.5 Crisis Response: Mobile Crisis Response to First Nation Communities

Delegates provided the following suggestions to help ensure the Mobile Crisis Response Team develops and maintains ongoing relationships with Manitoba First Nation communities. Salient suggestions as outlined below involve:

1. Outreach, Promotion and Communication
2. Community Approach

Outreach, Promotion and Communication. The Mobile Crisis Response Team can maintain the relationship with communities in various ways. A significant way is to provide essential services needed for crisis response including outreach to communities and to advise how the Mobile Crisis Team can assist the local response team with services to families and the community, and follow-up aftercare services with the communities for continuous support.

The Mobile Crisis Response team be promoted through the distribution of business cards, presentations at community meetings and workshops that introduce team members and explains their mandate and to establish a dedicated central mobile crisis response phone line.

Communication is essential to building relationships with communities. Maintaining regular contact to stay in tune with communities is an important way to ensure dialogue and open discussions are a part of building trust and relationships with the community. Information can be shared with the health office and its workers to connect with community. Contact can be maintained through emails, telehealth and regular community visits. Travel to communities and visibility in the community is important. Alternatively, MKO can coordinate regional assemblies, events and community workshops. Invitations to conferences and updates on crisis response can be done through newsletters, reports and social media.

Community Approach. The conference delegates identified a preferred way to approach communities to ensure someone is available and accessible to help out anytime. It is important that members of the Mobile Crisis Response Team are personable, approachable, kind, understanding and good role models to the youth. They will need to keep an open-mind to all cultures and religions. Remember people who seek help are sharing private and sensitive information – teams will be willing to listen to their concerns. It will be important they do not try to change people but rather support people to make their own decisions. People in the community can relate to others much more easily when there is common ground. Mobile Crisis Response Teams will need to be consistent in their approach and remain visible in the community before, during and after a crisis.

2.6 Crisis Response: Debriefing After a Crisis

Conference participants informed that, following a crisis in the community; the Mobile Crisis Response Team can best help local caregivers, workers in particular, debrief after a crisis in the following ways:

1. Financial Resources
2. Being Present, Provide Comfort and Support Services
3. Indigenous Cultural Practices
4. Follow-Up and Aftercare Services
5. Self-Care Plans to Prevent or Avoid Burnout

Financial Resources. Conference participants shared that the Mobile Crisis Response Team can help caregivers debrief after a crisis by providing financial support for travel assistance.

Being Present, Provide Comfort and Support Services. Conference participants reported that the Mobile Crisis Response Team's presence in the community, to provide comfort and support services following a crisis, is helpful. Notable support services would include debriefing the crisis, therapeutic services to caregivers to give them an opportunity to share and release feelings and explore ways and means of preventing similar crises from happening in the future.

Indigenous Cultural Practices. Ceremonies were identified by conference participants as a helpful way the Crisis Response Team can help local caregivers debrief following a crisis. These ceremonies would be ones where community members feel comfortable. Participants reported having feasts, sharing circles, going to the elders to sit down and talk, and attend a pipe ceremony, sweat lodge, and/or culture camps to acquire teachings is helpful. The team's respect for local practices is deemed significant insomuch as they would not impose "other ways" but respect the community's ways of doing things. A significant way for the Crisis Response Team to help local caregivers (Council, health staff, community youth, and elders) is to debrief following a crisis.

Follow-Up and Aftercare Services. Follow-up and aftercare support services are important and helpful after a crisis is stabilized. Aftercare is a term conference delegates used in their workbooks, which means providing the following supports and services: work with families in their homes, house calls and personalized aftercare plans. Aftercare materials that outline the supports and services available to ensure individuals, families and the community are educated on wellness and aftercare services such as counselling services, crisis intervention support, support groups for women, youth and men, AA and 12-step programs and community (Light The Candle) vigils. The Crisis Response Team coming into the schools to do education and training sessions related to Safe Talk and Suicide Prevention is helpful. Conference participants see it as important that the Crisis Response Team attend community meetings. Follow-up and aftercare services are critical components of the Crisis Response Team's ways to help local caregivers after a crisis to ensure there is no one left behind or forgotten. Aftercare and follow-up involves continuous monitoring of people impacted by the crisis to see how they are progressing and to prevent any further self-harm.

Self-Care Plans to Prevent or Avoid Burnout. The participants stated that the Mobile Crisis Response Team helping local caregivers develop a personal care plan aimed at preventing burnout was important help following a crisis. Some participants saw that with the presence of the Mobile Crisis Response Team, local caregivers might take time off to recharge.

2.7 Crisis Response: Current Community Resources Used for Local Response Team and Healing

Conference participants listed the community resources that they see provide supports in crisis response in the communities as outlined in the table below.

Indigenous Cultural Practices	Health Resources	Education Resources	Other
	Health Directors. National Native Alcohol and Drug Abuse Program (NNADAP). Indian Residential Schools (IRS). National Aboriginal Youth Suicide Prevention Strategy (NAYSPS). Brighter Futures Initiative (BFI). Building Healthy Communities (BHC). Family Violence Worker. Jordan's Principal Initiative (JPI) Health Centers, Nursing Station or Treatment Centers were identified as providers of crisis response and healing. Beatrice Wilson Health Centre, the NCN Family and Community Wellness Centre and the Nelson House Medicine Lodge were noted as a few facilities.	Despite the breadth of service personnel, crises persist calling forth comments that the providers of these services are "not too aware" or that, "In our reserve we don't have any resources or trained people to deal with people that are thinking of suicide."	First Nations Inuit Health (FNIH) Mental Health therapist, doctors or Nurses.

2.8 Crisis Response: Current Community-Based Resources That Could Be On the Community Response Team

Conference participants suggested additional local resources for the community response teams as outlined in the table below. Participants also suggested that a 24-hour crisis line and a local crisis response team Facebook page all rolled into a community database on local crisis response team resources. Participants noted the need for this database to be publicized so that the community would know whom to contact in times of crisis.

Indigenous Cultural Practitioners	Health Resources	Education Resources	Other
Elders or Knowledge Keepers were frequently acknowledged as parties to the local crisis response team. Participants listed these individuals as possessing both traditional and western medicine who provide teachings and ceremonies all the while serving as mentors to youth in the community. In implementing land-based gatherings, the knowledge keepers could be key informants in cultural workshop. Participants also suggested weekly meetings between the Knowledge Keepers and the youth.	Emergency Response Team including paramedics (first responders), ambulance and EMS personnel all need to get organized, have someone on call to talk to in person or to monitor and follow-up with victims.	Local school principals, teachers and counsellors were identified to be on the local crisis response team. The suggestion included the need for crisis response team members to go into the schools to deliver talks and wellness presentations. A significant number of participants listed the youth as key players on any local crisis response team. Youth could reach out to other youth that are contemplating self-harm, offer peer-group support, training and mentoring. The youth could be trained in ASSIST, First Aid/CPR, bullying prevention, suicide prevention, and self-awareness.	The Tribal Council level was deemed an appropriate component of a local crisis response team. Child and Family Services are suggested as appropriate members of the crisis response team. Chief and Council (including appropriate portfolio holders) and band office personnel were members suggested as part of the local crisis response team. R.C.M.P. and/or First Nation Safety Officers and justice workers were suggested members of the local crisis response team.

Specialized Services

In response to "Besides the therapist and psychologist, what other resources would you recommend…" conference participants identified the list of resources noted in this table as specialized services to First Nations.

2.10 Mental Health Wellness: Teams

Conference participants were divided on the existence of a Mental Health Wellness Team in their communities. Participants commented that the Mental Health Wellness Team be comprised of people who are team-oriented, trained, have a positive image and good communications skills. The responses were divided into three categories:

1. Mental Health Wellness Teams Exist
2. Mental Health Wellness Teams do not Exist
3. Does Not Know if the Community Has a Mental Health Wellness Team

Mental Health Wellness Teams Exist. Conference participants reported that some communities have a Mental Health Wellness Team but that the composition varies from community to community. Some include local Mental Health Workers or Therapists (male and female), NNADAP, Brighter Futures, Counsellors, Nurses, a Health Director, Social workers, Therapists, Elders, frontline workers, community workers and the leadership. A participant noted Keewatin Tribal Council has a Mental Health Crisis Response Team.

Mental Health Wellness Teams do not Exist. Some participants believe they did not have a Mental Health Wellness Team in the community declaring if a team existed it would not be considered a team because everyone works alone in departments [silos].

Does Not Know if the Community Has a Mental Health Wellness Team. Conference participants also shared they did not know if a local Mental Health Wellness Team existed in the community but they offered some definite suggestions of who they would like to have on the team. These would be people who come together when a crisis happens. Participants named Chief and Council, Mental Health Therapists, Counsellors, Band Constables, Safety Officers, R.C.M.P., Knowledge Keepers, Elders, Teachers, BFI, BHC, Treatment Centers personnel, NNADAP, Health Director, CHR, CPNP, Health Staff, Jordan's Principal Initiative, Child and Family Services and Parent Mentors. One participant was explicit in their recommendation in this regard: "Two youth, three elders, health workers, school guidance counsellor, one teacher and a couple of community members."

2.11 Mental Health Wellness: Essential Services Priorities

Conference participants identified four main priority areas of essential services to support the mental health wellness of the communities. These priority areas include:

1. Crisis Response
2. Indigenous Practices and Practitioners and Networking
3. Suicide Prevention, Education, Support and Aftercare
4. Community Infrastructure and Employment Opportunities

Crisis Response. Crisis response is an essential service to the communities. The crisis response will involve assessing the resources required to address the crisis, ensure a crisis response team is in place and that the emergency services including the R.C.M.P. are contacted and supports are put in place to ensure the well being of individuals and the community.

Indigenous Practices and Practitioners and Networking. The knowledge of the Elders and Indigenous Knowledge keepers are essential to

community health and wellness. Despite the impact of colonization, communities have maintained the language and cultural practices. Conference participants want to ensure that the strengths in the language and culture are maintained and used to its fullest to maintain the health and wellness of the community. They would like to have networking with communities through culturally oriented workshops and meetings to share resources and develop comprehensive approaches to ensure supports are in place.

Suicide Prevention, Education, Support and Aftercare. It is important to have and maintain supports through counselling, follow-up and aftercare services after a crisis has been stabilized. The supports are needed to deal with Murdered and Missing Indigenous Women, alcohol and drug abuse, bullying and lateral violence such as gossip.

Community Infrastructure and Employment Opportunities. Many respondents cited the lack of housing and employment as contributors to the crises experienced in the communities; more housing and more job opportunities are needed. Communities lack facilities or space to host the Crisis Response Team and a Health Center facility would be helpful to have the space required for crisis response services. It was stated that the leaders need to deal with unemployment, improve housing and that more houses should be built or converted for supports and aftercare to forestall the crises.

York Factory Chief Ted Bland and youth at Manitoba Keewatinowi Okimakanak (MKO) "Healthy Life, Healthy Mind: Manitoba Youth and Leadership Conference on Mental Health"

Community Infrastructure Needs

- Treatment Centres
- Healing Lodge or Health Centre Facility
- Youth Centre for the youth to keep active
- More housing and improved housing builds.

2.12 Mental Health Wellness: Essential Services to Independent First Nations

As of March 2017, eleven independent First Nations exist, five in the north and six in the south. As an Independent First Nations, these 11 are not affiliated with any of Manitoba's seven Tribal Councils. Conference participants identified six main areas of essential services to support the mental wellness of the Independent First Nation communities. These areas of support include:

1. Effective Communication and Reporting
2. Crisis Response Team
3. Access to Funding for Wellness Teams
4. 24-Hour Crisis Help Line
5. Approach in Working with First Nation Communities
6. Community and Education Awareness

Effective Communication and Reporting. Effective communication is key to support the Mental Health Wellness of Manitoba's eleven Independent First Nations. Maintain some plan to engage with Independent First Nations to ensure daily dialogue, to keep in touch with the communities and get involved in community events. Observation and listening is a key to ensure the community's voice is being heard and carried outside the community. The communities can stay informed on services and initiatives through the community resources. It is important to keep records and to track the progress of the communities' mental health. This will nurture the communities towards a sense of belonging with MKO.

Crisis Response Team. Crisis Response teams can be developed through outsourcing with other First Nation groups or flexible partnerships and networks with community Health Centers and leadership. Whatever approach is taken, it is important the Crisis Response Team works with the leadership on the development and training of community resources of a local crisis response team that will provide care to people. Community visits to offer support during and after a crisis, debriefing sessions and tracking progress would be supportive. The needs and problems are to be assessed by visiting the communities and having one-on-one talks to determine the needs to make a better community. Every First Nation is different. Ensure the level of risk is assessed including the impact of crisis in the community.

Access to Funding for Wellness Teams. Access to funding for Independent First Nations to address youth suicide in the community would be supportive. Have a Wellness Team for Independent First Nations which includes north and south for the next Request for Funding Proposals.

24-hour Crisis Help Line. Develop a 24-hour Crisis Help Line that connects to each community and gives access for immediate help to assist in stabilizing the crisis. A key aspect of stabilizing the crisis is to enable callers to share survival stories in confidence.

Approach in Working with First Nation Communities. As noted in the Mobile Crisis Response to First Nations communities earlier in this report, the approach taken in working with Independent First Nations is to keep an open mind to learn the community's history and culture, to be accessible as needed, to be responsive within a certain time limit, and to have dedication and willingness to help anyway possible.

Community and Education Awareness. Community and education awareness through workshops or sharing circles will allow people to talk about their experiences and be educated on suicide and mental health issues. People need a safe place to be heard and be informed on the mental health issues. The Mental Health Wellness Coordination Initiative can create more opportunities through workshops that will attract First Nations.

2.13 Mental Health Wellness: Self-Care, Aftercare and Supports

Despite the frequency of crises in First Nation communities in general and in Manitoba First Nation communities in particular, conference delegates shared numerous examples, services and activities they recognize as self-care happening in the First Nation communities. These include:

1. Indigenous Ceremonies, Spirituality and Land-based Activities
2. Family and Community Events
3. Self-Care and Self-Help Groups
4. Education
5. Sports, Hobbies and Recreation
6. Sobriety, Healthy Diet, Exercise and Rest

Indigenous Ceremonies, Spirituality and Land-Based Activities. Ceremonies and reconnecting with the land is a common thread running throughout the engagement process and it is identified again here.

Self-care in the community was characterized by the return to ceremonies, land-based activities such as hunting, fishing, trapping, gathering and culture camps. Indigenous ceremonies, spiritual expressions embody a resurging spirituality grounded in an ancestral way of life. Respondents pointed to the sweat lodge, prayer and meditation, smudging, seasonal and community feasts, singing drum songs, pow-wows, and regular sharing circles, traditional teachings from elders, youth and elder gatherings were also suggested as good supports for self-care, aftercare and prevention.

Family and Community Events. Family and community events were noted as hallmarks of self-care for the conference participants. Prayerful raising of children and grandchildren while immersing oneself in community events such as seasonal festivals, family fun days or visiting with friends and family fosters love and care. Taking care of the mind, body and soul and ensuring the company you keep is positive makes for a less stressful life. Talking to Elders and helping or volunteering to keep the community clean, taking part in a bingo game contributes to individual, familial and community self-care. As one participant noted, “When the community is taking care of you will feel better about yourself.”

Family and community events play a central role in the health of a community and delegates called for more activities to get community members involved in the life of the community. Get the youth involved in activities such as cooking, sewing, arts and crafts classes, and family activities were suggestions. There were requests to have leaders not allow people to drink or do drugs and to get rid of bootleggers and drug dealers.

Self-Care and Self-Help Groups. Conference participants stated the actual self-care in their community contrasts sharply with how it should appear. At present, participants report engaging the leadership, debriefing and talking with one another after a traumatic event without “getting something in return” that self-care is what is needed.

Participants also noted community members go to urban centers to see a FNIH Mental Health Worker who comes in once a month. Ideally, the community would be taking care of itself, taking responsibility for the elders and the family. Community-based self-help groups would be led by local resource people – BFI/BHC, NNADAP, Health Centre, pastoral, spiritual support supplemented by the occasional visit from a FNIH Mental Health professional. These programs and teams would be readily available at times of crisis, to do workshops or conduct programs that bring the community together to debrief, support, and heal together.

Counselling and therapy entail the supports and aftercare of a regular therapist or counsellor in the community, so the people who have been in a crisis can get regular sessions with them and provide that mental health support help after a crisis.

Self-help groups were also noted by the delegates. Have Alcoholic Anonymous and Narcotics Anonymous meetings for people that come out of treatment centres, create a buddy system so that everyone has someone to talk to and check up on them for emotional support. They can meet once a week and talk about how they are feeling and do things together that are positive. We need to keep in touch, make meeting arrangements or appointments for follow-ups, and ask the victim what they are interested in as people have different ways of coping. Delegates offered that it is critical to figure out the problem first – identify gifts and talents in one another and also to nurture them along the way.

Education. Education in a form that provides detailed information on different kinds of crises and prevention programs aimed at improving lifestyles, cultural programs aimed at [re] gaining First Nation identities. Delegates also suggested workshops that promote suicide prevention and awareness and provide tools and resources as needed. Regular suicide prevention community workshops and conferences to teach young men how to treat women with respect and to stop date rape. Bringing in speakers, small group sessions focused on the crisis, stress management, sharing self-harm stories and workshops for students in schools were all notable suggestions by the delegates.

Sports, Hobbies and Recreation. Sports, hobbies and recreational activity are tangible examples of self-care in the community. Besides traditional and cultural pursuits, the conference attendees also shared that self-care took the form of conventional, mainstream sporting activities like hockey, volleyball, football and local Olympics. Complimentary family nights and land-based activities to rejuvenate and re-strengthen the self and spirit were mentioned by the delegates. Attendees indicated self-care also finds expression through constructive habits and hobbies that keep the mind happy. Sewing, beading, gardening, reading and writing books and poetry, fiddling, playing guitar and singing, painting and playing chess are but a few examples. For others, doing things that brings you personal joy, personal grooming and spa days, creating and realizing goals, watching motivational movies, skit making, driving and taking road trips or just being creative are all reasonable self-care practices.

Sobriety, Healthy Diet, Exercise and Rest. Conference participants cited sobriety, healthy diet, exercise and rest as sound examples of self-care they have used at the community level. Loving one's self and de-stressing through exercise (walking, yoga), healthy eating (fruits and vegetables), proper hygiene, living a substance abuse-free lifestyle, getting a good 8-9 hours of sleep and listening to music all contribute to self-care.

Norway House Chief Ron Evans, MKO staff Albert Apetagon and NHCN youth and Elder at Manitoba Keewatinowi Okimakanak (MKO) "Healthy Life, Healthy Mind: Manitoba Youth and Leadership Conference on Mental Health."

2.14 Mental Health Wellness: Integrating Indigenous Healing Practices

Conference participants recognized the importance of returning to alternative healing processes held by Indigenous Knowledge Keepers and Elders. Participants provided knowledge of protocols to access alternative healing processes from Indigenous Knowledge Keepers or Elders and cite conditions under which community members compensate them for the alternative healing processes that assist communities. The five cited protocols include:

1. Tobacco and Clothe Offering
2. Food Offering
3. Indigenous Ceremonial Healing
4. Monetary Gifts (Honoraria)
5. Travel Expenses

Tobacco and Clothe Offering. Conference participants acknowledged the protocol of presenting the Indigenous Knowledge Keeper or Elder with tobacco and cloth (also referred to as print) for the services they are being asked to perform. Tobacco or a tobacco and clothe offering is presented for Indigenous Knowledge Holder or Elder services whereupon the service provider might receive one or a combination of effects limited only by the service recipient's imagination and financial capability.

"When a person seeks to access knowledge or a ceremony, they must first understand what it is that they are seeking. First Nations have different protocols and methodologies. It is advised to seek the specific protocol if a person is going to attend a ceremony, feast or event. The general protocol and methodology is to present the Indigenous Knowledge Keeper or Elder with tobacco and a cloth. The cloth is usually broadcloth and one to two meters long. The color of the print depends on the circumstances."
(Saskatchewan Indian Cultural Centre. (2009). Cultural Teachings: First Nation Protocols and Methodologies. Saskatoon, SK. *p. 12)*

Food Offering. Conference participants noted that practitioners of alternative healing processes are deserving of respect and acknowledgment and that listening to them can go a long way. Participants urge those seeking these services to approach it with and open mind – do your own research and that communication is a key. In accessing these alternative-healing processes, participants noted the centrality of food and feasts in the healing process.

"The offering of food is an important spiritual practice that is intended to look after relatives that have gone before us. Special pipe ceremonies and prayers are conducted with this offering of food. It is First Nations' law that prayers at feasts are only given for good fortune, well-being and happiness." (ibid. p. 33)

Indigenous Ceremonial Healing. Conference participants noted that while a community may not practice traditional healing, it was interpreted as one of the many problems why the community is the way it is! Loss of cultural identity, characterized as a Christian-based community with church-influenced leaders, helps in many ways but it takes a community to recognize the spiritual practices. We need to work together (departments). Participants advocate seasonal sweats hosted by Traditional Healers, culture camps, smudge with Elders, and to bring back to the land to teach the young people their culture.

"Youth and Elders need to reconnect; the middle generation needs to connect with both the young and old." (ibid. p. 7).

"As the generations before, it is the collective responsibility of First Nations today to pass on these traditions and customs to future generations in accordance with established customs and protocols." (ibid p. 47)

Various Indigenous Knowledge Keepers have stated that in order to appropriately understand [First Nation] laws and ceremonies a person had to live a good lifestyle. This lifestyle entails living a

healthy and addiction free life. When a person seeks this knowledge then they have begun a spiritual journey. Elders have described this knowledge seeking as the formal education system of First Nations." (ibid. p. 15)

Monetary Gifts (Honoraria). Conference participants stated Monetary Gifts (Honoraria) are provided to Knowledge Holders and Elders for their services. They noted, however, that everyone wants to be paid and cautioned calling upon the Knowledge Holder and Elder who only does this work for the money. Volunteerism has to be celebrated; bartering (food, gas, rides, sweat equity, cleaning their house or yard-work for Indigenous Knowledge Keeper or Elder services) was also noted as an acceptable medium of acknowledgment and gratitude. Monetary gifts (honoraria); smudge; smudge and ceremonial supplies including sweet grass or assistance gathering wood and rocks for sweat lodge ceremonies; gifts of food, clothing, pots and pans, moccasins and gauntlets, blankets, gift cards and the like have been provided at ceremonies. Participants also noted Indigenous Knowledge Holders and Elders also receive, singularly or in tandem, respect and gratitude, and recognition awards from the community.

"Most Indigenous Knowledge Keepers or Elders teach that the gifts are given at the discretion of the person. The more contemporary gift is monetary, especially for meetings or other such events when prayer is needed from Elders. Some Elders do not want monetary gifts but is usually best to offer." (Ibid. p. 13).

People exchanged services and goods for other services and goods in return. First Nations have a history of bartering and it is time for new ideas to help people cope financially and raise money for worthy projects. A barter system is an old method of exchange. (http://www.timescolonist.com/business/first-nation-unveils-barter-currency-1.112277#sthash.8H0fRZaS.dpuf.

Travel Expenses. Conference participants shared that accessing alternative healing processes from a local Indigenous Knowledge Keeper or Elder and those living outside the community raises the issue of travel costs. Government funding through FNIH [Traditional Healers Program] helped get service-providers to the community or transport those in need to the service-provider's community. Participants were clear that some local service programs or Chief and Council had limited financial resources to facilitate this and that this is a "hit and miss" circumstance.

2.15 Mental Health Wellness: Building Trustworthy Relationships with Communities

Communication and relationships are the two certainties for First Nation peoples in building a trustworthy relationship. Trust within the communities can be best built on this good foundation. The delegates surmised the key elements to building trust with the communities are:

1. Communication
2. Privacy and Confidentiality
3. Sharing Information in an Open, Honest, Respectful and Transparent Manner
4. Forgiveness and Sobriety
5. Build Relationships
6. Home Visits
7. MKO Crisis Response Team and Wellness Teams

Communication. Communication in its diverse forms is foundational to trustworthy relationships. These diverse forms of communication were shared in the workbooks that guided discussions

during the conference. Sharing Circles promote unity and accountability or can be used to honour our Elders, Youth, Chief and Council. Delegates want the leadership to keep in touch [strengthen community relationships]. With clear communication, step-by-step informed approach, community involvement on every level, willing to change, and keeping an open mind. Maybe our local health centres should have a planning and procedures manual for our workers to start implementing communication strategies as soon as possible. Everyone congregates there when a crisis happens.

Privacy and Confidentiality. Privacy and confidentiality were important considerations for delegates. Disregard of this very important consideration is unprofessional at best and unlawful at worst. Breaking privacy and confidentiality is recognized as a definite way to destroy trust within the community. Practice confidentiality daily, with proper confidential training you'll be able to better relate to one another.

Sharing Information in an Open, Honest, Respectful and Transparent Manner was important for delegates for trust to take root within the community. They noted the need for regular or seasonal community gatherings with the youth in the community or the ones at risk as this helps bond the family and community. There are so many divisions in the departments; everyone wants to do their own thing. Also, for our leaders to let the departments have control of the funding because it seems like they have all the control and no trust at all. The community can also receive updates on good and bad news in the community through regular staff meetings; weekly, monthly, quarterly and annual reports from the leadership and service providers in the community. The communities could also have a day to do trust exercises to build that trust.

Forgiveness and Sobriety. Delegates noted additional attributes of forgiveness and sobriety as key prerequisites of trust within communities. Past trauma would not interfere with their future endeavours. The ensuing trust would be earned, not given and parents would build trust with their children. Most important is keeping in touch with the group and having a buddy system to build trust for ongoing relationships to continue communication with everyone in the community.

Build Relationships. Building relationships of understanding between the generations was noted by a number of delegates. Teaching the youth will guide them to do the same thing when they are older as they are going to be the teachers and leaders. Get the youth to know the history of the community and being knowledgeable of where [your] people come from. In building relationships, the youth expressed the importance of encouraging free thought and ideas and to keep it positive. Updates with the community members as noted above, such as giving support to those in need, establishing peers and buddy systems and banishing drug dealers are suggested means of building relationships. Making fun memories, showing respect, loyalty, and being humble also help. Delegates urged that relationship building not be pushed; that by easing into it you build a trusting relationship. Institute major events and celebrations like Pow-Wows and family gatherings. By not using other's flaws or mistakes against them you will build trust. Be mindful to avoid "divide and conquer" tactics and learn to overcome differences; be honest and open to build that trust. Trust can be built by supporting one another, having unity in addressing a crisis in the community. One delegate commented on the destructive quality of lateral violence and gossip stating, "The last part is what I see within different communities, people talking about each other, which creates hate between one another."

Home Visits are urged by conference participants. Visiting one another strengthens community relations and communications. It was noted that in the days before televisions, telephones and the Internet, community members visited one another. Meals, stories and laughter would be shared and good community relations would be cemented. Delegates request the return of visiting one another.

MKO Crisis Response Team and Wellness Teams are important resources for building trust in the communities. Delegates suggested the teams visit the community and gain knowledge of the crisis and the community; awareness builds trust between the service providers and those who use the service as they experience common ground and connections. Teams should ease in and stay awhile and not to run because money runs out or deadlines are not met. Delegates expressed the need that the teams should have ongoing communication with the community even between crises and not just when a crisis arises. Delegates shared the importance of visibility – that the Crisis Team and the Wellness Team being there at community events and promoting their services and work builds trust. Coming in to spend time, more than once, so they can become more comfortable, take part in meet and greets – introducing people, programs, and familiar faces leading the initiative. The Crisis Team and the Wellness Team have to build trust through a monthly update on crisis issues.

2.16 Capacity Development and Training: Mental Health Wellness and Crisis Response Team

Conference participants identified the following training needs as important knowledge, skills and abilities for the Crisis Response Team workers in their communities. Training needs are prioritized by the number of times they were identified by delegates (most-least). Likely due to potential of training opportunities, participants listed a host of training needs unrelated to mental health and wellness. These listings include such matters as information technology, accounting, human resource management and construction. In essence, participants were not averse to requesting everything as training is viewed as a way to get more people to work. The training needs as it relates to Mental Health and Wellness are as follows:

1. ***Applied Suicide Intervention Skills Training* (*ASSIST*)** was the most cited training need by conference participants. They expressed a strong desire to recognize suicide behaviour and how to approach it, deal with suicide it and talk about it in the community.
2. ***Mental Health First Aid*** training was the second most requested training.
3. ***Cultural Awareness Workshops*** that inform on the history of Indigenous culture (preferably a hands-on), traditional teachings, including traditional family parenting and the seven sacred teachings.
4. ***Communication Skills***. Youth delegates, in particular, identified the need for local workers to be trained in communication skills. This need was summed up in the words of a youth who shared, "some of them [workers] need to actually take the time to listen and not just shake their head." Improved interpersonal relations are understood to result from sound communication skills training.
5. ***Basic Counselling Skills*** training was stated as a need for the local Mental Health Wellness Team. Emphasis was noted for training in confidentiality.
6. ***Crisis Intervention and Crisis Management training*** was listed as a significant need. Knowing what to do in a crisis is seen as central to the capabilities of a functioning Mental Health Wellness Team.
7. ***Wellness Activity*** Training that promotes life, knowledge, respect and open-mindedness and fosters community gatherings was listed as a training need.
8. ***Critical Incident Stress Debriefing***
9. ***Drug and Alcohol Addiction***
10. ***Grief and Loss***
11. ***Trauma [informed]***
12. ***Safe Talk***
13. ***Awareness for Bullying and Stress Management.***

2.17 Capacity Development and Training: Community Level

Conference participants stated all community members require Crisis Response Training in their community. health personnel, community resources, community members, police, education and leadership were identified in particular. It bears acknowledging that staff will perform identical functions across communities but job titles are not always consistent. For instance, a frontline worker might be called a wellness worker in one community but a counsellor or health resource worker in another community.

Health Services and Emergency Services	Other Service Providers	Community
Community-based resource workers at the Health Centre – doctors and nurses, EMR's, First Responders and the ambulance. Health Director, Health Liaison Officer, Health Resource Workers, Diabetes Workers, Mental Health Therapists and Wellness Workers such as the BHC, BFI, and NNADAP Counsellors. Security guards should be trained because a lot of times they are the ones who witness a crisis. Community members willing to take the training on how to handle crisis situations should also be offered the training.	The leadership - Chief and Council/Mayor and Council because people tend to approach them first, Band Constables, band office administrators and elders. CFS Workers. Housing Administrators. Fire Department and Firefighters. Radio Station employees, broadcasters, janitors. Elders, Knowledge Holders, Traditionalists. Clergy. Youth, youth leaders and the Junior Chief and Council. The local school board and the staff in school including the school counsellors should also be included for training.	Those who are trusted and do not gossip. Those who are interested in receiving training should be allowed because everyone should benefit from this type of training. After all, the participants noted, a crisis could affect those that you love. In order for a community to be healthy, we have to take care of each other. So the training should be "open to community" with a representative from every family, possibly the heads of each of household.

Participants commented the above-noted resources need to “keep clean” as they are important role models for the community. It is important the community resource people lead by example as it boosts self-awareness, self-esteem and enlightens the mind. They should be able to speak the local Indigenous language, the English language and be mature and responsible individuals. These people should be able to relate to issues because they have done their personal healing and wellness.

Due to the high suicide rate and that the youth are the next generation who will lead and take care of the community in the future, it is essential they are equipped with the knowledge in First Aid, CPR, suicide intervention and crisis intervention. The youth believe they should not have to experience the impacts of suicide but suicides do happen.

Part 3:

Manitoba Keewatinowi Okimakanak Mental Health Wellness Coordination Initiative

Statistical Information

Suicide Rates | Premature Mortality | Life Expectancy | First Nation Populations

March 2017

3.1 Background

Introduction

Despite years of calls for action by First Nation[1] peoples in Manitoba, suicide and homicide continue to significantly impact our young people living on reserve and in urban centres. MKO, for example, asserts that between 2000 and 2008 there were 1,815 suicide attempts and 97 deaths in Manitoba (MKO Health, 2010, Northern Manitoba First Nations Regional Health Assessment and Analysis). This rate of suicide attempts within the North is both double the provincial average and higher than anywhere else in Manitoba.

SIMILARLY, THE HOMICIDE RATE FOR FIRST NATIONS PEOPLES IN MANITOBA IS THE HIGHEST IN THE COUNTRY, WITH 13.3 HOMICIDES PER 100,000 RESIDENTS (STATISTICS CANADA REPORTED).

9X Higher

The homicide rate among Aboriginal peoples in 2015 was nine times higher than that of non-aboriginal Manitobans[2].

In addition, to suicide attempts and homicide, self-inflicted injuries (cutting) represents a significant and prevalent heath concern among our young people. In 2012/2013 there were approximately 629 hospitalizations related to self-inflicted injury within the Manitoba region.

THIS REPRESENTS A RATE OF 56.6 SELF-INFLICTED IN HOSPITALIZATIONS PER 100,000 PEOPLE AGED 10 YEARS AND OLDER.

As a result, many of our communities are caught in a perpetual cycle of crisis, grief and trauma. This sense of trauma is compounded by the impacts of colonization and genocide that have disrupted Indigenous identities and play out in our communities through high rates of poverty, family breakdown, substance abuse and violence.

The high rates of suicide and homicide as well as the challenging socio-emotional contexts of families, is not a surprising social trend given current research focused on the influence of historical trauma on the psychological safety of First Nations peoples. Aguiar and Halseth (2015) for example, argue that "the trauma experienced as a result of the residential school experience has built upon trauma from earlier forms of injustices and oppression, and continues to be built upon by contemporary forms such that the trauma is cumulative, with oppression and abuse becoming internalized, leading to a sense of shame and hopelessness that is transmitted and built upon through the generations." (Aguiar and Halseth, 2015, pg. 7).

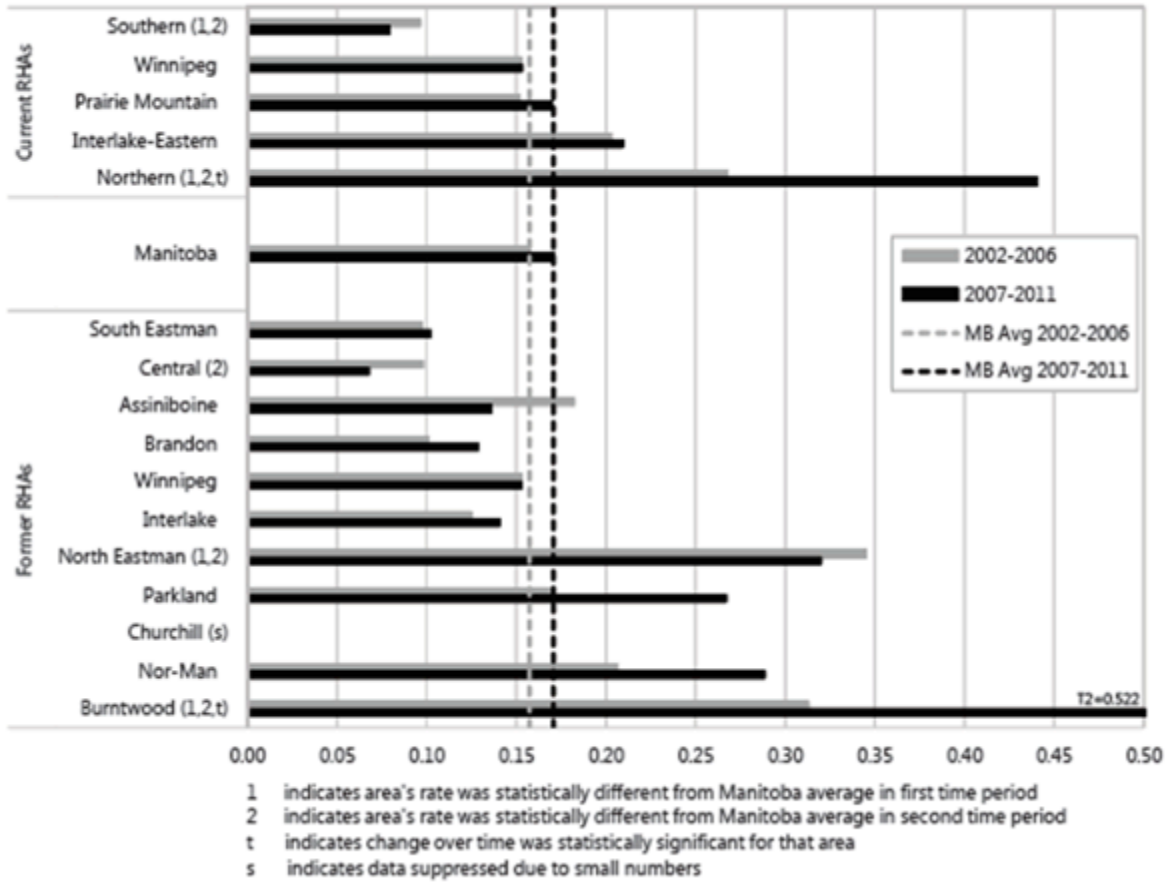
1 Throughout this report First Nation and Aboriginal people will be used interchangeably as some research use different terminology to describe the First Nation population.
2 Albeit

Further, the intergenerational transfer of trauma through families causes significant damage to the well-being of children. Wesley-Equimaux and Smolenski (2004) note that "The residue of unresolved, historic traumatic experiences and generational or unresolved grief is not only being passed from generation to generation, it is continuously being acted out and recreated in the Contemporary Aboriginal Culture." Consequently, many First Nation children and youth are growing up disconnected from their culture resulting in dysfunctional relationships complicated by a lack of supportive resources to help them cope. Often it is the inability to respond to complex stress and negative social conditions that results in addictive behaviours and the sense of helplessness and hopelessness, particularly among our young people. Similarly, trauma in First Nation communities is complex resulting from a worldview based on relationships and rationality. As a result, any death, whether it is by suicide, homicide, accidents, or natural causes are deeply felt and the emotional impacts affect the whole community.

3.2 Suicide Rates (By Regional Health Authority)

Figure 3.8.1: Suicide Rate by RHA, 2000-2004 and 2005-2009

Age- and sex-adjusted average annual rate of suicide per 1,000 residents aged 10+

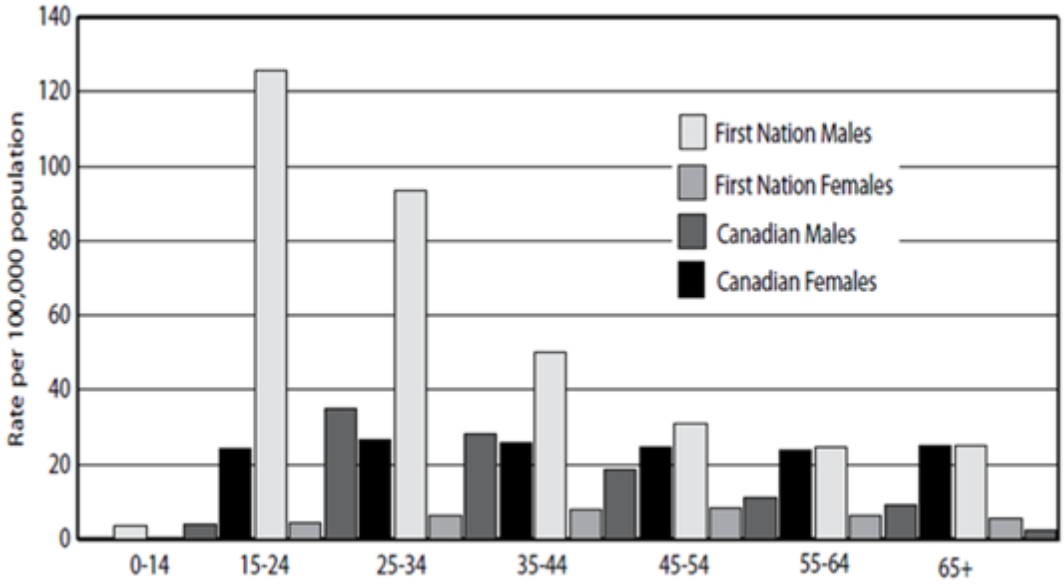


1 indicates area's rate was statistically different from Manitoba average in first time period
2 indicates area's rate was statistically different from Manitoba average in second time period
t indicates change over time was statistically significant for that area
s indicates data suppressed due to small numbers

(Source: MCHP published RHA 2013)

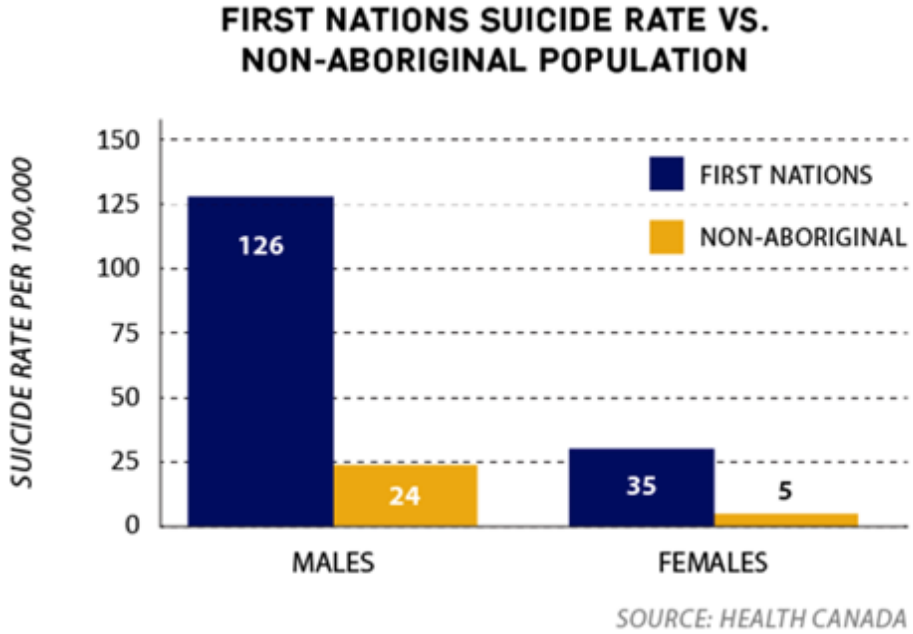
3.3 Suicide Rates (By Age Group)

Figure - Comparison **of Suicide Rates** by Age Group, First Nations and Canadian Population



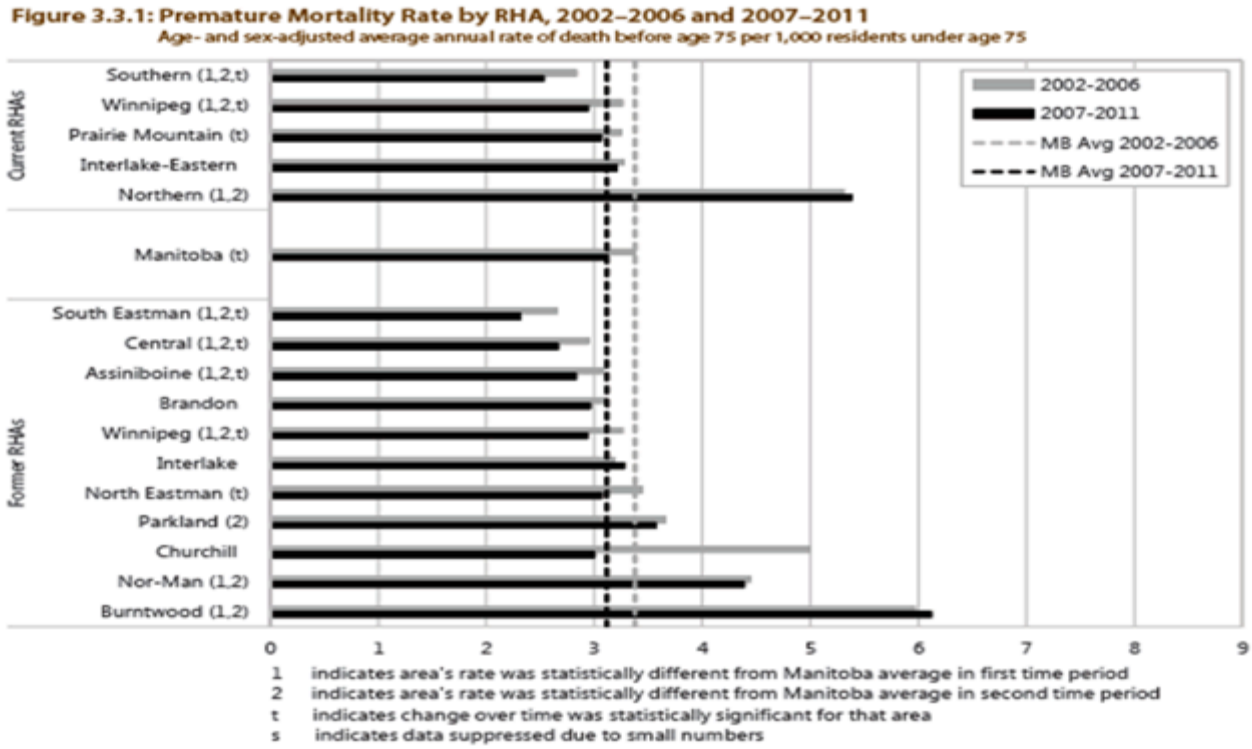
(Source: Statistics Canada 2012)

3.4 Suicide Rates (Comparison Aboriginal vs. Non-Aboriginal)



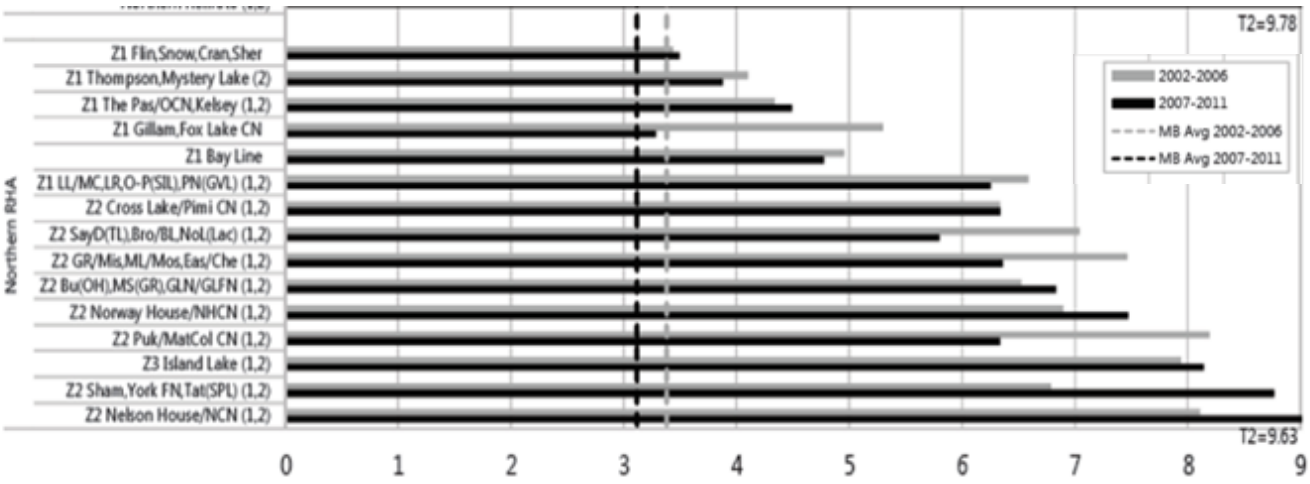
3.5 Suicide Rates (Premature Mortality Rate by RHA)

Figure**: Premature Mortality Rate** by RHAs in Manitoba 2002-2011



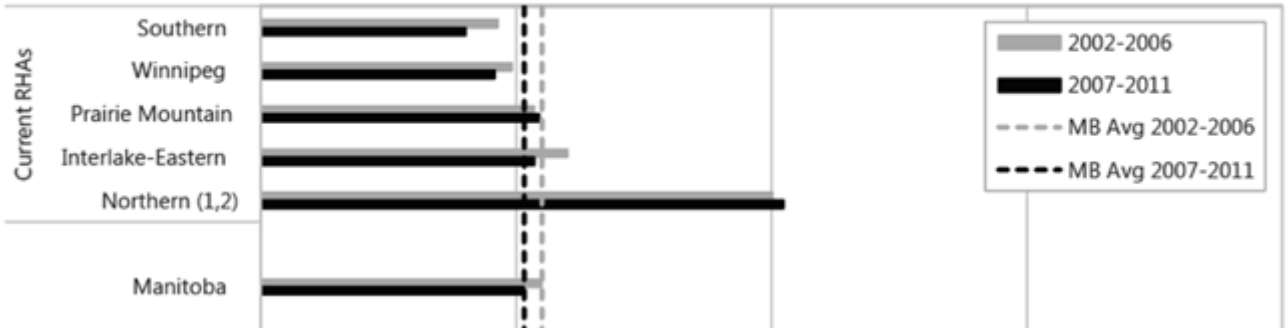
3.6 Suicide Rates (Premature Mortality Rate in Northern RHA by District)

Figure: **Premature Mortality Rate** in **Northern RHA by district, 2002–2006 and 2007–2011** Age- and sex-adjusted average annual rate of death before age 75 per 1,000 residents under age 75



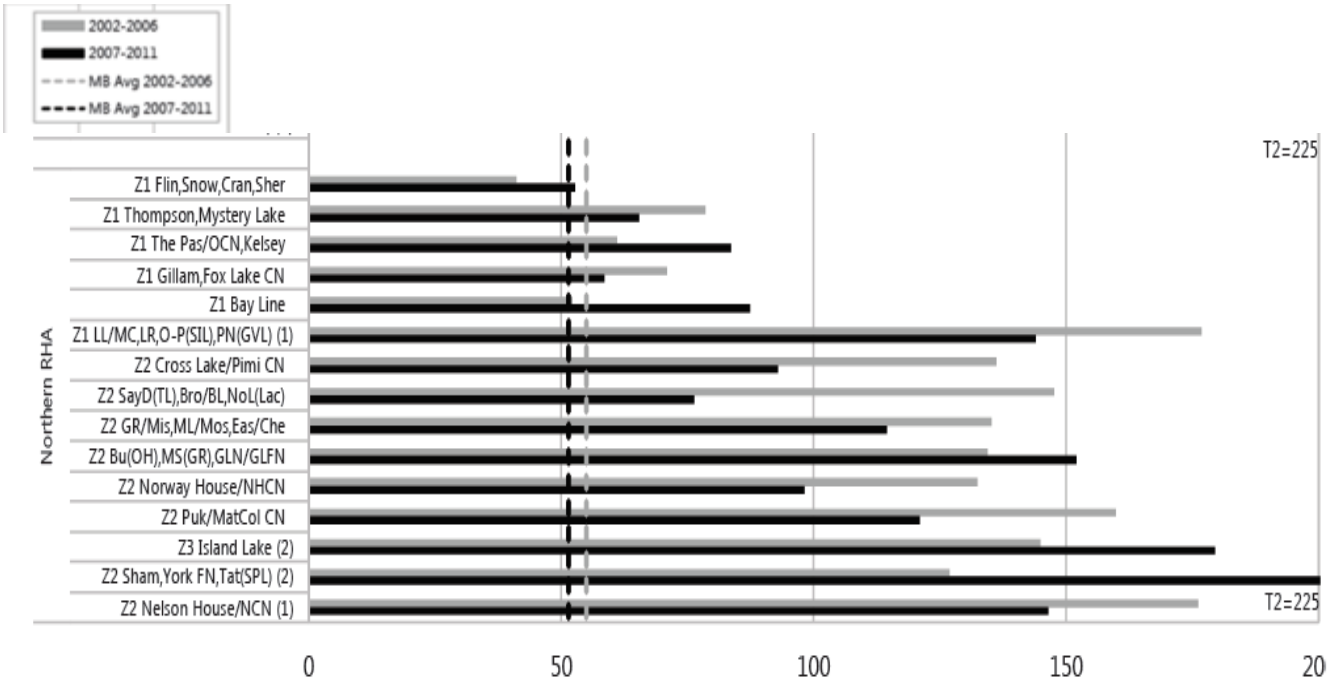
3.7 Potential Years Of Life Lost (By RHA)

Figure 3.7.1: Potential Years of Life Lost by RHA, 2002–2006 and 2007–2011
Age- and sex-adjusted average annual rate of PYLL per 1,000 residents aged 1-74



3.8 Potential Years Of Life Lost (By District)

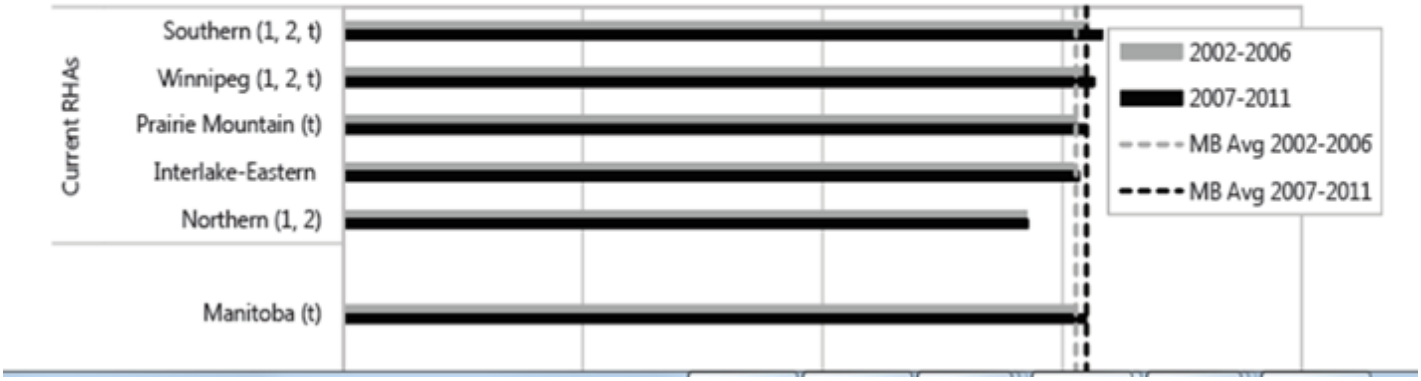
Potential Years of Life Lost by District, 2002–2006 and 2007–2011 Age- and sex-adjusted average annual rate of PYLL per 1,000 residents aged 1-74



3.9 Male Life Expectancy (By RHA)

Figure 3.5.1: Male Life Expectancy by RHA, 2002–2006 and 2007–2011

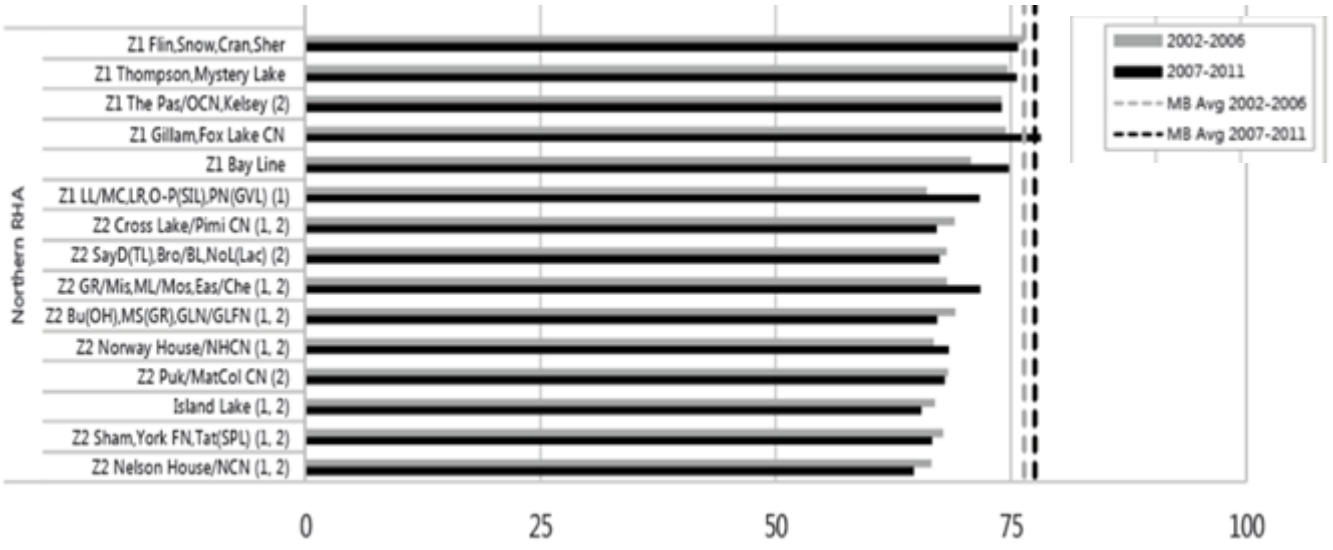
Life expectancy (at birth) in years



(Source: MCHP published RHA 2013)

3.10 Male Life Expectancy (By District)

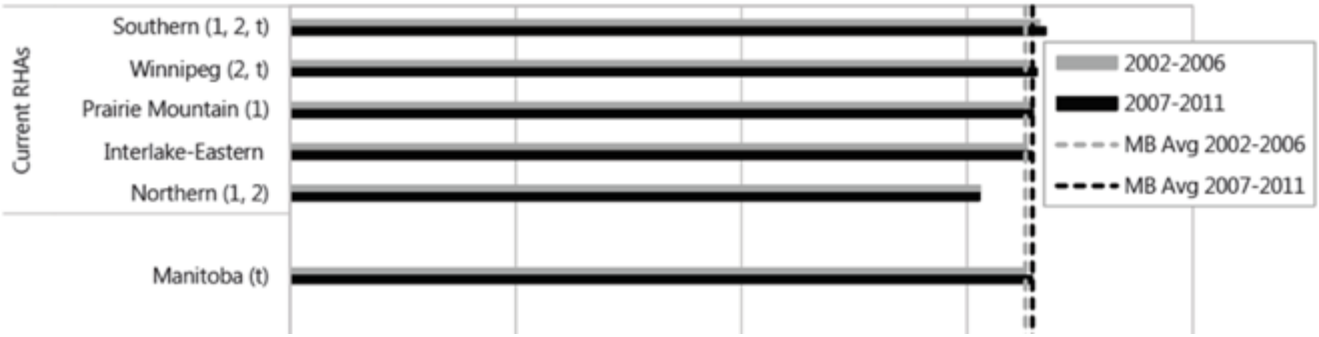
Figure 3.5.2 Male Life Expectancy in Northern RHA by District, 2002–2006 and 2007–2011



3.11 Female Life Expectancy (by RHA)

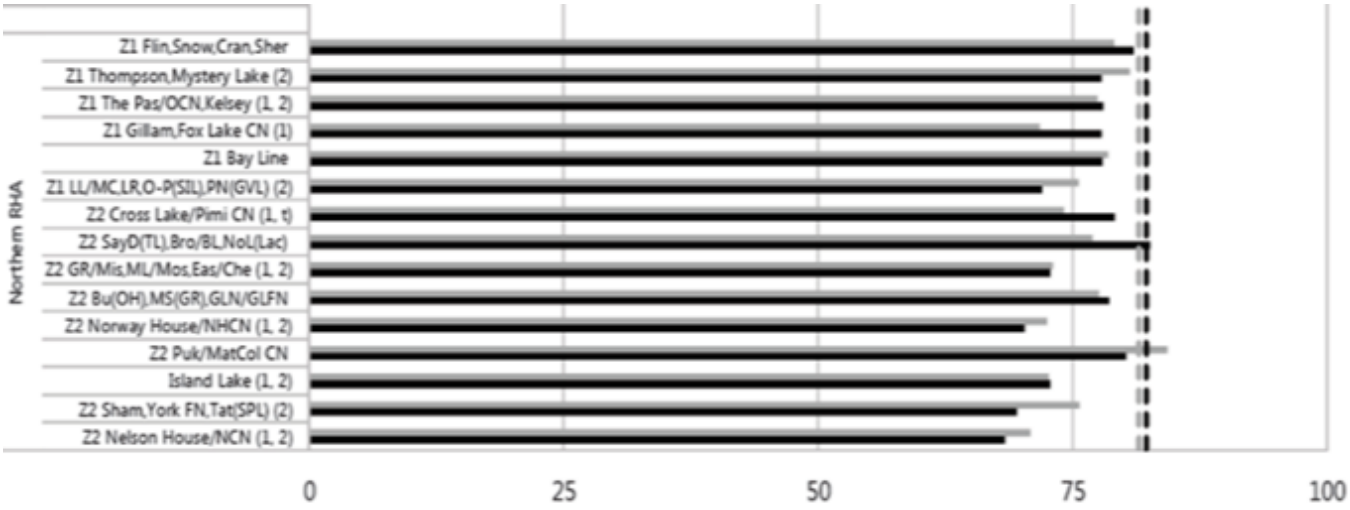
Figure 3.6.1: Female Life Expectancy by RHA, 2002–2006 and 2007–2011

Life expectancy (at birth) in years



3.12 Female Life Expectancy (by District)

Figure: Female Life Expectancy in Northern RHA by District, 2002–2006 and 2007-2011



3.13 Manitoba First Nation Population, Communities and RHAs

	First Nation	Tribal Council/Independents	Registered Population	Former RHAs	
1	Cross Lake	INDEPENDENT FIRST NATION	8,569	Burntwood	Northern RHA
2	Nisichawayasihk Cree Nation	INDEPENDENT FIRST NATION	5,120	Burntwood	
3	Norway House Cree Nation	INDEPENDENT FIRST NATION	8,064	Burntwood	
4	O-Pipon-Na-Piwin Cree Nation	INDEPENDENT FIRST NATION	1,660	Burntwood	
5	Garden Hill First Nations	ISLAND LAKE TRIBAL COUNCIL	4,712	Burntwood	
6	Red Sucker lake	ISLAND LAKE TRIBAL COUNCIL	1,103	Burntwood	
7	St. Theresa Point	ISLAND LAKE TRIBAL COUNCIL	4,214	Burntwood	
8	Wasagamack First Nation	ISLAND LAKE TRIBAL COUNCIL	2,162	Burntwood	
9	Barren Lands	KEEWATIN TRIBAL COUNCIL	1,153	Burntwood	
10	Bunibonibee Cree Nation	KEEWATIN TRIBAL COUNCIL	3,116	Burntwood	
11	Fox lake	KEEWATIN TRIBAL COUNCIL	1,251	Burntwood	
12	God's Lake First nation	KEEWATIN TRIBAL COUNCIL	2,752	Burntwood	
13	Manto Sipi Cree Nation	KEEWATIN TRIBAL COUNCIL	938	Burntwood	
14	Northlands	KEEWATIN TRIBAL COUNCIL	1,093	Burntwood	
15	Sayisis Dene First Nation	KEEWATIN TRIBAL COUNCIL	828	Burntwood	
16	Shamattawa First Nation	KEEWATIN TRIBAL COUNCIL	1,611	Burntwood	
17	Tataskweyak Cree Nation	KEEWATIN TRIBAL COUNCIL	3,867	Burntwood	
18	War Lake First nation	KEEWATIN TRIBAL COUNCIL	317	Burntwood	
19	York Factory First Nation	KEEWATIN TRIBAL COUNCIL	1,349	Burntwood	
	Total Burntwood Region		**53,879**		
20	Opaskwayask Cree Nation	INDEPENDENT FIRST NATION	5,990	Nor-Man	
21	Chemawawin Cree Nation	SWAMPY CREE TRIBAL COUNCIL	1,852	Nor-Man	
22	Marcel Colomb	SWAMPY CREE TRIBAL COUNCIL	430	Nor-Man	
23	Mathias Colomb	SWAMPY CREE TRIBAL COUNCIL	3,759	Nor-Man	
24	Misipawistik Cree Nation	SWAMPY CREE TRIBAL COUNCIL	2,018	Nor-Man	
25	Mosakahiken Cree Nation	SWAMPY CREE TRIBAL COUNCIL	2,229	Nor-Man	
	Total Norman Region		**16,278**		
	Total Northern Region		**70,157**		
20	Fort Alexander	INDEPENDENT FIRST NATION	7,851	North Eastman	Interlake-Eastern RHA
21	Berens River	S.E. RESOURCE DEV'T COUNCIL CORP	3,396	North Eastman	
22	Black River First Nation	S.E. RESOURCE DEV'T COUNCIL CORP	1,355	North Eastman	
23	Bloodvein	S.E. RESOURCE DEV'T COUNCIL CORP	1,806	North Eastman	
24	Brokenhead Ojibway Nation	S.E. RESOURCE DEV'T COUNCIL CORP	2,056	North Eastman	
25	Hollow Water	S.E. RESOURCE DEV'T COUNCIL CORP	1,967	North Eastman	
26	Little Grand Rapids	S.E. RESOURCE DEV'T COUNCIL CORP	1,653	North Eastman	
27	Pauingassi First Nation	S.E. RESOURCE DEV'T COUNCIL CORP	655	North Eastman	
28	Poplar River First Nation	S.E. RESOURCE DEV'T COUNCIL CORP	1,868	North Eastman	
	Total North Eastman		**22,607**		
42	Dauphin River	INTERLAKE RESERVES TRIBAL COUNCIL	374	Interlake	
43	Kinonjeoshtegon First Nation	INTERLAKE RESERVES TRIBAL COUNCIL	755	Interlake	
44	Lake Manitoba	INTERLAKE RESERVES TRIBAL COUNCIL	2,074	Interlake	
45	Little Saskatchewan	INTERLAKE RESERVES TRIBAL COUNCIL	1,246	Interlake	
46	Peguis	INTERLAKE RESERVES TRIBAL COUNCIL	10,099	Interlake	
47	Pinaymootang First Nation	INTERLAKE RESERVES TRIBAL COUNCIL	3,274	Interlake	
48	Fisher River	INDEPENDENT FIRST NATION	3,880	Interlake	
49	Lake St. Martin	INDEPENDENT FIRST NATION	2,693	Interlake	
	Total Interlake		**24,395**		
	Total Interlake Eastern		**47,002**		
35	Sapotaweyak Cree Nation	SWAMPY CREE TRIBAL COUNCIL	2,541	Parkland	Prairie Mountain RHA
36	Wuskwi Sipihk First Nation	SWAMPY CREE TRIBAL COUNCIL	634	Parkland	
37	Ebb and Flow	WEST REGION TRIBAL COUNCIL	3,136	Parkland	
38	O-Chi-Chak-Ko-Sipi First Nation	WEST REGION TRIBAL COUNCIL	1,126	Parkland	
39	Pine Creek	WEST REGION TRIBAL COUNCIL	3,587	Parkland	
40	Skownan First Nation	WEST REGION TRIBAL COUNCIL	1,509	Parkland	
41	Tootinaowaziibeeng Treaty Reserve	WEST REGION TRIBAL COUNCIL	1,466	Parkland	
	Total Parkland Region		**13,999**		
50	Birdtail Sioux	DAKOTA OJIBWAY TRIBAL COUNCIL INC	901	Assiniboine	
51	Waywayseecappo First Nation	DAKOTA OJIBWAY TRIBAL COUNCIL INC	2,732	Assiniboine	
52	Canupawakpa Dakota FN	INDEPENDENT FIRST NATION	683	Assiniboine	
53	Sioux Valley Dakota Nation	INDEPENDENT FIRST NATION	2,594	Assiniboine	
54	Gamblers	WEST REGION TRIBAL COUNCIL	269	Assiniboine	
55	Keeseekoowenin	WEST REGION TRIBAL COUNCIL	1,274	Assiniboine	
56	Rolling River	WEST REGION TRIBAL COUNCIL	1,079	Assiniboine	
	Totl Assinboine Region		**9,532**		
	Total Prairie Mountain Region		**23,531**		
57	Buffalo Point First Nation	INDEPENDENT FIRST NATION	132	South Eastman	Southern RHA
58	Dakota Plains	DAKOTA OJIBWAY TRIBAL COUNCIL INC	265	Central	
59	Dakota Tipi	DAKOTA OJIBWAY TRIBAL COUNCIL INC	403	Central	
60	Long Plains	DAKOTA OJIBWAY TRIBAL COUNCIL INC	4,404	Central	
61	Roseau River Asnishiabe First Nation Gov't	DAKOTA OJIBWAY TRIBAL COUNCIL INC	2,634	Central	
62	Sandy Bay	DAKOTA OJIBWAY TRIBAL COUNCIL INC	6,677	Central	
63	Swan Lake	DAKOTA OJIBWAY TRIBAL COUNCIL INC	1,413	Central	
	Total Southern Region		**15,928**		
	Total Manitoba First Nation		**156,750**		

Part 4:

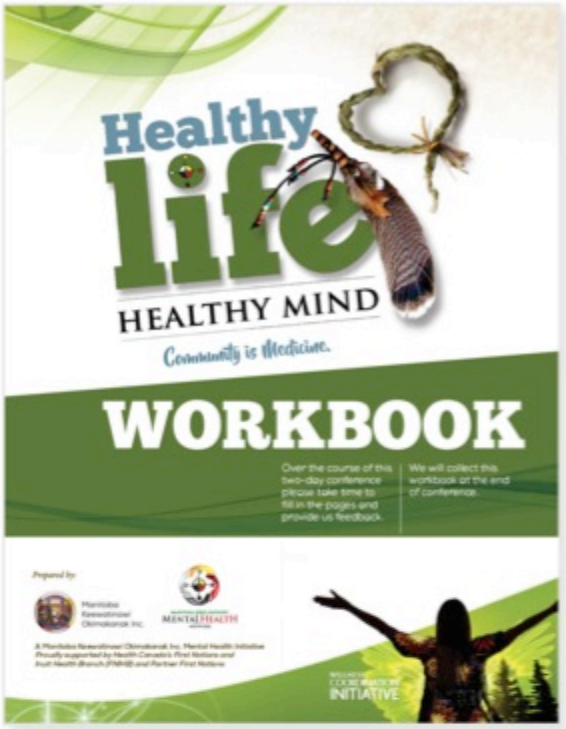
Manitoba Keewatinowi Okimakanak Mental Health Wellness Coordination Initiative

Appendices

4.1 What Participants Had to Say About the Conference?

- I really liked the workshop. It's interesting to come together as Nations to hear and listen to what services are provided in communities.
- I suggest you host at local communities in the MKO region, like CMA but First Nation Mental Wellness Association. Have community debriefs and adapt education and cultural training to have this taught in the provincial and federal curriculum.
- Thanks for having me here; I really enjoyed listening to those who are telling me I matter to all. I really do like entering this kind of stuff. Thank you for this, I loved it and enjoyed it.
- Understanding UNDRIP, TRC, and treaties. These subjects should be taught in our schools so our youth will know where they came from. After all they will be our future leaders.
- Thank you for the conference in health.
- Some of the presenters need to pick it up with info; dull presentation.
- I found this workshop helpful.
- The conference was an overall excellent experience. A lot of good information.
- I think communities should invite more youth to attend the next conference. The First Nations can provide travel and accommodation for the ones not covered by MKO. Ekosi.
- Keep up the work. Good job.
- This helped and made me think a lot. Thank you MKO!
- Make the questions a lot less complicated and provide better food.
- Thank you.
- Children in CFS or extension of care (they feel the same) should get a chance to be involved in their community. Send a group of urban youth to meet with youth in the community to create a buddy system; and they can have that outside bond and support through social media.
- This conference answered a lot of my thoughts and questions. It was fun.
- This was a great conference.
- Tobacco tax, no political will, and look at the big picture.
- Would suggest more gatherings with leadership and youth, and elders. Hold forums about wellness.
- The youth that represent each community should be a little older (early 20s) so they can relate to each community, and also has to be ongoing not only a couple years, it is very important.

4.1 Workbook Questionnaire



WHAT LOCAL RESOURCES SHOULD BE ON THE LOCAL CRISIS RESPONSE TEAM?

Training of local crisis response teams is imperative (Theme 1)

Interdisciplinary teams respecting cultural norms and values (Theme 2)

5

DOES YOUR COMMUNITY HAVE A LOCAL MENTAL HEALTH WELLNESS TEAM? WHO IS ON IT? IF NOT, WHO SHOULD BE ON YOUR MENTAL HEALTH WELLNESS TEAM?

WHAT TRAINING IS NEEDED FOR YOUR WORKERS IN YOUR COMMUNITY?

6

WHO SHOULD BE RECEIVING THE TRAINING IN CRISIS RESPONSE IN YOUR COMMUNITY?

7

HOW CAN TRUST BE BUILT WITH COMMUNITIES?

Relationships Matter (Theme 3)

Protocols, procedures and communication strategies need to be clearly delineated (Theme 4)

WHAT SUGGESTIONS OR RECOMMENDATIONS DO YOU HAVE FOR THE MKO MOBILE CRISIS RESPONSE TEAM TO ENSURE AN ONGOING RELATIONSHIP WITH FIRST NATION COMMUNITIES?

8


WHAT WOULD A COMMUNITY-BASED PROTOCOL ENTAIL IN RESPONDING TO CRISIS?
Self-Care is important (Theme 5)
An Environmental Scan of Community-Based Programs and Services is required to focus the work of the mental wellness teams (Theme 6)
HOW CAN MKO MOBILE CRISIS RESPONSE TEAM DEVELOP AND MAINTAIN SUPPORT FOR INDEPENDENT FIRST NATIONS?


WHAT KIND OF SUPPORTS (AFTERCARE) ARE NEEDED TO STOP ANOTHER CRISIS FROM HAPPENING?
Unanswered Questions and Key Challenges
WHAT DO YOU THINK IS PRIORITY WHEN IT COMES TO A CRISIS?


BESIDES THE THERAPIST AND THE PSYCHOLOGIST, WHAT OTHER RESOURCES WOULD YOU RECOMMEND?
HOW DO YOU KNOW IF A CRISIS HAS BEEN STABILIZED? WHAT DOES STABILIZED LOOK LIKE?


ADD ANY OTHER COMMENTS BELOW.

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Proactive solutions for our First Nations'
Mental Wellness crisis will
allow individuals
and communities to thrive and
have meaningful growth.

For more information and to provide
your input, please contact:

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MANITOBA FIRST NATIONS'
MENTAL HEALTH
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A Path to Mind, Spirit and Body Wellness

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