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SUPPLEMENT ARTICLE

WILEY

Invited Commentary: ACCESS Open Minds National Indigenous Council

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The ACCESS Open Minds (ACCESS OM) Indigenous Council was created in September 2017, connecting Indigenous leaders from within the ACCESS OM network. Elders, youth and site leads from Elsipogtog First Nation (New Brunswick), Eskasoni First Nation (Nova Scotia), Aschiikuwaadaauch (Mistissini, Quebec), Sturgeon Lake First Nation (Saskatchewan), Puvirnituq (Nunavik, Quebec) and Ulukhaktok (Inuvialuit Settlement Region, Northwest Territories) initiated the creation of this council, which meets to share knowledge and provide leadership on matters affecting or pertaining to Indigenous communities within the context of ACCESS OM.

The council discusses ways to implement the ACCESS OM research and evaluation protocol with and for Indigenous communities, ensuring that OCAP principles on data ownership are respected (https://fnigc.ca/ocapr.html). The council strives to create more opportunities for Indigenous researchers. Local youth and family engagement strategies are shared in order to empower and support the next generation through intergenerational teachings. The council is excited to be contributing to the supplement by providing our thoughts on the transformations happening at the seven ACCESS OM sites across Canada, that are included in the supplement.

In reading the summaries about the Indigenous ACCESS OM sites, it becomes clear that the best way to support the needs of Indigenous clientele is to use models that prize the integration of Indigenous voices, values and cultural perspectives into the healing and wellness journey. Often these are models that have been created by Indigenous people for Indigenous people.

It would be interesting to learn how non-Indigenous ACCESS OM sites, such as Réseau d'intervention de proximité auprès des jeunes de la rue (RIPAJ) located in a large city such as Montreal, or sites in Edmonton, another large city (that have significant proportions of Indigenous clientele in the mental health system), address the cultural diversity of their clientele. More specifically, what model(s) are being used to best support this clientele from an Indigenous perspective. Is there a concerted effort to hire Elders, Healers or other staff that have Indigenous knowledge or are able to speak an Indigenous language?

It appears that what has been omitted so far from many of the ACCESS OM non-Indigenous sites, is a description of the diversity of the youth and families that are being served and how their cultures, languages and values are addressed within the mental health context. How are sites addressing the existence of these cultural differences or are they simply not being addressed at all? It would have been interesting to hear if sites experience challenges in interweaving Western and Indigenous practices, values and ways of offering mental health care.

What is missing from many summaries is the Indigenous voice and reflections on diversity in general. However, this is of primary importance if the health care system, especially in the area of mental health, is to engage in best practices. Without a fundamental understanding of the clientele being served and without an ability to serve clients in their language, this raises questions about the efficacy of the system and the quality of the support being provided.

We would strongly suggest that any non-Indigenous site that has not yet contemplated how to incorporate Indigenous voices and cultural perspectives into their system of health care do so in a systematic way. We would also encourage non-Indigenous sites to collaborate with Indigenous communities and engage in knowledge sharing because much of the foundational work has already been done, many models already exist and it is just a matter of each site selecting the model that will best meet their clients' needs. And the best way of knowing what clients' wants and needs are, is to ask them and make them an integral part of their health care process. There seems much to be gained by adding the Indigenous perspective on health that are being used by Indigenous communities, but can these models be easily transferred and implemented into urban settings? If not, what adaptations are needed in order for clients, especially youth and their families, to be well supported?

We recommend that sites incorporate an overall history of their community, which would help deepen our understanding of positive and negative issues that each site is currently facing.

1 | CHATHAM-KENT, ONTARIO

Chatham-Kent site is well beyond the curve when it comes to transformation. Although the described challenges are legitimate and concerning, they are manageable and not extraordinary. Overall, ACCESS OM has enabled a conversation to take place to improve capacity among an existing network of service providers along with powerful voices of youth, family and friends and good community support.

Chatham-Kent does a lot for their site and community. This can be seen from reading about all of the different organizations that they collaborate/work with, educating them about mental health awareness, ACCESS OM and youth referrals. This includes school boards, home and community care, mental health and addictions nurses, addictions programs, and the list goes on.

2 | EDMONTON, ALBERTA

At this ACCESS OM site, the community mapping exercise helped in the identification of gaps in the mental health care system. This led to the opportunity to build partnerships and create multidisciplinary teams. ACCESS OM clinicians were hired and were allowed mobility to travel to see youth where they choose to be seen. The paper does not highlight very much youth and family engagement, which one could then assume to be low and of less influence, though this is hard to determine.

Edmonton is an example of a systems approach to change. This required working with and around union rules. Working within such a highly bureaucratic healthcare system which suggests that the chances of sustainability are excellent. This article gave the best in depth examples of the ACCESS OM five central pillar objectives.

3 | PÉNINSULE ACADIENNE, NEW BRUNSWICK

In this very rural community with many low income families, there is high need for mental health care among youth and demand for services for youth with unmet needs is high.

Community mapping was done with a focus on youth consultation. This had not been done before, and most services in this community are not youth friendly. Existing services often left youth more traumatized with high barriers accessing institutional, regulated and inflexible, disconnected services. A primary concern in the past with youth seemed to revolve around criminality. Could this be related to intergenerational poverty, diminished life prospects, family breakdown/instability and negative social behaviour?

ACCESS OM has helped to identify issues youth are concerned about. ACCESS OM staff now meets the individuals where they are at; for example, meeting a youth at the local coffee shop to complete an assessment or offering counselling sessions. It is amazing that they are able to provide that for the youth.

Questions remain about how youth access ACCESS OM services. How is ACCESS OM linked with existing provincial Integrated Service Delivery services for children and youth with mental health issues?

4 | RIPAJ YOUTH HOMELESS NETWORK, QUEBEC

This paper highlights the strong pre-existing 15 year relationship among service agencies with a common goal to improve services for street involved youth. RIPAJ is already a one door service and can deal with a wide range of needs for youth with some service centres able to provide similar services, that is, psychotherapy. This article allowed the reader to gain insight into what Montreal is doing to support homeless youth in regards to mental health and well-being; and provides ideas for other sites who want to help the homeless population within their community.

The most salient change occurred in youth and family engagement. Youth were primarily the consumers of services and played little role in planning them. This paper highlights that youth are more satisfied and feel empowered through their involvement with ACCESS OM. Including these youth voices in the paper rather than just second hand anecdotes would have been more powerful. ACCESS OM has provided an opportunity for agencies to enhance their current service model, increase service capacity and work towards greater youth and family inclusion—the ACCESS OM model seems to be most effective in agencies where there is already an existing service in place that is average to good.

5 | UNIVERSITY OF ALBERTA, ALBERTA

This ACCESS OM site features a high-density youth environment and specific cohort of youth, most under the age of 25 and academically

successful. However, this cohort experiences high levels of mental health struggles, anxiety, stress, depression and psychosis. The consultations and community mapping led to better communication between intra-university services as well as recognition of the need to work with off-campus services. Referral and service barriers were also identified.

Overall our impression is that ACCESS OM has been highly successful at this site as it seems to have transformed services. That said, this also corresponds to our view that similar ACCESS OM sites that are further along the youth mental health services continuum and a pre-existing movement towards a better service model, ensured the additional funding would be highly beneficial and transformative.

6 | ULUKHAKTOK, NORTHWEST TERRITORIES

In Ulukhaktok, local health services are primarily made up of non-Indigenous nurses flown up from the south which is common practice in Northern communities. Hiring an ACCESS OM clinician was not feasible for the hamlet and not in the best interests of local youth due to issues of trust and stigma. The community felt it was better to have a local person act in this role. As a result, they hired local lay health workers (LHW), renamed as ACCESS OM Youth Workers (AYW), who were trained by ACCESS OM as well as locally.

A LHW and AYW approach makes sense and was a logical decision. Mistissini, a First Nations community, that is another ACCESS OM site, implemented a similar approach many years before becoming an ACCESS OM site. Although this approach has worked quite well for a time and still used to some degree, it has gradually become less reliable over time. Employing local community members can burden individuals who may have their own domestic burdens to bear. Who helps them with vicarious trauma? Also, some locals may prefer to discuss their family and personal issues with trained professionals who are not community members due to gossip concerns; a localized approach can be fraught with issues of confidentiality and quality assurance and may drop adherence to professional ethics. That said, we should not throw the baby out with the bath water; on-going and regular training, support and professional guidance on adhering to ethical guidelines about confidentiality and disclosure can strengthen this local approach.

The need for qualitative research is very well highlighted in this paper. Many standardized questionnaires are not validated for Northern and Indigenous populations, and are problematic at best. This is an important opportunity for the ACCESS OM research advisory committee to step up its game on qualitative research efforts and come up with a sound approach. We wholeheartedly agree!

It was great to read about all the different programs that Ulukhaktok has to offer, but we wish there was more in depth descriptions of the cultural programs or cultural aspects of the community.

7 | ESKASONI FIRST NATION, NOVA SCOTIA

Community suicide tragedies were an early impetus for transformation of services in this community and laid the groundwork long before the implementation of ACCESS OM. Eskasoni developed a 'Fish Net Model' to serve the community, developed by the community for the community which consisted of "casting a wide net across the community in a variety of ways and for an assortment of interventions" (Hutt-MacLeod et al., 2019). Eskasoni's model of care was already in line with the ACCESS OM objectives before they became a site. ACCESS OM was able to enhance existing services. Current services include respect for the Indigenous culture within the community.

When implementing the pan-Canadian ACCESS OM project within the community of Eskasoni, it is great to see that they adapted the project with regards to Mi'kmaq traditions, values, learnings, language and historical contexts. Because of cultural and language barriers, the community of Eskasoni was/is respectful in adapting changes that would be suitable when working with First Nation's youth and their families.

It is unclear if Eskasoni will actually be able to sustain the ACCESS OM model. They appear to be caught within the same bureaucratic funding trap that faces most First Nations across Canada: limited funding from federal agencies responsible for funding First Nations and Inuit communities for mental health services (i.e., Indigenous Services Canada [formerly Indigenous and Northern Affairs Canada] and the Non-Insured Health Benefits Program for First Nations and Inuit).

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