HSIF Mental Health and Addictions Project

Project Management Team (PMT) Meeting

September 12, 2014
9:00 a.m. – 4:00 p.m.
Hilton Garden Inn, 17610 Stony Plain Road, Edmonton, AB

MINUTES

Attendance:

Gail Lightning, Treaty 6 PMT Rep
Thurman Littlelight, Treaty 7 PMT Rep
Janice Willier, Treaty 8 PMT & BHC Rep
Marty Landrie, AHS Rep (North)
Patty Shade, MH&A Subcommittee
Anita Makokis, T6IF
Shona GreyBear, T8IF
Linda Frost, Treaty 7 PMT Rep
Beverly Ward, Treaty 8 PMT Rep
Fiona Hossack, FNIHB Rep
Nicole Eshkakogan, AHS (South)
Justin Wong, MHAP Evaluator
Ann Gladue-Buffalo, T7IF
Janice Chalifoux, MHAP Coordinator

Guests:

Richard Sampson, FAST Coordinator
Rupert Arcand, Alexander MHA Project
Sandra Harris (via Teleconference)
Linda Borley, Alexander MHA Project
Julie Morrison, FAST Presenter (via Teleconference)

Observers:

James Wai, Aboriginal MH Coordinator, AHS
Toby Heavy Runner, Kainai Wellness
Stan Grier, Crisis Intervention Coordinator (AKHS)

Agenda Item		Discussion	Action
1.	**Welcome and Opening Prayer**	Thurman Littlelight will chair; Fiona Hossack is asked to share co-chair duties on behalf of FNIHB.	**Complete.**
2.	**Roundtable Introductions**	Individual introductions provided around the table.	**Complete.**
3.	**Review and Approval of Meeting Agenda**	*Motion was made to accept today's agenda with amendments – added on Detox and Siksika (psychiatrist) discussion items.*	*Mover to Accept: Linda F* *Seconded by: Marty L* **All in Favour. Carried.**
4.	**Acceptance of Previous Meeting Minutes**	Discussion for approval of July 18, 2014 PMT Minutes; *meeting document approved via email ratification process.*	*Mover to Accept: Coreen E* *Seconded by: Marty L* **All in Favour. Carried.**

5.	MHA Project Status	Discussion	Action
5. a)	**MHAP Process Evaluation and Systemic Surveys Update – Project Evaluator** **AHS Survey**	• An information package was distributed containing the draft AHS, FNIHB and Process Evaluation survey questions. • Evaluator has been working closely with Doug Vincent from AHS; Doug is assisting with the survey launch and met with the survey team and is converting to their online system. • Need to clarify OCAP™ concerns regarding the AHS survey; does not need to apply if info stays internal; since outside source is involved, to what extent will OCAP™ apply? • Proof of concept next; identify AHS service orgs around pilot communities; send survey to a few people to test; after proof of concept, roll out the survey to managers of AHS facilities to forward to personnel interacting with FNs the most. • After survey, AHS staff will have an option to participate in a focus group to decide how they will organize to follow up. • Point of clarity regarding AHS Aboriginal Health Program – they do not actually deliver services. • Survey benefit to First Nations - AHS and FNIHB to identify what services have been denied or not provided; use as evidence that there is a gap in service; can reconcile with Zone and department they work in. • Use anonymous identifiers in the report; some have 3 levels of service but First Nations themselves don't have data that provides or tracks that information. • FNs with OCAP™ own the information, and if they know who AHS is servicing, it's a benefit to the FN; can use a certain code so that FNs are privy only to what is particular to them. • To come up with a strategy, need to know where the gaps are; have to know what is happening and what is not. • Other considerations: split database for analysis; this table cannot store information indefinitely; survey can inform AHS internally about how they are responding to FN requests.	**Evaluator will ask AHS to hold off on rolling out the proof of concept until OCAP™ concerns are addressed.** **Evaluator to add "To What Extent Has AHS Supported Your Efforts To Work Better With Aboriginal People?" and "Was the AHS Aboriginal Health Program Consulted?" to Question G, page 4 on survey.** **PC will meet with AFNIGC next week to discuss OCAP™ concerns and update the PMT by late next week on meeting outcomes.** **Additional issues can be sent to the PC for discussion with AFNIGC.** **Additional comments or questions on the survey can be sent to Evaluator.**

5.	MHA Project Status	Discussion	Action
5. a)	**Surveys** *(continued)* **FNIHB Survey** **MHAP Process Evaluation Survey**	• FNIHB survey is different because expectation is they will provide services. • Information to be gathered here include: If a FN called for service and FNIHB cannot provide it, what are the internal processes before denial goes out; does FNIHB have a mechanism to liaise with AHS; if a request is not accepted what are the follow-up systems; what is the logging system? • This survey is focused on a process evaluation to get an idea of the MHA project process and its effectiveness thus far. • Questions for PMT members can be done through interviews or small focus groups; an interview schedule is available. • To provide a summary report by October 31st, the interviews would have to be completed by September 30, 2014.	**Evaluator to include "Would you contact AHS?" on Question 6(d) of the survey.** **PMT members were asked to schedule an interview with the Evaluator for the survey as soon as possible.**
5. b)	**Project Coordinator Report**	• The PC Report is provided in the meeting packages. • Would like a Motion to approve the Financial Report of July 18, 2014, as was presented. • Due to time constraints, the PMT agreed they would review the Project Coordinator's Report later and email the PC with any follow up questions.	*Mover to accept: Linda F* *Seconded by: Marty L* **All in favor. Carried.** **PMT to review PC Report and provide feedback.**
5. c)	**Financial Update**	• BHC provided an updated financial report for review. • IFs are all on board; seeking a fulltime admin assistant. • Funding priorities are to support current community projects, regional activities, activities to address project gaps and lastly to look at new projects if any surplus available. • Previously agreed to provide additional $25,000/community but what should timeline be? First $25,000 rolled out fast but later than anticipated; affected project deliverables. • Project reporting requirements - BHC asked existing projects to report on what they have spent the original $25K on; new funding agreements will include reporting requirements.	

5.	MHA Project Status	Discussion	Action
5. c)	**Financial Update** *(continued)*	• BHC proposed portioning the funds, rather than allocating the full amount; better to cash manage on both sides. • During the project review process, it was determined that all but one project has spent within HSIF guidelines. • Was communicated to projects over the summer during project reviews that we would try to wrap up community activities by end of November; this is not possible as not all projects have provided updated workplans; availability and capacity seem to be issues; would like to give a deadline for them to complete and submit revised workplans. • BHC would like financials from the last $25K, but also need revised workplans and new budgets to coordinate new agreements – **September 30th** deadline approved for communities to submit required docs; PC to follow up. • Approvals for workplans have to go through PMT; can do this via email; after approval, BHC can do up new agreements. • Still waiting on Siksika & Paul if they will be continuing. • Retroactive reporting - it was discussed and agreed that original funding conditions did not specify financial reporting and workplan progress reporting activities. • BHC responded that money rolled out quickly; was not known at the time of original rollout that there would be more funds; as Contribution Agreement holder, they must ensure checks and balances; projects did previously agree to spend within HSIF guidelines but this was not monitored; these findings will be reflected in the Project Evaluation. • It was stated that exceptions should be made; is there any flexibility, can we do more? Response is we have to ensure to stay within HSIF guidelines on funding and activities. • Stoney and TCV have expressed an interest in accessing MHA funds; follow up required if surplus becomes available.	*Moved by Nicole E to*: • *Support existing MHA community projects with extended timelines, provided a financial report on the original $25,000 is received by BHC, along with collaboratively revised workplans and budgets, by September 30th;* • *Allocate $6250 per month for four months starting October 2014 (for a total of $25,000) to interested community projects with approved workplans;* • *Enact a January 30th deadline for community projects to complete funded activities and provide a final project report;* • *Include financial and project reporting requirements, as well as a requirement to participate in community project evaluation activities before the end of February 2015, in new funding agreements.* *Seconded by: Fiona H* **All in favor. Carried.** *Moved to accept Financial Report as presented: Nicole E* *Seconded by: Fiona H* **All in favor. Carried.**

6.	Project Governance	Discussion	Action
6. a)	**Alberta Health PMT Representation**	• This meeting date conflicted with prior commitments for the most recently appointed Alberta Health rep, Kesa Shakize. • Was shared that Trish Hansen is the new director for AH.	**The PC will update the new AH rep.**
7.	**Strengthening Project Connections/Exploring Partnership Development**	**Discussion**	**Action**
7. a)	**FAST- First Nation Action & Support Team** *(PowerPoint presentation and discussion summary attached)*	• The PC provided background on the reason why FAST was here; different organizations will be invited to PMT meetings to share information about best practices for MHA. • Richard Sampson, FAST Coordinator, was introduced to the table; he travelled from BC to make the presentation; Julie Morrison and Sandra Harris also took part in the presentation via teleconference. • FAST is a good support program for community members; it's a model that comes from the community, building on strengths for dealing with crisis and using our own cultures to support each other; this requires hard work and compassion. • The FAST members already have and/or will receive training in suicide awareness, suicide intervention, grief and loss, community mobilization, crisis response, self-care, critical incident stress management, trauma training and debriefing. • In the beginning, focus was on suicide; there were 8 suicide completions within a short period of time in Gitxsan when Leaders got together; average of 3 attempts per week. • Mission Statement: Give knowledge to community on how to get rid of suicide; FAST is modelled after ASCIRT & refined. • First Nations aged 15-35 are 3 times more likely to commit suicide if they live on reserve just because of where they live; doesn't have to be like this even though that's how it is now. • They had to shift mind focus from what it was to what it could be; community had enough; saw FNs as being under attack.	

7.	Strengthening Project Connections/Exploring Partnership Development	Discussion	Action
7. a)	**FAST- First Nation Action & Support Team** *(continued)* *(PowerPoint presentation and discussion summary attached)*	• The team started with 14 communities that decided to work together; team selection occurred with money from FNIHB in 2006; now funded by the FNs Health Authority (NAYSPS). • All Leaders and community members support this program; Health Directors were the working group; team consists of Elders, adults and young people; volunteers got training (train-the-trainer) to deal with suicide from Dr. Darien Thira. • The power of the program comes from the volunteers; they have experience with suicide; stringent interview process to make sure volunteers were healthy enough to do the work. • The team follows protocol identified by each community to go in and provide services; FAST volunteers in the community keep in contact with individuals in the community. • When they started out, team was doing interventions but they changed this to train people in each community for interventions (RCMP or others); FAST team now does post-intervention and prevention activities. • FAST activities include: training communities for crisis response and intervention; debriefings; workshops for self-esteem, peer mentoring and grief & loss; youth leadership and life skills programs; and self-care for team members. • Communities need to look at building self-esteem; majority of FAST callouts respond to individuals under the influence. • **Community mobilization is key**, and communities can start by looking at suicide completions as a lesson – why did this happen? What can we do? What can we learn? What is this person trying to teach us? • Overall, people need to be concerned to make a difference; FAST is about community serving the community, where they provide the resources and support.	**PC will provide a copy of the FAST presentation to all in attendance.** **PC will provide a more detailed summary of this presentation for sharing.**

7.	Strengthening Project Connections/Exploring Partnership Development	Discussion	Action
7. b)	**MHA Subcommittee Update – Patty Shade**	• Patty Shade provided an update of MH&A Subcommittee activities and status; Patty is PMT link to the subcommittee. • Subcommittee had a 2-day meeting; looked at the treatment centre outcome study; study was to evaluate programming, resources and processes; look at branding/changing terms (relapse/recidivism has been renamed). • Priority areas and budgeting were discussed at the meeting. • Priorities include modernization of the NNADAP program (update manual); explore where to get funds for detox – this is also a national NNADAP board issue; priority was detox for operational planning; seek support for the development of culturally-appropriate parenting programs; how to use TeleMental Health more; front-line worker training and healing opportunities (House of Healing); youth programs. • IRS will be coordinated through Region; Region has hired an IRS Coordinator; Gail and Coreen are following up. • Mental Wellness Teams: trying to put away funds for these teams in each treaty area. • FASD program is under Wellness in Standoff. • No accredited training for IRS workers; need something in place when this winds down; questions about debriefing; no time to talk about Mental Wellness Continuum Framework. • Drug Utilization Prevention Program (DUPP) regarding prescription drug misuse; Sue Howard leading; exploring on-line training for NNADAP and frontline workers; Sue is also leading the In-Community Treatment Review for NNADAP. • Since the renovation of the treatment centre in Beaver Lake, there's no family-oriented treatment program/centre funded through NNADAP; only program available for this is in Round Lake, BC, which poses a big concern for Alberta.	**PC to see where the MHAP can support or implement a detox activity.** **Explore participation of MH&A Subcommittee members in a focus group for MHAP service mapping.**

7.	**Strengthening Project Connections/Exploring Partnership Development**	**Discussion**	**Action**
7. c)	**MHA Community Mapping Framework**	Introduction and discussion of MHA Priority Framework development process and related documents/templates.	**Tabled to next PMT meeting.**
8.	**Community Projects**	**Discussion**	**Action**
8. a)	**Alexander Community Project Presentation**	• Alexander MHA project team members were in attendance to provide an update on their community project in Treaty 6; the table welcomed Linda Borle and Rupert Arcand. • The goal of the Alexander Community Project is to develop a culturally appropriate FASD toolkit – the 'Kind Heart Project'. • A cross ministry approach looked at the program to assist with young people and adults; there are community members, Elder and agency people involved in identifying priorities; a lot of children and youth are involved with the law; hired a mentor to work with youth in the community. • Not just dealing with FASD but complex needs; received feedback on other programs, these were not working. • Wanted to look at a culturally sensitive way of talking about FASD and use the project funds in a community-based approach; use protocols, respect and sensitivity. • Started with ceremony because this was requested; a team from the U of A was part of the ceremony; initiated work with Justice and Mental Health. • From meetings, it was reiterated to honour and respect the protocol of the community; have conversations with people who wanted to help and give suggestions to move forward. • Elders felt that meetings with youth were important to start talking about sensitive topics; targeted Elders will look at what is developed and determine if it will work for them. • Rupert Arcand works with kids involved with law; conditions are hard to interpret for youth; contacted the FASD Network.	

8.	Community Projects	Discussion	Action
8. a)	**Alexander Community Project Presentation** *(continued)*	• Working at the community level was not easy; language and processes they used did not work at community level. • They honoured our ways; Elders' groups were part of the Network presentation. • There's always implied blame on the mother for FASD; a challenge was how to get the point across about functions of the brain without using scientific or technical language. • Other challenges included overcoming jurisdiction and helping the ones that burned bridges with family and services – who do you connect with and how do you connect them; there's apprehension from those diagnosed with FASD. • Their project recognizes and supports conversations with Children's Services and working with the Courts to develop protocol for clients once it's recognized they are FASD, so they can be linked with the appropriate services needed.	
8. b)	**Treaty 6 Community Projects Summary Report**	The T6 Integration Facilitator will provide an update on other community projects in Treaty 6.	**Tabled to next PMT meeting.**
8. c)	**Treaty 7 Community Projects Summary Report**	• The T7 Integration Facilitator provided an update on the Siksika community project in Treaty 7. • Met with the project team on August 27th; BHC rep attended; PC participated via teleconference; met to resolve issues with project expenses and to discuss project continuation. • New timelines might be an option to them; it's a community decision; still waiting to confirm. • It was clarified again that funding was not for capacity or administrative fees but for meeting and coordination costs. • Research for their project revealed a program developed by Saint Elizabeth; not just for Aboriginal Health staff but all staff across the board; very specific for Aboriginal health; it's a basic tool (Aboriginal Awareness Strategy) to be reflective of community; plan to work more closely with FNIHB.	**Piikani Project Update tabled to next PMT meeting.**

8.	Community Projects	Discussion	Action
8. c)	**Treaty 7 Community Projects Summary Report - Siksika Access to Psychiatrist** *(agenda addition)*	• Another discussion item brought forward for PMT direction was Siksika access to a psychiatrist. • Claresholm Addictions & Mental Health informed Siksika clients would need a psychiatric assessment to get into treatment for both addictions and mental health together. • Mental health assessments can be done by a social worker, nurse or psychologist. • A Mental Illness Assessment is a formalized tool; can identify if the clinic can provide those services. • Psychiatrist comes into play if the individual has a concurrent disorder with the mental illness. • AHS clarified that the formal process is to go to a clinic or hospital for admission to Claresholm. • Need to have a referral from a doctor for TelePsychiatry; if not a nurse practitioner can refer; whichever psychiatrist is available will provide the service.	
8. d)	**Treaty 8 Community Project Summary Report**	The T8 Integration Facilitator will provide an update on the T8 community project.	**Tabled to next PMT meeting.**
9.	**Moving Forward**		
9. a)	**Roundtable Wrap Up**	Participants shared their meeting experience and thoughts.	
9. b)	**Next Meeting Date**	Next PMT meeting is scheduled for November 13, 2014.	
10.	**Closing Prayer**	A closing prayer was not provided.	