

## **Part 1: Program Outlines**

The following section outlines three programs which we believe are excellent examples of mental health promotion in practice:

- Inclusion in Community, CMHA National Office, Toronto
- Helping Skills, CMHA Newfoundland and Labrador Division
- Seniors' Medicine Wheel, Portage Aboriginal Friendship Centre, Manitoba.

The programs cover a wide variety of mental health promotion issues and are relevant to many different individuals and groups in the communities where they are being implemented. Each initiative is unique - reflecting the reality of the community where it took place.

These particular programs were selected for several reasons. Each project incorporates many of the fundamental principles of mental health promotion -- capacity building, meaningful participation, partnerships, cultural sensitivity, social support, and a sense of the interconnectedness among different sectors of the community.

Additionally, while the programs originate from different sources, they all involve local people in a process that is essentially controlled by them, and responds to the resources and needs of their communities. The objectives of each project focus explicitly on improving people's mental health, using strategies selected by community members.

We've included different types of projects to illustrate that mental health promotion applies not only to the general population, but also to specific groups within that population. You will therefore find one project that responds specifically to the concerns of people with mental illness, one that is relevant to the generic population, and one that focuses on a particular population group.

This section introduces the projects briefly and presents an overview of the background, goal, objectives, process and partners for each one. In the chapters that follow, we take a closer look at how the projects were implemented and we provide tips and tools to help you bring mental health promotion to life in your own community.

### **Inclusion In Community**

#### **Canadian Mental Health Association, National Office, Toronto, Ontario**

##### **Background**

People living in communities across Canada are increasingly finding that they can't rely on the government or the service system to adequately address all of their health and social needs. Instead, people are learning to draw on their own capacities to provide support to one another, and are strengthening the human connections within their communities. The Inclusion in Community project is based on enhancing this awareness of mutual responsibility among ordinary citizens, and building on people's interdependence and sense of community.

The project involved five CMHA Branches across Ontario<sup>2</sup> supporting their communities to find new collaborative approaches for addressing the needs of people with mental illness. Each site brought consumers<sup>3</sup>, families, and generic community groups together to plan and implement a

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<sup>2</sup> The Inclusion in Community project also had a national component, which took place in three sites across Canada over a period of nine months. We chose to include information only from the Ontario-based sites here because, given the longer timeline of their component of project, they were able to implement the project objectives most completely.

<sup>3</sup> See glossary.

strategy to shift the focus from the exclusive reliance on mental health services to promoting the mental health of people in the community with serious mental health problems.

This shift in focus involved all sectors of the community -- from people with mental illness learning to become less dependent on services and more involved in community life, and community members acting as guides for people with mental illness, to health professionals working collaboratively with other sectors of the community to improve the quality of life for people with mental illness.

By developing collaborative partnerships with a wide range of community members and organizations, the Inclusion project created new and innovative relationships that would help to open up community life to consumers/survivors.

“Isolation from community life is the worst disability.”  
-John McKnight, 1990

Conceptual work for the Inclusion in Community project was accomplished largely by the CMHA's National Mental Health Services Work Group<sup>4</sup> through its work on [New Framework for Support](#). This policy document (which guides CMHA's thinking about supports for people with mental illness) promotes full community integration of people with mental illness through the mobilization of a range of formal and informal supports in the community. The message of the Framework is that informal supports such as service clubs and recreation facilities are resources for people with mental illness, which can enhance or, in some cases, even replace formal mental health services.

## Summary

Inclusion in Community involved five communities in promoting the inclusion of people with mental illness in the community. Consumers and other community partners joined together to find ways to address the mental health needs of community members with mental illness.

The project was co-ordinated through the CMHA's National office, funded by Ontario's Trillium Foundation, and implemented in five selected communities through local CMHA Branch offices. The process of selecting the sites involved several steps. CMHA Branches that wanted to participate demonstrated their interest and ability to carry out the project, and provided a confirmation of interest from potential community partners.

Sites were selected by the national steering committee with a view to achieving both balance and diversity among the communities represented. The sites included a variety of different communities in Ontario: a mix of urban and rural, francophone, anglophone and multilingual speakers. The project brought together citizens from many cultural backgrounds, creating new links between Aboriginal and non-Aboriginal Canadians, and strengthening links between a diversity of other groups.

The project's activities put Framework principles into practice at the local level by engaging new partners in the community process. Rather than turning to service providers to address the issues of people with mental illness, the communities that participated drew upon the resources of consumers themselves, their families and friends, generic community groups such as churches and service clubs, and other community members such as employers, landlords and businesspeople.

## Goal

The goal of the Inclusion project was:

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<sup>4</sup> The Inclusion project was steered by this Work Group, which has been involved in Framework development and promotion since 1983. Membership in the group includes consumers, family members and service providers.

- to shift the focus of selected CMHA Branches from a formal service delivery approach to a mental health promotion approach.

### **Objectives**

The objectives of the project were:

- to promote at least three new partnerships among consumers, families, local decision-makers, CMHA Branches, and the broader community;
- to implement strategies in five different sites which promote integration into the natural community
- to disseminate the results and learnings of the project throughout the CMHA infrastructure and to other groups concerned with mental health.

### **Process**

The challenge for the inclusion sites was to make community organizations and resources, such as recreation centres and service clubs, more accessible to consumer/survivors. The approach was to bring together a range of partners in a community to work alongside the usual mental health stakeholders -- consumers, family members and service providers. Given this challenge, and building upon work that was already being done in the CMHA Branches, project staff, community members, and volunteers worked together to choose and implement their sites' individual goals and strategies.

In the spirit of a true community development project, the focus and strategy selected in each site reflected the reality of that community, and its size, economy, population, facilities, resources, and history. The distinct strategies selected by the various sites were:

- increasing access to leisure and recreation services (Waterloo);
- community participatory theatre (Forest);
- increasing employment supports (Timmins);
- peer advocacy and expanding volunteer opportunities in generic community agencies (Cornwall);
- connecting people coming out of hospital with community supports and services to promote their recovery (Ottawa).

The process of moving from a service delivery framework to a community process model was neither smooth nor uneventful. Each of the sites had a different starting point and experienced different challenges in making the transition. As the participants themselves noted at the final meeting of all the sites, inclusion is not finished with the end of these specific projects -- there is always room to make our communities more welcoming and more diverse.

### **Partners**

The Inclusion in Community project was designed to develop partnerships in the sites were developed among consumer/survivors, families, CMHA staff, and community agencies. One of the primary goals of these partnerships was to encourage those groups not normally involved with mental health issues, like local citizen's associations clubs, to be more proactive in involving and welcoming people with mental health problems.

Local partners were engaged through planning meetings held in each of the sites. At the initial meetings, the concepts and goals of the project were introduced to a wide variety of community members, in order to discuss potential directions for the project, as well as to mobilize community support and resources.

The sites used many personal and professional connections in order to achieve their goals. Some of the community partners who became involved in the project include: an Aboriginal women's support centre, several community colleges, a municipal housing authority, the Navy Veterans, the Presbyterian Church, and several local and federal political leaders.

### **Sources:**

A New Framework for Support for People with Serious Mental Health Problems. Trainor, J., Pomeroy, E., and Pape, B. Toronto: CMHA National, 1993.

Inclusion in Community: Building Capacity. Project Proposal to the Trillium Foundation. Pape, B. Toronto: CMHA National, 1996.

Inclusion in Community: Building Capacity. Final Report to the Trillium Foundation. Pape, B and McKee, H. Toronto: CMHA National, 1998.

Inclusion in Community: A Guide to Local Action. McKee, H. Toronto: CMHA National. 1998.

### **Helping Skills**

Canadian Mental Health Association, Newfoundland and Labrador Division

The Helping Skills project grew out of a participatory research project conducted by the CMHA Newfoundland and Labrador Division that explored the impact of the northern cod moratorium on peoples' well-being. The research showed that although there was a great deal of innate strength and resiliency in the communities, there was also significant distress resulting from loss of employment, and, in particular, loss of a traditional way of life.

Community members expressed great concern about the lack of helping services available to people in rural areas, and about the erosion of social support resulting from the tensions and changes caused by the moratorium.

During the same period, the provincial health system was undergoing restructuring, with the establishment of Regional Community Health Boards responsible for health promotion, as well as mental health and addictions services, among other things. The priorities in this restructuring included encouraging greater community participation, and developing partnerships between the formal and informal sectors to address health needs.

The Community Health Boards charged with the responsibility to implement this mandate were, however, seriously under-resourced. Regional co-ordinators were reporting social and emotional distress to which they had no means of responding. Affordable counselling services were desperately lacking, and virtually non-existent in many rural areas. The priest, the family doctor and the public health nurse were the local over-stretched resources, and people were waiting for up to a year to see psychiatrists and other mental health professionals.

### **Summary**

The Helping Skills project addressed both the need to develop alternative support networks and the need to build partnerships. Local service providers recognized that the distress that people were experiencing was a result of their loss of employment and way of life, not because of any psychiatric concern. Therefore, the goal of the project was to create a new helping resource - a non-service oriented approach that drew on the strengths and capacities of local people to support each other through hard times.

The Helping Skills project proposed to train a network of volunteers in the essential skills of helping. Once they were trained, they would be a resource for people who needed understanding, support and a confidential listening ear.

The Helping Skills project formed partnerships with two Community Health Boards to create a train-the-trainer program. Counsellors (or service providers) in rural areas would be trained as facilitators, and would in turn deliver the program to volunteers in their communities.

The project was built upon the following key assumptions:

1. there were people in communities who possessed the motivation and innate capacity to help others;
2. with training these people could develop and enhance their helping skills;
3. the training would contribute to building informal helping capacity in communities;
4. by referring people to the network of volunteer helpers, counsellors would become more available to respond to people in psychiatric distress who really needed professional help.

The training would make a clear distinction between the activity of “helping” and that of “counselling” or professional therapy, and enable helpers to identify their own limits and the situations where additional support was required.

### **Goals**

- to create a model for developing informal helping resources;
- to build partnerships between formal and informal sectors in the area of mental health;
- to increase the knowledge, skills and involvement of community members to support their peers and address the health needs of their communities.

### **Objectives**

- to develop and pilot a “train the trainer” program for service providers to facilitate the learning of effective helping skills by community volunteers;
- to establish a corps of trainers and volunteer helpers with the skills to appropriately refer or otherwise assist people with emotional or social needs;
- to use and teach others how to use a mentoring model to transfer learned skills in areas such as active listening, empathy and setting boundaries.

### **Process**

The project was designed to unfold in three phases of six months each. A brief explanation of each phase follows.

#### **Phase I : “Train-the-trainers”**

In the first six months, CMHA staff made contact with the community Mental Health Coordinators and looked for candidates from partner agencies in the region. The agencies were asked to commit a portion of their employees’ time to the project. The potential trainers were asked about the kind of training they felt they needed in order to adequately prepare volunteers to be peer helpers. Based on these discussions, a consultant went on to design a training program.

The twelve trainers then spent ten days working full time with the consultant, learning about how to teach helping skills. The training focused on drawing out the participants’ first hand knowledge of what it means to be helpful and to be helped. Based on this process, a Facilitator’s Manual was written to provide a comprehensive “road map” for the training.

When they returned to their regions, the trainers spent up to two months promoting the program and recruiting interested and appropriate people from the community to become volunteer helpers.

### **Phase 2: “Transferring the Skills”**

During the second six-month period, the trainers focused on transferring skills to the volunteers within their area. This was accomplished through 20 weekly group sessions, using the teaching and mentoring methods they themselves had learned with the consultant in Phase I. Monthly teleconferences provided a forum for sharing progress and problem solving among the trainers. The consultant also visited each site to meet with the volunteer groups. In the final month of Phase 2, the ten trainers spent three days with the consultant evaluating the training process and planning ahead to monitor and maintain the helping network.

### **Phase 3: “The Network in Action”**

In the final six months, the volunteer helpers put their learning to use in their own communities. Some received referrals from various sources such as health professionals and people who referred themselves, while others simply used their new skills informally in their own lives and relationships. Throughout the duration of the project, the consultant was always available for problem solving and guidance. At the end of the third phase, an independent evaluator assessed the effectiveness of the skill transfer process.

This led to the development of Phase 4, program and training manual were revised to reflect the learnings of the project so far. A few changes were made to the language used in the manual, so that it reflected a more informal approach: “trainers” became “facilitators”, and “peer counsellors” became “volunteer helpers”.

During this time, staff also focused on promoting the project more widely, and delivering the revised facilitator training to people from other health regions.

### **Partners**

One of the main goals of the project was to build active partnerships between the formal and informal sectors of mental health. To accomplish this, the co-operation of agencies in the areas of health and social services was enlisted, and a portion of selected employees’ time was dedicated to being community trainers of volunteer helpers.

### **Sources:**

Building Helping Skills: Project proposal. Buchan, M. CMHA Newfoundland & Labrador Division, St John’s: September, 1995.

Building Helping Skills. Concluding reflections: What we learned. Buchan, M. CMHA Newfoundland & Labrador Division, St. John’s: 1997.

Helping Skills: Facilitator’s Manual. McConnel, S., and MacLeod, L. CMHA, Newfoundland and Labrador Division. 1998.

### **Seniors' Medicine Wheel**

#### **Portage Friendship Centre. Portage la Prairie, Manitoba**

The Aboriginal Friendship Centre in Portage la Prairie, Manitoba, like many across the country, provides a wide array of services to Aboriginal people of all ages. Services range from housing

and recreation, to addictions and literacy programs. It is a non-profit, charitable organization with a mandate to assist Aboriginal people's adjustment to living in an urban environment. The Friendship Centre first opened its doors in the 1960's as a drop-in centre. Currently the Centre serves more than 1,500 people a year.

Approximately 25% of the population in the Portage area is of Aboriginal descent, either Treaty, Status, non-Status or Metis. The Portage Friendship Centre, the only Aboriginal-based organization in the area, has a long history of providing much-needed programs and services which are sensitive to the cultural traditions and needs of this community.

The Seniors' Medicine Wheel project was developed to address the needs of the growing population of urban Aboriginal seniors. Approximately 15% of Aboriginal people living in the Portage area are over the age of 50.

A large number of these seniors attended residential schools as children, and have had to cope with the extreme physical, emotional and spiritual trauma that they experienced in that setting. For many seniors, trying to deal with the legacy of that abuse has led them to move away from the reserves and into urban centres, where they have lost touch with traditional cultural and social support systems.

In urban centres such as Portage la Prairie, Aboriginal seniors have often fallen through the cracks -- excluded from mainstream community life, and unable to access culturally-sensitive social and health care services.

This marginalization and isolation has had many health impacts, and has hindered Aboriginal seniors from accessing the health and social services they need. The Seniors' Medicine Wheel program was developed specifically to provide urban Aboriginal seniors with information, access, support and referrals to existing health services.

The project began as an attempt to connect Aboriginal seniors to culturally appropriate services -- a worthwhile project indeed, but not one that would necessarily be considered mental health promotion. Simply by bringing the seniors together, however, the Medicine Wheel project produced some unexpected, but very welcome results.

By bringing them together for weekly meetings and sharing circles, the project provided Aboriginal seniors with the seeds of a real mental health promotion project -- one which united the seniors with many of the community's children, and began a cycle of cultural sharing and emotional recovery.

Through this process, the seniors began to think of themselves as Elders, which is the name Aboriginal people generally use to refer to members of the community who are esteemed and valued -- who have wisdom to share.

## **Summary**

The Seniors' Medicine Wheel is summarized in a slightly different manner than the other two sample projects, in order to reflect both the unique way that it came about, and the people it served. Instead of breaking the program down into the categories of Goals, Objectives, Process, and Partners, we tell the story of the Medicine Wheel program, starting from its beginnings as an initiative designed to connect urban Aboriginal Elders with local health services, and moving to what it eventually became, an initiative to promote the mental health of children and seniors in the urban Aboriginal community.

The Elders who took part in the Seniors' Medicine Wheel program shared many concerns about their own health, as well as the health of the younger generations. They saw many things

they would like to change in their community, from substance abuse and family violence, to a loss of cultural identity and a sense of hopelessness amongst the community's youngest members.

During the initial phase of the project, a series of weekly gatherings facilitated by staff from the Friendship Centre brought Elders together to learn more about the various services that were available, and how to access them in order to improve their health.

In these meetings, the Elders were also able to share their concerns about what they were seeing in their community. They felt a sense of responsibility to take action to improve the situation for the children and youth who were growing up in what they knew was a physically, mentally and spiritually unhealthy environment.

Through their weekly discussions the Elders realized that they all shared a deep concern for the children and youth in their community, and feared that many of them were entering into a cycle of abuse that had begun generations earlier, with the residential schools. The Elders felt compelled to do something to improve the mental health and self-esteem of those children. They felt that by sharing their traditional cultural knowledge with the young people, they could help them to be proud of who they were. In teaching and sharing with the children, the Elders would also gain something -- the knowledge that they were making an important contribution to the mental health of their community.

The second, mental health promoting, phase of the Seniors' Medicine Wheel project was born. Through contacts at the Friendship Centre, they began to work with Aboriginal Head Start, a program already operating in the community, whose mandate was to foster spiritual, emotional, intellectual and physical growth in Aboriginal children, and to support parents and guardians as the prime teachers and caregivers of their children.

Given that another aspect of Head Start's mandate was to work with and support other community programs, forming a partnership between Head Start and the Medicine Wheel project seemed logical. This partnership united two initiatives which placed equal value on caring, creativity and pride flowing from the knowledge of traditional beliefs, language and culture.

The Elders were the only members of the community who still knew some of the traditional languages and teachings, and could pass them on to the younger generations. Because many of the Elders were survivors of residential schools, however, some of their knowledge of language and tradition had already been lost.

Working together benefited both the seniors and the children enormously. The Elders were giving something of great value to the children -- their time, their cultural knowledge and their wisdom. They were recognized, many for the first time, for the contributions they were able to make to the community. Through their nurturing relationship with the Elders, the children not only learn Aboriginal language and traditional beliefs, but they also develop confidence, respect, and a sense of their own value.

The Elders and children formed lasting relationships through the Medicine Wheel program. Some of the Elders actually adopted the children as grandchildren, and continue to spend time teaching and sharing together. The participants in the project worked together to create two workbooks: a colouring book for children that tells many of the traditional legends and stories, and a book recognizing the wisdom and contributions of the Elders. These books have been made available to other Aboriginal communities, to inspire them to take similar action to promote mental health.

It was evident to the staff at the Friendship Centre that the program was a huge success, because, at a certain point, it ceased to be a program and instead became a part of people's lives. Although the funding for the program came to an end, the work that the project began has

not. The Medicine Wheel program helped inspire a community to begin a healing process -- a movement that promotes both mental health and cultural regeneration.

**Sources:**

Aboriginal Head Start Initiative. <http://www.hc-sc.gc.ca/hppb/childhood-youthlacy/ahs.htm>

Mental Health Promotion Resource Directory. Canadian Public Health Association, Ottawa: 1998.

Seniors' Medicine Wheel Project Proposal. Portage Friendship Centre, Portage La Prairie: 1996.

Seniors' Medicine Wheel Final Report to Health Canada, Health Promotion and Programs Branch. Portage Friendship Centre, Portage la Prairie: 1998.

*"As an eagle prepares to leave the nest with all the skills and knowledge it needs to participate in lii, in the same manner so will I guide my children. I will use the culture to prepare them for Fife.*

*The most important thing I can give to my children is my time. I will spend time with them in order to learn from them and listen to them.*

*I will teach my children to pray, as well as the importance of respected We are the caretakers of the children for the Creator. They are his children, not ours. I am proud of our own Native language. I will learn it if I can and help my children to learn it.*

*In today's world it is easy for the children to go astray. So I will work to provide positive alternatives for them. I will teach them their culture. I will encourage education. I will encourage sports. I will encourage them to talk to the Elders for guidance, but mostly, I will seek to be a role model myself. I make this commitment to my children so they will have courage and find guidance through traditional ways."*

- Author unknown - Aboriginal Head Start Newsletter  
Winter 1997-98.