Community Crisis Planning for Prevention, Response, and Recovery First Nations Service Delivery Model

First Nations Mental Wellness Continuum Framework

Thunderbird Partnership Foundation

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Acknowledgements:

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Citation:

Community Crisis Planning for Prevention, Response, and Recovery: Developing a First Nations Land-based Service Delivery Model, © Thunderbird Partnership Foundation, 22361 Austin Line, Bothwell, Ontario, 2018

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Principal Statement of Inclusiveness

Throughout this document, various terms were used to refer to the First Nations peoples of Canada. Although the Community Crisis Planning, Prevention, Response, and Recovery First Nations Service Delivery Model flows from the First Nations Mental Wellness Continuum (FNMWC) framework, healing with the land is a practice and knowledge system that is common to Indigenous peoples everywhere. As such, we often make use of the terms *Indigenous* and *Indigenous peoples* when we refer to First Nations peoples of Canada.

The term Indigenous peoples refers to Original Peoples and their descendants around the world, and while the term Aboriginal refers specifically to those in Canada as defined in Section 35 of the Constitution Act of 1982, First Nations and Inuit peoples of Canada prefer the term Indigenous peoples instead of Aboriginal. This preference signals a general agreement with international law that identifies "Indigenous groups as autonomous and self-sustaining societies" and evokes shared historical memory, cultural meanings, and particular political interests, including the implementation of the United Nations Declaration of the Rights of Indigenous Peoples (Indigenous Foundations, 2009, Global Actions). As such the use of Indigenous and Indigenous peoples in this text signals similarities in knowledge systems and practices among Original Peoples and their descendants around the world and those in Canada, and it is understood to include the diversity of First Nations. Most important for our discussion is the use of these terms to underline pre-existing and recognized individual and collective rights to land and autonomy.

It is acknowledged that there are other tools, programs, and services (such as the health emergency management and planning tool, community health planning, community safety plan, and so on) that may help to address some aspects that are covered in this service delivery model (SDM). This SDM is intended for use as a supplementary tool, as others may not address the complex mental wellness needs of an acute crisis, and it is not intended for use in long-term crisis situations, such as a chronic housing shortage. The following are short-term crisis situations where the reader may find this SDM useful:

- Home or community building on fire
- Death of a citizen or family member
- Alleged suicide, homicide, assault, hostage taking, or kidnapping
- Search and rescue of citizens who have gone missing
- Dangerous and wild animals entering the community
- Forest fire
- Blizzard, ice storm, or extreme temperatures
- Flood threatening a community or home
- Communicable disease outbreak
- Hazardous material spill or explosion

It is also acknowledged that not all sections of the SDM will be useful for many communities in different types of crisis situations. Instead, readers are encouraged to use as many parts of the SDM as deemed helpful to their situation.

1. Introduction

Not long ago, "we were self-reliant, self-governing Nations living in harmony with our neighbours and all that lives on our lands or in our waters. We shared the land in ways that did not disrupt or threaten our survival – our physical, mental, emotional, and spiritual wellbeing (Mushkegowuk Council, 2016. p. 11).

The Indigenous values that form the foundation for this way of being are ever-present and accessible today. *"It is said, the Great Spirit worked to ensure what we would need to live life, forever and all time, no matter the circumstances, was thought of and put into Creation." (Dumont, 2014)* These quotes are the foundation for hope that, as Indigenous people and communities, we have answers within our knowledge and ways of being to address the underlying root causes of crisis to prevent the reoccurrence of *social emergencies*, while also applying strategic leadership to ensure our communities have the right resources at the right time to establish or sustain equity.

The service delivery model (SDM) is intended to support First Nations communities in their crisis planning, prevention, response, and recovery. The SDM is to be used by the communities as a reference document to support their own process of planning and development, not to be adopted as written. First Nations communities may have their own unique definition of crisis and capacity to plan, prevent, respond to, or recover from incidents or events. The intention reflected in this SDM is that the unique characteristics and priorities of each community are respected.

2. Service Delivery Model and Link to FNMWC

The intent of the Community Crisis Planning, Prevention, Response, and Recovery First Nations Service Delivery Model is to provide a reference guide that would support contextual tailoring for planning, decision making, delivering, and monitoring performance related to this specific service. The service delivery model includes templates, sample documents, case scenarios, and other resources for reference and to support the use of the SDM in community planning and implementation.

A ***service delivery model*** (SDM) is typically structured with a set of principles, standards, policies, and constraints used to guide the design, development, deployment, operation, and evaluation of services delivered by a service provider with a view to offering a consistent experience to a specific user population, community, or population within a community.

The foundation of this SDM is the *First Nations Mental Wellness Continuum (FNMWC)* framework, which promotes a strength-based approach. A core Indigenous value is the belief in strengths over weaknesses and assets over deficits, and this comes from Indigenous Creation Stories that teach about the inherent gifts given to Indigenous peoples by the Creator, commonly known as kindness, caring, honesty, and strength. Indigenous languages are also strength-based; there are no words that match the English language for describing the multitude of deficits, illnesses, or challenges. Indigenous languages are a gift of the Creator, and held within the language is one's world view, culture, and way of relating to all of life based on the truth that the Creator gave Indigenous people a *good life*. This concept is continuous across the many Indigenous cultures in Canada, although it is spoken about in many different ways. In a practical sense, a strength-based approach is understood to be inherent in language and values, and it is in this way that one can facilitate shared learning and support among community services and across the social determinants of health sectors. Most essential to a strength-based approach is the belief that when engaged to do so, people are resourceful and are capable of solving their own problems. The promotion of collaborative relationships with the client base is also essential.

Strength-based approaches typically facilitate a manner of doing things that starts from belief:

1. People (clients, communities, partners) have existing strengths;
2. First Nations have important cultural resources, and, with the right support, can translate Indigenous knowledge for application within community services;
3. People are capable of learning new skills and knowledge to address their concerns;
4. People can be involved in the process of discovery and learning; and
5. Strength-based approaches are founded on the idea that even at their weakest moments clients are resilient.

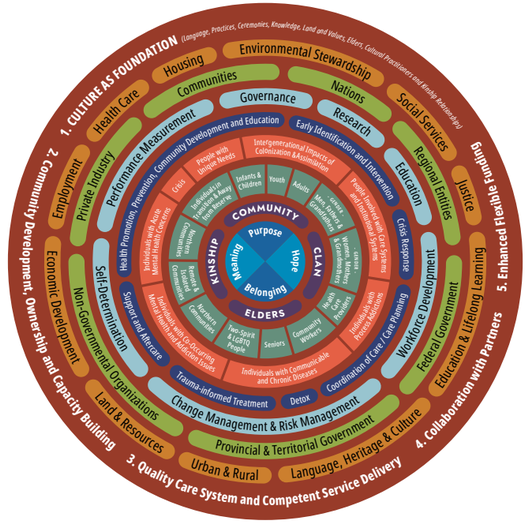


Figure 1 First Nations Mental Wellness Continuum (FNMWC) framework (Health Canada, 2015). For more, see the FNMWC graphic on pages 30 and 31.

The SDM developed specifically for First Nations conveys principles and standards from an Indigenous lens while ensuring cultural protocols and integrity are valued the same as with Western standards of practice. For example, a standard of practice might include rights, responsibilities, and client safety. From a Western or mainstream lens on service delivery, *rights* may be defined by license or other credentials that verify knowledge, skill, and scope of practice. From an Indigenous lens, rights of practice may be sanctioned by Elders, or Indigenous Knowledge Holders, sacred societies, or First Nations governments who have formal systems of accountability and supervision in their scope of practice.

Another aspect of the SDM will attend to the geographical context (urban, rural, remote, and isolated community locations) to ensure the model can inform a variety of initiatives. It is intended to support a variety of community initiatives including the following:

1. Community development initiatives;
2. Community health- and crisis-related planning;
3. Proposal development;
4. Communication across jurisdictions and sectors representing the social determinants of health;
5. Design of services;
6. Assessment of existing strengths, capacities, and services; and
7. Implementation of the First Nations Mental Wellness Continuum Framework.

The First Nations SDM is linked to the following themes of the First Nations Mental Wellness Continuum Framework (FNMWC):

1. Culture as Foundation

Culture is an important social determinant of health, and a holistic concept of wellness is an integral part of a strong cultural identity. Many First Nations communities believe that the way to achieve individual, family, and community wellness (a balance of mental, physical, emotional, and spiritual aspects of life) is through culturally specific, holistic interventions. When culture is considered the foundation, all First Nations health services can be delivered in a culturally relevant and safe way. The result of this conceptual shift will be policies, strategies, and frameworks that are relevant to local community contexts, recognize the importance of identity and community ownership, and promote community development.

2. Community Development, Ownership, and Capacity Building

Community development, ownership, and capacity building are significant factors that must be present at all service levels—design, delivery, implementation, and evaluation—when enhancing mental wellness in First Nations communities. Sustainable and effective community development initiatives involve community capacity building and a strong focus on inherent strengths within First Nations communities.

3. Quality Health System and Competent Service Delivery

A quality health system ensures an ideal continuum of essential mental wellness services to which all First Nations communities should have access. It is essential that this continuum of service be located within a quality care system and that the services and supports be of high quality and culturally competent. Other aspects of quality care and competent services include being responsive to the needs of individuals across the life span and to the needs of families and the community while being flexible in their delivery methods and reliable in their access and availability.

4. Collaboration with Partners

This involves federal government departments, provincial and territorial governments, First Nations governments, communities, non-governmental organizations, and private industry. It includes supports and services that cross sectors (e.g., health, justice, employment, and social services), requiring First Nations communities and organizations to work collaboratively and cooperatively to ensure that a First Nations SDM is available and that it is a comprehensive continuum of mental wellness service.

5. Enhanced Flexible Funding

Funding and decision making that affect First Nations are currently regulated within several federal departments (and provincial and territorial departments), making it challenging to address the Indigenous social determinants of health and to develop comprehensive approaches to mental wellness. Additional funding and flexibility as well as permanency of current funding are critical.

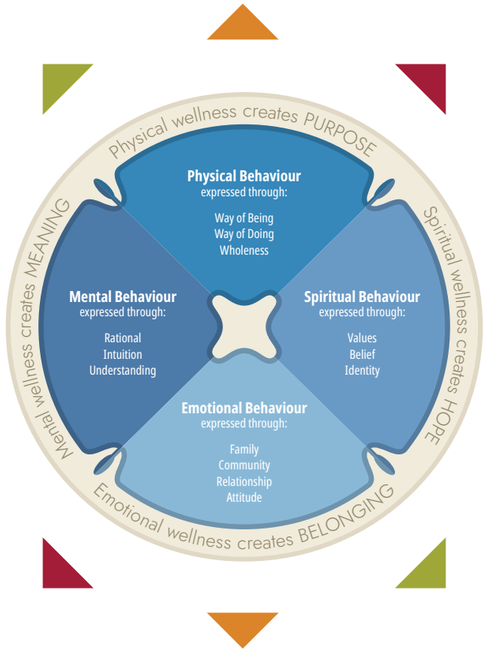


Figure 2: Indigenous Wellness Framework (Thunderbird Partnership Foundation, 2014)

At the heart of the FNMWC are the four wellness outcomes Hope, Belonging, Meaning, and Purpose which were adopted from the I*ndigenous Wellness Framework* as shown in Figure 2. The four outcomes have 13 indicators that are strength based and are defined from Indigenous knowledges from across the country. These indicators can be used as determinants of community health, to support local and regional strategic planning, program design and delivery, as well as monitoring and evaluation.

The core focus of the SDM is to enhance Hope, Belonging, Meaning, and Purpose. Working through the second ring (**earth red**) of the FNMWC embeds a connection to Elders, kinship, community, and clan. The third ring (**sage green**) speaks to the life span and unique populations as it identifies different age groups, genders, sexual orientations, health care providers, community workers, families, communities—urban, remote, isolated, and northern communities—as well as those in transition away from the reserve. In applying the guidance offered here in this SDM, it will be important that First Nations communities consider the unique needs of these populations when planning to respond to crisis. Crisis response is one of eight core services of the fifth ring (dark blue) and will be primary throughout this document, although the other seven elements identified also have meaning in creating the SDM. The remaining features of the Framework will be built in to the extent possible with priority focus on self-determination; community development, ownership, and capacity building; and collaboration with partners. The key theme of Culture as Foundation is highlighted under each layer, shown through the outer-most ring (**earth red** and **orange**), which supports the entire FNMWC Framework and identifies the important role of Elders, kinship, clan, and community for building the SDM.

Through the FNMWC Demonstration Projects, which was an initiative lead by the Thunderbird Partnership Foundation in 2015 and 2016 to share promising practices and community adaptations of FNMWC implementation, Kwanlin Dün First Nation (KDFN) was identified as a leader in a comprehensive approach to crisis prevention, response, and recovery. Their crisis and emergency response plan (CERP) supports connections with culture that are also critical elements of the plan and are inclusive of language, practices, ceremonies, land, and values; community development, ownership, and capacity building; and collaboration with partners, including multiple levels of government (see Appendix 1). KDFN has used a series of community engagement and planning activities to support the CERP development, including "Let's Keep Talking" community dinner and engagement gatherings and the development of a community safety and well-being plan to focus on implementation in these areas by KDFN departments. Two research initiatives related to community safety led to the identification of their needs, gaps, and strengths. The implementation of the community safety initiative is linked to crisis prevention by reducing crime and violence and the impacts on families and communities.

The Kwanlin Dün CERP team is unique in that it includes multiple levels of government and the strength of the foundation of Yukon land claims and self-government agreements. KDFN, as one of 11 Yukon First Nations with completed land claims and self-government agreements, is fully recognized as a government, and the intergovernmental relationships related to crisis and emergency flow from that. Self-determination is linked to activities in multiple sectors—including health, justice, social services, and heritage—which speaks directly to the FNMWC. KDFN also highlights the need to strengthen performance through measurement, support governance, and use research and education to develop workforces and support change. Risk management is also identified in the framework and must be considered in planning, preventing, or responding to crisis. Placing crisis response within the continuum of care ranging from health promotion to aftercare is also supported by the FNMWC.

This service delivery model is based on the great work of KDFN.

3. Defining Crisis

A community is responsible for defining crisis in their own terms. One definition used by the First Nations Health Authority (FNHA) in British Columbia is as follows:

> *A crisis is defined as an extraordinary circumstance that significantly challenges community capacity to respond (FNHA, 2014, p.2).*

Often, communities experience a crisis within the context of ongoing states of chronic crisis such as levels of stressful living conditions in the community, lack of stable housing, family violence, pattern of suicides, or misuse of alcohol or drugs. Models such as critical incident stress management used for debriefing these traumatic events are designed to focus on individuals and provide one-to-one counselling sessions to stabilize the individual following a traumatic event; however, these models are not effective in responding to community crisis. This service delivery model (SDM) will focus more on the single circumstance or event that occurs, as attempting to describe a SDM to respond to the multiple complex interwoven patterns of chronic crisis related to all determinants of health is beyond the scope of this document. The *tragic event* is identified as an acute situation and part of the ongoing interrelated problems in communities, sometimes identified as a *state of emergency*. These are unfortunately identified as chronic in some communities with needed major comprehensive responses.

First Nations in British Columbia link crisis response to emergency management and use the emergency management process of prevention/mitigation, preparedness, response, and recovery. The level of intensity and time through which the circumstances move are also useful concepts foundational to the FNHA approach. The FNHA identifies components of protocols that are helpful and will be used in the development of this SDM.

This SDM will focus on crisis to the exclusion of full-scale emergencies such as major floods or earthquakes.

4. Service Delivery Model Goals

The goals of the service delivery model are:

Hope (Indicators: belief, identity, and values)

1. Respectfully engage with community and families to help create methods that align with their beliefs, identity, and values in order for them to build from community strengths and to lead the process of crisis planning, prevention, response, and recovery.

Belonging (Indicators: family, community, attitude, and relationships)

2. Plan and implement short- and long-term actions that ensure optimal relationships and connections, build local community capacity, restore connections, and support recovery.

Meaning (Indicators: intuition, understanding, and rationale)

3. Use community and culturally appropriate methods of evaluation to ensure that prevention and response continues to improve and that identified problems are solved; and share knowledge, skills, and resources among First Nations communities and those that serve these communities.

Purpose (Indicators: wholeness, ways of being, and ways of doing)

4. Complete assessments to support community ways of being and doing through actions that ensure the best response to diverse and changing needs, risks, and priorities and lead to the best possible outcomes.

5. Community Characteristics and Capacities

There are community characteristics and capacities that need to be identified as the foundation for community work for crisis-related planning, prevention, and response. Communities can plan more effectively to engage resources within and outside the community when they have clearly identified characteristics and capacities.

Characteristics

1. **Geographic location and infrastructure** – urban, rural, remote, or isolated; neighbouring communities; transportation channels; communication options; power dependability (e.g., electricity, diesel); safe water and sewer, and so on.
2. **Population structure** (see **Populations ring** of the FNMWC) – infants and children; youth; adults; gender—men, fathers, and grandfathers; gender—women, mothers, and grandmothers; health care providers; community workers; seniors; two-spirit people and LGBTQ; families and communities; remote and isolated communities; northern communities; and individuals in transition and away from the community.
3. **Governance and administrative structures** – First Nation, self-governing First Nation, under third-party management, and so on; link to tribal councils or other regional bodies; and First Nations staff.
4. **Local agencies** – health centre or nursing station, fire hall and truck/equipment, RCMP or other policing, community safety staff or programs, social services, child welfare, education services, justice services and other services under First Nation or other government control.
5. **Regional/provincial/territorial agencies** – access to regional services and funding sources relevant to short- or long-term crisis response.
6. **Federal agencies** – access to federal services and funding sources relevant to short- or long-term crisis response.
7. **Others** – as defined by the community.

Capacities

1. **Strengths** – of the community, families, and individuals.
2. **Experience** – communities who have faced crisis before having accumulated learning.
3. **Resilience** – sources of resilience, identify the level of resiliency.
4. **Culture and keepers of culture and ceremony** – connection to cultural past and the strength of current cultural vitality.
5. **Language** – use of First Nations languages in homes, community, and school curriculum.
6. **Translation** – community members who can provide translation.
7. **Understanding of colonization, historical trauma, and impact on the present** – an understanding and the ability to identify patterns of human behaviour and community dynamics determined by the past is helpful.
8. **Trauma-informed response** – the ability to use a trauma-informed and culturally competent perspective in all responses and to work with the expression of trauma in all forms.
9. **Meeting basic needs** – safety, housing, food, water, sewer, and so on.
10. **Others** – as defined by the community.

If a community has participated in any of the following processes, it may already have the following characteristics and capacities identified:

1. Comprehensive community plan;
2. Community health planning guide; and
3. Community safe planning process.

5.1 Describe the Community and its Strengths[1]

One important cultural tradition across the linguistic groups of Indigenous peoples is to introduce oneself through culture: spirit name, clan, Nation, family lineage, and connection to the land one comes from. These cultural identifiers are the foundation of strength. This same principle applies to the community identity. It is important for communities to describe the meaning of its traditional or cultural name, the clan families of the community, its relationship with other Nations/tribal council affiliations, the family ties common to other communities, and the history of how the community came to be on the land it currently knows as home.

Telling a story of community strength can be empowering for any community; however, sometimes it can feel like denial of the hurt, pain, and struggle of the community as well. The purpose of gathering the story of strength is to support resources coming into the community responding to crisis with an understanding that, while the community may need support, there are strengths within the community, and it is with these strengths the community can lead and direct external supports.

Asset mapping is a good resource tool for mapping community strengths. It is important to ensure that the community include the informal assets within the community, such as community groups, clubs, cultural societies, natural helpers, and volunteers.

[1] For support to explore and develop a comprehensive statement of community strength that can be used in a community crisis prevention and response plan, please review the following: (2015). *Moving Toward a Stronger Future: An Aboriginal Resource Guide for Community Development*. Ottawa: Public Safety Canada, available at http://publications.gc.ca/site/eng/9.801098/publication.html

6. Community Crisis SDM Principles

Principles identified to guide crisis-related planning, prevention, response, and recovery include the following:

1. **Individual led** – clear coordination and leadership is established.
2. **Family led** – families know their needs the best and the response must value those needs.
3. **Community led** – principles defined by the community are the foundation across all measures of response.
4. **Attention to the whole person** – spirit, heart, mind, and body.
5. **Compassion** –victims, offenders, and their families are shown consideration.
6. **Outreach** –those who do not typically access community services are offered care.
7. **Proactive** –good data is used to anticipate crisis or respond early to reduce the likelihood or the impact of a crisis.
8. **Appropriate** – prevention, response, and postvention are always contextualized to the identity, capacity, and culture of the community.
9. **Risk identification and mitigation** – community has identified specific risk factors for crisis, and there are clear roles and responsibilities within the community to monitor the likelihood of a risk occurring and to inform others of potential risks based on these factors.
10. **Respect** –community-specific principles, protocols, and cultural practices are respected.
11. **Responsive to cultural and community diversity and protocols** – appropriate planning includes addressing the power imbalances in relationships with external service providers to ensure they are aware of the unique identity of the community and their specific protocols related to trauma, life, and death.
12. **Trauma-informed care** – organizational structure and intervention framework that involves understanding, recognizing, and responding to the effects of all types of trauma experienced as individuals early in life (e.g., child abuse, neglect, witnessed violence, or disrupted attachment) or later in life (e.g., violence, accidents, sudden and unexpected loss, or events that are out of one's control such as dislocation from land by removal or flooding or political fights over land and resources) and understands trauma beyond the individual impact to be long-lasting, transcending generations of whole families and communities.

13. **Cultural humility** – lifelong process of self-reflection and self-critique (rather than only learning about the culture of the other/cultural competency) to ensure mutually beneficial and non-paternalistic relationships.

14. **Cultural safety** – consideration of cultural, historical, and structural differences and power relationships within the care that is provided. It involves a process of ongoing self-reflection and organizational growth for service providers and the system to respond effectively to First Nations people.

15. **Cultural competence** – crisis prevention requires a conversation between the community and others to ensure the diversity and protocols of the community are integrated within and transform the knowledge about the community into specific crisis prevention, response, and recovery standards, policies, practices, and attitudes that will increase the quality and produce better outcomes.

16. **Foundation of land and culture** – land has always been fundamental for the health and cultural identity of Indigenous peoples. A commonly held belief is the interconnectedness of all life, which includes humans and all of Creation (animals, plants, rocks, visible and unseen forces of nature, the universe) that coexist in balance, harmony, respect, and caring relationships.

17. **Builds local and connected community capacity and confidence** – First Nations communities have inherent strength, and all interactions related to crisis work validate and reinforce the existing capacity for applying cultural knowledge and skills across crisis prevention, response, and post-vention.

18. **Others** – community defines and includes changes to any of the above described principles.

7. Community Crisis SDM Protocols

Culturally relevant and strength-based protocols rely on community-led groups or teams that may gather in community locations or in people's homes following a traumatic event for multiple follow-up sessions (Regal, Joseph & Dyregrov, 2007). Community cultural protocols identified for consideration in crisis-related planning, prevention, response, and recovery include the following:

1. Hospitality – how guests are welcomed to the community and the role of guests;
2. Clothing – appropriate clothing for various occasions, including ceremony;
3. Food – the type of food offered and how it is accessed, prepared, and served;
4. Clans or families – roles and responsibilities;
5. Men and Women – communication and gatherings involving men and women that may or may not be related;
6. Children – when it is acceptable to have children present, such as at a funeral;
7. Ceremonies – each has its own protocols;
8. Birth;
9. Death;
10. Grief and grieving process;
11. Rites of passage for young men and women;
12. Language and levels of language;
13. Gathering, storage, and preparation of plants for medicine;
14. Spiritual healing ceremonies;
15. Use of bundles, drums, rattles, and other cultural items;
16. Honouring of land;
17. Tobacco offerings;
18. Circles for a variety of purposes;
19. Feasts, potlatch, and other gatherings;
20. Marriage;
21. Conflict resolution and restorative justice;
22. Traditional law and application of traditional law; and
23. Others.

8. Crisis Response Planning

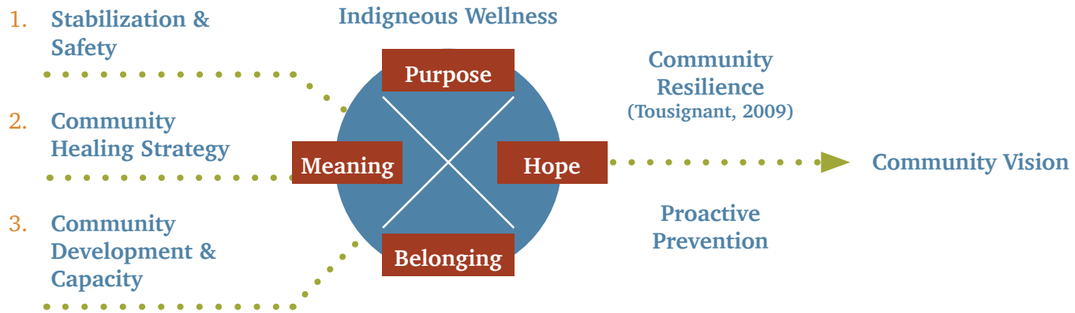
Each community will develop its own plan. Plans developed by other communities may be helpful references along with this SDM. Many communities have plans in place for crisis, emergency, pandemics, or other crisis. Some of them are current and others require updating. The approach of integrating emergency and crisis response planning taken by the First Nations Health Authority (British Columbia) and Kwanlin Dün First Nation (Yukon), for example, are more recent approaches.

Reasons for crisis response planning include the following:

1. Events or circumstances happen often without warning;
2. Impacts of these events or circumstances can be reduced if the response is early and effective;
3. Response is more likely to be launched sooner and be more coordinated and effective if a plan is in place;
4. Plan will be helpful if it is reflective of the community's cultural and other priorities and builds on community strengths and capacities;
5. Prior arrangements or protocols with agencies that may be called in by the community to help if it is a larger scale crisis and that are helpful in defining roles; and
6. Responsibilities and mutually agreed-upon methods are documented in advance.

8.1 General Considerations for Crisis Response Planning

The ability to respond effectively to crises is dependent on effective crisis planning and timely access to necessary resources, supports, and services. This will require an examination of existing strengths that can be drawn upon to address a crisis within the community. The ability to respond effectively will also involve access to external supports to help respond to the immediate needs of individuals, families, and the community beyond what the existing workforce and resources the community can provide. It will also mean defining a plan to address the underlying causes of the crisis and facilitate ongoing care and support (Health Canada, 2015). A good plan contains detailed operational information on how to effectively coordinate a community response to a crisis, one that reflects and supports the unique heritage, traditions, and culture of the community (Kwanlin Dün First Nation, 2016).



Parallel processes of crisis response leading to Indigenous wellness and long-term resiliency.

Figure 3: Parallel processes of crisis response leading to Indigenous wellness and long-term resiliency

Pre-planning for Crisis Response

- Identify strengths
- Assess risks
- Identify principles for prevention, response, and recovery

Preparation for planning:

1. Decide who will take the lead: which department or team.
2. How will you coordinate conversation? Is there an existing group or committee that you can work with? Do you need to include others?
3. Secure a mandate for the work from the relevant authorities; for example, Director, Manager, and Chief and Council.
4. Define the process to include community members outside of formal programs and services.

Each community will define its own planning process:

1. Look at community characteristics: geographic and cultural context and history.
2. Learn from community experience in planning for a response to community crises or emergencies.
3. Communicate and coordinate with Chief and Council, staff, community members, and partners.
4. Map roles, responsibilities, and methods for communication and coordination, internally and externally.
5. Assess current capacity including strengths and weaknesses.
6. Design response principles, structures, and processes.
7. Train citizens to build more capacity and resilience.
8. Mobilize the response in collaboration with other agencies, if needed.
9. Evaluate outcomes to help improve the plan.

9. Crisis Prevention

Crisis prevention is an action on the part of the community leadership, community members, First Nations staff, governments, or other agencies that will prevent crisis at one or more levels:

1. **Primary Prevention** (1st level, also known as universal prevention) – the crisis does not happen. The mission of universal prevention is to deter the conditions for a crisis to occur by providing all individuals the information and skills necessary to prevent the problem. All members of the population are seen to share the same general risk for crisis, although risk levels may vary greatly among individuals. Universal prevention is delivered to large groups without any prior screening for risk. The entire population is assessed as capable of benefiting from prevention. These primary prevention practices and approaches are activities and services provided in a variety of settings for the general population and targeted subgroups that are at high risk.

2. **Secondary Prevention** (2nd level) – the crisis response is early and effective to help prevent any unnecessary short-term impacts. Secondary prevention strategies focus on groups that are at greater levels of risk for crisis due to their membership in a population segment (e.g., children of caregivers who misuse substances or have addictions or students who are failing academically). "Risk groups may be identified based on biological, psychological, social, or environmental risk factors known to be associated with substance abuse (Institute of Medicine, 1994, p. 2), and targeted subgroups may be defined by age, gender, family history, place of residence" and so on. An individual's personal risk is not specifically assessed or identified and is selected based solely by membership in the higher risk subgroup. The selective prevention strategy is presented to the entire subgroup because it is at higher risk for substance abuse than the general population.

3. **Tertiary Prevention** (3rd level) – supports the recovery after the crisis to help prevent any unnecessary long-term impacts.

9.1 Examples of Primary Prevention

1. Cultural identity and connection to land, history, traditions, Elders, stories, ceremonies, and other aspects of culture.
2. Understanding intergenerational patterns and rebuilding and maintaining healthy family connections.
3. Self-determination, community control, and investment in developing nationhood.
4. Services and supports to prevent violence and abuse through improved community safety.
5. Self-awareness, emotional literacy, and skills in processing physical, emotional, mental, and spiritual impacts of intergenerational and new trauma.
6. Services and supports to assist individuals and families process old trauma and rebuild healthy relationships.
7. Community awareness and skill building to reduce bullying and lateral violence and to build capacity for non-violent communication and problem solving.
8. Clinical, cultural, and community services and supports to address addictions and mental health problems.
9. Risk assessment and mitigation for specific community events or programs.

Dudgeon et al, 2016 p. 3 identified these additional success factors:

1. Addressing community challenges, poverty, social determinants of health
2. Enhancing capacity of community worker with training to identify risk – Indigenous-specific
3. Cultural competence of staff/mandatory training requirements
4. Awareness-raising programs about suicide risk/use of DVDs (various media) with no assumption of literacy
5. Reducing access to lethal means of suicide
6. E-health services/internet/crisis call lines and chat services
7. Responsible suicide reporting by the media

Each community will have its own way of identifying priorities for preventative action.

Examples of Secondary Prevention

Selective prevention for youth to build life promotion skills and a vision for the future

1. School-based peer support and mental health literacy programs;
2. Culture being taught in schools;
3. Peer-to-peer mentoring, and education and leadership on life promotion;
4. Programs to engage or divert, including sport and cultural activities; and
5. Connecting to culture, land, and Elders.

Secondary prevention to mitigate the impact of crisis includes the following:

1. Immediate identification of a crisis and ability to mobilize that comes from community strengths;
2. Understanding of how an individual crisis incident is linked to other longstanding problems and issues in the community. For example, with an awareness of critical risk periods there is pre-planned responsiveness for those times;
3. 24/7 capacity to respond quickly to crisis no matter what time or day of the week;
4. Effective communication between and among Chief and Council, First Nations staff, cultural and community resource people, other agencies, and community members;
5. Community crisis response plan is in place to use as a guide for action planning, including assignment of tasks;
6. Maintenance of community control of the crisis response and respect for individual and family beliefs and priorities;
7. Ability to include internal and external resource people in a comprehensive and coordinated response without losing community control;
8. Ability to bring together and bridge cultural, community, and clinical services and supports in response to individual and family needs during the crisis, continuing care, and assertive outreach post-crisis;
9. Willingness to change the action plan as the impacts of the crisis become clear and opportunities and priorities shift;
10. Capacity to learn from experience—coming together after the crisis to evaluate and learn in order to strengthen the response capacity for future crises; and
11. Provision of hope for the future through education and preparation for employment.

Each community will have its own priorities in responding to crisis to mitigate its impacts and prevent further problems that may come from an ineffective response.

9.2 Examples of Tertiary Prevention

Tertiary prevention to focus on longer term recovery may include

1. having clear referral pathways to ongoing community-based cultural healing and practices, diagnosis, clinical counselling such as the use of cognitive–behavioural therapy (Drawson, 2016), ongoing and continuous access to culturally safe services, and external supports;
2. recognizing the shift from crisis response to recovery;
3. being able to plan for longer term recovery from the crisis that links back to primary prevention;
4. paying attention to individual, family, and community restoration and rebuilding of connections;
5. using a holistic approach in addressing hope, belonging, meaning, and purpose within the appropriate cultural context;
6. understanding that during the recovery stage a new crisis incident may emerge, requiring the return to crisis response while maintaining a focus on recovery for the previous crisis;
7. linking the recovery to strategies that address longstanding community problems and issues using a community development approach; and
8. reviewing of community crisis response plans and action plans used and learning from implementation to contribute to improvement of the plans and their process.

Each community will have its own priorities for prevention at this level, and plans will reflect their unique perspectives on the process of recovery.

9.3 Stabilization & Safety

Crisis has the potential to disrupt the integrity of a social system, family, or community as well as individual balance and wellness. Optimally, the communities would be free of crisis or at least have a community life with time between crisis incidents to recover from and resolve the impacts. Communities may go through periods where the crisis events are too close together to work through a complete process of recovery and restoration.

Longstanding problems and issues may fuel crisis incidents. Unresolved sexual violence or other traumas, violent and criminal behaviours, lateral violence in relationships, children being removed from families, unresolved grief and loss, and disruptions in cultural identity and self-determination linked to intergenerational patterns sourced from the many impacts of colonization are all examples that contribute to community chaos and crises.

The traumatic impact of a crisis on a community cannot be underestimated. At the individual and family levels, crisis response requires access to community-based and external supports to respond to urgent needs, assist with stabilization, and, where needed, transition clients to other services or some form of ongoing care. A crucial component of crisis response is the coordinated and timely follow-up and debriefing at the individual, family, and community levels.

Given the number of adverse experiences and the history of trauma in First Nations communities, a trauma-informed approach to care is highly recommended. With trauma-informed care, the service provider or front-line worker is equipped with a better understanding of the needs and vulnerabilities of First Nations clients affected by trauma. This knowledge increases their sensitivity to viewing trauma as an injury and their ability to support stabilization and healing based on compassion, placing the priority on a trauma survivor's safety, choice, and control. A trauma-informed approach may include the following:

1. Accessing other trauma-informed systems;
2. Assessing and treating trauma based on readiness of individuals, families, and community;
3. Debriefing to address secondary trauma in caseworkers and front-line supports;
4. Using effective and appropriate interventions (culture-based or Western) for specific sources of trauma are important; and
5. Ensuring capacity to assist external supports with accommodations, food, and space for care facilitation.

In some instances, models for debriefing trauma events focus on individuals by providing one counselling session to stabilize the individual following a traumatic event, while more trauma-informed and strength-based responses can be focused through multiple events (many follow-up sessions) of small groups that gather in the community or in people's homes following a traumatic event and is directed by community members (Regal et al., 2007).

9.4 Community Healing

1. **Eco-Map:** Use of an eco-map is not only a good tool for conducting a family-based assessment, but it also provides information on what resources are in the community and how the community responds in times of crisis and celebration. This is particularly important if the support services and workers are not members of the community being served. There are certain community issues workers should be familiar with so they can offer the best services possible: history of previous crises and responses, examination of crisis patterns, the role of cultural values and beliefs of the community, how tolerant the community is to individual differences (e.g., sexuality, spirituality, and so on), the political atmosphere of the community, how the community responds to celebrations, relationships between extended families, identifying influential individuals and families in the community, and important historical information about the community (e.g., residential school experience, maintenance of language, traditional activities, and so on) (National Native Addictions Partnership Foundation [NNAPF], 2002–2003).
2. **Cognitive–behavioural Therapy:** A recent scoping review identified cognitive–behavioural therapy as an effective model and was perceived as culturally acceptable. The results support incorporating traditional cultural activities in the treatment of mental health concerns. The development of traditional and cultural applications, especially those that may serve to bolster resilience, and measuring resilience as an outcome are needed (Drawson, 2016).
3. **Intergenerational Trauma:** Addressing underlying factors such as sexual abuse through a restorative justice process that facilitates community healing is critically important. Restorative practice is a framework for repairing harm when a wrongdoing or injustice occurs. It may involve the victim, the offender, their social networks, justice, health, child and family service agencies, police, and the community. Restorative practice is commonly thought of as a process, such as a circle or a facilitated dialogue. However, it can be any kind of collaborative effort that aims at repairing harm and constructing meaning. When approaching restorative practice, there is a need for practitioners to be aware of the colonial relations and respectful behaviours. Respect will be different across the Nations. It is appropriate to ask what would constitute respect. Elders and community members can advise on the protocol for including those impacted by the harm, their relations, and the Creator when appropriate. It is important that the origins of restorative practice and the collectivist nature of the work are respected and honoured always.

The Hollow Water First Nation's community healing model aimed at addressing sexual abuse with support of partnerships with justice (crown attorney), police, child welfare, and health and mental health programs to deal with abuse following these 13 steps (Bushie, 1999, Section 3):

1. Disclosures
2. Establish safety for the victim
3. Confront the victimizer
4. Support the spouse or parent of the victimizer
5. Support the families that are affected
6. A meeting between the assessment team and the RCMP
7. Circles with victimizers
8. Circles with the victim and the victimizer
9. Prepare the victim's family for the sentencing circle
10. Prepare the victimizer's family for the sentencing circle
11. A special gathering for the sentencing circle
12. A sentencing review
13. A cleansing ceremony

Another Indigenous-specific model to address sexual abuse focused on these following steps (Payne, 2013, Section 11):

A. Indigenous People/Tribal Communities must take responsibility for the safety and healing of children.;
B. Indigenous People/Tribes must have ownership of social problems as well as the development of solutions to those problems.;
C. Reclaiming and reviving cultural values, beliefs, practices to heal children and those victimised as children must begin with understanding historical trauma and in multigenerational dialogue.
D. On-going mentoring and support for "Indigenous couriers of community change" is essential for tribal communities to achieve long-term change in attitudes and responses toward children who were victims of sexual abuse.

4. **Cultural Interventions and Practices:** These could include using Indigenous language, prayer, smudge, sweat lodge or other ceremonial cleansing, traditional cultural teachings, access to Elders and cultural practitioners, ways of addressing complicated grief through feast for ancestors or loved ones who have passed on, culturally informed burial practices, access to the Creation Story to support decolonization, and sharing circles (NNAPF, 2015).

9.5 Community Development, Ownership, and Capacity Building

Facilitating community growth and development requires consistent attention and nurturing community strengths and capacities. Community development is an approach that can lead to better health, economic, and social outcomes in First Nations communities by empowering communities to define and manage their own services, utilize their cultural knowledge, and build on their unique strengths. Skills that support these activities include the following (Health Canada, 2015, p 15):

1. Building partnerships and relationships;
2. Engaging natural or informal supports within the community;
3. Using community dialogue and communication;
4. Establishing a cultural framework, including a statement of community principles;
5. Team building;
6. Decision making and planning;
7. Training in trauma-based practice to address intergenerational trauma;
8. Developing trauma resources for caseworkers, caregivers, and families that include history of colonization and cultural story of Creation;
9. Building linkages across the social determinants of health;
10. Using strategies aimed at supporting community change (change management); and
11. Increasing opportunities for community-to-community knowledge exchange and mentorship.

Indicators of effective community development initiatives include the following (Mignone, J, 2011, p 5):

1. Strong, healthy, and vibrant community;
2. Sound leadership;
3. Essential facilitation skills of community workers;
4. Well-organized across community services and with external partners;
5. Ready to move forward; and
6. Guided by core values defined by the community.

10. Crisis Response and Recovery

The ability to respond effectively to crisis is dependent on effective crisis planning and timely access to necessary resources, supports, and services. At the community level, this may involve access to external supports to help communities respond to the immediate needs of individual clients and families beyond what the existing community workforce can provide. It may also mean defining a plan to address the underlying causes of the crisis and facilitate ongoing care and support. At the individual and family levels, crisis response requires access to community-based and external supports to respond to urgent needs, assist with stabilization, and, where needed, transition clients to other services or aftercare. As mentioned earlier, a crucial component of crisis response is communication and coordination with timely follow-up and debriefing at individual and community levels. Communication is all-important during the various phases of planning, prevention, response, and recovery. Communication is needed not only with the Chief and Council to update them on the plan or situation but also with staff, partner agencies, individuals, families, and community.

CRISIS RESPONSE is an action on the part of community members, First Nations staff, governments, or other agencies to respond to crisis that may include one or more of the following:

1. Individual, family, and community engagement, focus, and leadership;
2. Responses adaptable to each individual community context;
3. Assessment of strengths and assets;
4. Assessment of urgent, short- and long-term needs—physical, emotional, spiritual, and mental (intellectual—information, knowledge skills, and so on);
5. Cultural supports that observe local protocols and may include Elders; ceremonies; talking, healing, or other circles; home visits; community meetings and gatherings; vigils and other appropriate cultural supports as defined by families and community;
6. Community supports that bring the community together to support one another using community groups, churches, service clubs, volunteers, organizations, and community relationships to work together;
7. Clinical supports and services that observe local protocols and may include a variety of clinical methods, interventions, and services such as short-term crisis-oriented counselling and clinical supports for individuals and families; home visits with local sponsor or cultural support person; assessment of longer term counselling needs; referrals; and other appropriate clinical supports and services as defined by families involved and by the community;
8. Other supports and services, depending on the nature of the crisis, such as RCMP or other policing services; emergency medical services (EMR) such as ambulance; Coroner's Office; Environmental Health Services; Medical Officer of Health; Search and Rescue; and other agencies either local, regional, or provincial/territorial or federal may be needed. Plus, third-party agencies or NGOs (e.g., Red Cross).

11. Policy Framework

11.1 Governance

The governance of the community crisis planning, prevention, response, and recovery service delivery may be specific to each First Nations community and may be determined by the nature of the crisis. The Chief and Council or the duly elected or appointed governing body of the First Nation is the ultimate decision-making authority. In some cases, the Chief and Council or the equivalent decision-making body may delegate the responsibility to a health board or equivalent body. In other cases, the First Nation may ask an external body to take over the day-to-day decision making under a broad mandate provided by the Chief and Council. For example, in the case of a communicable disease outbreak that is not a full-scale epidemic requiring emergency response, the Chief and Council may assign leadership to the Medical Officer of Health to direct the response.

11.2 Crisis Planning, Prevention, Response, and Recovery Continuum

The planning process informs priorities for prevention, response, and recovery. As the prevention activities are implemented, the plan may need to be amended. The experience of a response to a specific crisis and follow-up recovery will inform further planning and prevention activities, which create a circle of activity geared toward using experience, including evaluation and debriefing experience, to inform future planning and implementation.

11.3 Partnerships

The spirit of communication and collaboration is essential for coordinated and effective work across the continuum. The community crisis response plan should be clear about the roles and responsibilities of each partner. In some cases, roles and responsibilities may be shared.

First Nations Community: The partnership between Chief and Council and senior staff is essential for effective action. Optimally, the community crisis response plan would have been developed with Chief and Council and community member engagement. Once the plan is approved by the Chief and Council, it provides the foundation for action. Collaboration between departments within the First Nation is essential to coordinated action. Once again, the plan should provide a foundation for that partnership. The leadership and staff need to be willing and able to see community members as active and capable partners. Many community members have a range of skills and knowledge that can be very helpful as cultural, community, or clinical support people. Cultural skills including traditional and on-the-land skills can be very helpful in the case of a missing person, for example.

First Nation and Local or Neighbouring Village, Town, or City: Some First Nations communities are close to a municipality. Even the smallest villages have the capacity that can be helpful in responding to a crisis. Advance joint planning sessions or consultations on a draft community crisis response plan may be helpful in paving the way to smooth cooperation and collaboration in the event of a crisis. A negotiated mutual aid agreement may be helpful in defining the ways in which neighbours can help each other.

First Nation to First Nation: In some cases, neighbouring First Nations may choose to help one another. This may be due to tribal council or other political linkages, geographic proximity, historical family connections, or other relationships. Advance joint planning, consultation, and possibly a mutual aid agreement may provide a clear foundation for partnerships.

Link to Territorial or Provincial Agencies: In some cases, additional resources (money and people) may be needed and the First Nations Chief and Council or delegated authority may request help from provincial or territorial governments or other agencies. The challenge is to integrate the help into the response without losing control to outside decision makers. Advance joint planning, consultation on draft plans, and negotiation of an agreement are helpful in making a response faster and more effective.

Link to Federal or National Agencies: In some cases, additional resources (money and people) may be needed and the First Nation Chief and Council or delegated authority may request help from the federal government or national agencies. The challenge remains to integrate the help into the response without giving up control to outside decision makers. Activities such as joint planning, consultation on draft plans, and negotiation of an agreement among all parties in advance are helpful in making the response to a crisis faster and more effective.

Tools to Help with Working across Jurisdictions to Address Social Determinants of Health

There are a number of tools that have been designed to help identify and address disparities among the social determinants that affect the health of First Nations people. One tool that may be particularly useful is the Health Equity Impact Assessment (HEIA) tool designed by the Ontario Ministry of Health and Long-Term Care (MOHLTC) (2008, para. 3): The HEIA . . . has four key objectives:

1. Help identify unintended potential health equity impacts of decision-making (positive and negative) on specific population groups
2. Support equity-based improvements in policy, planning, program or service design
3. Embed equity in an organization's decision-making processes
4. Build capacity and raise awareness about health equity throughout the organization.

Referencing the FNMWC, these four objectives help decision makers at the program, service, or policy levels (**dark blue**, **dark green**, and **light green** rings) ask these important questions: How can more populations be included across the life span (**sage green ring**), especially those with specific needs (**orange ring**) who may be disproportionately affected by social determinants of health (**light orange ring**)? How can these programs, services, or policies attend to the five key themes of the FNMWC (**dark red-orange ring**) that help facilitate hope, belonging, meaning, and purpose (**centre blue ring**)? See the FNMWC graphic on pages 30 and 31.

Although this tool is not First-Nations-specific, the HEIA can help individuals, families, communities, and partners speak a similar language. Each individual, family, and community will have their own understanding of the HEIA tool; therefore, it is important to adjust the tool to fit current needs.

11.4 Operational Structure

The operational structure of the crisis response will be somewhat unique in each community. Under the overall direction of the Chief and Council and executive director or equivalent, a crisis response team (CRT) would likely be established. The leadership should be assigned to one departmental director or equivalent senior official. It is important that the person assigned to lead the CRT has decision-making authority, the confidence of the Chief and Council, and credibility among community members.

The workforce requirements would differ depending on the nature of the crisis, but may include the following:

Central Services: Not all First Nations have individual staff or units dedicated to communications, issue management, finance, human resources, or health and safety. Often, those functions rest with other staff. However, these functions all have to be covered to coordinate communications, issue management, spending of resources, approval of overtime or contracts, and ensuring laws and regulations related to the health and safety of employees and contractors are protected.

Mental Wellness Team: The clinical team members may include a psychiatrist, counsellors, psychologists, and addictions specialists all trained in crisis response and trauma-informed care. The cultural support people may include outreach workers, those who conduct ceremonies, Elders, land-based activity guides, and healing resource people. The community supports may be family members, church members, and volunteer helpers of any description.

Health Team: Depending on the nature of the crisis, nurses, doctors, and health centre or nursing station staff including medical specialists may be needed.

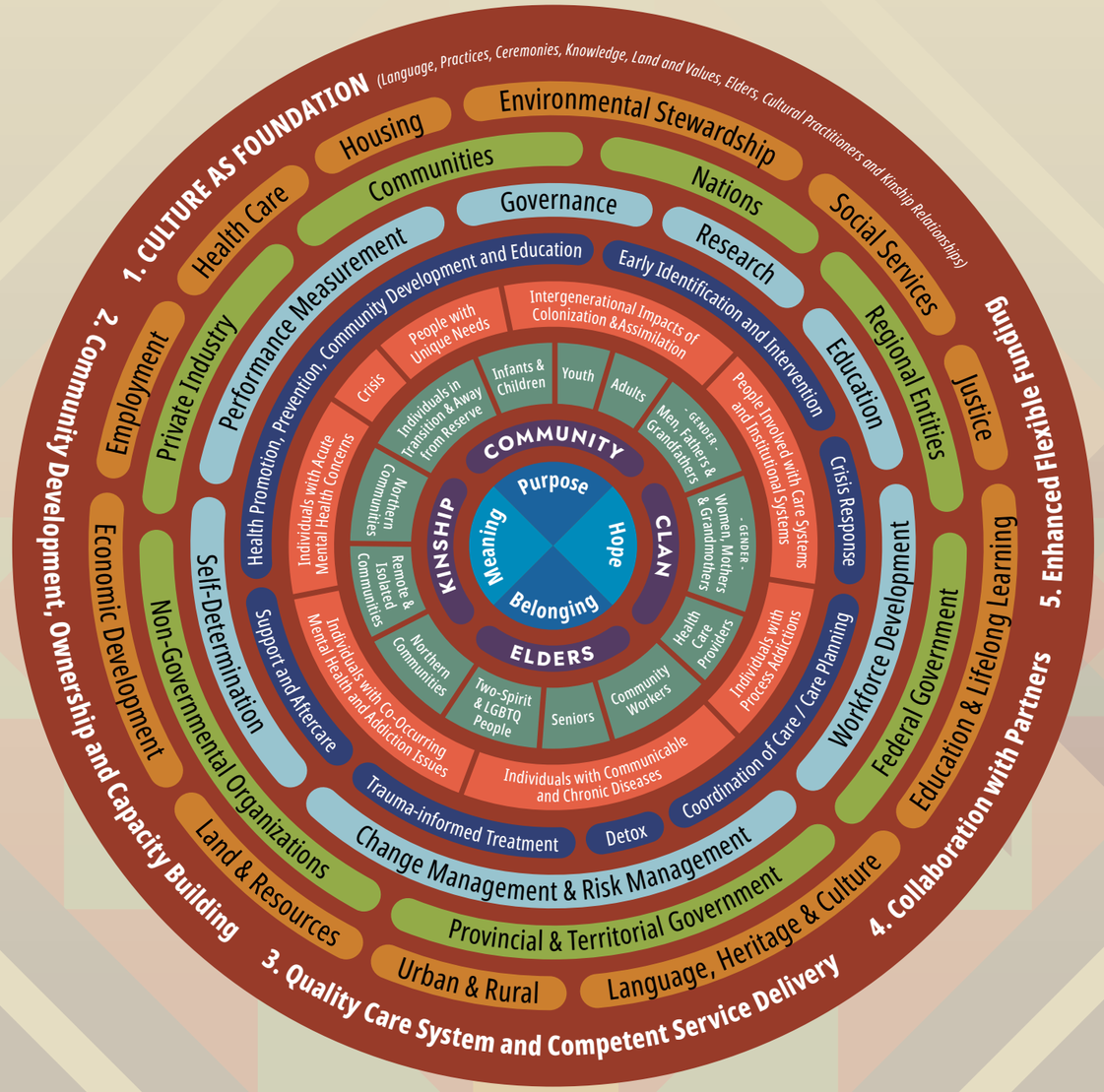
Community Services Team: Any issues to do with housing or infrastructure—such as a house fire or power, water, sewer, or other infrastructure issue—may require the assistance of maintenance staff trained in fire suppression, site clean-up, plumbing, electrical, or other aspects of community operations.

Education and Training Team: In some cases, day care children or grade school or post-secondary students may be involved in the crisis where the education and training team may need to be involved. This team would also support the First Nation in capacity building and related training.

Land and Renewable Resources Team: In the case of a wild animal at large or search for a missing person, the land and renewable resource team may have people with appropriate knowledge and skills to be helpful.

Representatives of these teams would be assigned to the Crisis Response Team as needed. The CRT would have the authority to assign responsibilities and tasks to First Nations staff members and approved volunteers.

First Nations Mental Wellness Continuum (FNMWC) framework



Thunderbird Partnership Foundation provides development and training on the First Nations Mental Wellness Continuum Framework. For more information, visit thunderbirdpf.org.

The following guide can help you navigate the FNWMC wheel.

FOUR DIRECTIONS	When we have Hope, Belonging, Meaning & Purpose (HBMP) in our lives, we achieve wellness. HBMP are outcomes of the 13 Wellness Indicators.
COMMUNITY	Considered primary facilitators of wellness (HBMP). Consider how these groups are affected by your work, policy, program or service inputs for the individual.
POPULATIONS	Consider how your policies, programs & services address the span of life & needs of specific populations when planning & assessing the needs for mental wellness.
SPECIFIC POPULATION NEEDS	These are the continuum of needs identified by communities. Consider how they are linked with substance use and mental health needs.
CONTINUUM OF ESSENTIAL SERVICES	Consider what essential services are needed to address the specific needs of the population.
SUPPORTING ELEMENTS	Identify needs within these supports to ensure you can move toward mental wellness. E.g. what needs to change in your workforce if Indigenous culture is the foundation?
PARTNERS IN IMPLEMENTATION	Consider who is responsible to support mental wellness, and engage with current and potential partners across jurisdictions and private industry.
INDIGENOUS SOCIAL DETERMINANTS OF HEALTH	Break down silos toward mental health across SDOH by identifying how they address or are impacted by substance use & mental health needs. All share responsibility for Indigenous wellness.
KEY THEMES OF MENTAL WELLNESS	Use these 5 themes to explore the current state of mental wellness, guide planning, direct change at all levels, and monitor progress. The themes can support strategic direction.
CULTURE AS FOUNDATION	As a key theme, identify how culture plays a role in your initiative & aligns with First Nation's worldview, knowledge, evidence, values & contributes to wellness (HBMP).

11.5 Monitoring Indicators

Each First Nation has its own data collection systems and methods for analyzing and reporting on data. In general, it would be hoped that the following indicators would be supported by data systems over time:

Questions	Indicators	Options for Measures
Did the prevention efforts work?	Employee rating of response	Questionnaires or interviews
	Community member rating of response	Questionnaires or interviews
	Crisis trends	Tracking of crises
	Determinants of health—economic, employment, educational, social, and so on	
Is the crisis response plan useful and effective?	Employee, partner, and community ratings of response	Feedback gathering from questionnaires, interviews, focus or debriefing groups, and community meetings, if any
Was the crisis response timely?	Time in-between crisis, notification, and launch of response	Tracking of crisis response
Was the crisis response effective?	Family and community ratings and qualitative feedback on response	Feedback gathering from questionnaires, interviews, focus or debriefing groups, and community meetings, if any
Were partnerships effective in providing useful resources?	Employee, partner, and community ratings of response	Feedback gathering from questionnaires, interviews, focus or debriefing groups, and community meetings, if any
Was the response balanced with the use of clinical or technical, cultural, and community resources?	Employee, partner, and community ratings of response	Feedback gathering from questionnaires, interviews, focus or debriefing groups, and community meetings, if any
At what level was recovery achieved?	Level of recovery at 3 and 6 months post-crisis	Native Wellness Assessment™ Outcome rating scale
How was the evaluation and learning used to support improvement?	Evaluation report completed and recommendations implemented	Tracking of crisis and modifications to the community crisis response plan, including additional training or capacity building
Did the First Nation remain in control?	Evaluation report was completed and addresses decision making throughout the crisis	Tracking of crisis response
Were individual and family priorities respected?	Ratings and qualitative feedback from individuals and families involved	Questionnaires, interviews, focus groups, or family meetings
Was the response cost-effective?	Expenditures by the First Nations and partners	Cost data
	Effectiveness indicators as above	
Did the experience of the crisis response build community confidence and capacity?	Levels of community assets, strengths, confidence, and capacity	Community development activities and assessments

11.6 Capital Requirements

The capital requirements will vary between communities. The new capital investments will be dependent on what the First Nation owns or is able to access through partnership arrangements. Minimum requirements, depending on the nature of the crisis, include the following:

Facilities

1. Meeting room space for the Crisis Response Team;
2. Meeting space for the community;
3. Meeting room space for individual or family meetings or service and support sessions;
4. Health care facilities, if no other accommodating space is available, as may be the case in isolated or remote communities;
5. Permanent and temporary housing, if needed;
6. Firepit as a community gathering site; and
7. Land-based site for cultural ceremonies and gatherings.

Equipment and Vehicles (if needed)

1. On-road vehicles to transport staff, equipment, and community members;
2. Off-road vehicles appropriate to the terrain and season (skidoos, four wheelers, and so on);
3. Chainsaws, axes, generators, and equipment for fire suppression, emergency communication, survival, and camping;
4. Heavy equipment and earth-moving vehicles;
5. Tracks for hauling;
6. Safety clothing and equipment; and
7. Medical equipment.

Supplies

1. Food for staff, volunteers, and community members;
2. Medical supplies; and
3. Home repair supplies.

12. Operational Guidance

12.1 Training Requirements

The training requirements that are relevant to planning, prevention, response, and recovery include the following:

Communication and Coordination

1. Communication plan development and implementation;
2. Issue management; and
3. Responding to the media and media interview skills

Planning

1. Strategic, operational, and action planning;
2. Engagement of community leadership, community members, and partners in planning;
3. Inventory of knowledge and skills of community members; and
4. Revising plans based on experience.

Service and Support for Crisis Prevention, Response, and Recovery Skills

1. Team development;
2. Roles and responsibilities;
3. Clinical counselling;
4. Cultural counselling;
5. Community engagement and development;
6. Traditional and land-based skills such as tracking and navigation;
7. Land-based healing, cultural skills, and protocols for ceremonies; and
8. Options for delivery, such as internet, land-based, and workshops.

Sources of Training

Thunderbird Partnership Foundation

A. Native Wellness Assessment™

B. Trauma-informed Care

C. Strength-based Approaches to Care

D. Culture as a Foundation

Crisis Trauma Resource Institute (CTRI), Winnipeg, Manitoba

A. Trauma, counselling, crisis response

Centre for Addictions and Mental Health (CAMH), Toronto, Ontario

A. Mental health, addictions, suicide prevention

Mental Health Association of Canada (CMHA) and provincial and territorial chapters

Mental Health Commission of Canada

A. Mental Health First Aid for First Nations

Centre for Education on Health and Aging (CERAH), Lakehead University, Thunder Bay, Ontario

A. First Nation Palliative Care, Grief and Grieving

Others

12.2 Roles and Responsibilities

Internal to First Nation

Chief and Council will provide overall leadership to the planning, prevention, response, and recovery that includes oversight of the strategic, operational, community crisis response and action planning, implementation, and evaluation. Political relationships with other governments or agencies will be established and maintained as needed.

Health Board or Advisory Committee, if available, a decision-making board or advisory committee will provide advice to the Chief and Council and staff or accept decision-making delegation from the Chief and Council to take on some of the roles and functions.

Executive Director (or equivalent senior official reporting to the Chief and Council) provides overall management oversight and coordination of planning, prevention, response, and recovery according to the direction of leadership; appoints members of the Crisis Response Team (CRT), including the lead departmental director or other senior official; provides strategic direction to the establishment and formalization, as needed, of agreements with partners; ensures that lessons learned from the crisis response is gathered and used to inform any revisions of plans, policies, and procedures for improvement.

Departmental Directors will carry out, under the direction of the executive director, the plans according to policies and procedures, including assignment of staff and recruitment of family and community members; incorporate partner agencies and staff into the teams implementing the plan; ensure the tracking of the crisis planning, prevention, response, and recovery activities to support monitoring and evaluation.

Departmental Staff will implement the plans under the direction of the director or the Crisis Response Team and document the activities; communicate with individuals, families, and community members, formally and informally; link with partner agency staff and provide orientation and guidance, as needed; identify conflicts or problems as soon as possible and initiate a conflict resolution process; and contribute to monitor and evaluate for improvement.

Contractors may be brought in by the First Nation or partner agencies, and their role is to take on clinical or technical, cultural, or community contract work as assigned by departmental staff and is within their scope of skills and experience, report back to staff, and contribute to monitoring and evaluating crisis-related work.

Cultural Support Resource People and Elders will be asked to participate and use the appropriate cultural protocols. They will offer advice and support to staff, families, and communities through ceremonies, cultural teachings, stories, songs, and dances according to local traditions and when appropriate. The diversity of religious and spiritual beliefs within the community and family systems will be respected and accommodated.

Extended Families have varying degrees of capacity depending on many factors. According to the current capacity and priorities of the extended family, members will be engaged in support to their family members and others. Roles such as purchasing food and preparation, medicine gathering, and support in ceremonies are examples of help that family members are often able to provide. In some cases, time dedicated to family roles and responsibilities will mean that First Nations staff members from the local First Nation may not be as available to carry out their work-related roles and responsibilities at the same level as usual.

Clan, Kinship, and Tribal Leaders and Members have connections that will be community-specific and need to be fully understood, as well as protocols respected, in order to appropriately support the roles and responsibilities individuals will take on; for example, holding community events such as vigils, funerals, or other gatherings and relying on the traditions and cultural knowledge and protocols to guide the activity.

Community Volunteers are members of the community who step forward to volunteer time and skills to crisis-related activities. Volunteerism within First Nations communities is often linked to family, clan, kinship, and tribal responsibilities. The volunteers need to be involved in planning, determining appropriate roles and responsibilities, and training in order to be fully prepared. In addition, they need to be part of the team in a similar way as staff and contractors in order to ensure safety and appropriate work assignments are offered.

External to the First Nation

Partner Agency Senior Officials and, in some cases, political leaders or governance board members need to be involved in advance planning and agreement negotiation. This work will set the stage for coordinated efforts in the event of a crisis. The community priorities and principles will be discussed during the negotiations and consensus sought. Respect for the leadership by First Nations communities at the Chief and Council, senior management, family, and individual levels must be respected as fundamental to any agreement. Dropping resource people into a crisis situation with no advance orientation, negotiation, and commitment to the planning for crisis prevention, response, and recovery should be avoided when possible.

Partner Agency Staff assigned to assist the First Nations staff in implementing the crisis response plan must be willing to join the CRT and be respectful and responsive to the direction of the First Nation. The investment in community and cultural orientation of partner agency staff prior to a community crisis event will assist in assuring cultural safety. The cultural competence of staff members working with the First Nations staff and community members will be the foundation in making a long-term positive impact on the prevention, response, and recovery of the community.

Volunteers not associated with partner agencies may be willing to support the crisis prevention, response, or recovery efforts. Establishing a buddy system whereby the volunteer from outside the First Nation is paired with a First Nations staff member may be the best way to ensure the most appropriate contributions and full utilization of the skills and experience brought by the volunteer.

12.3 Use of Culture Including Traditional Skills

The availability of a range of cultural and traditional skills will vary significantly between communities. In addition, community commitment to cultural life, language, and the revitalization of practices also varies significantly. The practising of mainstream religions may currently play a positive role in some communities. However, the influences, historical and current, can create tensions in some communities. The best approach is to honour and respect all beliefs and to provide options to the extent possible for individuals to choose what is most helpful to them.

Other activities done in advance of a crisis that may help with the engagement of Knowledge Keepers include the following:

1. Identification of which people in the community are Indigenous language speakers or holders of specific cultural knowledge, skills, and teachings;
2. Traditional knowledge research and respectful inquiry as to what protocols must be followed in order to appropriately request help, including gifting before, during, and after the contribution;
3. Understanding of the cultural rules and laws such as humility and secrecy that may help in engaging people with cultural knowledge and skills;
4. Advance planning that may include ceremonies to find out what people need before, during, and after a crisis to support their experience and to acknowledge deep respect and gratitude for what they bring;
5. Avoid forcing mainstream training as a requirement for all involved. The ability to engage and support cultural contributions as equal and important as clinical or technical contributions in the overall crisis planning needs to be developed in a community-specific way without using a common mainstream framework.
6. Seek feedback after a crisis response experience to continue to learn, grow, and improve.

12.4 Community and Team Communication and Organization

Communities each have their own methods for bringing the community together or organizing team meetings. What usually works in the community is the best way to continue.

Things to think about in organizing community or team meetings:

1. Issue an advance communication or notice, if possible, using methods that work, such as house-to-house flyers, newsletters, radio, local TV, Facebook, email announcements, text messages, First Nations website, local posters on bulletin boards, or signs.
2. Organize team meetings using email or a combination of methods.
3. Communicate a clear purpose with objectives and an agenda, and distribute this in advance to invite input.
4. Begin with a ceremony, if appropriate.
5. Begin and end the meeting with a prayer or appropriate locally acceptable method of bringing people together.
6. Engage the group in setting ground rules or a social contract on how they choose to communicate with one another, when appropriate; also decide on what happens as a consequence in the event that a ground rule is broken.
7. Use a range of methods that have worked in the community, from circles to formal chaired meetings.
8. Offer food and other refreshments as a demonstration of hospitality and welcome; use of seasonally available traditional foods is ideal, if possible.
9. Invite participation, engagement, and feedback.
10. Ensure microphones are available for use when using a large room or there is a large meeting or gathering so that people can be heard.
11. Ensure the meeting is documented and that privacy is respected if someone does not want their comments on the record.
12. Ensure cultural and clinical support people are available and identified when discussions involve sensitive topics.
13. Be prepared to handle anger, criticism, and conflict in respectful ways and understand that these dynamics are often related to stress, having too much to cope with, unresolved grief and trauma, and intergenerational effects.
14. Gain advance agreement on what to do in the event someone at the meeting is under the influence of drugs or alcohol or becomes verbally or physically violent.
15. Engage a neutral facilitator as the chair of the meeting so that, in some cases, it may be helpful when others become defensive or come under direct attack.
16. Circulate or post the minutes of the meeting and make sure follow-up is completed to ensure accountability, such as promises made at the meeting are met.
17. Evaluate the meeting or gathering to support improvement.

12.5 Case Management and Community Circle of Care

Many First Nations communities have a method for case management or coordination of care with multiple service providers and sometimes multiple departments. Electronic medical records and a case management computer application make coordination and documentation easier with multiple service providers. Whatever approach is used, it needs to be individual- and family-centred, build on strengths, and provide a range of clinical and cultural approaches. In some cases, there is an assigned case manager that has that function. In other cases, when there is no full-time case manager, the individual responsible for the coordination or management of care can vary depending on the most important needs of the family.

The system should be built on the principles and values of the community and ensure respect for individual and family priorities, which are fundamental to the support and services provided. The case management or Community Circle of Care (CCC) process is most likely to be most active in the prevention, response, and recovery phases. The method should be robust enough to respond to the needs of a peer group—youth, children, or adults—that have a shared crisis experience, such as an unexpected death.

Community education and engagement is necessary in the design of a case management or CCC to provide a foundation for the individual, family, or peer group to be active participants and drivers in the management of their care, not just a passive recipient. A trauma-informed approach involves and engages the strengths of the program participant.

12.6 Outcome Measures

Outcome measures and the indicators to be used in assessing success need to be developed and validated by the First Nations leaders, members, and staff. For the purposes of this service delivery model, the outcome measures will be linked to the objectives and build on the monitoring indicators that were identified in Section 11.5 above.

The goals of the service delivery model and related outcome measures are shown below:

Hope

- Respectfully engage with community and families to create methods that align with their beliefs, identity, and values for them to lead the process of crisis planning for prevention, response, and recovery that is built from community strengths.
- Outcome Measures – level of respect experienced; level of engagement; and completeness and comprehensiveness of planning, prevention, response, and recovery.

Belonging

- Plan and implement short- and long-term actions that ensure optimal relationships and connections and build local community capacity, restore connections, and support recovery.
- Outcome Measures – experience of positive communication and connectedness to family and community members; and connection to land and culture.

Meaning

- Use community and culturally appropriate methods of evaluation to ensure prevention and response continues to improve and identified problems are solved.
- Share knowledge, skills, and resources among First Nations communities and those who serve communities.

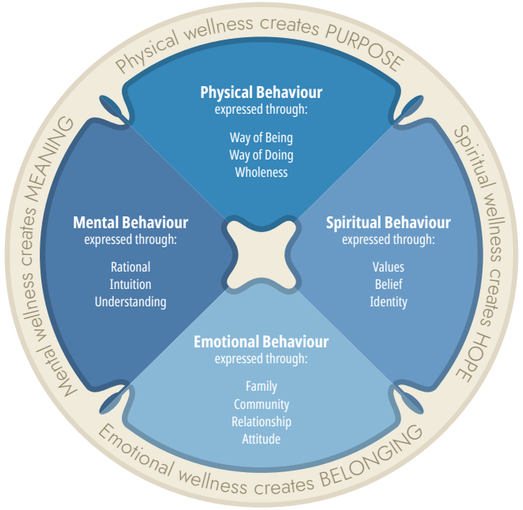


Figure 4: Indigenous Wellness Framework (Thunderbird Partnership Foundation, 2014)

- Outcome Measures – useful and culturally appropriate evaluation methods produce meaningful findings and support ongoing improvement; and record of helpful sharing through meetings, gatherings, and documents supported by feedback.

Purpose

- Complete assessments to support actions to ensure the best response to diverse and changing needs, risks, and priorities that lead to the best outcomes possible.
- Outcome Measures – assessments completed at individual, family, and community levels; levels of resilience demonstrated; trends in identified strengths and needs; evaluation results of specific event-based crisis response, general capacity to respond, and impact on level of ongoing crises experienced by the community.

13. Gaps, Strengths, And Stories

The work of supporting communities in planning, prevention, response, and recovery will need to continue. The work done in the past by First Nations communities, Indigenous organizations, and researchers has been helpful in the development of the service delivery model (SDM). The SDM needs to be tested by communities who wish to use it as a resource for the development of their own plans, policies, and measures. Based on experience and further research, the SDM could evolve further and be supported by the sharing of detailed examples of work done by other First Nations communities.

There are many challenges in developing a resource for national use. The size, characteristics, cultures, and priorities of communities vary significantly. Therefore, it must remain under community leadership to identify helpful resources and to do their own work. In some cases, they will need to develop plans that are crisis specific and, in other cases, their plans may be integrated and include other emergency responses such as floods or epidemics.

Utilizing Media Relations to Improve Wellness

The media can play a positive role in the face of a crisis. Solution-focused news has the potential to promote wellness and create an increased sense of hope, belonging, meaning, and purpose. Two reviews of all the news stories published in Ontario from 2010 to 2016 found that the number of Indigenous-specific stories was increasing and that the stories featured Indigenous peoples in a negative tone (Journalists for Human Rights, 2013; Journalists for Human Rights, 2016). The authors describe a negative tone as:

> *"An item [that] leaves the reader less likely to support, and/ or do business with the organization. This includes coverage that is critical of the company and does not include a reaction from its spokespeople or authoritative voice. Also, it includes factual reporting of negative news even when the item does not indicate bias (i.e. editorial commentary, praise or criticism)" (Journalists for Human Rights, 2016, p. 9).*

To combat the negative tone in the media, the *Truth and Reconciliation Commission of Canada: Calls to Action* report contains three specific media and reconciliation Calls to Action (see Calls to Action #84, #85, and #86). These three Calls to Action are specific to CBC/radio-Canada, Aboriginal Peoples Television Network (APTN), and journalism and media programs. These are good attainable goals moving toward increasing media coverage about the strength and resiliency of Indigenous individuals, families, and communities especially in the face of a crisis.

There are currently many different local, regional, national, and international media guidelines for reporting on a crisis. For example, reporting on suicide is one type of crisis that has substantial recommendations for all levels of media relations. When reporting on a death by suicide, the media can play a powerful role in raising awareness of social issues, but it also has the potential to do harm. Responding to this potential for harm, a senior journalist from ABC news said, "Media guide-

lines are important because often journalist [sic] don't know what language to use, how to report empathetically, and how to make sure reporting doesn't cause more distress to the person or family involved". The following examples highlight a few procedures, and while originally intended for the media, they are resources that may be beneficial to those who are contacted to speak with the media.

Start Here: General

There are many guides and frameworks about how to report on a death by suicide that come from many different governing bodies and professional areas. Many key concepts are common throughout these guidelines.

Avoid:

- Placing news story on the cover page
- Using the word suicide in the title of the article
- Disclosing the method or location of death
- Glamorizing
- Stereotypes and fear-driven responses

Do:

- Recognize that these issues can affect anyone, so exercise caution when interviewing
- Provide accurate details of how to access help or treatment
- Understand the realities of the community you are working in
- Include risk factors and warning signs
- Stories that promote hope, belonging, meaning, and purpose

Reporting in Indigenous Communities – http://riic.ca/the-guide/ is a website developed by Duncan McCue a CBC journalist from the Chippewas of Georgina Island First Nation. This website provides a well-thought-out, humorous, and easy-to-follow guide for those who are new to reporting in Indigenous communities and those who are well versed in the field. As described on the first page of the guide, McCue states that "Collectively, we can help each other do our jobs better, better serve Indigenous communities, and improve the quality of our news coverage." The guide is broken down into three sections where reporters may face challenges: at the desk, in the field, and on the air. Like this service delivery model, this guide is not intended to be read front to back, but instead used as the reader sees fit.

Local

Media relations during community crisis planning, prevention, response, and recovery may be unique to each First Nations community and may be determined by the nature of the crisis. It is important to consider the characteristics and capacities of the community (see Section 5). Some communities may have a spokesperson who feels comfortable speaking on camera or to a reporter. When this trusted source is asked to speak about a crisis, care should be taken as it may directly or negatively impact this person. However, there will also likely be communities where no designated community member is available.

Regional

Municipalities, provinces, and territories may also have their own set of guidelines that must be followed. The municipality of Edmonton has suggested that the national guidelines on suicide reporting be the primary guidelines for reporters and journalists, in their on-line resource: Edmonton Suicide Prevention Strategy 2016 – 2021 – https://www.edmonton.ca/programs_services/documents/PDF/suicide-prevention-strategy.pdf. The province of Nova Scotia also suggests following the national guidelines, with its on-line resource: Nova Scotia Reporting Guidelines on Mental Illness – https://novascotia.ca/dhw/mental-health/reports/Reporting-Guidelines-on-Mental-Illness-Jan2016.pdf. Be sure to look into guidelines for your area.

National

Canada

The line of work that the interviewer or interviewee is affiliated with will determine what set of guidelines to apply. Two of the more common guiding principles come from the areas of journalism and health care.

The Canadian Journalism Forum on Violence and Trauma (2017) gives journalists a framework to follow and suggests multiple ways to rephrase potentially triggering words and phrases. In doing so, this encourages strength-based and solution-focused journalism. The Forum added a section to their framework called, *Mental Illness Among Indigenous Peoples of Canada, (*sites.google.com/a/journalismforum.ca/mindset-mediaguide-ca/new-chapter-download*)* that may help reporters and journalists who are new to working with Indigenous communities.

The Canadian Psychiatric Association (CPA) worked collaboratively with media professionals to develop guidelines for psychologists who are asked by media to comment on the loss of life. Media Guidelines for Reporting on Suicide: 2017 Update of the Canadian Psychiatric Association Policy Paper (www.cpa-apc.org/wp-content/uploads/Media-Guidelines-Suicide-Reporting-EN-2018.pdf), is a short five-page document, that has a table of wording and phrases to avoid. It also offers support on how to take a strength-based approach in conveying the message (Neon, Fotti, Katz, Sareen & The Swampy Cree Suicide Prevention Team, 2008). At this time, the CPA has no information on reporting in Indigenous communities.

Australia

Mindframe is a national media initiative to encourage reasonable, accurate, and thoughtful media on death by suicide and to promote mental wellness. This short easy-to-read booklet is available in both print and electronic versions (www.mindframe-media.info/__data/assets/pdf_file/0011/9983/Mindframe-for-media-book.pdf) and is intended to be a quick reference guide for media professionals. This initiative reminds the reporter that special cultural considerations must be considered for Aboriginal and Torres Strait Islander peoples. It also reminds the reporter that suicide and mental wellness may be viewed differently by individuals, families, and communities who may hold a different world view (Everymind, 2014).

International

The World Health Organization (WHO) (2017) offers guidelines that can be followed worldwide when reporting on a death by suicide. WHO prepared a scientific literature review on media impacts on deaths by suicide that also contain a large section on responsible reporting, covering a range of topics—such as the use of photos, video footage, and web links—with special consideration for digital media, while providing accurate information about where to seek help.

Youth Voice in Media

The community of Attawapiskat First Nation in Ontario has declared a state of emergency several times over the past decade, during which the media would portray the community with a negative tone. Growing tired of the one-sided media reporting, youth in the community decided to take action and Reimagining Attawapiskat was created. This mixed media storytelling initiative and accompanying website (www.reimaginingattawapiskat.com/) asked youth to tell their story about the strengths and beauty of their community. The photographs, videos, and accompanying stories promote living life in a good way.

For more initiatives to support life promotion, visit the website: wisepractices.ca, which is expected to launch in October 2018. Wise Practices was developed by a team of Indigenous and non-Indigenous researchers and mental health experts in partnership with the Thunderbird Partnership Foundation, with support from the First Nations and Inuit Health Branch (FNIHB) and the University of Victoria. The website showcases wise practices for promoting life among young people based on what is already working in First Nations communities across the country, particularly in relation to preventing youth suicide. The resource is designed to be culturally relevant and responsive to the lived realities of young people and all who are invested in wellness for First Nations youth.

Appendix 1: Community Crisis Reponse Plan Sampler

Crisis and Emergency Response Plan (CERP) Sampler Based on the Kwanlin Dün First Nation CERP – November 23, 2016 draft 3 for discussion

1. Introduction:

The **KDFN Crisis & Emergency Response Plan** (CERP) is divided into five sections:

Introduction: The introduction provides an overview of the key concepts, values and principles that form the foundation of the plan.

2. Crisis and Emergency Response:

Crisis and Emergency Response: A key feature of this plan is that it describes a common approach for dealing with both crisis and emergency.. The plan differentiates between a crisis and an emergency. In common language, the terms may be used interchangeably, but for the purposes of this plan they will be defined separately. Crisis and emergency response may be seen as a continuum, where a crisis with more limited potential impact is on the left and a full-scale emergency requiring intergovernmental response is on the right.

Unexpected death (crisis)	Significant earthquake (emergency)

3. Crises and Emergencies

The CERP is also unique in that it provides operational guidance to address ten specific most likely examples of crisis or emergency that may require a KDFN response. To avoid repeating certain key response elements, this chapter speaks to operational direction common to both crisis and emergency response requirements, such as organizational structure, roles and responsibilities, communication protocols, threat level assessment and evacuation protocols.

Ten examples of crisis and emergency response can be seen in the Table of Contents (TOC) for the KDFN CERP. While the CERP is based on an *all hazards* approach to ensure that common crisis and emergency management elements exist for almost every situation, the TOC lists the ten most likely events that Kwanlin Dün is likely to face. Detailed operational instruction is provided, including information on how best to co-ordinate response efforts, including first responders, the City of Whitehorse and the Yukon Government. In each tab, the common response elements noted in the previous section are flagged for easy reference.

4. Preparedness, Mitigation and Business Continuity:

This section identifies KDFN staff and Kwanlin Dün Citizens who have specific and certified training – and experience – that may be called upon during a time of crisis or emergency. Actions to help families, children, Elders and those with special needs prepare for or deal with a crisis or emergency are also identified.

5. Appendices: This final section provides templates

The final section, Appendices, provides templates for a *Community Response Team Plan and Safety Analysis*, an evacuation alert and an *evacuation order*, as well as development and implementation workplan for this plan.

Table of Contents

Appendix 2: Templates

Community Characteristics and Capacities

1. **Comprehensive Community Planning Resources**
    1. https://www.hiawathafirstnation.com/wp-content/uploads/MChigeeng-First-Nation-CCPpdf
    2. https://komoks.ca/wp-content/uploads/2019/10/CCP-Version-1.0-March-2014.pdf
    3. https://tsawout.ca/wp-content/uploads/2019/10/Tsawout_CCP_1-52-opti.pdf
    4. https://cottfn.com/wp-content/uploads/2014/03/COTT-CCP-Draft-Final.pdf

2. **Community Health Planning**

    Advocacy, partnership, & relationships: see First Nations Health Managers Association Website: http://www.fnhma.ca/knowledge-circle/best-practices-and-tools/advocacy-partnerships-and-relationships/

Template #1 - Specific Incident Response Action Plan and Status Report

As each crisis is different, the community crisis response plan will need to be activated and a brief format action plan completed and updated as more is known about the crisis and the response is implemented. New information is added daily or twice daily during very active periods of response, with the new additions being highlighted for quick review. Sections could be added or deleted to customize the planning and reposting template. This is an example of one format.

Incident Name: [Description of Incident or Event]
Incident Date: [date]
Response Plan Draft: [#] Draft Date: [date] Draft Time: [time]
Completed by: [name of staff person]

Action	Details	Status
1. Communication		
2. Family Support		
3. Youth Outreach and Support		
4. Elder Outreach		
5. Community Support		
6. Staff Support		
7. Community Events		
8. Scene Identification / Clean-up		
9. Learning Circle Debriefing and Next Steps		

Example of Completed Template #1

Incident Name: Murder of Young Person in Community
Incident Date: [date]
Response Plan Draft: [#] Date: [date] Time: [time]

Action	Details	Status
1. Communication		
Circle of Departments held beginning at [time and date] (name departments)	Action planning circle beginning with a check-in, smudge and prayer.	Circle completed at [time and date]. Team to meet again at [time and date] before community meeting.
RCMP liaison	[name staff person] in constant communication with RCMP and will fan info out to ED and all departments.	Chief and Council confirmed [name] as spokesperson. Name not to be released until notified as OK. Name of victim released in media [date]. Charges laid [date and time] in [name of court] and name of accused not released as protected by Young Offenders Act.
Press	[names of Chief and Council and/or staff] to manage press.	Press conference completed. [name] radio and [name] TV and [name] newspaper interviews completed [date].
Meeting with Chief and Council and RCMP	Meeting planned for [time and date] as soon as details are available – more communication to follow.	[Time and date] meeting completed.
Coordination between departments	Check-in planned for [time and date] at [location].	Check in completed by [time and date] pm. Second check in planned for [time and date].
Flyer to be developed for delivery ASAP notifying community of supports and events	Flyer developed [time and date]	Flyer delivered [time and date] with Chief and Council members and senior staff delivering and visiting some homes.
House to house visiting by Chief and Council and/or staff	Possibility of visits to be discussed with Chief and Council.	Decision made [date] and visits planned for [date].
Safety Flyer for community	[Name] to prepare a flyer for planning for safety for self and supporting others in being safe to be circulated at community meeting [date] and distributed to the community after.	Safety flyer distributed to participants at community dinner [date] and delivered house to house [date].
Facebook and First Nation website distributed facts	Use Facebook First Nation account and website to counter misinformation and rumours ASAP.	Updates completed twice daily.
Youth targeted for specific communication and inclusion	Work with Youth Councillor to develop strategies for youth.	Youth specific circles planned for [date and time].
2. Family Support		
Family support will be offered to all family and extended family members of victim	Once family is identified, [names] will coordinate family visits and supports.	Family support in place at [names] home and at [community building] at [times and dates]. Community dinner and meeting [date] included family and [community facility] drop in open from [time] to [time] on [dates].
In the event that the person is from another First Nations community, this Nation will be included as soon as possible	Communication with the other FNs will be led by [name].	Home Nation of the victim and related Nation(s) representatives were included in the dinner and meeting and support to local home provided through home visits by support services staff.
3. Youth Outreach and Support		
Include youth in community dinner and meeting on [date] and provide support		Good attendance and participation by youth at meeting and dinner. Support offered.
Hold youth circle ASAP	Youth circle to be held at [time and date]. It will be coordinated with [names of people and agencies].	[names of departments and staff] coordinating logistics for youth circle. All high schools invited.

Youth Support	Contact names and number for contact by cell phone over the weekend will be handed out at youth circle and posted.	[Number] First Nation staff will be on call over the weekend. If home visits needed or meeting youth at health centre or wellness house, work will be done by two staff members working together.
4. Elder Outreach		
Elders will be invited to assist in supporting the community.	[Names] will connect with Elder Coordinator and other Elders.	Elder Coordinator involved at [time and date] meeting. Elders involved in community meeting and dinner [time and date]
5. Community Support		
Gathering Place for community to be held at [location] beginning [date and time start and end] or later depending on need	[Names] to coordinate staffing of at least two people for community support.	Department(s) staff to provide support on drop in basis for [time and date] to [time and date] and at community dinner on [time and date].
Ceremonial, spiritual, and religious support to be planned once more details known.	[Name] to lead ceremony as needed.	[Name] completed pipe ceremony, sacred fire planned and [other First Nation involved] ceremonialist will be invited to work with team. Cultural Protocol to be followed.
Community Meeting and Dinner tentatively planned for [Date and time] to meet, share information, support, and meeting with RCMP as needed	Community meeting at [location]. [Name] to confirm availability of cooks to be on standby.	Community meeting and dinner held [date] followed by candle light vigil at site of the death.
Staff support on call	Contact names and number for contact by cell phone over the weekend will be circulated to the community.	[Number] FN staff will be on call over the weekend. If home visits needed or meeting people at health centre or [other location], work will be done by two staff members working together.

Family of Accused Support	On request, support will be offered by [department] to the family of the accused.	[Department] has communicated willingness to assist to family.
6. Staff Support		
Security protocols to be in place at each location related to this and other current threats to safety	[Departmental lead] will check on the availability of RCMP. Directors responsible for making sure consistent protocols in place.	
7. Community Events		
Elder's Gathering Planned for [date]	[Name] to talk with Elders Coordinator to assess whether to proceed and plan accordingly.	Elder's lunch and meeting cancelled until the new year.
8. Scene Identification / Clean-up		
The scene will be identified for the family for prayers, etc.	The family will be notified when scene available to public.	Candlelight vigil held [time and date].
The scene where the body was found will be physically cleaned up and spiritually prepared once the location is released by RCMP.	[Name] will organize the clean-up in consultation with [name] and [name].	Body has been removed and scene will remain secured by RCMP until [time and date]. RCMP completed physical clean up and spiritual ceremony completed [date].
9. Learning Circle, Debriefing, and Next Steps		
Once the planned action is complete, the main staff and other support people will be gathered in circle to talk about what was learned		
Individual or group debriefing offered		
Next Steps planned		
Changes to Community Crisis Response Plan made based on learning		

Template #2 – Risk Assessment and Mitigation Plan

Risk	Mitigation Measures	Comments
Environmental / Road / Camp		
Health		
Conflict Between People		
Alcohol and Drug Incidents		
Legal		
Financial		
Political or Reputational		
Other		

Youth Wellness Gathering Example

Risk Mitigation Plan

Risk	Mitigation Measures	Comments
Environmental / Road / Camp		
Forest Fire	1. Risk of forest fire tracked, and if a fire is threatening the camp, the gathering will be cancelled or moved to a safer location 2. If fire threatens the camp during the gathering, the gathering will be ended and the camp evacuated	
Camp Fire or Explosion	3. 24-hour surveillance of the camp will identify any fire in camp and equipment is on site to fight the fire 4. No fires will be allowed in the walled tents or at the camp sites 5. The sacred fire and other fires will be supervised 6. Smoking will be allowed only in designated areas 7. All propane and other flammable materials are secured and the equipment maintained 8. Camp will be evacuated if necessary	Include in briefing with chaperones and participants
Flood	9. The flood risk is very low due to the time of year and location	
Earthquake	10. The risk of a significant earthquake is low	

Evacuation Needed	11. An evacuation policy and procedures will be written and communicated 12. A very loud horn will be used with repeated horn blows to communicate need for evacuation 13. A megaphone will be used for crowd control and communication to the group 14. All those present in camp are asked to go to one of two muster points (parking lot and large tent) and transportation will be arranged from there	Include in briefing with chaperones and participants
Camp Hazards	15. Security staff will be responsible for assessing the camp area and surroundings, identifying risks, and mitigating them as much as possible	
Lake Travel and Swimming	16. A boat will be made available to assist in rescue, if needed 17. No boats will be on the lake as part of the program, and gathering participants are asked not to go out in their own boats during the weekend 18. Individuals going to the lake or creek to swim or wade are asked to go in pairs (buddy system), and youth under 18 are to be accompanied by an adult 18 years or older	Include in briefing with chaperones and participants
Wildlife Hazard	19. One firearm will be kept in camp with one person identified to use it (with Firearms acquisition certificate and training) 20. If appropriate, spray and a banger will be used, followed by rubber bullets and then live ammunition, only as needed	Include in briefing with chaperones and participants

Dogs and other Pets in Camp	21. All dogs and other pets are to be kept secured in a building or a vehicle for the duration of the camp 22. On the event the dog or other animal has to be walked, they are to be on a leash and taken away from the people in the camp	Include in briefing with chaperones and participants
Environmental Spill	23. In the event that a potentially toxic substance is spilled the appropriate authorities will be notified and assistance in spill mitigation requested	
Camp Site Security	24. The gate will be staffed and vehicles other than emergency or camp maintenance vehicles parked off-site 25. Individuals not registered or not planning to register will not be admitted to the camp area 26. A curfew will be set of 11 p.m. and enforced by security personnel 27. Camp will be patrolled during the day and night	Include in briefing with chaperones and participants
Vehicle Accident	28. All unnecessary vehicles will be parked off-site 29. The security side-by-side ATV and boat will only be operated by those security staff members with appropriate licensing and permission 30. In the event of an accident within the camp or on the road nearby, the nursing/first aid staff will be notified to coordinate the medical response	

Risk	Mitigation Measures	Comments
	Health	
Physical Illness or Injury	31. Gathering participants will be informed of arrangements for accessing first aid or nursing services 32. The nursing/first aid station will be clearly identified and all staff aware of the location 33. Nursing staff and staff with first aid skills will be on-site 24 hours and equipment and supplies made available 34. The evacuation time for a person needing medical attention in [nearby town] is [minutes] away 35. For a major emergency or potentially urgent or high risk situation, the ambulance will be called 36. For a minor or non-urgent medical situation a private vehicle with appropriate commercial insurance will be used for transport	Include in briefing with chaperones and participants
Emotional/Psychological Crisis	37. Gathering participants will be informed of arrangements for accessing support and counselling during and after the gathering 38. Cultural and clinical counselling staff will be on-site and available 24 hours per day to respond to emotional or spiritual needs or crisis 39. The nursing/first aid station will be the access point for seeking emotional or spiritual support 40. The evacuation time for a person needing medical attention in [nearby town} is [minutes] away 41. For a major emergency or potentially urgent or high risk situation, the ambulance will be called 42. For a minor or non-urgent medical situation a private vehicle with appropriate commercial insurance will be used for transport	Include in briefing with chaperones and participants
Infectious Disease	43. Handwashing or use of disinfectant will be encouraged, bathrooms and outhouses kept clean 44. Identification of any infectious disease that puts other persons at risk will be made by nurses and the person instructed in preventative measures if needed 45. All nursing, first aid staff and cleaning staff will use universal precautions in the handing of bodily fluids	Include in briefing with chaperones and participants
Food-born Illness	46. All kitchen staff are trained in food safety, and normal measures will be implemented for refrigeration and reduction of risk of contamination or cross-contamination	

Missing Person	47. All people leaving camp should notify their chaperone or another member of their group 48. Missing persons are to be reported to the registration desk during regular hours and to security between 9 p.m. and 9 a.m. 49. The report will be treated as an incident and the incident response policy put into effect	Include in briefing with chaperones and participants
Conflict Between People		
Physical Conflict	50. Security staff will be on-site 24 hours per day – if conflict arises, the RCMP liaison officer will be called if a potentially criminal act has been committed 51. Depending on the nature of the conflict, a restorative justice approach will be used to address the conflict with the affected parties and chaperones, if needed	Include in briefing with chaperones and participants
Lateral Violence/Bullying	52. Any acts of lateral violence through words or actions will be identified and addressed through a restorative justice process	Include in briefing with chaperones and participants
Conflict Between Presenters	53. Any conflict between presenters will be investigated, if possible, resolved or mitigated and, as a last resort, both presenters will be removed from the gathering agenda and the camp, if necessary	
Criminal Activity	54. In the event that an action that could be deemed to be breaking the law is identified, the RCMP liaison officer will be notified and consulted 55. In an emergency situation, the RCMP will be called and the liaison officer notified	

Alcohol and Drug Incidents		
Possession of Alcohol or Drugs	56. Alcohol and drugs in the possession of youth or adults will be confiscated and turned over to the RCMP for disposal 57. The participants will be notified that alcohol and drugs can be turned over to the camp organizers during the grace period without questions or consequences up until 11 a.m. Friday morning, after which it will be a serious breach of guidelines to be in possession of the substance 58. The individual in possession of the alcohol or drugs will be asked to leave the gathering as soon as possible 59. Safe transportation and accommodation will be arranged	Include in briefing with chaperones and participants
Under the Influence of Alcohol or Drugs	60. A person identified as under the influence of alcohol or drugs will be interviewed to gather facts 61. The person will be escorted to the nurse to receive an examination to identify possible health risks 62. The individual under the influence of alcohol or drugs will be asked to leave the gathering as soon as possible 63. If needed, the person will be isolated and supervised on-site until arrangements can be made 64. Safe transportation and accommodation will be arranged	Include in briefing with chaperones and participants

Supplying Alcohol or Drugs	65. An adult or youth identified as supplying alcohol or drugs to another individual (youth or adult) will be asked to leave the gathering 66. If the activity is breaking a law, a report will be made to the RCMP 67. The individual under the influence of alcohol or drugs will be asked to leave the gathering as soon as possible 68. Safe transportation and accommodation will be arranged	Include in briefing with chaperones and participants
Legal		
Lawsuit against First Nation	69. In the event that a situation arises that has the potential for a lawsuit, legal counsel will be engaged and advice sought 70. Any correspondence will be drafted or reviewed by legal counsel prior to being sent 71. A written record of all communication will be kept for future reference 72. Waiver forms will be signed by all participants, volunteers, and anyone visiting the site	

Financial		
Conference not able to cover costs	73. Fundraising will be as active as necessary to secure the funds necessary to host the conference 74. An accurate budget will be maintained throughout the planning process 75. Final determination of funds received and payment made against the conference budget will be reported to Chief and Council within one month of the end of the conference 76. Shortfalls will be communicated to funding partners and a negotiation is organized to seek partners in covering any significant over-expenditure	
Political or Reputational		
Confidence of First Nations citizens impacted	77. Communication with First Nations citizens about the gathering is consistent throughout the planning period and during the gathering 78. Questions arising from citizens are addressed in a timely way 79. Conference information package includes necessary information	
Confidence of other First Nations, funding agencies, and other stakeholders impacted	80. Communications with other First Nations, funders, media and other stakeholders about the gathering is consistent throughout the planning period and during the gathering 81. Questions arising are addressed in a timely way 82. Conference information package includes necessary information	

Appendix 3: Case Scenario

Case Scenario – Unexpected Death in the Community

The Director of Justice was informed by the RCMP of a death in the First Nation community which is near a city of 25,000 people. The death is a suspected suicide of a young woman named Jay Sanders. Jay is 16 and lived in the community with her mother, grandparents and two younger siblings. A suicide note was found near her body when her grandmother found her body. Emergency services were called and resuscitation was unsuccessful. There is no previous attempted suicide recorded.

Jay was attending high school in the city. Her father's family and her many cousins live in another First Nation community two-hours outside of the city. Her father is employed in a mine in a remote area of the Northwest Territories and is on shift at present. Jay's parents have been separated for one year. Jay has an older sister currently living in a group home at age 18. Jay has a large extended family in the First Nation community.

The suicide note mentions bullying and a recent breakup with a boyfriend. In the note, she named two former girlfriends that had recently ended relationships with Jay as well. The death was as a result of a drug overdose and the type of drug is known although the source is unknown. There is a concern that there may be drugs in the house that could result in death if misused. With further investigation, it was found that Jay had a history of depression and had been seeing a doctor and a counsellor for the past year and a half. The visits had been sporadic and no medication had been prescribed. There had been a concern of alcohol misuse at specific points over the past two years.

The First Nation community responding to the crisis has three departments of health, justice and education which includes a mental wellness team with outreach, support and cultural capacity. Several current programs are designed for youth. The department of health has clinical counsellors and both groups of staff members are trained in crisis response. The department of education is involved in supporting students in elementary and high school. The Chief and Council, executive offices and communications staff have also been trained in the implementation of the Community Crisis Response Plan.

Questions to Consider:

1. What more information is needed?
2. What are the priority issues and concerns?
3. Who needs support most urgently?
4. What clinical, cultural and community support people and services are available?
5. What First Nation departmental staff and other resource people should be involved?
6. What other agencies outside of the First Nation need to be asked to help?
7. Who is responsible for communication internal to the community, externally and with the press? Who will be the spokesperson?
8. What actions should be taken, when and by which department and staff members?
9. Complete the first draft of the action plan (using template if helpful).

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