

CASE 9

From Theory to Action: Implementing an Internationally Developed Mental Health and Substance Abuse Program in Indigenous Communities in the Americas¹

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BACKGROUND

On June 4, 2016 Juan Santos, leader of the Indigenous Mitzu² tribe, was awoken in the night by an alarming call. Juan was known as a respected member of the community. He left his rural community at the age of 14 to complete his high school studies in the country's capital on the tropical island of Basseterre, off the coast of Central America. His success throughout high school earned him the prestigious Island Scholar award to pursue a university education in sociology. It was this experience that exposed him to diverse groups of people, social conditions, and global issues. Juan returned to his community upon graduation where he now works diligently with his community in developing collaborative efforts to enhance the quality of life of rural peoples.

Juan was astonished to find out that two young girls, ages 14 and 17, had committed suicide by hanging themselves in a remote wooded area, five miles from their community. Initial circumstances regarding the root cause of their deaths was unknown; however, a suicide note dated February 12, 2016, authored by the girls, was found nestled away in a diary. It came to Juan's attention that several suicide risk factors were prominent, outlining the young women's challenges living in an isolated community.

With his attention fixated on the risk factors for suicide coupled with the social injustices faced by the indigenous people of the Mitzu tribe, Juan decided to declare a state of emergency for his community due to the growing suicide trend. The proclamation came after four Mitzu youth

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² *The name of the community is fictional.*

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aged 7, 12, 14, and 16 committed suicide in the community within the span of six months, prior to this newest incident. Juan decided to take measures beyond his local government and plead for international support for the development and implementation of a suicide prevention strategy for his community. Juan made an urgent appeal to the United Nations Permanent Forum on Indigenous Issues (UNPFII) and requested technical support from the Pan American Health Organization (PAHO).

EPIDEMIOLOGY OF SUICIDE AND SUBSTANCE ABUSE IN THE AMERICAS

Alarming statistics show that indigenous peoples across the globe face a higher risk of suicide than their non-indigenous counterparts. Suicide rates in indigenous communities have been reported to be four times greater than in non-indigenous communities on average across the region (PAHO & the Economic Commission for Latin America and the Caribbean (ECLAC), 2011). For instance, First Nations communities in Canada experience suicide rates of 126 males and 35 females per 100,000 people, as stated by the Centre for Suicide Prevention, a nonprofit organization in Calgary, Alberta (Centre for Suicide Prevention, 2013). This figure is substantially higher than average within the Canadian general population, which is reported as 24 males and 5 females per 100,000 people (Centre for Suicide Prevention, 2013). In the United States, Native Indians have displayed similar trends with youth suicide rates of 19.5 per 100,000 people between the ages of 15 to 43; a rate 1.5 times greater than the national USA average (Centers for Disease Control and Prevention, 2015). South American countries such as Chile, Brazil, Argentina, Nicaragua, Paraguay, and Venezuela have a greater proportion of indigenous youth committing suicide than the non-indigenous populations. Across the region, a higher proportion of males have been reported to successfully complete the act, while women display a greater number of unsuccessful attempts (PAHO and ECLAC, 2011).

The link between mental health conditions and suicide is related to the influence of risk factors, such as substance abuse. It becomes essential to highlight the relationship between risks and suicide present in indigenous peoples, as preventative frameworks are contingent on a holistic understanding of the many factors leading to disparity and social suffering present within these communities. Within the Americas, indigenous populations display a disproportionate rate of substance abuse as compared to non-indigenous peoples. Alcoholism prevails as a leading contributor to comorbidity and serves as a precursor for unintentional death through life threatening behaviour and accidents. In Native Indian populations in the United States, admission to the hospital for alcohol-related diagnoses are three times higher than the national average (Walker, Walker and Kivlahan, 1988). Similarly, it is reported that 43.7 per 100,000 deaths in the Canadian aboriginal population are attributed to alcohol use in comparison to 23.6 per 100,000 in the general population (Chansonneuve, 2007). Furthermore, there is a higher prevalence of binge alcohol drinking among Inuit and Native Indian mothers in comparison to their non-aboriginal counterparts in the Northwest Territories (MacMillan, MacMillan, Offord, & Dingle, 1996). Indigenous peoples of South American countries echo these trends as in the case of Venezuela, where significant rates of alcohol in mountainous villages have promoted physical and social complications for up to 46% of the indigenous population (Arévalo, et al., 2013).

EXPRESSIONS FROM THE LETTER: THE ORIGINS OF SOCIAL DISPARITIES

This town is a forgotten place, with no hope, no support and nothing for us to look forward to. I share a room with my grandmother and my two cousins, the men are always fighting after getting drunk, and we cannot take the stress anymore.

– Deceased girls, May 3rd 2016

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Indigenous adolescents and youth represent approximately 50% of the total adolescent and youth population in the Americas (PAHO and ECLAC, 2011). Between 67% to 90% of indigenous youth reside in impoverished rural areas with severe illiteracy, high rates of mortality due to injury, and lack of health care support for such injuries, which have often been cited as a result of the rural nature of indigenous communities. As such, financial disparities within such communities are augmented due to the lack of accessibility (PAHO and ECLAC, 2011). These barriers present unique challenges for such underserved populations despite often living in robust developed nations. Indigenous peoples are often described as living in 4th world conditions, which denote minorities living within the boundaries and bureaucratic administration of first and second world countries. These indigenous people have lost the power to direct the course of their livelihoods because of the poor upholding of basic rights (Graburn, 1976). The lack of basic rights often contributes to social and cultural inequities that lead to systematic barriers to progress in society.

The relationship between public health and social disparity is of growing concern for the international community. Despite the rich cultural make-up of indigenous peoples in the Americas, health disparities and trends are often parallel across the region. The United Nations Declaration on the Rights of Indigenous Peoples recognizes this pattern as the result of human rights violations. The neglect towards the understanding of self-determination, land/treaties, and cultural expression, to name a few, with the lack of fulfillment in upholding such rights across the Americas, has been correlated with poor mental states, disability from injury, and reduced life quality (The Inter-Agency Support Group on Indigenous Peoples' Issues, 2014).

PROXIMAL INEQUITIES

Social injustices and neglect of proximal determinants of health serve as fundamental precursors for the deterioration in physical, emotional, mental, and/or spiritual well-being (Wein, Reading, 2009). Proximal determinants of health include, but are not limited to, housing, health behaviours, education level, employment, and physical environments.

Housing

It was identified from the young girls' letter that their community had been subject to overcrowding due to a lack of infrastructure for housing. This is echoed through their expression of living in a "forgotten place." These young girls resided in a one-bedroom house that accommodated six people from as young as two years of age to 76 years of age. Their story is felt across many nations within the Americas. Overcrowding has been linked to the onset of elevated stress levels, learning difficulties, and behavioural challenges in youth. Substance abuse and other social problems have been reported as a result of the inability to indulge in personal space and relaxed living in such conditions. The influence of poor housing serves as a driving factor for emotional stress and trauma (National Collaborating Centre for Aboriginal Health, Wein and Reading, 2009). The World Bank's poverty assessment for Ecuador found that households comprised of indigenous peoples often lacked fundamental housing services, which include access to clean water, sewage, and basic electricity (Incayawar, 2007). The lack of development in indigenous communities, coupled with the effects of poverty and animosity between the indigenous and their non-indigenous suppressors, has fostered sentiments of social exclusion within communities. Alternative coping mechanisms and feelings of hopelessness are augmented, as the connection between the voices of governments and communities are often mismatched. For example, within Latin America, 88% to 95% of the indigenous communities live in exclusion because of discrimination and structural policies (Incayawar, 2007). This determining factor may lead to feelings of hopelessness and despair, which have profound effects on youth during adolescence.

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Health Behaviours

One of the most well studied health behaviours in indigenous peoples is the misuse of alcohol. This often leads to self-harm, excessive intoxication, and the initiation of drinking in youth. Misuse of alcohol may often become embedded in the cultural framework of indigenous communities. For instance, the Carib indigenous population in Venezuela partake in corn liquor drinking ceremonies, which promote excessive intoxication. These ceremonies have been associated with settling of grudges, facilitation of fighting, and often abuse of women through intoxication (Seale, Shellenberger, Rodriguez, Seale, & Alvarado, 2002). The psychological and mental impacts associated with the repercussions of drinking facilitate mental turmoil and intergenerational stressors that maintain substance abuse as an outlet.

Employment, Education, and Negative Health Outcomes

Socioeconomic factors have been cited as key determinants of health. These determinants are often augmented due to the rural and isolated nature of indigenous communities. As such, an exacerbation of health care challenges may generate negative health outcomes.

We can't afford to go to school. Our parents never went, and the nearest high school is in the capital, 3 hours from home.

– Deceased girls, May 15th 2016

The lack of access to financial and physical resources enables the development of poor nutritional behaviours and the onset of diseases such as diabetes and cardiovascular disease (National Collaborating Centre for Aboriginal Health, Wein and Reading, 2009). The most significant contributors to poor mental health and substance abuse are the circumstances of poverty. Low income and educational attainment has been linked to anxiety and low self-esteem. This increases physiological stress, which often results in frustration, violence, poor parenting, social exclusion, suicide, and substance abuse (National Collaborating Centre for Aboriginal Health, Wein and Reading, 2009).

DISTAL INEQUITIES

Historical Impacts of Colonialism

Colonialism has resulted in a disconnect between indigenous peoples and their traditional land. The United Nations Office of the High Commissioner for Human Rights has identified the cultural, mental, and physical connection necessary for the mental well-being of indigenous peoples in honouring their right to traditional lands and treaties. The land represents more than possessions and production; it serves as a means of spirituality, economic sustainability, cultural continuity, and traditional knowledge passed down through generations (United Nations, 2013). The weaning of traditional peoples from their land has grave implications on traditional food choices and the ability to make autonomous decisions in supporting physical needs. For example, hunting restrictions, climate change, and access to nutritious food in remote areas result in uncertainty of both the quality and quantity of resources on their land, affect Indigenous Peoples' physical health, and augments stress (Norton-Smith et al., 2016). The ramifications of such inequity are felt through the loss of self-determinism, which encompasses the ability to govern lands and resources within the territories of indigenous peoples (Norton-Smith et al., 2016). The deceased 14-year-old girls state:

Without us here, our community will be forced to come together, to celebrate, to remind themselves of who the Mitzu are. We have no purpose, but maybe us dying will give them one.

– Deceased girls, May 25th 2016

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The use of suicide as an expression of hopelessness has been tied to feelings of culture discontinuity, which is the lack of identification with one's historical heritage due to the impacts of forced migration and colonialism. Death in some indigenous communities thus serves to strengthen community bonds; it allows for the expression of community ideals and cultural traditions. For example, grave digging ceremonies, coffin making, and body washing traditions reaffirm community connectedness and promote the embracing of social roles and individual meaning in society (Wexler & Gone, 2012).

ROLE OF THE PAN AMERICAN HEALTH ORGANIZATION AND THE UNITED NATIONS

PAHO is the regional office of the World Health Organization (WHO) for the Americas, and serves as the specialized health agency for the United Nations (PAHO, 2017). PAHO's headquarters is located in Washington D.C.; however, the organization includes 27 country offices and three specialized centers in the region (PAHO, 2017). Through the guidance of its 48 member countries and territories, PAHO engages in collaborative efforts between governments, specific country agencies, and local organizations to fight communicable and non-communicable diseases and their causes, to strengthen health systems, and to respond to emergencies and disasters (PAHO, 2017). In collaboration with various ministries of health, government organizations, civil societies, universities, social security agencies, community partners, and governing bodies, PAHO seeks to promote evidence-based decision making in informing sustainable development and health promotion strategies. The organization promotes the inclusion of health in public policies and calls upon collaboration between multiple sectors to improve the quality of life of people in the Americas (PAHO, 2017).

THE ROLE OF THE UNITED NATIONS PERMANENT FORUM ON INDIGENOUS ISSUES

UNPFII serves as an advisory body to the economic and social council of the United Nations (United Nations Economic and Social Council, n.d). In line with the UNPFII mandate, the forum will:

1. Provide recommendation, advice, and points of concentration from various organizations and leaders to the council, programs, funds, and other United Nations agencies through the economic and social council; and,
2. Generate awareness and interdisciplinary collaboration for the development of activities for indigenous issues.

The UNPFII also assists in knowledge translation of pertinent indigenous issues from annual permanent forum sessions (United Nations, 2016). The UNPFII seeks to establish methods of implementing the initiatives of the UN Declaration on the Rights of Indigenous Peoples (UNDRIP), which addresses pertinent conflicts, peace, and resolution strategies. The UNPFII has specifically called on WHO/PAHO to develop a program targeted towards youth suicide rates, substance abuse, and self-harm in international indigenous populations with particular focus on countries within the Americas (United Nations, 2016).

PAHO'S SUGGESTED INTERVENTION FOR REMEDIATING MENTAL HEALTH, SUICIDE, AND SUBSTANCE ABUSE

PAHO, in conjunction with the UNPFII, has identified mental health and suicide as issues of concern among indigenous peoples. WHO recognizes the link between the lack of health care opportunities within low to middle income countries in tackling the mental, neurological, and substance use disorders as contributors to suicide rates (WHO, 2010). To address suicide prevention among indigenous peoples, PAHO proposes to adapt an existing tool, the Mental Health Global Action Program Intervention Guide (mhGAP IG), to the needs of the indigenous community. This mhGAP was designed upon recognition that 80% of individuals residing in

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lower to middle income countries who suffer from mental, neurological, or substance abuse challenges do not receive any care for their conditions. Current interventions within certain countries in the Americas often lack evidence-based rationale or success in implementation to combat mental health and substance abuse challenges (WHO, 2010). The mhGAP thus seeks to remediate these disparities through enhancing the accessibility of evidence-based interventions in non-specialized health care settings.

How the mhGAP IG Works

The mhGAP IG serves as a set of targeted criteria for health care management to guide the assessment and delivery of care for priority conditions by health professionals and care takers in non-specialized settings. This tool is a flexible guide that focuses on specific priority conditions and may be adapted internationally in accordance with those who use it. The specific priority conditions are: depression, psychosis, bipolar disorders, epilepsy, developmental and behavioural disorders in children and adolescents, dementia, alcohol use disorders, drug use disorders, and self-harm/suicide (WHO, 2010). The mhGAP IG outlines focused methods for initially triaging and identifying those who display signs of the above conditions. As displayed in Exhibit 1, the tool follows a sequential set of steps for managing current conditions of elevating the rigor of care for suspected priority conditions. The selection of priority conditions was brought forth from evidence displaying large health disparities in mortality, disability, exacerbated costs, and inadequacies in meeting fundamental human rights (WHO, 2010). The tool has been crafted from extensive systematic reviews and inputs from the World Health Organization Guideline Development Group, which is comprised of international experts and individual topic-specific experts. The WHO and topic experts can access relevant recommendations and strategies outlined in the toolkit for a specific demographic (WHO, 2010). Through a guided set of assessment questions, critical identifiers promote either the use of preventive management strategies, physiological therapies, or specific treatments through interventions (Exhibit 2). In response to Juan's plea, PAHO agreed to provide technical support in piloting this Program in his community and focus on suicide and self-harm modules (Exhibit 2).

CULTURALLY SENSITIVE APPROACHES TO IMPLEMENTATION

Juan urgently focused his efforts on collaborating with PAHO in implementing the suggested interventions by UNPFII. One month after the girls' deaths, he was able to foster financial and advisory support from his local ministry of health to apply the self-harm and suicide mhGAP IG modules for his community. He was able to advance this initiative through securing limited funding from the ministry to set up basic infrastructure such as assessment stations equipped with medical supplies and preventative substance abuse information such as pamphlets, books, and access to electronic resources. He implemented technology for communication with the nearest hospital, located three hours away from the community. This was a groundbreaking achievement in both establishing community capacity and improving Basseterre's health system outreach. The mhGAP IG tool provides a skeleton of how to approach and triage health care needs within each respective community. The Guide ensures that a referral system is established for the continued care of cases by specialists when the concern is beyond the expertise and scope of non-specialized health care workers or community health care providers.

Juan came to the realization that the mhGAP was too broad in its applicability. The tool was not designed in recognition of the distinct challenges faced by indigenous populations. Juan thus recognized that cultural adaptations specific to his community would be necessary. This task would be contingent on adjustments in: (1) the thorough translation of the mhGAP tool to the local Mitzu language; (2) the expected challenges of program implementation through the

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capacity of the local health care systems to support the Program's directives; (3) addressing sociocultural influences, such as the embedding of alcohol into the daily cultural framework of the Mitzu community; and (4) the identification of key stakeholders (World Health Organization, 2010).

On August 1, 2016, Juan eagerly greeted PAHO's technical support team as they arrived on the island to initiate the implementation of the mhGAP IG. PAHO's support serves a critical role in helping to facilitate the conversation in identifying necessary human resources, task assignments, financing, information dissemination, and methods of monitoring and evaluating the Program's effectiveness (WHO, 2010). Juan's first step was to mobilize the little funding provided from the ministry to assist with enlisting translation services, which were essential in interpreting and contextualizing the mhGAP tool for the specific social, educational, and linguistic conditions of the Mitzu community. Upon completion of this task, Juan then set forth to secure community involvement from other leaders he thought would be an asset to the mhGAP implementation.

Non-specialized health care providers and community health workers serve as integral components in the implementation, sustainability, access, financing, and quality of care provided (WHO, 2010). Their roles may vary across the region but encompass trusted community members, leaders, and officiates. With the technical support of PAHO, Juan urgently gathered a list of trusted community members to form his action plan working group. With recognition of important community and health care stakeholders for implementation, he first called the local spiritual leader, Ronaldo Phillips, for his consideration. Phillips is a familiar confidant and ally to the community under periods of distress and plays a critical role in the social atmosphere. He has also been chosen to serve as a mental health gatekeeper for youth through his close connection to the community. Next, Juan contacted the community liaison who is familiar with community concerns and is responsible for voicing the community's collective opinions at the Basseterre national level. Her expertise derives from being a resident throughout her life and being familiar with common community challenges. Her role was assigned to allow for holistic and empathetic support of youth. Holistic practices aim to enrich social, psychological, mental, and physical aspects of youth development and success. She would also serve as a profound example of an individual who has used protective factors within the community itself to develop resilience and success as a Mitzu woman.

Ms. Renée, a retired traditional indigenous healer, volunteered to act as the non-specialized health care provider. She hosts weekly ceremonies tailored to reducing social suffering through the development of positive social framing and community bonding through spiritual song, dances, and blessing ceremonies. Juan also incorporated the visiting community physician, who agreed to make biweekly health assessments upon Juan's emergency declaration and maintain frequent communication between the community and larger health care facilities, in the event that serious concerns arise and active medical attention is required for community members. To fulfill the General Principles of Care (GPOC), as seen in Exhibit 3, and acknowledge the key considerations for interactions with those in need, Juan ensured that all members of his working group conducted guided mhGAP training sessions as offered through the technical support from PAHO.

Juan's next challenge, with the adaptation of the Program, was developing methods of remediating alcohol consumption in the community. Alcohol serves as an integral component of daily socialization and carries a positive connotation. With this recognition, Juan decided to use this opportunity to both educate community members of the harmful effects of alcohol and

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conduct suicide and self-harm assessments. Through the utilization of the General Principles of Care, he ensured that communication of possible dangers and risks were highlighted during drinking festivities, in addition to providing and fostering a positive, non-judgmental, and non-stigmatizing interaction between himself, as a community leader, and those engaging in alcohol consumption or contemplating suicide/self-harm (WHO, 2010). He used this opportunity to employ step one and two of the self-harm and suicide assessment and management guide with help from Ronaldo Phillips (Exhibit 3). They were able to assess key risk factors, such as emotional distress, and identify those who displayed feelings of hopelessness or expressed violent behaviours in association with alcohol consumption. Individuals who met the criteria in Exhibit 3 were removed from the situation and placed in contact with Ms. Renee who initiated traditional healing practices for social pain.

The inability for the Ministry of Health to fully fund the Program resulted in minor setbacks to Juan's outreach capacity. He was unable to develop secure and supportive environments through the implementation of healing tents for distressed youth as suggested by the GPOC. Juan was able to mobilize support from the community to use homes volunteered as a place where youth could decompress and indulge in spiritual connectivity through Ronaldo Phillips' and Ms. Renée's guidance. Here, youth were able to indulge in traditional meals and culturally appropriate medicinal healing techniques, which placed them back in touch with their culture and mended broken bonds between the generations. This simple, yet effective adaptation to the Program, strengthened community capacity and allowed for direct lines of communication between at-risk youth. The mhGAP also emphasized step six of the GPOC attention to overall well-being through applying holistic approaches to health care with assistance from the mhGAP action-plan team.

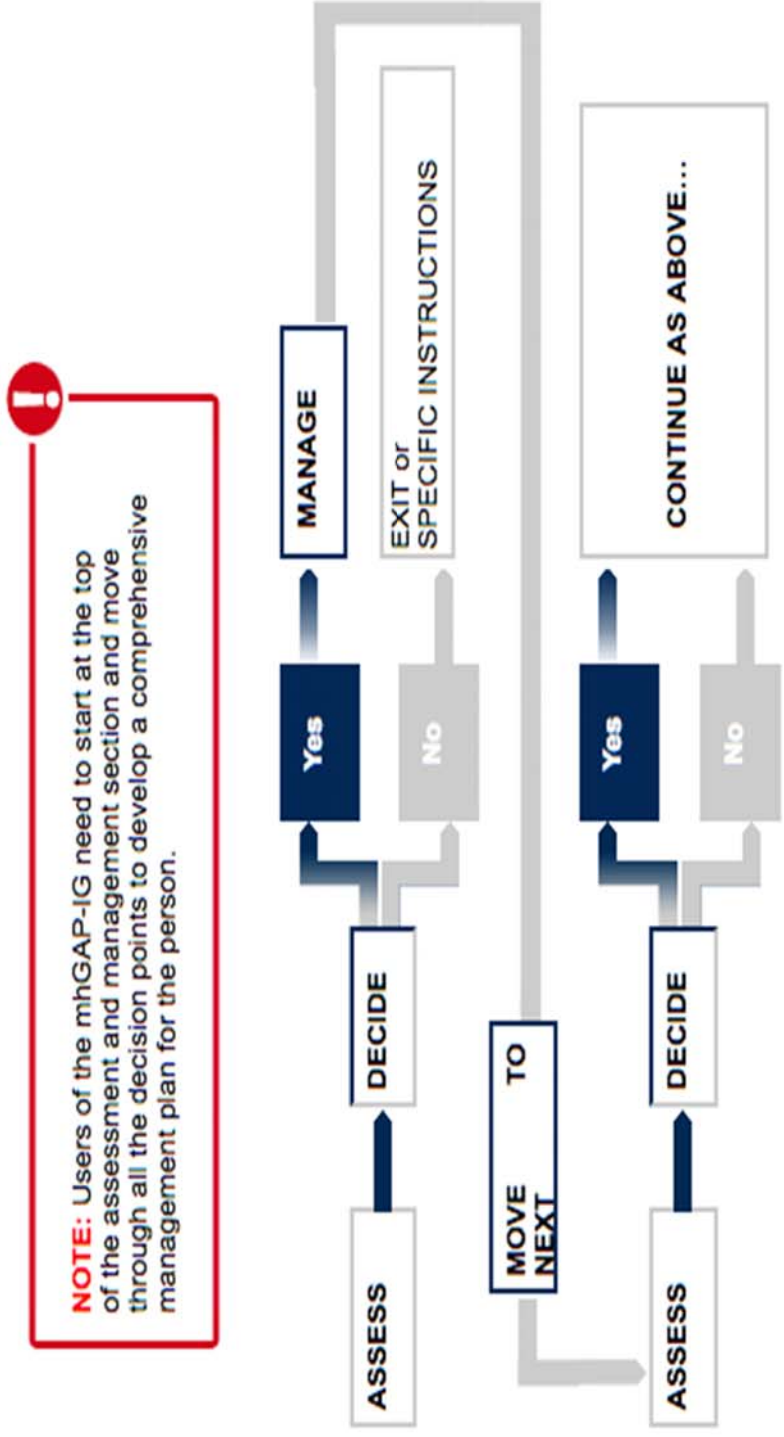
JUAN'S NEXT STEP

Juan understood that his biggest barrier to implementing this Program was addressing the necessary cultural considerations that are reflective of community values. With the urgency of the situation, Juan specifically adapted pieces of the Program with the technical support of PAHO. However, he was unsure if he had considered all culturally relevant aspects of his community for the successful deployment of this intervention, as the tool had not been designed to target the unique challenges of indigenous populations. He hoped that financial investment and a better understanding of the disconnection often felt between one's reality and one's social/spiritual well-being would be improved to enhance the effectiveness of the Program. This bond would rely heavily on governmental and agency support to develop better social conditions for indigenous peoples, particularly enhancing proximal factors. Juan wondered what the implications of only deploying a suicide and self-harm program would have on substance abuse and other mental conditions. Due to the immediacy of the problem in his community, he hoped the mhGAP would quickly mobilize efforts to remediate the situation. He intended to manage suicide and self-harm diligently, while other contributing deficiencies in social determinants of health would be mitigated to remediate suicidal ideation, self-harm, substance abuse, and the onset of other mental conditions thus fostering resilient youth. He believed that the on-going involvement from the community and the community leaders would be necessary in managing the intervention in the long term. However, the following concerns remain:

- What methods of managing concurrent issues with limited resources would be effective for the Mitzu community?
- How would Juan foster community input and collaboration in developing social supports beyond the emergency declaration?
- What methods would he use to assess the Program's effectiveness and conduct process evaluations?

EXHIBIT 1

Principle framework for the management of priority conditions and intervention implementation



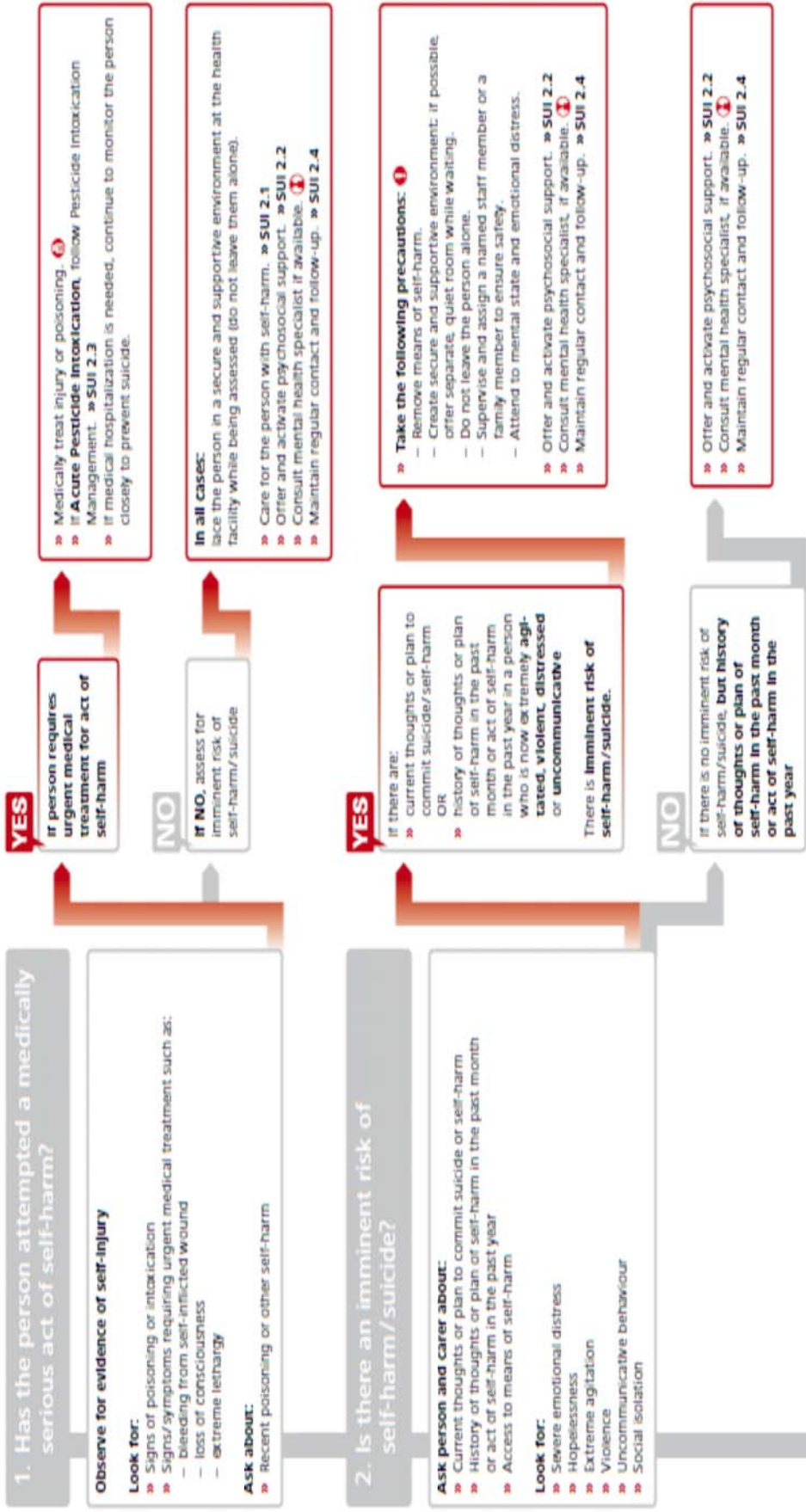
Source: World Health Organization, 2010.

EXHIBIT 2
Suicide Self-Harm Intervention Guide

Self-harm / Suicide

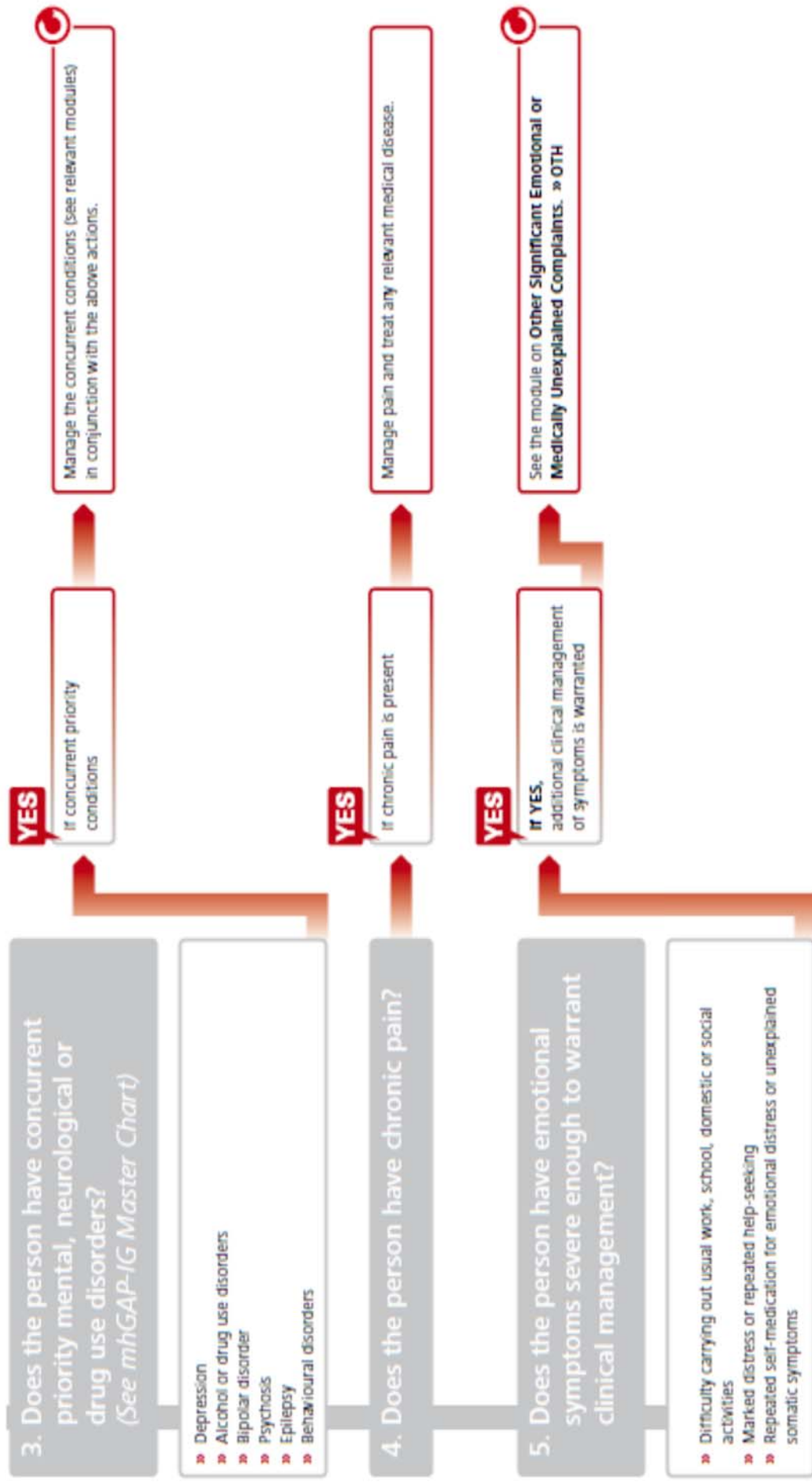
Assessment and Management Guide

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EXHIBIT 2 (cont'd)



Source: World Health Organization, 2010.

EXHIBIT 3

General Principles of Care for Program Implementation

General Principles of Care



1. Communication with people seeking care and their carers

- » Ensure that communication is clear, empathic, and sensitive to age, gender, culture and language differences.
- » Be friendly, respectful and non-judgmental at all times.
- » Use simple and clear language.
- » Respond to the disclosure of private and distressing information (e.g. regarding sexual assault or self-harm) with sensitivity.
- » Provide information to the person on their health status in terms that they can understand.
- » Ask the person for their own understanding of the condition.

2. Assessment

- » Take a medical history, history of the presenting complaint(s), past history and family history, as relevant.
- » Perform a general physical assessment.
- » Assess, manage or refer, as appropriate, for any concurrent medical conditions.
- » Assess for psychosocial problems, noting the past and ongoing social and relationship issues, living and financial circumstances, and any other ongoing stressful life events.

3. Treatment and monitoring

- » Determine the importance of the treatment to the person as well as their readiness to participate in their care.
- » Determine the goals for treatment for the affected person and create a management plan that respects their preferences for care (also those of their carer, if appropriate).
- » Devise a plan for treatment continuation and follow-up, in consultation with the person.
- » Inform the person of the expected duration of treatment, potential side-effects of the intervention, any alternative treatment options, the importance of adherence to the treatment plan, and of the likely prognosis.
- » Address the person's questions and concerns about treatment, and communicate realistic hope for better functioning and recovery.
- » Continually monitor for treatment effects and outcomes, drug interactions (including with alcohol, over-the-counter medication and complementary/traditional medicines), and adverse effects from treatment, and adjust accordingly.
- » Facilitate referral to specialists, where available and as required.
- » Make efforts to link the person to community support.
- » At follow-up, assess the person's expectations of treatment, clinical status, understanding of treatment and adherence to the treatment and correct any misconceptions.

- » Encourage self-monitoring of symptoms and explain when to seek care immediately.

- » Document key aspects of interactions with the person and the family in the case notes.
- » Use family and community resources to contact people who have not returned for regular follow-up.
- » Request more frequent follow-up visits for pregnant women or women who are planning a pregnancy.
- » Assess potential risks of medications on the fetus or baby when providing care to a pregnant or breastfeeding woman.
- » Make sure that the babies of women on medications who are breastfeeding are monitored for adverse effects or withdrawal and have comprehensive examinations if required.
- » Request more frequent follow-up visits for older people with priority conditions, and associated autonomy loss or in situation of social isolation.
- » Ensure that people are treated in a holistic manner, meeting the mental health needs of people with physical disorders, as well as the physical health needs of people with mental disorders.

4. Mobilizing and providing social support

- » Be sensitive to social challenges that the person may face, and note how these may influence the physical and mental health and well-being.

General Principles of Care



- » Where appropriate, involve the carer or family member in the person's care.
 - » Encourage involvement in self-help and family support groups, where available.
 - » Identify and mobilize possible sources of social and community support in the local area, including educational, housing and vocational supports.
 - » For children and adolescents, coordinate with schools to mobilize educational and social support, where possible.
- 5. Protection of human rights**
- » Pay special attention to national legislation and international human rights standards (Box 1).
 - » Promote autonomy and independent living in the community and discourage institutionalization.
 - » Provide care in a way that respects the dignity of the person, that is culturally sensitive and appropriate, and that is free from discrimination on the basis of race, colour, sex, language, religion, political or other opinion, national, ethnic, indigenous or social origin, property, birth, age or other status.
 - » Ensure that the person understands the proposed treatment and provides free and informed consent to treatment.
 - » Involve children and adolescents in treatment decisions in a manner consistent with their evolving capacities, and give them the opportunity to discuss their concerns in private.

BOX 1

Key international human rights standards

- Convention against torture and other cruel, inhuman or degrading treatment or punishment. United Nations General Assembly Resolution 39/46, annex, 39 UN GAOR Supp. (No. 51) at 197, UN Doc. A/39/51 (1984). Entered into force 26 June 1987.**
<http://www2.ohchr.org/english/law/cat.htm>
- Convention on the elimination of all forms of discrimination against women (1979). Adopted by United Nations General Assembly Resolution 34/180 of 18 December 1979.**
<http://www.un.org/womenwatch/daw/cedaw/cedaw.htm>
- Convention on the rights of persons with disabilities and optional protocol. Adopted by the United Nations General Assembly on 13 December 2006.**
<http://www.un.org/disabilities/documents/convention/convoptprot-e.pdf>
- Convention on the rights of the child (1989). Adopted by United Nations General Assembly Resolution 44/25 of 20 November 1989.** <http://www2.ohchr.org/english/law/crc.htm>
- International covenant on civil and political rights (1966). Adopted by UN General Assembly Resolution 2200A (XXI) of 16 December 1966.**
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INSTRUCTOR GUIDANCE

From Theory to Action: Implementing an Internationally Developed Mental Health and Substance Abuse Program in Indigenous Communities in The Americas¹

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BACKGROUND

Intergenerational trauma compounded throughout centuries by the effects of colonialism have left indigenous peoples within the Americas in grave despair. Indigenous communities are subject to a variety of human rights violations and social neglect, which contribute to reduced physical and mental health. The United Nations Permanent Forum on Indigenous Issues has identified these insufficiencies in acknowledging higher rates of poor mental health, substance abuse, and elevated rates of suicide, when compared to non-indigenous peoples. The World Health Organization has developed the Mental Health Gap Action Program Intervention Guide (mhGAP IG) to assess, monitor, and manage, neurological, and mental health conditions, including suicide, in non-specialized health contexts. This case provides an example of how one fictitious indigenous community located off the coast of Central America is seeking to use the mhGAP IG due to the recent suicide clusters within a six month period. The case seeks to highlight how international agencies collaborate in developing interventions for the populations they serve, specifically, between the Pan American Health Organization and the Americas. The protagonist, Juan Santos, is left to question how he will implement the mhGAP in his community with limited resources to encompass cultural considerations and appropriate community engagement to lower suicide rates, mental health, and substance abuse.

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OBJECTIVES

1. To understand the implications of shortcomings in various social and cultural determinants of health and the onset of and influence on mental health, substance abuse conditions, and suicide.
2. Evaluate the risks and/or benefits of interventions in indigenous communities, with particular attention to cultural continuity, patient-centered care, and outcome assessment tools.
3. Develop an understanding of community collaboration and participatory relationships between public health agencies and indigenous communities.

DISCUSSION QUESTIONS

1. How can public health agencies improve suicide-reporting-data collection for under-reported and suspected cases?
2. Which key elements of implementation science must be adapted for the uptake of interventions in culturally diverse communities?
3. What methods must be employed to assess the Program's effectiveness and relevance?

KEYWORDS

Indigenous peoples; youth; suicide; mental health; PAHO; mhGAP; substance abuse; alcohol; self-harm; cultural continuity; cultural sensitivity.