Building Equitable and Effective Partnerships With Rural and Indigenous Communities

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Abstract
Leadership in infant and early childhood mental health must take into consideration issues of diversity, historical context, power dynamics, and difference in worldview and experiences. This article describes the importance of equitable and effective partnerships with rural/remote, underserved, and Indigenous communities in the United States and Canada. It is important to build strong, foundational, respectful relationships rooted in humility, mutual learning, and trust. Effective leaders must also consider diverse concepts of children, childhood, and mental health as they are understood by different communities. All strategies, decisions, and activities that are brought into a community must be adapted in partnership with members of that community and also must be culturally grounded and aligned with the philosophies and practices of the community.

The first 6 years of life are critical for optimal development and future well-being (Cassidy & Shaver, 2016; Cozolini, 2017; De Bellis, Hooper, & Sapia, 2005; Grossmann, Grossman, & Waters, 2006; Hughes, 2009; Oppenheim & Goldstein, 2007; Perry, 2002, 2008). To thrive, children require nurturing care, including meeting health and nutritional needs; opportunities for learning and exploration as well as security, support, and safety; and responsive caregiving that fosters attachment (Black et al., 2017).

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Infant and early childhood mental health (IECMH) prevention and intervention services, within the context of the caregiver relationship, provide opportunities to foster optimal child development (National Research Council & Institute of Medicine, 2000). Research has shown that these opportunities become even more effective through the provision of IECMH programming across sectors and through a variety of care, early intervention, health promotion, parent education, psychological and psychiatric, and early childhood education services (Anderson, Shinn, & Fullilove, 2003; Britto et al. 2017; Burton, Cohen, & Jain-Aghi, 2014; Leach & Yarker-Edgar, 2009; Meisels & Shonkoff, 2000).

Ideally, these integrated and cross-sectorial services would be available within the community where the family lives. Moreover, benefits can be gained when members of the community

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Services in rural and remote communities are underfunded or inconsistently funded, resulting in a predominant focus on crisis intervention instead of prevention and early intervention.

recognize and value the importance of these services and support families to access them. Consequently, this article focuses on situations in which access to resources and services has been compromised due to cultural, historical, and geographic inequities and/or a variety of differing perspectives about the importance of early childhood development and mental health.

Challenges in Rural and Indigenous Communities

We begin by describing a set of challenges faced by rural and Indigenous communities; specifically, inequity, service provision, and community capacity. We provide two case examples to illustrate these challenges within the Appalachian region in the United States and northern First Nations communities in Saskatchewan, Canada. This discussion is then followed by an examination of themes in service provision and recommendations for the field.

Inequity

The World Health Organization (WHO), with the help of Margaret Whitehead (1990), defined health inequities as "differences in health which are not only unnecessary and avoidable but, in addition, are considered unfair and unjust" (p. 427). This definition specifies seven types of health disparities: (1) natural, biological variation; (2) health-damaging behavior that is freely chosen; (3) short-term health advantages of one population over another; (4) health damaging behavior among those for whom lifestyle choices are severely restricted; (5) exposure to unhealthy or stressful working conditions; (6) poor access to basic services; and (7) natural selection. WHO also specifies that "inequities are avoidable inequalities," with social and economic conditions impacting risk of illness or access to prevention and treatment of illness (WHO, n.d.).

The communities in Ohio and Saskatchewan differ, yet both share similarities in the inequities that they face and the impact that these have on children and families. Both regions carry a long legacy of historical racism, colonialism, oppression, and systemic abuse. The result is generations who continue to be impacted by ongoing substance use issues, fear of engaging with authoritarian systems, poverty, poor health outcomes, and continued isolation.

Service Provision

Dimensions of cultural and health-based inequalities have a much bigger impact on individual health and well-being than economic inequalities (Hudson, 2012). Services in rural and remote communities are, at times, underfunded or inconsistently funded, resulting in a predominant focus on crisis intervention instead of prevention and early intervention. Although dedicated individuals work with and within remote and rural communities, many times they do so without a strong system of support or mechanisms to sustain and expand their work. High staff turnover, limited salaries, and limited capacity often hinder the provision of well-coordinated, culturally informed, and high-quality services.

It is also important to consider how the social determinants (e.g., early life experiences, employment/unemployment, food, transportation, social support, stress) affect the use and effectiveness of health and mental health services. When support is offered without consideration of either cultural and historical context or socioeconomic realities, they merely scratch the surface, providing superficial solutions that do not provide the holistic and comprehensive assistance that address underlying societal concerns. For example, offering resources and information about the importance of good nutrition on early childhood development is not an effective prevention technique unless also considering the high prices of nutritional food within remote communities that may make them inaccessible. Adequate attention to such realities is often missing in service provision for rural and Indigenous communities, directly impacting outcomes.

Community Capacity Building

Any prevention or intervention efforts must occur parallel to community capacity-building efforts in order to have long-term sustainable impacts (Brimblecombe et al., 2014). Models of community capacity building have been developed in other contexts that encourage strength-based approaches rather than models that are based on gaps, needs, or deficits, while still acknowledging the socio-political and economic situation (Jackson et al., 2003). Within these approaches, communities can take into consideration these inequities and develop strategies to lessen their impact.

Developing community capacity in rural, underserved, and remote communities requires that the following 10 constructs are considered (Brimblecombe et al., 2014:

- fostering community ownership;
- building on strengths;

- making decisions together;
- providing opportunities for learning and skill development;
- finding ways to work together;
- gathering supplies (people, funding, equipment);
- having strong communication;
- passing on knowledge to the next generation;
- having strong leadership and voice; and
- sharing the true story.

When increasing or building capacity to address early childhood development and mental health, one must thoroughly assess the capacity of the community to support and own these efforts and ensure that any staff development is accompanied with continued support. Challenges in providing equitable resources are further complicated when there is limited funding and initiatives brought in by external parties who are not aware of the intricacies of the community. When addressing disparities in mental health and mental health services, it is also imperative to be aware of unintended consequences that can arise when not looking holistically at the dynamics and challenges that exist (Hudson, 2012).

Harnessing the power of local expertise and partnering to support meaningful professional and leadership development provided by local and visiting content experts can ensure the effective communication of content and the connection to follow-up support found within the community. When considering rural and underserved communities with distinctive cultures, this type of partnership can make the difference between merely sharing information and supporting integration of best practices into the fabric of local systems and services.

Saskatchewan, Canada: Building Capacity Within Remote, First Nations Communities

Saskatchewan is a geographically large province located in the center of Canada. The province has a small but diverse population. According to 2016 census reports, 10.7% of the overall population is of First Nations descent. Lately, increasing rates of suicide by children (in some cases 9 and 10 years old) in northern First Nations communities (located above the 60th parallel) have highlighted disparities in family and child development, early intervention, and mental health support and services provision in remote, First Nations communities. Those who live on-reserve in northern, remote Saskatchewan have voiced the need for increased capacity to address children's health and well-being both on- and off-reserve. The provision of these services would need to follow the recommendations set forth in Truth and Reconciliation Commission of Canada's (TRC) Calls for Action. The TRC's Calls to Action were created in an effort to "redress the legacy of the residential school system and advance the process of Canadian reconciliation" (TRC, 2015a, p. 1). The provisions of these services also need to reflect Article 2 (non-discrimination); Article 3 (best interests of children); and Article 6 (right to life, survival, and optimal development; UNICEF, n.d.) of the UN Convention on the Rights of the Child; which Canada is party to.

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For most remote communities, mental health professionals work on a rotational basis and are not able to get into the communities more than once or twice a month.

Barriers to Accessing Mental Health Services

Some First Nations communities in northern Saskatchewan face multiple barriers, including poverty, substandard and crowded housing, racism, and the consequences of historical abuse and colonialism (Assembly of First Nations, 2011). Focusing on prevention and early intervention while dealing with more immediate crises may not be a priority. Despite this reality, specialized IECMH services (sometimes for children under 6 years old and in most cases under 8) are, for the large part, unheard of in northern Saskatchewan. For most remote communities, mental health professionals work on a rotational basis and are not able to get into the communities more than once or twice a month. Appointments are saved mostly for crisis intervention, medication prescribing or renewing, or both and, as such, primarily serve adolescents and adults. Instead of being offered through mental health services, IECMH support is provided through a number of different community-based programs, many of which have targeted criteria for enrollment.

Gaps in mental health services for youth and adults in remote First Nations communities have been addressed to a certain extent through the development and implementation of telehealth services. Research has suggested that these services can meet some needs of families by providing quick access, safety, and confidentiality (Gibson et al., 2011). Although these services were not meant to serve infants, children, and families, there is some potential in expanding this model of service.

To increase access to IECMH services in this context, innovative and collective approaches are necessary. Adaptive leadership and collective system change theories have been seen as promising approaches because both provide concrete strategies that can be used to inform leaders and programs

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Unfortunately, many external organizations that have provided services for northern First Nations communities in the past have assumed that all communities are the same.

on how to engage communities, identify strengths and gaps in formal and informal support and services, build shared language and knowledge, and build internal capacity. Adaptive leadership tenets also recognize the need to empower existing and new leaders within communities who can continue capacity-building efforts once external groups have left. Such perspectives can potentially support more sustainable efforts to increase access and minimize gaps in mental health services to First Nations communities.

Understanding First Nation Communities

Unfortunately, many external organizations that have provided services for northern First Nations communities in the past have assumed that all communities are the same. This is a falsehood and can become a large barrier as such assumptions presume that universal programming will be easily adopted and implemented in communities. These assumptions further affect relationships between internal and external partners.

Those living in First Nations communities, however, do share a commonality: they have all been impacted by colonialism and historical trauma. While experiences may have differed among individuals, communities, and families, historical trauma and colonialism have impacted all First Nations individuals. These impacts have caused family disruption, parenting challenges, physical and mental health concerns, addictions, and cultural disconnection (National Collaborating Centre for Indigenous Health, 2015; TRC, 2015b).

Initiatives started in communities that were community-driven and community-led in order to be broadly assessed (Gibson, et al., 2011). The Brighter Future (Health Canada, First Nations Inuit Health Branch, 2006) and Aboriginal Head Start (Office of Audit and Evaluation, Health Canada, & Public Health Agency of Canada, 2017) programs used community development models to address the needs of families within communities. Dependency on external funding may not be sustainable over time, but this is a start in addressing the community-wide needs.

Models for Service: Paraprofessionals

The use of paraprofessionals to provide community support and services has both positive and negative consequences in First Nations communities. The practice of employing paraprofessionals is ideal, if these individuals received adequate support and ongoing professional development. Such an approach provides support from within the community and, as such, can be structured to meet community needs and to continually assess these needs. As well, services provided from within the community may be more readily accepted because of the implied understanding of culture and historical trauma.

On the other hand, there are two potential downfalls to this model for service using paraprofessionals. First, it may be difficult for families to trust the boundaries of confidentiality when receiving services from people that they know. Second, if the paraprofessionals are not given adequate support, including support to deal with their own health and well-being issues, burnout of staff may result.

Capacity Building and Collective Action

Within northern Saskatchewan, building capacity in services of very young children and their families can be achieved through formal and informal capacity-building strategies. Strengthening pre-existing programming that provide services to children and families is ideal because families already have connections to these services. These include traditional services providing family and/or child support and interventions such as Kids First North and Early Childhood Intervention Services. Other services such as public libraries, family support centers, child care centers, and recreation activities can also be leveraged as IECMH prevention and support services. Moreover, strengthening formal parent support (e.g., parent mentors) and informal family support (e.g., Elders, extended families) can also support optimal child development.

Funding is a critical component of capacity building and collective action that needs attention for First Nations children and families. Many face the ongoing challenges of accessing medical services while on the reserve. These challenges reflect the continual battle between federal- and provincial-funded services. In Canada, all First Nation communities receive funds from the federal government because these communities are under the jurisdiction of the crown through the signing of treaties. This provision can cause gaps in the provision of provincially funded health services and federally funded health services (Assembly of First Nations, 2018). To address this issue, Jordan's Principle was passed in 2016 stating: "Jordan's Principle makes sure all First Nations children living in Canada can access the products, services and supports they need, when

they need them. Funding can help with a wide range of health, social and educational needs." (Government of Canada, 2019).

In summary, working with communities to increase their capacity to address IECMH is important and involves a dynamic, multilevel approach to intervention. Reflecting on the experiences of First Nation communities in northern Saskatchewan, impactful changes in systems and services must account for the historical contexts, awareness of the strengths and limits of current service systems, and promoting change from within the community. The momentum for change in Saskatchewan is evident, and community leaders and advocacy can keep that momentum moving forward.

Southeast Appalachian Ohio, United States: Building an Early Intervention System of Care

Nestled in the foothills of the Appalachian Mountains, southeast Ohio is home to more than 30,000 children from birth to 3 years old spread throughout 10,000 square miles, 25% of Ohio's land acreage (U.S. Census Data Quick Facts, 2019). In the 21-county region served by Hopewell Health Centers Early Childhood Programs, children enjoy access to more than 14 state parks, a national forest, open landscapes, strong community pride, and histories of extended networks of professionals and partners working together to support their community.

Understanding Appalachian Communities

Unfortunately, these resources are often overshadowed by the history of created dependency on unreliable sources of income—including strip-mining, coal industries, chemical companies, and hydraulic fracturing—when big companies enter local communities, offering jobs and payouts for access to local resources, land, and local infrastructures. Outside professionals entered communities lacking an understanding of the local infrastructures and entered offering to "fix" the "broken" systems and connect local residents to outside "experts." When the underground resources were gone, the big companies packed up and left behind land stripped of its resources and communities with gaps in services and interrupted networks of professionals, confused about how to engage in ways to effectively meet the needs of families left behind. The result over time became communities leery of outside influences, a lack of financial resources enjoyed in other parts of Ohio, and broken systems of support.

Models for Service: Federally Qualified Health Centers

Amidst the challenges, community champions can always be found, and stories of resilience emerge. One such story led to the development of community capacity to serve children from birth to 3 years old with special needs in rural Appalachia Ohio. In 2015, after losing in-home access to occupational and speech therapy for children in Ohio Early Intervention, early childhood professionals at Hopewell Health Centers set out to develop a sustainable system of care that could ensure ongoing access to in-home services. Hopewell Health Centers, Inc. is a Federally Qualified Health Center (FQHC) that provides integrated primary and behavioral health care services to the underserved residents of nine counties in southeast Ohio. Working with their local board of developmental disabilities, the early childhood team learned about the needs specific to children birth to 3 in early intervention and developed strategies to meet the requirements of billing services through a system of payment while maintaining the integrity of early intervention service provision.

Overcoming many challenges, the FQHC was able to bring services into scope and begin delivering services by late 2016. The following year, they partnered with Ohio Department of Developmental Disabilities to become a payer of last resort and expanded access to occupational therapy, physical therapy, and speech therapy to early intervention teams in three rural counties.

Through this work, Hopewell Health Centers leaders learned of the need for access to IECMH services in early intervention. Reaching out to state partners in the Ohio Department of Mental Health and Addiction Services and the Ohio Department of Developmental Disabilities, they proposed a pilot project to implement early childhood mental health (ECMH) consultation in early intervention, a protocol developed by Hopewell Health Centers ECMH professionals working in early intervention. With state-level support, Hopewell Health Centers worked to add IECMH services into early intervention. By the time another state pilot to expand access to specialized services in southeast Ohio was coming to a close in 2019, Hopewell Health Centers and local early intervention teams had successfully developed and implemented a sustainable system for providing early intervention services in underserved and underfunded counties. Putting the newly developed system to the test, the local FQHC partnered with 11 new counties to develop plans to meet the unique needs of each early intervention team. Early childhood professionals across agencies worked together to recruit local service providers, blend funding, and develop contracts to ensure that younger children in each of the counties had access to occupational therapy, physical therapy, and speech therapy in their natural environment. In addition, teams were offered access to ECMH consultation and began working on plans to expand access to local ECMH therapy services in the natural environment when needed.

Capacity Building and Collective Action

Developing community capacity in these rural, Appalachian, underserved, and remote communities demonstrates examples of the 10 constructs outlined by Brimblecombe et al., 2014. In this example, the local community developed and owned the strategy to respond to the identified need. Cross-sector collaboration drove the work, each system sharing strengths and resources as they learned about each other and found new ways to work together. The result was strengthened

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In the 21-county region served by Hopewell Health Centers Early Childhood Programs, children enjoy access to more than 14 state parks and a national forest.

communication and a strong system of care that represents the resilience and innovation of Appalachian early childhood professionals in southeast Ohio. In the first 6 months of expansion of services, there were 17 new specialized service providers—occupational therapists, physical therapists, speech therapists and ECMH therapists—added to early intervention teams in 10 counties. These therapists provided nearly 1,000 visits with 185 children from birth to 3 years old in their natural environment. This rapid integration of providers into early intervention teams allowed for exponential growth of the program and provides evidence of the successful collaboration within and across agencies at local and state levels. Together, they have developed a system for ongoing collaboration and feedback to ensure the sustainability of access to specialized service providers in Appalachia Ohio.

Common Themes and Recommendations

As illustrated by the case studies in this article and the testimonies from Indigenous change makers (Zoubak, this issue, p. 66), equitable and reciprocal partnerships with culturally specific rural communities and historically marginalized and underserved groups are the backbone for any effort. In the following sections, we identify several common threads that connect the case studies presented in this article.

Historical Trauma, Colonization, and Disenfranchisement

In an ethnographic study of strategies to improve health equity with Indigenous populations, Browne et al. (2016) stated "promoting health equity requires understanding the erosion of Indigenous peoples' power and resources as purposeful in the service of historical and contemporary colonial conquest." Acknowledging this history and the driving forces behind the structures of existing family-serving systems is a first step toward equitable health and education service delivery. The second step is understanding that systems gravitate toward the maintaining of "current status" or "status quo" (Stroh, 2015). When partners work together toward change, system mapping and analysis can be helpful in determining the inequities that continue to be perpetuated. At the same time, a history- and trauma-informed approach should guide this collaborative effort.

Community Leadership and Capacity

Both case studies illustrate the benefits of relying on existing strengths and expertise within Indigenous and rural communities and organizations. Using only outside expertise can alienate local partners and, in some cases, create the pattern of unreliable funding and unsustainable funding efforts that do not account for the intricacies of the community. Equally important is cultivating equitable and reciprocal partnerships in which local knowledge holders, community members, professionals, and leaders are heard. It is also important to provide resources to build local capacity to support children and families, which can be done through appropriately structured trainings, certifications, scholarships, or being able to create professional development opportunities that speak to the specific issues of the community. Leveraging local resources is helpful, but it is also important to understand the limited capacity of rural and Indigenous systems that are often underfunded and overstretched.

Comprehensive Asset Mapping and Strategic Planning

As with any effort or project, asset mapping and strategic planning should be the jumping-off points. This process is especially important when tackling a new initiative in underserved and geographically remote places. Activities should be conceptualized with thoughtfulness about sustainability prior to implementation to avoid creating temporary extended access and the disruption of existing services, thus leaving communities with no support or access to services. As shown in the case studies, collaboration and leveraging of existing resources (versus duplication) should be embedded in this process from the start.

Flexibility

Services should be adapted on the basis of contextual and environmental realities (e.g., geographic remoteness, availability of staff, cultural or linguistic goodness of fit, community priorities, rates of staff burn out). An inflexible or culturally irrelevant approach would neither benefit the organizations involved nor the community members.

Strength-Based Approaches

System change can be a slow and sometimes invisible process. Even when efforts to improve health and well-being for young children seem fruitless, it is possible to support a strength-based narrative and highlight successes. Doing so balances the skewed perception of rural, Indigenous, and underserved communities and supports the resilience that is present.

Conclusion

The content and cases examined in this article provide entrée to understanding the promising opportunities and relevant barriers that exist when seeking to increase access to preventive mental health services for very young children. A legacy of inequity, trauma, and a lack of community infrastructure have the potential to weaken communities and the services designed to help them and these must be acknowledged. At the same time, we have highlighted opportunities to build health systems and mobilize services that are rooted in pathways to support communities from within. Ultimately, effective and sustainable IECMH services are gained through partnership and leaning on the voices and expertise of the communities being served. Moving forward, we need leaders who understand this call and will work tirelessly to elevate the voices of those in rural and Indigenous communities so that such sustainable change can be replicated broadly.

Disclaimer

This article was co-authored by Ekaterina Zoubak in her personal capacity. The opinions expressed in this article are the author's own and do not reflect the official views of the Substance Abuse and Mental Health Services Administration, the Department of Health and Human Services, or the United States government.

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Erin Lucas, LISW-S, is director of Early Childhood Programs at Hopewell Health Centers, Inc., a Federally Qualified Health Center (FQHC) providing integrated health care in southeast Ohio. Ms. Lucas has a vision for creating effective collaboration within and across systems to meet the needs of young children and families in rural Appalachian Ohio. Ms. Lucas directs the work of wellness programing, early intervention services, infant and early childhood mental health (IECMH) consultation and therapy, training, and consultation to schools to promote the integration of trauma-informed care. Under her leadership, the early childhood team has partnered with the Ohio Department of Mental Health and Addiction Services, Early Childhood Initiatives, to expand provision of IECMH consultation and training to preschool partners in 18 counties, partnered with local Alcohol, Drug and Mental Health Services Boards to expand the consultation model to include a school-age model of consultation to promote trauma-informed care, and has partnered with the Ohio Department of Developmental Disabilities and local early intervention teams to create solutions for increasing access in rural and underserved areas to allied professional therapy in early intervention.

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When the underground resources were gone, the big companies packed up and left behind land stripped of its resources and communities with gaps in services.

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