DEVELOPING SENIOR'S SERVICES ON RESERVE: A CASE STUDY

by

PETER W. VLAHOS

B.A. Dalhousie University, 1985
BSW University of Calgary, 1990

A GRADUATING ESSAY SUBMITTED IN PARTIAL FULFULLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF SOCIAL WORK

in

THE FACULTY OF GRADUATE STUDIES
School of Social Work
THE UNIVERSITY OF BRITISH COLUMBIA

March 2005

Accepted as conforming to the
standard required for the
degree of Master of Social Work

_____

Dr. Deborah O'Connor

Abstract

There are currently thousands of continuing care beds located throughout the Province of British Columbia. Curiously, less than one hundred of those beds are located and managed within First Nation communities. The purpose of this case study was to examine a successful process by which a long term care facility was developed within a First Nations community located in the interior of British Columbia. As minimal research exists in this particular area, this case study was exploratory as there are no models for the development of senior's health services on Reserve. Qualitative analysis identified characteristics that encapsulated the range of variables that existed when a First Nations community chose to undertake the development of health and social services for their seniors. Findings highlighted the necessity for sharing information, developing strategies that are community based and managed and the need for available resources at both provincial and federal levels. Additionally, this case study reinforced the requirement of community developmental strategies to be further explored through a cultural lens that promotes and encourages grass roots involvement and empowerment.

Table of Contents

List of Tables

List of Figures

Introduction

It is anticipated that the number of people in Canada who are sixty five years of age and older will grow by approximately thirty percent in the next ten years. This rate of growth will correspond with an increase in demand for health care services for seniors that has been unparalleled in Canada's history. It is expected to threaten the very stability of the Nation's health care delivery system (Hogan & Hogan, 2002; Romanow, 2002; Schrier, 2002; Statistics Canada, 2003).

This problem is further exacerbated for seniors who are registered First Nations,[1] living on Indian reservations. Until very recently, services to seniors living on Reserve have been limited to whatever time federally funded Community Health Nurses (CHN) or Community Health Representatives (CHR) could spare. These primary care practitioners were not mandated to provide anything other than cursory health care services. Examples of these health services included administering immunizations, and providing health workshops on a range of topics e.g., substance misuse, nutrition, breast feeding, and other educational/preventative oriented topics. However, when elders required more acute levels of care, such as dressing changes, or monitoring of medication, they historically had to move off of Reserve to obtain these services (Seniors Advisory Council of BC, 1996).

Recently, First Nation communities throughout Canada have been given an opportunity to develop health services for their seniors by way of a national home and community care program administered through the Federal Department of Health Canada, First Nations and Inuit Health Branch (FNIHB). The First Nations Home and Community Care program will allow First Nations elders access to the following health

[1] For the purposes of this study, 'First Nations' refers to those people who are registered Indians residing on Reserve.

care services from their homes: initial assessment, case management, home care nursing (home based registered nursing care, health education for the elder and their families and clinical nursing supervision of other support services), personal care aides (bathing, foot care, activities of daily living), home support workers (e.g, housekeeping, laundry, and meal preparation), and in-home respite services (providing care for elders who cannot be left alone while their family members or usual caregivers rest) (Health Canada, 2000a).

Although there is currently an exciting opportunity to develop health services for elders who reside on Reserve, very few First Nations people have the in-house expertise necessary to undertake the planning. This study examined the successful development of a long term care facility initiated by two First Nations elders located on Reserve in the interior of British Columbia. Through the examination of their successful developmental process, the following research question was answered: ***What is the development story of the long term care facility in Community X?***

In relation to this research question, a myriad of other questions arise, such as:

1. What might be some of the implications for future planning in the area of the provision of services to First Nation elders that reside on Reserve in British Columbia?

2. Can this development process or aspects of this development process be utilized by other First Nation communities?

3. What are the implications of this study for other minority cultures in Canada who are striving to meet the requirements of their respective seniors' populations?

4. How does this particular development process contribute to knowledge in social work and community development practice?

Significance of This Study

By answering the aforementioned questions, this study will attempt to directly contribute to knowledge development regarding seniors' health care services on Reserves and amongst other minority populations. It will also attempt to inform social policy in this matter leading to a greater understanding as to why there continues to be minimal development in the area of seniors' health and human services on Reserves. Furthermore, social workers and other practicing community development workers can learn from the successful development process described in this study and utilize strategies in developing similar services on other Reserves or amongst other populations of ethnic minorities in Canada. Finally, as First Nation communities strive towards self-determination and self-governance, this study will contribute valuable insights into the successful provision and ownership of services offered to their respective elderly populations and contribute to these goals.

Conceptual Context

Introduction

This section will survey the literature related to the current health status of First Nations seniors, with the intent of demonstrating the continuing disparity in their health status in relation to the rest of the population of senior citizens in Canada. Next, health policy literature will be surveyed illustrating how health policy continues to impede, rather than support, development of health services for First Nation seniors. Finally, community development literature will be explored with the purpose of highlighting

community development processes that can further inform the research in the area of developing services for seniors who reside on Reserve.

Health Status of First Nation Elders

Dr. John Miller, the BC Provincial Medical Officer of Health in his Provincial Health Officer's 1996 Report, noted that "Aboriginal peoples, as a group, remain the most disadvantaged of our citizens, and have the poorest overall health status" (Provincial Health Officer's Report, 1996). Dr. Miller also recommended that Aboriginal communities should be given control over the resources they need to improve the conditions that affect their health status, through augmentation of the trend to self-governance and settlement of land claims. He suggested that inequities in health service delivery and supports to Aboriginal people should be eliminated, through cooperative efforts of the federal and provincial governments (p. 96). One year later, in a public discussion paper entitled, *Health Goals for British Columbia* (Ministry of Health and Ministry Responsible for Seniors, 1997), one health goal outlines broad statements of future health policy aims:

> Goal #5: Improved Health for Aboriginal Peoples. Aboriginal peoples experience very significant health status inequities that have occurred as part of the historical legacy of our province and country. This goal highlights the need for action to reduce these inequities, including changes to ensure greater self determination for Aboriginal communities. (p. 5)

His successor, Dr. Perry Kendall, acknowledging his concern about Aboriginal Health issues, specifically focused on the Aboriginal population of British Columbia in his 2002 report. He reported that "the health status of Aboriginal people is improving" (p. 23), and that "life expectancy for Registered Indians in Canada continues to improve. By 2016, the gap between Registered Indians and the general Canadian population is expected to narrow to seven years for men and 3.8 years for women" (p. 25). Other chronic health conditions that are notably worse amongst First Nations people when

compared to non-First Nations people include: arthritis, high blood pressure, breathing problems, heart disease, diabetes and cancer (p. 34). Additionally, many First Nations communities continue to be plagued by housing shortages, sub standard drinking water and polluted air. Kendall attempted to explain the poor health status of Aboriginal People compared to the general Canadian population:

> This is a complex issue. Poor health status reflects the historical disadvantages experienced by Aboriginal communities. Colonialism, racism, diseases, and the loss of cultural and political institutions have resulted in powerlessness and dependency, from which they have only recently emerged, and with the legacy of which they still must struggle. The residential school experience and the forced separation from families in the name of integration resulted in family disruption. Poverty, unemployment and inadequate housing all contribute to ill health for Aboriginal people, as for others … Finally, the loss of a traditional lifestyle and traditional foods has had a particularly deleterious effect on Aboriginal people, contributing to high rates of obesity and diabetes. (p. 34)

Further, as people age, these factors combine to create acute health issues that Canada's health care system, to date, has not adequately responded to. Romanow (2002), in his recently released report on the *Future of Health Care in Canada*, states that "in 2000, the gap between life expectancy of registered First Nations people and other Canadians was estimated at 7.4 years for men and 5.2 years for women" (p. 218). Romanow identified many of the same health indicators noted in Dr. Kendall's report. In fact, Romanow did not see any improvements until the Aboriginal 'disconnect' is adequately addressed:

> In fundamental terms, there is a disconnect between Aboriginal peoples and the rest of Canadian society, particularly when it comes to sharing many of the benefits of Canada's health care system. There are at least five reasons for this disconnect: competing constitutional assumptions; fragmented funding for health services; inadequate access to health services; poorer health outcomes; and different cultural and political influences. (p. 212)

The *Report on the Royal Commission on Aboriginal Peoples* (Canada Communication Group, 1996), described overcoming the disconnect by stating that self-determination for Aboriginal peoples is an immediate necessity. We also believe that in

light of the deep relationship between powerlessness and ill health, that Aboriginal health and healing must be returned to Aboriginal control. Finally, we found overwhelming evidence that control of health and social services by outsiders simply does not produce good results – in any community. (p. 227)

Furthermore, because so many of Canada's First Nations live in rural and remote settings, they are not only disconnected culturally, but also geographically, which only serves to intensify an already complex health service delivery situation (Health Canada, 2000; Rural Research and Analysis Unit, 2001, Rural Secretariat Research and Analysis Group, 2001). For example, Keating (1991) observed, that rural populations often consist of different cultural groupings – communities within communities. Each of these cultural groupings has their own ways of caring for their respective seniors (Aleman, et. al, 2000; Fisher, Ross, & MacLean, 2000; Gesler, Rabiner, & DeFriese, 1998). Indo-Canadian and Chinese families, for example, place a strong value around caring for their elders within the confines of their own homes. Although this practice should be lauded and supported, in fact, public health policy does not, leaving many Indo-Canadian and Chinese families to care for their seniors in relative isolation with no external support.

Ironically, although Canada's various cultural groups have a wealth of knowledge in regards to caring for their respective senior populations, there is no process in place to allow us to tap into this healing knowledge and integrate it into the current acute care 'illness' focused system. Within First Nation communities, as observed by the disparity of health status, this has meant that many Elders and their families continue to fall through the cracks of this developmental knowledge gap. Unfortunately, health policy, although well intentioned, has done little to fill this fissure.

Health Care Policy and First Nation Seniors

Kendall (2002) describes health care policy as it relates to First Nation seniors:

> over the past two decades, significant changes have occurred in the delivery and control of health services, for both Aboriginal and non-Aboriginal communities. The devolution of health services provides opportunities for local decision-making and control, but it also presents some challenges to maintain overall planning and program standards. (p. 81)

What Dr. Kendall does not mention is that health transfer to First Nations is somewhat of a misnomer, given that resources and the responsibility of delivering higher levels of health services remains the joint responsibility of provincial and federal governments. Essentially, what has only been 'transferred' to First Nation communities is the management of the communicable disease prevention and control program, effectively relegating First Nations to be the administrators of their respective booster and immunization programs (Health Canada, 1995). As a result, as clearly illustrated in a recent report commissioned by the Aboriginal Health and Wellness Committee (2002), the scope of services offered by First Nations via the health transfer process and the relationship of the health transfer process to Provincial health services remains unclear (see Table 1).

In relation to the transfer of health care services, the *Report of the Royal Commission on Aboriginal Peoples* (Canadian Communication Group, 1996) further elaborates:

> … the benefits of transfer have been significant. Gains include flexibility in the use of program funds, more freedom to adapt services to local needs and priorities, reduced paperwork in accounting to MSB, and a greater sense of community ownership of services. But there are significant disadvantages, too … The drawbacks remain much as they were when the program began: the restricted nature of the programs and services that can be transferred, the brief time available for planning and community education for program responsibility, the cap on funds regardless of need, and the possible failure of the federal government to live up to its fiduciary obligations to Aboriginal people. (p. 117)

Table 1. Health Services Matrix for Aboriginal British Columbians

Service Provider	Status Indians		All Other Aboriginal People: Non-status, Métis, Inuit
	Living on reserve	**Living off reserve**	
Federal	MSP premiums+ Non-Insured Health Benefits+ Alcohol & Drug* Public health* Environmental health* Residential care+ Home & Community Care*+ *Optional*	MSP premiums+ Non-Insured Health Benefits+	
Provincial	BC Ambulance (billed to HC) Pharmacare (2nd payer to NIHB)	BC Ambulance *(as with other residents)* Pharmacare (2nd payer)	BC Ambulance Pharmacare MSP premium subsidy *(all above as with other residents)*
Health Authority	Acute care Continuing are Public health Environmental health*	Acute care Continuing care Public health Environmental health*	Acute care Continuing care Public health Environmental health*
First Nation	Health Services Transfer* *Optional*		

* Scope of services not comprehensive; interpretations often at variance with provincial definitions.

+ Funding only, does not provide direct services.

As highlighted in Table 1, above, the greatest flaw in the Health Transfer process has been the lack of communication between the federal and provincial governments. While the federal government was 'transferring' the responsibility for the delivery of a wider range of health services to First Nations, they did not include the Provincial governments in the health transfer planning and development process until quite

recently. Contributing to the lack of communication is the ongoing constitutional debate. The question of whom is ultimately responsible for the provision of health care services to First Nation seniors, therefore, remains unanswered. If the limited range of health services for First Nations elders is any indication, the non resolution of constitutional issues remains one of the ongoing impediments to developing on Reserve services for First Nation seniors.

Moreover, to illustrate the unresolved constitutional issues, BC provincial government health employees, most notably home care assessors, have not yet provided services on Reserves, claiming that First Nations health is the responsibility of the Federal government. Thus, elders who need to be assessed for their care requirements are often assessed by para-professionals or even by Band social workers, rather than by a multi disciplinary team including provincial nurse assessors. This was pointed out by the now defunct Seniors Advisory Committee of British Columbia (1996) in a report they commissioned specifically to examine outstanding health service delivery issues for First Nation seniors:

> there are still policy inconsistencies in the delivery of health services to Aboriginal people depending on the status of the person, and whether they live on or off reserve. In many cases, confusion still exists over who should provide and pay for services, which means that services can be denied or not accessible in some instances. (p. 68)

Not long after the Senior's Advisory Council of British Columbia report, *The First Nations and Inuit Regional Health Survey* (Health Canada, 1999), spoke of "an endemic of chronic disease conditions" (p. 51), and the immediate need for increased levels of care for First Nations elders. As mentioned earlier, it was in response to this chronic need that the Federal Government finally introduced a national Home and Community Care program. Although this program has been generally well received by most First Nation communities, unfortunately it is not sufficiently resourced to meet the actual

health service requirements of First Nation elders. Again, the Federal Government did not communicate with the provinces resulting in a quagmire of issues regarding jurisdiction, liability, service provision, capacity building and funding that remain unresolved to this day. First Nations do not yet have the sufficient capacity and expertise necessary to undertake the planning and development of this type of services to the scale required, reiterating the need to increase knowledge in this area.

What good is knowledge and capacity without having full autonomy and control over health services? In answer to this question, the First Nations Chiefs' Health Committee (2000), a provincial health organization representing those First Nations who are active in Treaty negotiations with the Province of British Columbia, released a public discussion paper outlining a process whereby First Nations Health in the province of British Columbia would be transferred completely over to the control of BC First Nations. Indeed, this approach seems to fit perfectly with the provinces' encouragement of First Nations self determination in the area of health (British Columbia Royal Commission on Health Care and Costs, 1991). It also seems compatible with the goal of the Federal government for First Nations to acquire full control over their own systems of health service delivery. In fact, the First Nations Chiefs' Health Committee is funded by the First Nations and Inuit Health Branch of Health Canada, who indirectly, commissioned the discussion paper. Since its release, however, both levels of government have shifted away from their respective policies on supporting First Nations self determination in the area of health care. This tangible example of government rhetoric demonstrates actions that do not support the underpinnings of a health care system that was established to support equal access and equitable levels of health care for all citizens of Canada.

The BC provincial government released its updated blueprint for health (British Columbia, Legislative Assembly, Select Standing Committee on Health, 2001), which outlined the following recommendation:

- Work with the federal government and First Nation communities to coordinate programs and health care services to improve access to available services.
- Promote education and prevention strategies in aboriginal communities.
- Support health education training for aboriginal students.
- Work with aboriginal groups to develop and implement aboriginal health plans for each region.
- Encourage partnerships between aboriginal communities and health organizations.
- Ensure appropriate aboriginal consultation in the coordination and regional organization of health services.

Absent are references to self-determination and the ability to acquire increased control over their own health services. This contradicts what was outlined in the RCAP (1996) stating that self determination for Aboriginal peoples was an immediate necessity and that it was imperative for Aboriginal health and healing to be returned to Aboriginal control.

Shortly after the provincial report was released, the First Nations and Inuit Health Branch began making overtures to the Chiefs' Health Committee that their work towards the complete transfer of health responsibilities to First Nations will no longer be condoned. At one point, in the recent past, FNIHB threatened to discontinue funding the First Nations Chiefs' Health Committee.

In the face of the provincial and federal governments' refusal to grant First Nations full autonomy over their own health care, there are other significant health policy trends underway in Canada and in British Columbia. First, there is a move away from 'institutionalizing' seniors towards supporting seniors to stay in their homes. Although, at first glance, this approach may be preferable to moving to institutional care

especially because it allows for a more culturally relevant setting, the downside is that the costs for this type of housing and supportive service arrangement will depend less on governments and not for profit organizations and more on private enterprise to provide (Armstrong, 2002a; Armstrong, 2002b; Caro, Morris, & Norton, 2000; Cohen & Pollack, 2000; Health Association of BC, 2000; Report to the Annual Premiers' Conference, 2002).

Romanow (2001) clearly stated that home based services should be more appreciably recognized as an essential part of Canada's health care system, but only if this approach is adequately resourced. By way of an example, the previously mentioned First Nation Home and Community Care program covers only one third of actual costs involved with home based services. The remaining costs must be covered by a combination of Provincial/Territorial governments and the individual consumers.

Furthermore, at this time it is unknown whether or not assisted living and supportive housing initiatives will be possible to implement on Reserve, given the already limited resources, unresolved jurisdictional issues and lack of developmental history in this general area (Rowles, Beaulieu, & Myers, 1996). Second, there is a trend towards a 'user pay' or 'privatization' of a number of health services (British Columbia, Legislative Assembly, Select Standing Committee on Health, 2001; Cohen & Pollack, 2000; Health Association of BC, 2000; Lee, 2003; Romanow, 2002). For many seniors in Canada who receive only a minimal pension, it raises the specter of not being able to afford even their basis shelter and food requirements.

Finally, because of the ceiling on health spending, more of an onus is being placed on health determinants, health outcomes and primary (or preventative) care (Cardiff et al., 1998; Dean, 1993; Health Canada, 2000; Hollander & Walker, 1998; Miller, 1999; Romanow, 2002; Statistics Canada, 2003). This is arguably an

advancement in the areas of accountability and ultimately sustainability, however, as the majority of First Nations are currently in the initial developmental stages of establishing health services in their respective communities, it begs the question of whether or not they are adequately prepared at this point. As demonstrated in the recent past with the health transfer initiative, both the provincial and federal governments tend towards advancing strategic policy shifts without necessarily communicating amongst one another and without the inclusion of First Nations input.

In the face of the ebb and flow of the policy changes, the Federal government's refusal to grant First Nations control over the delivery of health services, a lingering constitutional wrangle over which level of government is ultimately responsible for the delivery of health services to First Nations elders continue to remain neglected. Brown (1995) outlined six characteristics of the meaning of respect from a First Nations perspective: (i) capacity to treat people as inherently worthy and equal in principle; (ii) acceptance of others; (iii) willingness to listen actively to patients; (iv) genuine attempts to understand patients and the unique situation of each; (v) attempt to provide adequate explanations; and (vi) sincerity during interactions. The continuation of disrespect of First Nations people and in particular, First Nations elders, clearly reflects a legacy of the dominant society continuing to administer oppressive health policy that perpetrates dependency resulting in a lack of First Nations stewardship in the area of health services.

The purpose of this case study was to examine a developmental success story of a long term care facility located on a First Nation Reserve located in south central British Columbia. Despite a multitude of barriers, including the rural setting, this facility was inspired by two First Nation elders from within the community and has grown from being a small independent living facility to one that has sixty two beds, and the only

dementia care unit on Reserve in Canada. Smylie, et. al. (2004), discuss the uniqueness of the Aboriginal perspective regarding leadership, governance and participation. The authors describe that these issues need not be seen as obstacles but rather viewed as opportunities for providing relevant and appropriate health care services.

Models of Development Processes

The Seniors Advisory Council of BC (1996) reported that there are three First Nation's owned and operated institutional or long-term care facilities in the province of British Columbia, with two of the three located on-Reserve (pp. 68-69). Additionally, 63 of the 829 long-term care beds located within First Nation facilities throughout Canada, or approximately 8% of the national total, are located at Community X, BC (DIAND, August 18, 2003, personal correspondence). When considering the fact that there are only 829 First Nation long term care beds in Canada, this is in marked contrast to the thousands of total long term care beds and facilities located off Reserve in Canada. Furthermore, a literature review on the development of First Nation continuing care facilities revealed an identified gap. (Rowles, Beaulieu, & Myers, 1996). Nevertheless, some literature does speak to community development within First Nations (Elias, 1991; Health Canada, 2000; Napoleon, 1992; Palermo, 2000; Wharf, 2002), referring to the process of evaluating existing services for seniors (Gallagher, Gnaedinger & Mullen, 1999), and to community development concepts (Bruce & Whitla, 1998; Campfens, 1997; Ewalt, Freeman & Poole, 1998; Lawton, Newcomer, & Byerts, 1976; Palermo, 2000; Payne, 1997; Stoesz, Guzzetta, & Lusk, 1999). Clearly, further research relating to the development of continuing care services for First Nations is required.

There is certain literature that speaks in general to community development within First Nations (Elias, 1991; Health Canada, 2000; Napoleon, 1992; Palermo, 2000; Wharf, 2002). The focus of the majority of this research has been on economic

community development as opposed to human service growth. Gallagher, Gnaedinger and Mullen (1999) describe the process of evaluation existing services for seniors, however, their findings do not address First Nations people. Community development concepts in general have been well explored in the research (Bruce & Whitla, 1998; Campfens, 1997; Ewalt, Freeman & Poole, 1998; Lawton, Newcomer, & Byerts, 1976; Palermo, 2000; Payne, 2000; Stoesz, Guzzetta, & Lusk, 1999). Notwithstanding this wealth of knowledge specific to community development and planning, there are no models for the development of seniors health services on Reserve. Specifically, the research does not address the range of internal (community) and external (national and international) factors that come into play when a First Nations community chooses to undertake the development of health and human services for their seniors.

I believe that the research involved with this case study will have a direct contribution in the area of community development for First Nations people. As stated previously, I am reluctant to suggest that the process undertaken by Community X may or may not be generalized to other First Nations communities, however, given the lack of success for this type of health facility development, it could serve to further inform existing models and concepts of community development practice.

Conclusion

As the literature clearly demonstrates, there remain many outstanding issues pertaining to the provision of health services for First Nation elders. Although current trends in federal and provincial health policy suggest that progressive opportunities do exist addressing some of these long outstanding issues, there is a gap in the information base necessary to respond to these opportunities. This research project is a minor attempt to address this knowledge gap by examining a specific case of the successful

development of a First Nations long term care facility that continues to provide a range of high level health services to a population of First Nation elders.

Methodology

Introduction

This case study aims to identify the process by which a long term care facility was developed within a First Nations community. Because little or no research exists in this particular area, this case study will be exploratory (Yin, 1994). Incorporating the story telling culture of First Nations people, and attempting to portray respect through an acceptance of and a willingness to listen, I chose to interview two First Nations people to determine their perspective of the developmental process of creating their long term care facility. To this end, the research design was less structured than a confirmatory study, and by virtue of examining the developmental process of one on-Reserve facility, employed a small sample size (Silverman, 2000).

My study began with a descriptive analysis of the socio-historical context of health care provision to First Nations people in Canada with a particular focus on First Nations in British Columbia. Interviews with two key informants, completed on two separate occasions, were included. Finally, a qualitative interpretation of the interview data was undertaken and conclusions drawn. A description of each step follows, complemented by a brief assessment of the validity and reliability of the proposed research and discussion of ethical issues.

Data Collection Methods

As Mason (2002) points out, "if you plan a case study analysis, you will need to ensure that you have generated the appropriate range of data to permit a full and meaningful analysis of the case in question" (p. 37), while keeping in mind, as Stake

(1995), states, that "case study research is not sampling research. We do not study a case primarily to understand other cases. Our first obligation is to understand this one case" (p. 4). This notion is particularly applicable when examining the views of First Peoples (Northey, Tepperman, & Russel, 2002). Smith (1999) argues that assumptions, methodologies, and epistemological premises of conventional research must be challenged in order to assert indigenous ways of knowing. She states that any research must be valuable, accountable and empowering to indigenous people involved and must fit with aboriginal world view. For example, much can be learned by studying a community development process that was successful in one community, regardless of whether or it would be applicable in another. Concepts of development may differ from one community to the next, especially given that many First Nations are located some distance from urban areas and amenities.

The process of utilizing a focused conversational interview with key informants has been well documented (Dexter, 1970; Rubin & Rubin, 1995; Stouthamer-Loeber & Bok van Kammen, 1995). This case study also utilized a focused conversational interview with two key informants. The objective of this study serves to draw out key concepts and developmental strategies that may be applied from one community to the next, and indeed, from one cultural grouping to the next. For example, Palermo (2000) from Dalhousie University in Halifax, Nova Scotia and the Wagnatcook First Nation in Nova Scotia, published a community planning model employed by that particular First Nation group that offers applicability amongst other First Nation and non-First Nation communities.

My case study utilized an interview guide (see Appendix 1), which contained a series of open ended questions designed to further explore the developmental framework utilized by the First Nations named community in developing their long term

care facility. The interviewees were audio recorded and asked questions relating to the early developmental days of the facility. The two interview session(s) took place in neutral settings where open and frank discussions took place. St. Denis (1992) describes how community based participatory research is a methodology that gives respect for the individual commitment to social change emerges as a way to empower communities. Through 'listening to learn' I was honored with the fact that the informants shared their lived experience for the possibility of sharing their community development process with other First Nations people.

Sampling

The selection of this particular facility and the study participant(s) was straight forward, as there are only three long term care facilities located on-Reserve in British Columbia. The selection was narrowed down to one due to geographic proximity. Moreover, since so few of these types of services have been developed, there are not many key informants to choose from, regardless of the location of the community.

In this case study, the first key informant was personally known to me by virtue of her lengthy tenure as Executive Director of the long term care facility. She began her work with the facility during its genesis and was inextricably involved with its early developmental process and has played an integral role in its sustainability and growth to the present.

Following the recommendation of the first key informant, I solicited the involvement of the second key informant. The second key informant has been an elected member of the Chief and Council of the Band government and was also involved with the facility during its early development. The unique role of the second informant is two fold in that not only was he involved with the development of the facility, but also played a role in its development at both a policy and political level. Both key informants are

registered members of the First Nation and have made a life long commitment to the empowerment of their community.

Reliability and Validity

As Mason (2002), states, "reliability involves the accuracy of your research methods and techniques" (p. 39). In order to achieve reliable data of this case study, the author audio-taped the interview(s) and subsequently transcribed them verbatim to text. The researcher then reviewed the transcripts for accuracy, and also had the interviewees review the transcripts for accuracy once completed. Mason (2002) also states that "if your research is valid, it means that you are observing, identifying or 'measuring' what you say you are" (p. 39). Although, as pointed out earlier, this case study cannot be generalized beyond the sample facility, its findings has potential for contribution to community development practice in the area of developing health care services for seniors living on Reserve.

Due to the limited research in this particular area of community development, confirmability, becomes an issue (Bickman, 2000; Miller & Dingwall, 1997; Seale, 1999).

Data Analysis

For this case study, two interview transcripts were drawn upon to conduct a thorough analysis. As Silverman (2000) points out, "it is the quality of your data analysis that will matter, not whether you can show how clever you were to access your data" (p. 121). This study consisted of both an interpretive and reflexive analysis. Mason (2002) states that an interpretive analysis, "will involve you in constructing or documenting a version of what you think the data mean or represent, or what you think you can infer from them" (p. 149). It stands to reason that this interpretive approach is already strongly associated with qualitative research. As well, Mason states that

"whatever form of interpretive reading you adopt, you will be involved in *reading through or beyond* the data in some way" (p. 149). Due to the fact that I was professionally immersed in the practice of developing services for seniors on Reserves throughout British Columbia for the past ten years, this case study also contained a reflexive analytical component where I incorporated my subjective perspective. Mason addresses this concern by saying that one must continuously assess his "role and perspective in the process of generalizing and interpretation of data" (p. 149).

In order to assist in the process of data analysis, both transcripts were coded manually, into the following four categories: (1) difficulties and unique challenges that were faced developing this project; (2) issues that made developing this facility 'special' or unique; (3) key differences between this (on Reserve) long term care facility development story compared to those of other, generic long term care facilities; and (4) features of this facility that made it different in comparison to others (e.g., those located off Reserve). The data was then interpreted and described in a manner that depicted the developmental story of a long term care facility for seniors in one First Nations community.

Ethics

Past research has helped to produce current ethical codes that are designed to protect the physical and psychological well-being of human research participants (Yegidis & Weinbach, 2002). This code of ethics is necessary to ensure, in part, that participation of informants is voluntary and informed, and that confidentiality for the informants and, in this case, the First Nations community and the identity of its long term care facility is maintained. In order to address ethical concerns in relation to this research project, I submitted a detailed ethical review application to be reviewed by an independent panel of the University of British Columbia. Additionally, via initial

telephone contact and letter of introduction, both key informants were advised that they were under no obligation to participate in this study. As well, I told them that I would remunerate them for their time by providing for lunch after both the initial and follow-up interviews.

Informed consent from both key informants was obtained through both oral communication and in writing by way of letters of consent. Both the initial letter of contact and the letter of consent were attachments to the application for ethical review submitted to UBC. Finally, whereas confidentiality is at issue in this case, there being only three facilities of its type in British Columbia, and few people who have been involved in their development, every effort was made to limit the identification of either key informant. I achieved this by not disclosing the details of the research project publicly and by the fact that the key informant(s) had an opportunity on the consent form to either grant or not grant permission for the interview data to be used beyond the scope of this study. Regardless, the taped interview and interview transcripts, were safe locked at UBC for a period of five years after which time they will be destroyed.

Finally, there is a political dimension to this qualitative research project (Hammersley, 1995; Homan, 1991): in particular, the issue of non-First Nations conducting research on and about First Nations. Personally, I feel the ethical dilemma of formulating research for the expropriation of knowledge and/or claims of contributing directly to First Nation social work practice paradigms has the possibility of exploiting the very people it claims to support. Having worked for over fifteen years on Reserves throughout British Columbia, I have had to personally reconcile my role as a white professional 'outsider' on numerous occasions, and have experienced that First Nations people ultimately pass judgment on the quality of the social work and professional code of conduct rather than on one's race of origin. Furthermore, I found that by being up

front and demonstrating respect in explaining my role(s) in the community and adhering only to those roles, I experienced no difficulties working cross-culturally. Therefore, with this history of experience and clear role definition, I approached this case study with both confidence and anticipation.

Limitations

This is a singular case study of one successful development of a long term care facility within a First Nations community. Although the process of utilizing a singular case study has been demonstrated in research (Hamel, Dufour, & Fortin, 1993; Stake, 1995; Yin, 1994), the interviews for this study were restricted to two key informants from a single First Nations community. As well, as previously stated, I have extensive experience working with First Nations peoples, however, this research was conducted by someone of European ancestry and interpreted subjectively through a Eurocentric lens.

Conclusion

The method utilized for this study was a case study of the process of developing a long term care facility on Reserve. Data was gathered by interviewing two key informants on two separate occasions. Procedures to appraise the validity and reliability were incorporated into the study. Additionally, an interview guide was created and data collected from the interview with the key informants was coded into the following general categories: (1) difficulties and challenges that were faced developing this project; (2) issues that made developing this facility 'special' or distinctive; (3) key differences between this (on Reserve) long term care facility development story compared to development stories of other, generic (off Reserve) long term care facilities; and finally, (4) features of this facility that made it different in comparison to others. Ethical issues

have been scrutinized with no evidence of any harm being caused to either of the key informants or to the community and the facility which was the focus of this study.

Findings

The following is the account of the unique aspects of the development story of the long term care facility located on Community X as recounted by two key informants over two separate interviews. This development story initiated over 20 years ago and unfolded over three distinct phases. The facility's story of growth continues today with the advent of a fourth phase that will see the facility come full-circle. It began as an assisted care, independent living project and in response to today's funding, policy, and demographic realities, a number of assisted living units will be constructed to complement the existing sixty-two long term care beds. What follows is an overview of the major findings of this case study.

How was this development story different than that of a more generic long term care facility?

Many long term care facilities in British Columbia were developed and operated by church or not for profit societies as well as by for profit businesses. This particular facility is owned and operated by a First Nation government. To this day, as discussed earlier, only a handful of First Nations throughout the Canada have long term facilities located on their Reserves. Moreover, capital and operating resources are negotiated and secured with funders long before facilities are built. This was not the case with this facility, which was originally planned and funded primarily by the First Nations government, with some assistance through a capital loan (re: mortgage) from the Canada Housing and Mortgage Corporation (CMHC):

> "I think one of the things that was really important at the beginning is they (Chief and Council) really supported that it be run as a social model not as a business. It needed to be viable so that it wasn't a drain on the Band as a whole, but really they wanted to create the opportunity to have decent paying jobs that were equal to what you'd be paying working in the same type of facility off-Reserve. It wasn't there to be a big money maker, the dollars go back into the facility so that you can keep it marketable, so that things aren't falling apart when you walk in. It's got a good feeling about it. It's well maintained." (Informant #1, p. 7. Oct. 11, 2003)

A development of this magnitude in this community would clearly mean that many people in addition to the elders would benefit from it. Most notably, it would provide opportunities for community members to train for a health related career and be employed locally. This level of sustainable community development initiative was rare for its time and continues to be a challenge for the majority of First Nations in British Columbia.

Another factor that differentiates this long term care facility development story from others is how it evolved over a period of twenty years. Its humble beginning was as an assisted living facility that residents could drive their cars up to so that they could come and go as they pleased. It then progressed to a semi-independent facility, where registered nurses had to be in proximity twenty four hours a day, every day. Finally, it became an extended care facility that houses and cares for a substantive number of high needs seniors afflicted with dementia and a range of other chronic and debilitative conditions. The majority of intermediate and long term care facilities are designed and built for specific types of residential populations. It is therefore exceptional to undergo a transformative evolution over a period of twenty years as in the case of this facility. Its development coincided with the 'learn as we go' philosophy of the Chief and Council and facility staff, as opposed to a service delivery vision, business plan, or outside government influence as is so often the case with the development of health and human service programs and services.

What made developing this facility 'special' or distinctive?

This First Nation is located in very close proximity to a large, urban, non native population and has a large number of non-First Nations residing within its boundaries. Rather than hinder the development process, however, this ultimately proved to be of benefit to the home in the longer term for a few reasons. The region now had an additional long term care facility to serve the aged of the whole region, rather than be restricted to serving one population group:

> "We have the non-Native people who live in our community who are 6,000 in number and many of them access the health care services provided at the Band…I think the Facility has always been very responsive to people's needs…this philosophy is really helping to support the Region (Interior Health Authority) now as they're working through more pressures on the dollars and less flexibility in their (long term care) program." (Informant #1, p. 5. Oct. 26, 2003)

Thus one of the distinctive characteristics of this home is that from the beginning, it served both First Nation and non-First Nation seniors:

> "Back in those days we had a very strong (Provincial) government under the Bennett's and we had very strong old families in the…area. Of those strong families, we had five non-Native who chose our facility to be home for their families" (Informant #1, p. 2. Oct. 11, 2003).

To this day, the admission of non First Nation residents into a First Nation care facility remains a historical landmark in the field of health and human services. Indeed, this facility's waiting list still contains the names of non First Nation elders whose preference is to stay in a First Nations long term care facility.

Another distinctive developmental factor in the development of this facility was the amount of resources, early on in its operation, that the Band government invested in the facility just to keep it operational. Unlike many other initiatives on-Reserve, throughout British Columbia, the Chief and Council of Community X at that time heavily subsidized both the operating and capital costs of the facility:

> "In 1987 we built the second phase. One of the things that was instrumental in that decision being made was that we were being subsidized by the Band $5,000.00 to $6,000.00 a month just to maintain, just to keep ourselves open." (p. 4, Oct. 11, 2003)

Clearly, with no business plan, long term funding and support agreements with any level of outside government or investors, the Council of the day invested in a dream – to keep their elders close by so that they can be cared for by their own families and community members in a culturally sensitive manner.

It should come as no surprise then that notwithstanding the substantive number of non First Nation residents, this home, from the first day it opened, has ensured the provision of First Nation culturally sensitive programs, services, foods and medicines. For example, native foods (e.g., berries, wild meats), medicines, and other practices (e.g., smudging) are made available to those that request them. Moreover the appearance or ambience of the home, both on its interior and exterior, also reflects the fact that this is a First Nation long term care facility:

> "The cultural side of it, there were lots of people that they did have come in that donated Native art, I forgot how much Native art we have in here, but the whole theme of the facility itself has a real heavy theme…so it's a real home atmosphere with the Native culture there." (Informant #2, p.8, Oct. 11, 2003)

Lastly, an additional atypical developmental dynamic of this particular facility is that eventually it possessed the capacity to care for residents afflicted with Alzheimer's and other related dementias.

> "We made a decision to build to the standards of multi-level care which allowed a person who was extended care to remain in the facility. It set out the physical layout so that we could manage a heavier level of care. Where it's interesting is that multi-level care had designs around the physical structure but through licensing they were never able to license as a multi-level facility because it falls under two different Acts – one is under the Community Care Facility Act which is what we operate under, and an extended care facility worked under the Hospital Act. So they didn't actually have a mechanism to give you a license. But that is all changing now because of the response to the pressures on health care. There's a lot of transitioning going on, not just with funding but also through licensing." (Informant #2, p. 4. Oct. 26, 2003)

Few First Nations in Canada currently have the capacity and infrastructure to provide such an advanced level of care to their respective senior populations. Moreover, the BC Provincial government does not provide capital or operational funding for long term care facilities any longer. Indeed, as indicated earlier, the trend has been to eliminate long term care funding and replace it partially with assisted living and home care resources. This First Nations community optimized a rare opportunity to build and operate an extended care home with the assistance of Provincial resources. Today, of course, this developmental and operating support would simply not be available to them.

What were some of the difficulties and challenges that were faced developing this project?

It is now well known that the role of residential schools in the history of First Nations people served to contribute directly to their loss of power and cultural identity. Due to this well known fact, during the genesis of the project in the early 1980's, the elders of Community X persisted with their thinking that this was just another institution like the residential school system:

> "There were a lot of elders that didn't trust the process, wanted to live at home, would choose a lesser quality of life as opposed to leaving home and going into a facility. Culturally speaking, most First Nation peoples do look after their elders, and their elders stay at home and become part of an extended family." (Informant #1, p. 3. Oct. 11, 2003)

> "…we're trying to work against the residential school era, where a lot of elders in our community now are individuals who would have gone to residential school when they were young. They're just not that eager to go into an institution…It's institutional care which kind of makes the hair on the back of your neck go up, because it's not about being an institution, it's about being a home." (Informant #1, p. 8. Oct. 11, 2003)

Clearly, notwithstanding the fact that their health and human service care requirements were not being addressed, the elders of this community did not want to be locked away in yet another institutional, or residential school type setting.

Moreover, this community, had a relatively small on-Reserve population (with even less of a population of elders), and was only recently proclaimed First Nation by DIAND, when it decided to pursue this initiative: "I think one thing people have to realize is … that we were a fairly new Band so … our Elders are just getting to the point now where they could use a facility like this" (Informant #2, p. 8. Oct. 11, 2003). Long term care facilities subsist on an 'economy of scale' model – this community clearly did not have the numbers, or enough physical bodies to financially substantiate an undertaking of this magnitude.

The genesis of this facility was inspired when a couple of the community elders were going to be moved to a facility away from the community:

> "…there had been a couple of Elders in our community who had been in care. Of those elders, the families felt that they weren't being treated with respect and dignity and that their culture wasn't being supported in an off reserve facility. In fact, one of the elders was going to be moved from the interior to Vancouver for her care…The community elders of the day really didn't support that nor did the community…they really applied some pressure to the Council to do something towards developing something on-Reserve…it was a decision that had been based on your heart leading the way as opposed to a good, solid business plan. Over the years, we've made many of our decisions based on what needed to be done not necessarily on what we could afford to do…Off Reserve, it's much more driven by the business plan." (Informant #2, p. 2. Oct. 26, 2003)

Thus, the threat of losing their elders to 'the outside' world served to mobilize Community X to develop a home located on the Reserve that would ultimately provide a range of health and human services a culturally sensitive manner. This developmental experience is in stark contrast to those facilities that are constructed for motives of making a profit, or alternatively facilities that are built to respond to a large population

of seniors that requires this level of care, as opposed to a response based on the needs of only a couple of elders.

Moreover, during the early planning and operating stages of the facility, there was no local capacity to staff and operate the facility. At the start, the manager of the facility "…was a registered nurse … she became the administrator. She wasn't Native and she didn't live in the community" (Informant #1, p. 3. Oct. 26, 2003). Interestingly, at this point, the Band did not begin staffing the facility with community members once it was constructed and ready for operation:

> "I think one of the main things that we did early on is the decision was made that the Facility not be a make work project. By that I mean that you're not going to open the door and Sally's brother and sister are going to be hired – or cousin, or uncle – just because of someone they know. To work as a health care worker in the facility you have to have a basic, minimum education even though that's not the requirement under licensing, at least at that time. You just had to have an aptitude for providing care. What we've always done, and one of the things that I'm really proud of is we always maintained a level of education requirements to come in. You had to have gone and had a minimum of a 10 month course before you were hired. Support staff – which are your housekeeping, laundry, dietary – we have a minimum of a grade 10 education. For a lot of our (community) members it's an entry level position that they can come to with really a minimal education level and earn a decent living. I would say that probably 30% of all of our staff our First Nations people, either from our own community or from this area. We do have a reverse discrimination policy and hiring practices that we follow vigilantly. We always look for First Nations person first as far as finding employment opportunities." (Informant #1, p. 7. Oct. 11, 2003)

Another challenge in the development story of this facility was that during its early operation there was very little financial support from any level of government:

> "Back in those days, the other thing that was really interesting is we didn't have any Provincial funding, we only had First Nations people funding under the auspices of Indian and Northern Affairs Canada, that had a very firm policy around – the person had to be a Native living on-Reserve, the facility had to be (Provincially) licensed in order for us to obtain funding from the Department. So that was one of the things that I believe that the Band did well to begin with. They built a facility that met all of the licensing standards of the day and continued to do that with every phase that we built. That allowed us to be funded Federally." (Informant #1, pp. 1-2. Oct. 11, 2003)

This lack of funding required that this community forge ahead with government to government partnerships. These intergovernmental discussions were taking place many years before the advent of the current Treaty, Land Claim, and Specific Claim negotiations that are all but common place today.

> "The original mandate for the Facility was to provide a home for Native people living on-Reserve, as well as to provide employment for Band members. So in order to maintain that or fulfill that mandate, I think we recognized early on the need to partner with the Province, with the Region, with whoever would help assist us to fund the facility." (Informant #1, p. 2. Oct. 11, 2003)

How is this facility different?

Firstly, unlike other long term care homes in the Province of British Columbia, the rules and regulations as to who can reside in the home and be served by its staff is not always necessarily clearly spelled out in policy books:

> "Where this facility is different…is we're the basin, where you fall through the cracks and there is no one at home to look after you. If you've not maybe had wise choices in your lifestyle and you don't have family support, or estranged family, or there is none – then that's where we provide the best support to people within those circumstances." (p.3, Oct. 11, 2003)

In a sense, therefore, this home has an unwritten mandate to serve those who have been turned away from other homes, or generally speaking, the system. An example is those who simply do not have enough resources to cover the costs of their care.

An additional factor that makes this home different is that it now has a stable operating funding source: "we do have a partnership which is unique with the funding of 45 beds (out of 63) by the Province" (Informant #1, p. 5. Oct. 26, 2003). This secure funding meant that the home was able to respond positively to those elders, as mentioned, that were turned away at other junctions within the health care system. It has also spoke volumes in regards to the issue of sustainability – many long term care facilities have recently suffered from severe cutbacks in provincial funding which has forced the closure of dozens of facilities throughout British Columbia. To date, this

plight has not been experienced by this facility and from all indications from the regional health authority responsible for providing its provincial funding, there are no plans in the future to instigate funding cutbacks.

Another characteristic that marks this First Nations facility as being distinct is its ongoing efforts towards achieving the high standards:

> "We've been developing quality indicators…and because we want to be evaluated and accredited, we want to take a look at what can we do better…We've just agreed to participate in a smaller rural survey, a resident satisfaction survey that the Region is going to be conducting…It's important to know where you fit and also be able to make the comparison with your peers, not just within." (Informant #1, p. 6. Oct. 26, 2003)

The focus on quality of care coupled with a work environment that fosters First Nations and non-First Nations working together, has also meant that the staff of the facility have been able to focus on developing mission, vision and values statements and to incorporate these statements into the overall quality of care to the residents they serve. Of course, this experience is in strong contrast to the low morale and stressful work environments that seem to be present throughout the health care system these days.

> "I think people who work at the Facility…treat the people who live here like they are part of their family. They make sure that people have their dignity, that they have choices. They get lots of TLC. I hear people when they come in and they say 'oh, it's do nice to see the residents are touched,' because you'll have someone with their hand on someone's shoulder, or just a stroke of the cheek, or holding hands walking…They're small things but they're very powerful…I think too we have talked about this, but we have a number of staff who are First Nations. I don't know what it is about a First Nations caregiver, but they really do give of themselves. They're more open, they're more willing to cross that line of 'you're part of my family.' It's an intuitive thing. I think it really helps set the tone and our non-Native staff feel the same way as well. It's a good combination." (Informant #1, p. 9. Oct. 26, 2003)

That is not to say that this Home has not experienced its share of staffing issues and growing pains. Indeed, the staff is now represented by three unions which in itself is an exception to the rule as the majority of First Nations in British Columbia do not normally welcome unions unto their communities:

> "In 1995, in the third phase. I think we were very vulnerable, we were in a position where we did not have a collective agreement. The Province was not willing to increase our funding so that we could pay our staff at a comparable rate to other facilities doing the same work off-Reserve. The only thing that they recognized as a tool was a collective agreement, or an employees' association agreement. Some of our employees were in the process of developing an employees association and we were very vulnerable because we were going through a lot of change and so they made the decision to unionize to protect their rights. It really was for them about getting equal pay for equal work." (Informant #1, p. 7. Oct. 26, 2003)

> "Where our argument came with the unionization of the Home was not in the fact that unionization, as much as it was the jurisdiction. They certified provincially and the Band fought very hard to have that overturned so the jurisdiction would be Federal. They (the Band) weren't successful. So we are deemed not to be Indian enough, and they chose to use a sliding scale to determine our 'Indian-ness' and so we're successful in that round." (Informant #1, p. 7. Oct. 26, 2003)

Conclusion

Four of the early challenges in this development story include: (i) the fact that the elders and community members did not want another residential school like institution built; (ii) the decision to build a facility was based on the care requirements of two elders who would have otherwise had to leave the community, rather than upon a broad population of elders with similar care requirements. Thus sustainability became an issue from day one, (iii) because of this ongoing financial demand, this First Nation forged ahead with government to government negotiations long before the establishment of formal Treaty and health accord discussions of today, and (iv) in the early days the facility was managed and staffed, for the most part, by people who were not from the community and not of First Nations origin.

Secondly, there are a number of distinctive characteristics to this development story which include: (i) the fact that there is a substantive non-First Nations population that live on this Reserve – some of whom became residents of the home when it first opened; (ii) the significant amount of resources that the Chief and Council invested to keep the facility operational in its early days; (iii) a commitment to include all facets of

First Nations culture (re: that community's cultural practices) into the service delivery plan, and (iv) this First Nation was able to capitalize on provincial long term care resources for both capital and operations before those resources became non existent.

Thirdly, this development story was different from those of other long term care facilities, for the following reasons: (i) rather than a not for profit, a for profit, or a government initiative, this is a story about a First Nations government developing a long term care facility; (ii) additionally, it is different than other facilities of its type because it took twenty years to create. This graduated development, or the 'learn as we go along' model, is the exception, rather than the rule, (iii) finally, because this was a First Nation Government initiative, it has ultimately been of benefit to the broader community, an example being the number of meaningful and rewarding health careers filled by trained and qualified staff from the community.

Finally, there are the characteristics of this facility that make it different from other long term care facilities: (i) this is a home that prides itself on catching and caring for those seniors who are not otherwise served because of gaps in the system; (ii) unlike many other long term care facilities in British Columbia, it did not lose any of its funding from the BC provincial government during the last four years, (iii) there is a competent, motivated staff in place that chooses to focus on standards and accountability, and not merely concerned about whether or not their jobs are at stake and (iv) the staff of this facility, perhaps not unlike most off Reserve facilities, but certainly unlike the majority of First Nations in British Columbia, are unionized. What follows is a brief discussion on the implications of these findings for other First Nations as well as other minority cultures that wish to develop services for their respective seniors' populations.

Discussion

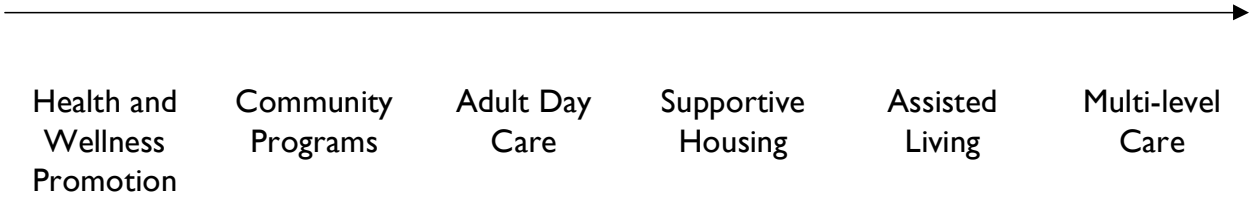
In order to put the findings of this study into discernable context, the following discussion will focus on four main questions: (i) What might be some of the implications for future planning in the area of the provision of services to First Nation elders who reside on Reserve in British Columbia; (ii) Can this development process or aspects of this development story be utilized by other First Nation communities? Other minority cultures?; (iii) What are the implications of this study for other minority cultures in Canada who are striving to meet the requirements of their respective seniors' populations?; and finally, (iv) How does this particular development story contribute to knowledge in community development and social work practice?

Implications for future planning

The findings from this case study underline a number of important planning considerations in ensuring that First Nation seniors receive the supports and services they require throughout the latter stages of their lives.

It is important, at this point, to reflect on what is meant by 'aging in place' and 'the continuum of care'. To assist in the discussion, please refer to Figure 1. At the left hand side of the diagram, elders live in the community as active members and are recipients of the health and wellness and community programs. As they age and their health care needs progress, they may require advanced levels of services and eventually will move from their residences into supportive housing complexes. Here they might remain living independently yet receive supplementary services (i.e., visits from home care aids, meals on wheels). From supportive housing, seniors can move to assisted living if they are no longer able to function completely independently.

Figure 1. Continuum of Care



They benefit from the assistance of home care aids, home care nursing services, prepared meals and so on. Multi-level care is realized when elders become completely dependent on health and human services in order to survive. Once elders are admitted into a multi-level care facility, they may effectively remain there until they pass on.

However, as has been illustrated throughout this paper, severe gaps in services and programs continue to persist for the majority of First Nations elders in Canada. Thus, some of the planning lessons that can be learned from this case study and applied towards future planning in this important area include:

- Address sustainability (e.g., who pays of what and for how long?). This is a particularly timely issue in British Columbia, where a number of health and human services are now being delivered by privately owned 'for profit' companies – some of these companies are not even Canadian.
- Determine local capacity (facilities and services staffed by fully trained locals), and ensure that strategies for addressing gaps in capacity are built into the planning process in the beginning stages.
- Linkages must continue to be forged and nurtured between First Nations and Regional, Provincial and Federal health and human services. These linkages must be stronger than merely, as suggested by the BC provincial Government in 2001, 'developing and implementing aboriginal health plans for each region,' (British Columbia, Legislative Assembly, Select Standing Committee on Health, 2001).
- Long outstanding jurisdictional issues must be resolved. For BC, this means the resolution of Treaty and Land claims. Many First Nations in the negotiating process are currently leaving health and human service issues out of the discussion process fearing that they will sign on the dotted line only to find later that they are unable to meet the escalating costs of health care items like pharmaceuticals.
- Continue to explore experimental health and human service models (e.g., primary care), and the implications of this new and emerging system in caring

more effectively for minority groups of seniors. For example, could a primary care system on reserve mean that more elders will be able to remain at home? Also, might a primary health care clinic, located on Reserve, provide a fertile environment for the incorporation of traditional and non-conventional health care practices into the care plans of First Nation seniors?

- Finally, with policy makers, health and human service providers and researchers focus on population health and particularly, outcome measures, there nonetheless remains a disparity between what this all means to the 'outside world' as opposed to how it may be translated in First Nation communities. For example, can effective, sustainable, relevant services be delivered in impoverished communities? Also, is our society adequately addressing the systemic and structural issues that continue to act as barriers to First Nation self determination?

How could these lessons be utilized by other First Nation communities?

This is a case study of a dynamic and successful First Nation owned and operated long term care facility; however, it has taken over twenty years to get to this point. Patience, then, is one of the more obvious lessons for other First Nations. It takes time to develop an infrastructure that has the capacity to care for the aged and similarly, time to develop the necessary capacity and subsequent integrity and trust. Another important lesson for other communities is the fact that this type of development also takes vast amounts of financial resources. Although this particular story is one where only two elders inspired what eventually became a 63 bed facility, this is an unrealistic development approach. Firstly, the health policy flavour of today is a mixture of privatization and assisted living, as opposed to long term care. Assisted living is less costly, and core services and programs can be complemented by others on an user pay basis. Ultimately, as alluded to in the very early development stages of the facility in Community X, most if not all First Nation elders are not only adverse to moving from their communities, they also do not want to move into another institution; it reminds them of residential schools. Many First Nation communities, due to their rural locations, do not have a substantive non-First Nation population living within the community that

can fill the empty beds. Moreover, most First Nations may not have a similar type of relationship with their health authority that would neither commit to referring seniors to the facility, nor commit to funding a substantive number of beds over a lengthy period of time.

Although the planning lessons outline above are extremely important and can be applied to any level of human service development, the most important lesson(s) to learn from this story are those expressed by the elders themselves. They know their needs and will be unequivocal about how those needs can be addressed. Failure to be guided by their collective wisdom could result in constructing a white elephant – a facility that no First Nation elders will live in. Alternatively, other First Nations communities, using the continuum of care diagram (Figure 1), as a reference, can utilize the development lessons outlined in this paper to ensure that their elders are receiving the optimum level of care by maximizing all available resources, without having to invest millions of dollars of resources in building a long term care facility. The final lesson, therefore, is to search out alternative models of service delivery, finding one or a combination that will best meet the needs of the community elders without over taxing the human and financial resources of the First Nation.

What are the implications of this study for other minority cultures in Canada who are striving to meet the requirements of their respective senior's populations?

With the current drive in British Columbia, and other jurisdictions in Canada, to privatize many facets of health and social services, it can be argued that the some of the lessons learned from this case study can be applied not only to other First Nations, but indeed, are also directly applicable to seniors from other minority cultures. Arguably, it can be asserted that the lessons learned from this development story speak directly to the four universal pillars of caring for the aged: quality care, public accountability, public

funding, and not for profit delivery, or in the absence of that, an assurance of accessibility and universality. This comparison can be illustrated in the example of Indo Canadian and Chinese communities located throughout the Interior of British Columbia. They, like any other minority cultures in the Province have been concerned with the challenge of ensuring that their senior population is well cared for. Traditionally, this has been accomplished by families within the confines of their homes. However, with the onset of dementia related maladies, the inability of many Indo Canadians and Chinese Canadians to manage home based care financially, and the growing paucity of specialized medical support services in rural and remote communities, the question of what to do with their growing and needy elderly population requires some answers. Of course, because of cultural practices and beliefs, the extent of this problem remains somewhat of a mystery because very few Indo Canadian or Chinese Canadian families will discuss this type of issue publicly and do not make themselves available for interviews with researchers.

Nonetheless, the time is approaching when the health needs of Indo Canadian and Chinese seniors residing in rural and remote communities will require advanced levels of intervention and like First Nations and other cultural minorities, they will want to be in a position to successfully address these needs. It is at that time when they can look to how other minority groups have responded, and they can learn from development stories like this one. The extent to which the lessons of Community X and their story of development can be applied to the Indo-Canadian and Chinese communities is best left to future research, however, it can be argued that both this story of development and the lessons learned from it can, at least in part, be applied. For example, they will need to listen to their elders, who presumably, like their First Nation counterparts, will be very resistant to moving away from their homes, families and

communities. Additionally, there are the roles of traditional and cultural approaches to health care that may be incorporated, in a partnership, with conventional approaches. This has worked well in Community X, and would ensure an optimal level of care for Indo Canadian seniors as well.

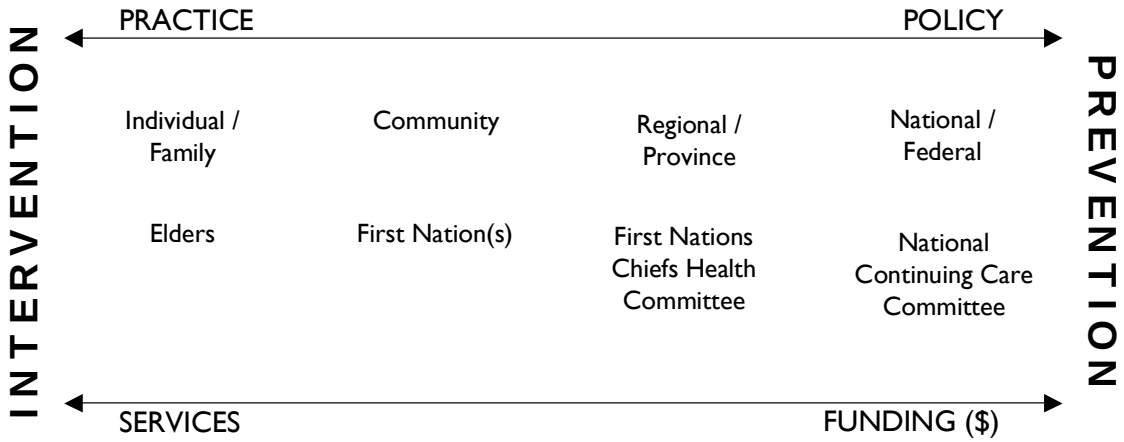
By way of a final example, there are the issues of sustainability and flexibility within the health care system. Who will pay for these services and for how long? Are there enough Indo-Canadian and Chinese Canadian seniors in any given rural community to sustain a long term facility? Is a long term care facility necessarily the way to address the health and human service issues? Will sustainable solutions like incorporating a primary health care clinic within a long term care facility be considered? Again, it will be a matter of superimposing Figure 1, the continuum of care diagram, over the population in question and determining of the types of care required how to deliver them in a cost effective (sustainable) manner. Perhaps, there are rural and remote communities with an infra-structure already in place (e.g., primary health care clinic, diagnostic and treatment center), or which are in the process of planning for these services. It might then be a matter of partnering or piggy backing on these services – as was the instance with the facility in Community X. Rather than build another long term care facility in that part of the region, the health authority chose to refer non-First Nation seniors to the facility. This strategy served to both make the facility viable, but also increase the capacity of the health Region to provide an advanced level of care for their population of seniors.

How does this particular development story contribute to knowledge in community development and social work practice?

To illustrate the implications of the development story of this home on both social policy and social work practice, refer to Figure 2, below. Services to First Nations

elders are visually presented as a "Compendium of Care Model," and connections are clarified between the individual "practice" and the national "policy" levels.

Figure 2. Continuing Care of First Nations Elders: Compendium of Care Model



The diagram, developed by the writer, attempts to illustrate three main points. First, when addressing the development of services for First Nation elders, the unsettled 'big picture' needs to be kept in mind. Federal and Provincial policy is unresolved regarding the care of elders, meaning individual care cases in most First Nations, often remain unsolvable. However, if human service practitioners are made aware of the implications of the broader picture, they will not be deterred when searching for intervention solutions. Rather, they can continue along the compendium until at least short term resolutions can be realized.

Second, the diagram illustrates that effective intervention is not probable unless the elder is supported by her family and her community, all of which are involved in the decision making process. Additionally, preventative services for First Nation populations of elders are unsuccessful over the longer term unless policy reflects the realities of their health and human services required – or, the realities of the socio-economic state of

affairs of their communities. With the continuation of discordant Federal and Provincial health policies, First Nation elders continue to be underserved by the system. One example is the Non Insured Health Benefit program as administered by the First Nation and Inuit Health Branch (FNIHB) on behalf of First Nations. Effectively, this program offers all status First Nation people a range of health benefits. However, in British Columbia, changes in provincial health care policy have placed a higher demand overall on the non-insured program, resulting in cutbacks to dental, vision, and hearing services, as well as to prescription drug allocations. Arguably, these cutbacks have had a very negative impact on the health status of First Nation elders (BC Provincial Health Officer, 2002).

Finally, the diagram reflects unaddressed issues at all levels of the compendium of care. Individuals, families and communities are only beginning to express concerns about meeting the health care requirements of their respective elders. Moreover, most First Nation communities in British Columbia still have to send their elders outside of the community for supportive housing, assisted living and multi-level care. Although many First Nations have been working towards resolving long outstanding human service issues in regards to elders that reside on-Reserves, the Provincial and Federal governments have not yet concluded how they will meet the wide range of health and human service needs. It is further complicated for First Nations in British Columbia where the majority have rejected the Treaty Process. Even though Community X recently took steps towards self-government, one of the interviewees points out that:

> health is one area that under self government – although the authority to manage is there – they [Chief and Council] haven't chosen to take that step … I think part of that is a recognition that it needs to be funded appropriately.

A holistic understanding of the compelling connections locally, regionally and nationally can, therefore, only serve to further assist the human service provider attempting to

intervene in the short term and plan over the longer term at all levels of the elder care compendium: individually, at the community level, and at the regional/provincial and federal policy levels.

Browne and Fiske (2001) discuss how health care for First Nations people, particularly for those residing on Reserve (receiving Federally funded services) had been founded on "colonial ideology that emphasizes paternalism, dependency, victim blaming, and medicalization" (p. 128). My case study serves as a model for First Nation community empowerment by demonstrating their development, management and sustainability of a high level of health service on Reserve in the face of historical adversity.

Conclusion

Today, the issue of adequate health and human services for First Nation Elders is far from being solved. One glaring omission from Figure 1 (Compendium of Care), is the research and development necessary to ensure that the compendium of care is effective. In the absence of more research, front line human service providers are able to offer only immediate band aid solutions for elders who require advanced services. Moreover, there remains a global health care issue in Canada establishing a sustainable system that can meet all the care requirements of a burgeoning population of seniors, many of whom do not have sufficient resources to care for themselves. In the words of one of the interviewees, "in order to have a health care system that's viable and sustainable over time, huge changes have to be made, fundamental shifts in thinking." As we have seen, the problem of capital and program funding is much more pronounced amongst First Nations. Thus, the change in thinking should allow for resources to construct the infrastructure to contribute towards sustainable operating budgets and to ensure that

the necessary capacity is developed. Currently, the resources are in place at both the federal and provincial levels of government; however, much work needs to be done to share information and develop strategies that are both community based and managed. As shown in Figure 1, this is imperative in order for any type of successful intervention within First Nations.

As the current generation of elders continues to pass on so do the last vestiges of their cultural knowledge. It is through their guidance that creative approaches to blending conventional and traditional care and healing methodologies can be achieved. It is therefore incumbent upon us to tap into this knowledge base before it is too late in order to arrive at solutions to solving the chronic problem of providing for their care. As we have observed from this development story, initiatives at this complex level take years to refine in order to be successful. Even then, the issue of sustainability is constantly in question. Those First Nations that wish to develop similar levels of resources must, therefore, ensure that their goals are interwoven with their long term development planning.

References

Aboriginal Health and Wellness Committee. (2002). *Aboriginal health and wellness plan, 2002/03-2005/06*. Kelowna, BC: Interior Health Authority.

Aleman, S., Fitzpatrick, T., Tran, T. V. & Gonzalez, E. W. (Eds.). (2000). *Therapeutic interventions with ethnic elders health and social issues*. New York, NY: The Haworth Press Ltd.

Armstrong, W. (2002a). *Eldercare on the auction block: Alberta families pay the price*. Edmonton, AB: Alberta Chapter of the Consumers' Association of Canada.

Armstrong, W. (2002b). *Jumping on the Alberta bandwagon: Does BC need this kind of assisted living*? Edmonton, AB: Alberta Chapter of the Consumers' Association of Canada.

Bickman, L. (Ed.). (2000). *Validity & social experimentation*. Thousand Oaks, CA: Sage Publications.

British Columbia, Legislative Assembly, Select Standing Committee on Health. (2001). *Patients first: Renewal and reform of British Columbia's health care system*. Victoria, BC: Office of the Clerk of Committees, Standing Committee on Health.

British Columbia Royal Commission on Health Care and Costs. (1991). *Closer to home: The report of the British Columbia Royal Commission on health care and costs*. Victoria, BC: Author.

British Columbia, Provincial Health Officer. (2002). Report on the health of British Columbians. Provincial Health Officer's Annual Report 2001. The health and well-being of Aboriginal People in British Columbia. Victoria, BC: Ministry of Health Planning.

Browne, A. The meaning of respect: A First Nations perspective. *Canadian Journal of Nursing Research, 27*(4), 95-109.

Browne, A., & Fiske, J. First nation women's encounters with mainstream health care services. *Western Journal of Nursing Research*, 23 (2), 126-147.

Bruce, D. & Whitla, M. (Eds.). (1993). *Community-Based approaches to rural development*. Sackville, NB: Mount Allison University.

Campfens, H. (Ed.). (1997). *Community development around the world: Practice, theory, research, training*. Toronto, ON: University of Toronto Press.

Canada Communication Group. (1996). *Report of the Royal Commission on Aboriginal Peoples* (Vols. 1-5) Ottawa, ON: Author.

Cardiff, K., Green, C., McGrail, K., & Wood, L., (Eds.). (1998). Summary of the 11th Annual Health Policy Conference: *Determinants of health: Impacts on health*

and social policy. Vancouver, BC: Center for Health Services and Policy Research, University of British Columbia.

Caro, F. G., Morris, R., & Norton, J. R. (Eds.). (2000). *Advancing aging policy as the 21st century begins*. New York, NY: The Haworth Press Ltd.

Chief's Health Committee. (2000). *Transition management strategy, a new way to First Nations health*. Vancouver, BC: Author.

Cohen, M. & Pollack, N. (Eds.). (2000). *Without foundation: How Medicare is undermined by gaps and privatization in community and continuing care*. Vancouver, BC: Canadian Center for Policy Alternatives (BC Office), British Columbia Government and Service Employee's Union, British Columbia Nurses' Union, & Hospital Employees' Union.

Dean, K. (Ed.). (1993). *Population health research, linking theory and methods.* Thousand Oaks, CA: Sage Publications Ltd.

Dexter, L. (1970). *Elite and specialized interviewing*. Evanston, IL: Northwestern University Press.

Elias, P. (1991). *Development of aboriginal people's communities*. North York, ON: Captus Press Inc.

Ewalt, P., Freeman, E, & Poole, D. (1998). *Community building: Renewal, well-being, & shared responsibility*. Washington, DC: National Association of Social Workers Press.

Fisher, R., Ross, M. M., & MacLean, M. J. (Eds.). (2000). *A guide to end-of-life care for seniors*. University of Ottawa, ON and University of Toronto, ON.

Gallagher, E., Gnaedinger, N., & Mullen, S. (1999). *How are health reforms affecting seniors? A participatory evaluation guide*. Ottawa, ON: Minister of Public Works and Government Services Canada.

Gesler, W. M., Rabiner, D. J., & DeFriese, G. H., (Eds.). (1998). *Rural health and aging research; Theory methods and practical applications*. Amityville, NY: Baywood Publishing Company, Inc.

Hamel, J., Dufour, S., & Fortin, D. (1993). *Case study methods*. Thousand Oaks, CA: Sage Publications.

Hammersley, M. (1995). *The politics of social research*. Thousand Oaks, CA: Sage Publications.

Health Association of British Columbia. (2000). *Private participation in BC's health system: Shades of gray*. Vancouver, BC: Author.

Health Canada. (1995). *Long term evaluation of the health program transfer initiative*. Ottawa, ON: Author.

Health Canada. (1999). *First Nations and Inuit health regional health survey: National report*. Ottawa, ON: First Nations and Inuit Regional Health Survey National Steering Committee.

Health Canada. (2000). *Health Canada's sustainable development strategy 2000: Sustaining our health*. Ottawa, ON: Author.

Health Canada. (2000a). *Home and community care planning resource kit*. Ottawa, ON: Author.

Hogan, S. & Hogan, S. (2002). *How will the ageing of the population affect health care needs and costs in the foreseeable future*? University of Canterbury, New Zealand: Commission on the Future of Health Care in Canada.

Hollander, M., & Walker, E. (1998). *Report of continuing care organization and terminology*. Ottawa, ON: Health Canada.

Homan, R. (1991). *The ethics of social research*. New York, NY: Longman Inc.

Keating, N. C. (1991). *Aging in rural Canada*. Vancouver, BC: Butterworths Canada Ltd.

Kendall, Dr. P. (2002). *The health and wellbeing of aboriginal people in British Columbia*. Victoria, BC: Ministry of Health Planning.

Lawton, M., Newcomer, R., & Byerts, T. (Eds.). (1976). *Community planning for an aging society*. Stroudsburg, PENN: Dowden, Hutchinson & Ross, Inc.

Lee, M. (2003). *Bleeding the hinterland: A regional analysis of B.C.'s tax and spending cuts*. Vancouver, BC: Canadian Center for Policy Alternatives.

Mason, J. (2002). *Qualitative researching*. Thousand Oaks, CA: Sage Publications.

Miller, Dr. J. (1996). Provincial Health Officer's Report, 1996

Miller, Dr. J. (1999). A report on the health of British Columbians. Victoria, BC: Ministry of Health and Ministry Responsible for Seniors.

Miller, G. & Dingwall, R. (Eds.). (1997). *Context & method in qualitative research*. Thousand Oaks, CA: Sage Publications.

Ministry of Health and Ministry Responsible for Seniors. (1997). *Health goals for British Columbia*. Victoria, BC: Author.

Napoleon, A. (1992). *Community-Based Development Planning in Native Communities*. Victoria, BC: Ministry of Advanced Education, Training and Technology.

Northey, M., Tepperman, L, & Russel, J. (2002). *Making sense: A student's guide to research and writing*. Don Mills, ON: Oxford University Press.

Palermo, F. (2000). *First Nations community planning model*. Halifax, NS: Cities and Environment Unit and Wagmatcook First Nation.

Payne, M. (2000). *Modern social work theory*. Chicago, IL: Lyceum Books Inc.

Report to the Annual Premiers' Conference. (2002). *Strengthening home and community care across Canada: A collaborative strategy*. Retrieved March 7, 2003 from http://www.premiersforhealth.ca/pdf/homecare_eng.pdf.

Romanow, R. J. (2002). *Building on values: The future of health care in Canada*. Saskatoon, SK: Commission on the Future of Health Care in Canada.

Rowles, G., Beaulieu, J., & Myers, W. (1996). *Long term care for the rural elderly*. New York, NY: Springer Publishing Company.

Rubin, H. & Rubin, I. (1995). *Qualitative interviewing; The art of hearing data*. Thousand Oaks, CA: Sage Publications.

Rural Secretariat Research and Analysis Group. (2001). *Rural Canadians survey 2001*. Ottawa, ON: Canadian Rural Partnership.

Schrier, D. (2002). *Consequences of an aging population: Can existing levels of social services be sustained*. Victoria, BC: BC Stats, Ministry of Government Services.

Seale, C. (1999). *The quality of qualitative research*. Thousand Oaks, CA: Sage Publications.

Seniors Advisory Council. (1996). *Health profile of aboriginal seniors in British Columbia*. Victoria, BC: Office for Seniors, Ministry of Health and Ministry Responsible for Seniors.

Silverman, D. (2000). *Doing qualitative research: A practical handbook*. Thousand Oaks, CA: Sage Publications.

Smith, L. (1999). Decolonizing methodologies: Research and indigenous peoples. New York, NY: St. Marten's Press.

Smylie, J., Myrth, N., Tait, C., Martin, M., Chartrand, L., Hogg, W., Tugwell, P., Valaskakis, G., & Macaulay, A. (2004). Health sciences research and aboriginal communities: Pathway or pitfall? *JOGC* (March), 211-216.

Stake, R. (1995). *The art of case study research*. Thousand Oaks, CA: Sage Publications.

St. Denis, V. (1992). Community based participatory research: Aspects of the concept relevant for practice. *Native Studies Review, 8*(2), 51-74.

Statistics Canada. (2003). *Health care in Canada*. Ottawa, ON: Canadian Institute for Health Information.

Stoesz, D., Guzzetta, C, & Lusk, M. (1999). *International development*. Needham Heights, MA: Dowden, Allyn & Bacon.

Stouthamer-Loeber, M. & Bok van Kammen, W. (1995). *Data collection and management: A practical guide*. Thousand Oaks, CA: Sage Publications.

Wharf, B. (Ed.). (2002). *Community approaches to child welfare*. Peterborough, ON: Broadview.

Yegidis, B. & Weinbach, R. (2002). *Research methods for social workers*. Boston, MA: Allyn and Bacon.

Yin, R. (1994). *Case study research: Design and methods*. Thousand Oaks, CA: Sage Publications.

Appendix 1: Interview questions

Developing senior's services on Reserve: A case study

1. What was your role in the development of the facility?

2. What do you remember as being the major barriers in the developmental process of the facility?

3. What do you remember as being the projects' major developmental milestones?

4. Is there anything in particular that stands out during the development process that you believe was a major factor in its completion?

5. To what extent did federal and provincial health policies of the day play a factor in the development of the facility?

6. In what ways do you believe culture was a factor in the development of the facility (ie: active involvement of community elders, etc.)?

7. What advice would you give to other First Nation communities wanting to develop a similar service for their elders?

8. Now that the facility has been operational for some time, are there still gaps in services to the elders in the community?

9. If yes, what can be done to address them?

10. Are there any other comments you would like to add?