The Engagement of the Raising the Spirit' Mental Wellness Team with First Nation communities in the Manitoulin, North Shore and Bemwijaang Tribal Council areas

by

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A thesis submitted in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy (PhD) in Rural and Northern Health

The Faculty of Graduate Studies
Laurentian University
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THESIS DEFENCE COMMITTEE/COMITÉ DE SOUTENANCE DE THÈSE
Laurentian Université/Université Laurentienne
Faculty of Graduate Studies/Faculté des études supérieures

Title of Thesis Titre de la thèse	The Engagement of the Raising the Spirit' Mental Wellness Team with First Nation communities in the Manitoulin, North Shore and Bemwijaang Tribal Council areas
Name of Candidate Nom du candidat	Manitowabi, Susan Jane
Degree Diplôme	Doctor of Philosophy
Department/Program Département/Programme	Rural and Northern Health
Date of Defence Date de la soutenance	August 31, 2021

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Abstract

The “Raising the Spirit” Mental Wellness Team (MWT) was funded as a pilot project in 2007. Funding for this project was made available by the federal government under the Mental Wellness Advisory Committee (MWAC) Strategy (see appendix 1). This pilot project partnered with ten First Nations communities from the Manitoulin Island, North Shore and Waabnoong Bemwijaang Tribal Council areas, in Northeastern Ontario. The goal of this pilot project was to work collaboratively with mental health and addiction workers and other service providers to improve access to specialized services; enhance knowledge, skills, and capacities of community workers; provide support, consultation, clinical supervision, coaching and mentoring; and, braid traditional and mainstream approaches to wellness.

The focus of this research study was to evaluate how the MWT pilot project maintained the engagement and support of the participating First Nations communities. Areas explored included: the collaboration within and across Aboriginal communities; the integration of mainstream and traditional approaches; and, capacity building at the community level.

Self -reflective journals, photovoice and narrative storytelling interviews were chosen because of their congruence with traditional ways of knowing and understanding which were also viewed as being culturally appropriate. These evaluation methods were extremely powerful means of telling the story of the relationship between the MWT and the First Nations communities involved in this project.

One major contributing factor that enhanced the ability of the MWT pilot project to maintain the engagement with the First Nations communities was the strong commitment to the intent of the

pilot project by all partners. Although there were many challenges that could have impacted the ability of the MWT to engage with the First Nations communities, there was good support from the First Nation leadership who recognized the benefits of enhanced mental health and addictions services in their communities. The pilot project offered an opportunity for the First Nations communities to access additional mental health and addiction services as well as increased access to traditional healing services. The Traditional Advisory Committee (TAC) was instrumental in creating opportunities through the Traditional Teaching Series for frontline workers to learn more about traditional healing practices and teachings. This had the added benefit of increasing their skills and abilities to utilize both traditional and mainstream approaches in their service provision to their clients, as well as themselves and their families.

Keywords

Mental Health and Addictions, traditional knowledge, evaluation, engagement, collaboration, integration of mainstream and traditional approaches, capacity building

Co-Authorship Statement (where applicable)

Use Body Text or Normal style for text in this section.

Acknowledgements

I would like to express my appreciation to the ‘Raising the Spirit” Mental Wellness Team pilot project for allowing me the opportunity to work with them on the evaluative component of their project. I would like to thank all the participants – the MWT, the steering committee members, the frontline workers, the First Nations leadership and members of the traditional advisory committee for sharing openly and honestly with me about their experience with the pilot project.

To my supervisor, Susan James, I would like to thank you for all your support, patience and understanding. To my committee members, Marian Maar, Peter Menzies, Celeste Pedri-Spade and Nancy Young, I like to thank you for being there for me and for your support and guidance.

I would also like to express my gratitude to my family for encouraging me along the way.

My sincere gratitude also goes out to those traditional people and Elders who took an interest in my work and supported me to continue along this journey.

I would also like to acknowledge the generous support of the Ontario Training Centre (OTC), the National Network for Aboriginal Mental Health Research – NNAMHR Small Research Award.

Table of Contents

Abstract iii

Co-Authorship Statement (where applicable) v

Acknowledgements vi

Abbreviations xiii

Glossary xvi

A Note on Terminology xvi

Glossary of Terms xvii

List of Figures xxv

List of Pictures xxvi

List of Tables xxvi

List of Appendix xxvii

Preface - Stepping-stones on My Journey xxviii

Figure 1 – Stepping-stones on My Journey xxviii

1. Chapter 1 - Beginning the Story 1

1.1 Remembering who I am 2

Picture 1 – Island on Whitefish River First Nation 2

1.2 My Inspiration 5

Picture 2 – Photos of Violet and Art McGregor 5

Picture 3 – Art and Violet McGregor-ba 8

Picture 4 – Elder Nmenhs (Arthur McGregor) 9

1.3 Reasons for pursuing my PhD 11

1.3.1 Inspiration for Others 11

1.3.2 Documenting the History and Development of Mental Health Services on Manitoulin Island 13

1.3.3 Advancing Indigenous Knowledge 14

1.4 My vision 15

1.5 Literature Review 17

1.5.1 Indigenous Health and Indigenous Mental Health 18

Indigenous Heath 18

Figure 2: Average CWB Scores, First Nations and Non-Aboriginal Communities, 1981-2016 19

Indigenous Mental Health 19

1.5.2 Challenges to Mental Health Care 23

1.5.3 Collaborative (Shared Care) Models 25

Figure 3 – Canadian Collaborative Mental Health Initiative - Collaborative Mental Health Framework 26
1.5.4 Cultural Safety and Mental Health 27
1.5.5 Indigenous Knowledge 33
1.5.6 Relational Worldview 34
Figure 4 - Medicine Wheel - The Hub – adapted from Herb Nabigon-ba 35
1.6 A new opportunity presents itself 37
1.7 A Change in Plan 42
1.8 Conclusion 43
Chapter Two: The Mental Wellness Team Approach to Mental Health and Addiction Services. 46
2.1 Introduction 46
2.2 The Mental Health of Indigenous People in Canada 49
2.3 The Demography of Indigenous People in Canada (Statistics Canada, 2006) 53
2.4 Historical Perspective – The Role of the Federal Government in the Health of Indigenous Peoples 58
2.5 Mental Health and Addiction Services in Ontario 59
2.5.1 The Federal Level 59
2.5.2 The Provincial Level 61
2.5.3 The Regional Level 62
2.6 The Development of Mental Health Services in the Sudbury/Manitoulin First Nations Area 63
2.6.2 The Significance of the Nadmadwin Mental Health Clinic to Aboriginal Mental Health Care 66
2.6.3 Development of Service Agreements with Network North 66
2.7 The Development of the Mental Wellness Team Pilot Project 68
2.7.1 Development of the Mental Wellness Advisory Committee 68
2.7.2 The First Nations and Inuit Mental Wellness Strategic Action Plan 69
2.7.3 First Nations Resource Team Proposal 71
2.7.4 The “Raising the Spirit” Mental Wellness Team (MWT) Pilot Project 71
2.8 Geographical Location of the “Raising the Spirit” Mental Wellness Team Pilot Project 75
Figure 5 - Map of First Nations communities involved in the MWT Pilot Project 75
2.9 Overview of the MWT Pilot Program 76
2.8.1 Program Coordinator 78
2.8.2 Concurrent Disorder Specialist 78
2.8.3 Traditional Coordinator 79

2.8.4 Traditional Advisory Circle 79
2.8.5 Elder-in-Residence (EIR) Program 80
2.10 Conclusion 80
Chapter Three – Evaluation of the "Raising the Spirit" Mental Wellness Team Pilot Project 83
3.1 Rationale for the Evaluation 83
3.2 Indigenous Methodologies 84
3.2.1 The importance of locating oneself in the Research 87
3.2.2 Locating Indigenous Methodologies alongside Qualitative Landscapes 88
3.2.3. Articulating a Relational Methodology 89
3.3 The MWT Pilot Project Methodology 90
Figure 6. The MWT Pilot Project Methodology 94
3.4 Data Collection 96
3.4.1 Storytelling Interviews 96
3.4.2 Focus Groups 97
3.4.3 Self –Reflective Journaling 98
3.4.4 Photovoice 99
3.4.5 A Second Round of Interviews 100
Table 1 - Interview and Focus Group Breakdown (2010) 101
Table 2 - Interview and Focus Group Breakdown (2012) 102
103
3.5 Data Analysis 103
3.8 Conclusion 105
Chapter Four: Findings from the Evaluation of the Raising the Spirit Mental Wellness Team Engagement with First Nations Communities in the Manitoulin, North Shore and Bemwijaang Tribal Council Areas 107
4.1 Evaluation of the "Raising the Spirit" Mental Wellness Team Pilot Project 107
4.2 Background 109
4.3 Findings from the Evaluation of the Mental Wellness Team Pilot Project 112
4.3.1 Communication and Communication Challenges 113
4.3.1.1 The Visionaries View 113
Figure 7 - Key Areas Impacting the MWTs Relationships with First Nations 114
4.3.1.2 The Steering Committee View 115
4.3.1.3 The MWT Team Staff 115
4.3.1.5 The First Nations Leadership View 117

4.3.1.6 Summary 117
4.3.2 Commitment to the Project 118
4.3.3 Collaborative Relationships 120
4.3.4 Capacity Building 123
4.3.4.1 Traditional Teaching Series 124
4.3.4.2 Crisis Response Training 127
4.3.4.3. Professional Development Training 128
4.3.4.4 Modelling Wellness 128
Picture 5 – One Part of the Medicine Wheel 130
4.4 Ability to Engage with Communities 130
4.4.1 Consultations 131
4.4.2 Project Infrastructure 131
4.4.3 Service Needs 133
4.4.4. Funding Issues 135
4.4.5 Geography 136
Picture 6 – The Wide Open Road 138
Picture 7 – Communication in the Midst of Chaos 139
4.5 Successes 139
4.5.1 Braiding Mainstream and Traditional Approaches 139
4.5.2 Cultural Safety 141
Picture 8 – The Importance of Culture 142
4.5.3 Access to Specialized Services 143
4.6 Impact on Relationships 145
4.6.1 Relationships with First Nations Communities 145
Figure 8 – Case Example from a Self-reflective Journal 146
4.6.2 Relationship between the Steering Committee and the Communities 146
4.6.3 Relationship between the Steering Committee and the MWT Staff 148
4.6.4 Relationship with Project Manager and the MWT staff 148
Picture 9 – Nurturing the Team to Life 149
4.7 Recommendations 150
4.7.1 Proper Infrastructure 150
4.7.2 Establishment of Service Agreements 151
4.7.3 Communication Strategy 152

4.7.4 Provision of Regional Services 153
4.7.5 On-going Evaluation of the Project 153
4.8 Limitations 154
4.9 Future Directions 155
4.10 Conclusion 157
Chapter Five: The Elder's Advisory Committee and Role of the Elders in Residence Program 160
5.1. Background 161
5.1.1 Ontario Training Centre in Health Services and Policy Research 161
5.2. Definition of Elders and Healers 162
Figure 9 – Raising the Spirit MWT Organizational Structure – Original Vision 164
Figure 10 – Anishinabek Nation NgoDweWanngizid 165
Figure 11 - Raising the Spirit Mental Wellness Team Organizational Chart 166
5.4. Elders-in-Residence (EIR) Program 166
5.4.1 Establishment of a Roster of Elders 169
5.4.2 Honorariums 171
5.4.3 Elder in Residence (EIR) Program Screening/Approval Process 172
5.4.4 Access to the Elders-in-Residence (EIR) Program 174
5.4.5 Elder's Services as Specialized Services 177
5.4.6 Staff Eligibility 178
5.4.7 Other Issues Related to the EIR Program 178
5.4.8 Discontinuation of the Elders- in-Residence Program 179
5.5. Negotiating the tension between Indigenous/non-Indigenous worldviews 179
5.6. Areas for further discussion 182
5.7. Conclusion 183
Chapter Six: Conclusion: Completing the Journey 185
6.1 Introduction 185
6.2 My Personal Struggle - Writing 186
6.2.1 Floundering 186
6.2.2 Agonize 191
6.2.3 Overcoming my struggle 192
Figure 12 -Medicine Wheel diagram 194
6.2.4. The Tug 195
Picture 10 – Walking Stick received from George Martin 197

6.3 Conclusion 197
References 200
Appendix 1 – MWAC Strategic Plan – 5 Pillars 216
Appendix 2 - CCMHI Collaborative Mental Health Framework 217
Appendix 3 – Mental Wellness Team Pilot Project – Program Coordinator 218
Appendix 4 - Mental Wellness Team Pilot Project – Concurrent Disorders Specialist 221
Appendix 5 - Mental Wellness Team Pilot Project – Traditional Counsellor/Coordinator 223
Appendix 6 - Letter of Introduction 225
Appendix 7 – Work plan – Mental Wellness Team Pilot Project –Evaluation of the Engagement Process with First Nations Communities 227
Appendix 8 - Submission to National Network for Aboriginal Mental Health Research – NAMHR Small Research Award 228
Appendix 9 - Narrative Storytelling Interview – Participating Service Providers/Agencies 229
Appendix 10 - Narrative Storytelling Interview Guide – Mental Wellness Team 230
Appendix 11 - Narrative Storytelling Interview – Mental Wellness Team Steering Committee 231
Appendix 12- Narrative Storytelling Interview – First Nations Leadership 232
Appendix 13: Questions for Reflective Journaling 233
Appendix 14 - Gibb's Reflective Cycle 234
Appendix 15 – Consent Form – Participating Service Providers/Agencies 235
Appendix 16 – Consent Form – Health Directors 237
Appendix 17 – Guide for Leadership Interviews 239
Appendix 18 - Community Workers Focus Group Guide 240
Appendix 19 – Letter of Introduction to Health Directors – Second Round of Data Collection 241
Appendix 20 – Raising the Spirit Mental Wellness Team (MWT) Elders-in-Residence Program 242

Abbreviations

AANDC – Aboriginal Affairs and Northern Development Canada

AHAC – Aboriginal Health Access Centre

AHF - Aboriginal Healing Foundation

AHWS - Aboriginal Healing and Wellness Strategy

APS – Aboriginal Peoples Survey

CCMHI – Canadian Collaborative Mental Health Initiative

CDS – Concurrent Disorders Specialist

COO – Chiefs of Ontario

CWB – Community Well-being

CWP - Community Wellness Program

CWW - Community Wellness Worker

DGA – Data Governance Agreement

EIR – Elders-in-Residence

FNIH - First Nations and Inuit Health

FNMWCF – First Nation Mental Wellness Continuum Framework

FNIMWSAP - First Nations and Inuit Mental Wellness Strategic Action Plan

FNRLHS - First Nations Regional Longitudinal Health Survey

FPWC - First Peoples Wellness Circle

HCC - Health Council of Canada

ICES - Institute for Clinical Evaluative Sciences

INAC - Indigenous and Northern Affairs Canada

ITK - Inuit Tapiriit Kanatami

MARRC – Manitoulin Anishinaabek Research Review Committee

MWAC – Mental Wellness Advisory Committee

MWT – Mental Wellness Team

NADS – National Anti-Drug Strategy

NAHO - National Aboriginal Health Organization

NNAMHR - National Network for Aboriginal Mental Health Research

NELHIN – Northeast Local Health Integration Network

NEMHC – Northeast Mental Health Centre

NMHAC – Native Mental Health Association of Canada

NNAPF – Nation Native Addictions Partnership Foundation

OCAP – Ownership, Control, Access and Possession

ORAPC = Ontario Regional Addictions Partnership Committee

OTC – Ontario Training Centre

PC – Program Coordinator

RHS - First Nations Regional Longitudinal Health Survey

RTS - Raising the Spirit

SAGE – Supporting Aboriginal Graduate Enhancement

SC – Steering Committee

SMI – Serious Mental Illness

TAC - Traditional Advisory Circle

TC – Traditional Coordinator

TPF – Thunderbird Partnership Foundation

TRC – Truth and Reconciliation Commission

UCCMM - United Chiefs and Councils of M’Nidoo Mnising

WHCSSPN – Wikwemikong Health Care and Social Service Providers Network

WHO – World Health Organization

Glossary

A Note on Terminology

It is important that the reader understand the various terminologies used to describe Indigenous peoples in Canada. The Indian Act identifies several categories for "Indian". The term 'Indian' refers to an Indigenous person who is registered under the Indian Act. A status Indian refers to a person who is registered as an Indian under the Indian Act. A non-status Indian means that the person has lost status (under current or former provisions of the Indian Act or whose ancestors were never registered). Treaty Indians refers to those community members whose ancestors signed a treaty with the Crown. Historically, the Inuit and Metis were not covered under the Indian Act. However, the Supreme Court of Canada's decision on April 14, 2016 expanded the definition of Indians to include Non-status Indians and Metis people. (Chan, 2016)

The term 'First Nation' refers to a person belonging to and /or identifying with a First Nation community, this could include both 'status' and 'non-status' Indians who are neither Metis nor Inuit. The term 'Native' was used when referring to the collective group of First Nations, Metis and Inuit peoples. The term 'Metis' refers to "a person who self-identifies as Métis, is distinct from other Aboriginal peoples, is of historic Métis Nation Ancestry and who is accepted by the Métis Nation." (Metis National Council, 2011, p.2). Inuit refers to a specific group of people originating from the far northern region of Canada.

Aboriginal people as used in the in Section 35 (2) of Constitution Act includes Indian, Inuit and Metis peoples of Canada (Department of Justice Canada, 1982). The term 'Indigenous', in keeping with the United Nations Declaration on the Rights of Indigenous Peoples that recognizes the sovereignty of Indigenous peoples as distinct from other racial or ethnic groups, has come

into common usage. The term “Indigenous peoples” is gaining popularity and is being used as a collective noun for First Nations, Inuit and Metis and is often used interchangeably with First Peoples, First Nations and Aboriginal Peoples.

Every effort has been made to ensure that the terminology used by others in cited references is maintained. Therefore, for the purposes of this paper, the terms Aboriginal, First Nations and Indigenous have been used interchangeably however preference will be given to the usage of the term ‘Indigenous’. Use of the term Métis will not be included in this thesis simply because this thesis is focusing on the evaluation of the Mental Wellness Team pilot project and deals primarily with First Nations communities in the Manitoulin, North Shore and Bemwijaang Tribal Council areas.

Glossary of Terms

Anishinaabe Kinomaadwin – translates to Anishinaabe (Aboriginal) teachings.

Anishinaabe-kwe – this is a term that is used to refer to an Indigenous woman from Canada and the United States who are culturally related and that include the Odawa, Ojibwe, Potawatomi, Oji-Cree, Mississaugas, and Algonquin peoples.

Anishinaabe-Kweok – the plural form of Anishinaabe-kwe, referring to many Indigenous women (see above).

Anishinaabewin - loosely translated refers to teachings about life.

Anishinaabemowin – this term refers to the Anishinaabe language, the language that is spoken by the Anishinaabe people. It is one of the oldest native languages in Canada. Translated, it means 'the language of the good person'.

Ba – Anishinaabemowin term used to signify that someone has passed on into the spirit world.

Band Council Resolution - a record of a First Nation Chief and Council decision required to initiate, authorize or approve numerous transactions under the Indian Act.

Bear clan – people belonging to the bear clan are the ones responsible for providing protection for the community. Bear clan people may also be the medicine people because of their knowledge of the healing ways of the plants that are available to them (Union of Ontario Indians, n.d.).

Boozhoo, Aanii, – These are forms of greeting used by the Anishinaabe people. "Boozhoo" is a formal greeting that is used when speaking to Elders or other people of importance such as a chief, grand chief or addressing groups of people. "Aanii" is an informal greeting used when meeting people in informal settings. Often time people revert to using the informal greeting.

Clan – In Anishinaabe culture, each clan has its own roles and responsibilities and when working together served the greater good of the community. There are seven clans within Anishinaabe culture - the crane, the loon, the bear, the deer/hoof, bird, marten and fish clan (Union of Ontario Indians, n.d.).

Clan System - The Clan System for most Indigenous cultures was traditionally a form of governance for the people. Every clan had their own roles and purpose that pertained to the greater good of the entire community. Within the Ojibwe Clan System each clan had not only

their own purpose, but the members of that clan were said to have certain personality traits to assist with upholding the clan structure (Union of Ontario Indians, n.d.).

Collaborative Mental Health Care – This is "a concept that emphasizes the opportunities to strengthen the accessibility and delivery of mental health services in primary health care settings through interdisciplinary collaboration" (Gagne, M.A. 2005, p1).

Cultural Awareness - Being culturally aware is the ability of a person to understand the differences between themselves and people from other countries or other cultural backgrounds, this includes understanding the differences in attitudes and values held by others.

Cultural Competence – refers to the ability of helpers to be learn about and integrate knowledge about the cultural differences of their clients and to demonstrate competence in the provision of services that are sensitive to clients' cultural needs.

Cultural Safety – The concept of Cultural Safety originated with the Maori Nursing program in New Zealand (Ramsden, 2003). Cultural safety provides a framework to examine unequal power relations and the social and historical processes that organize these relationships (Smye & Brown, 2002) which allows for discussion about whether the current health system benefits or places Aboriginal people at greater risk. Cultural safety goes beyond cultural awareness, cultural sensitivity and cultural competence to ensure culturally safe service provision as defined from the patient's perspective (Ramsden, 2003). This involves reflection on the part of the service provider in order to provide services in a culturally safe manner. Since its inception in the early 1990s, the concept of cultural safety has gained momentum in Canada and is used in a variety of settings such as education, medicine, child welfare, corrections, and mental health.

Cultural Sensitivity – Being aware that there are cultural similarities and differences that exist

between groups of people and that your culture is no better than any other culture.

Doodem - Anishinaabemowin term translated to mean “totem” or clan

Elders - Elders are viewed as individuals who are acknowledged within their communities for spiritual and cultural leadership and knowledge of some aspect of tradition; they have gained specific knowledge and gifts throughout their life’s journey; they are respected for their life experiences and knowledge about culture, tradition and ceremonies; they are acknowledged for living a healthy life; and, they are often called on for advice, help and support.

First Nation/First Nations – There is no legal definition of the term “First Nation” however, this term is used to describe Indigenous people in Canada who are neither Metis nor Inuit. When speaking about the ethnicity of First Nations peoples, the term “First Nations” is used. The singular form “First Nation” is used when speaking about a band, a reserve-based community, or a larger tribal grouping. For example, in the Sudbury area, we refer to First Nations people as belonging to either Atikameksheng First Nation or Wahnapitae First Nation.

Healers – Healers possess gifts (the gift of touch, doctoring, energy work, midwifery, and/or a variety of healing methods) to provide a wide range of services (spiritualist, herbalist, seers, medicine man/woman who use their gifts) to provide help and guidance for those seeking holistic health (Antone & Hill, 1990; Martin-Hill, 2003, Hill, 2008).

Indian Act – A piece of legislation enacted in 1876 that allowed the Federal Government to control most aspects of Aboriginal people’s lives (CBC news, 2011).

Indigenous Ways of Knowing – Absolon (2008) describes Indigenous ways of knowing as knowing your identity, where you come from, knowing and honouring your ancestors, ensuring

that Indigenous voices are heard as well as promoting Indigenous ways of knowing, being and doing.

Jidmoonh-kwe – Anishinaabemowin term translated to mean "squirrel woman". This was a name that was given to me when I was a child by my Great Uncle Dan. This name reflects my characteristics and provides purpose and guidance for me in my life.

Kia Ora – This is a greeting used by the Maori people.

Kinomaadwin – translated to English means teaching, learning or educating.

Knowledge Keepers – Indigenous knowledge is passed down from one generation to another from individuals who hold this knowledge. These individuals are referred to as knowledge keepers (Battiste, 2002).

Mental Health Development Initiative - The Mental Health Development Initiative was a program of the Northeast Mental Health Centre that provided clinical support, supervision and consultation to the First Nations communities within the region that had service agreements with Northeast Mental Health Centre.

Mental Illness – People with mental illness often present with a wide range of mental health conditions that affect mood, thinking and behavior such as depression, anxiety disorders, schizophrenia, eating disorders and addictive behaviors. While not always present, many people may develop mental health concerns from time to time.

Mental Wellness – According to Keyes (2002) mental wellness is more than the absence of a mental illness, it is a broader, positive term associated with wellbeing, inherent strengths, and functioning in life. Mental Wellness is viewed as being integral to our overall health (Mental

Health Commission of Canada, 2012). Indigenous peoples understand mental wellness from a holistic perspective. Mental wellness incorporates community relations as key to development of mental wellness and focuses on achieving balance of spirit, heart, mind, and physical being (Dell et al., 2011). According to Dumont (2015), wellness includes belief in one's connection to language, land, and beings of creation, as well as ancestry, and being supported by a caring family and environment (Restoule, Hopkins, Robinson & Wiebe, 2015).

Miinwaa - Anishinaabemowin term translated to mean "also/as well"

Mkwa - Anishinaabemowin term translated to mean "bear"

NNADAP – National Native Alcohol and Drug Addiction Program

Natural Helpers – This term refers to those individuals in Indigenous communities who use their special gifts to help others. Natural helpers have a very distinct role to play in the community. Often in times of crisis, natural helpers will see what needs to be done and do it.

Ndizhnikaaz – Anishinaabemowin term translated to mean "my name is…"

Ndoonjiibaa- Anishinaabemowin term translated to mean "I am from…"

N'Swakamok - Anishinaabemowin term translated to mean "where three roads meet"

NSTC – North Shore Tribal Council

Relational Worldview – This is a way of looking at the world which views life as a harmonious relationship between many interrelating factors in one's circle of life. According to the National Indian Child Welfare Association (NICWA), a relational worldview reflects Native thought process and balance as the basis for health at all levels – individual, family and/or organization.

Residential School System – Government run schools dating back to the 1870s that were designed to remove the involvement of Aboriginal parents in the intellectual, cultural, and spiritual development of their children. The ultimate goal was to eliminate the 'Indian' in the child and absorb them into mainstream society.

RTS – Raising the Spirit – one of eight mental wellness team pilot projects that were established in response to the Mental Wellness Advisory Committee (MWAC) strategy in (2006). The 'Raising the Spirit' mental wellness team project started in 2008.

Sagamok Anishininabek is a First Nation community in the North Shore Tribal Council area in North East Ontario. Sagamok mental health clinic was into the catchment area of Northeast Mental Health Centre (formerly Network North Community Mental Health Services).

Serious Mental Illness (SMI) – People who are considered to have a SMI usually exhibit conditions such as schizophrenia, paranoid and other psychotic disorders, bipolar disorders (hypomanic, manic, depressive, and mixed) and other major depressive disorders (single episode or recurrent).

Supporting Aboriginal Graduate Enhancement (SAGE) - SAGE first started out as a province-wide, inter-institutional, peer-support/faculty-mentoring educational program in at University of British Columbia (UBC) which spread to other provinces. Laurentian University developed its own chapter of the SAGE program to support Indigenous students transitioning to masters and doctoral programs.

Shoganosh - This term refers to a white person (someone from European descent).

Shoganosh ways – refers to the ways in which a white person conducts themselves, in other words - (white) ways. This often refers to understanding of the world from a western, dominant perspective whereas Indigenous people operate from an Indigenous worldview.

Spirit World – The Anishinaabe people believe that when a baby is born into this world, the spirit of that baby travels from the spirit world and returns to the spirit world once their journey on the physical world is complete.

Traditional Medicine – The World Health Organization define traditional medicine as "the sum total of the knowledge, skill, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness." (http://www.who.int/medicines/areas/traditional/definitions/en/)

Turtle Island – Indigenous people refer to North America as 'Turtle Island.' A Creation story as told by Basil Johnson (1976) describes how the Creator sent a great flood to cleanse the earth and how the muskrat, one of the smallest of all the animals was successful in bringing up a handful of dirt that was placed upon the turtle's back that transformed into 'Turtle Island' or what we now know as North America.

Wigwaskinaga- This is an Anishinaabemowin term used to describe the community where I come from, that is Whitefish River First Nation or Birch Island.

Wikwemikong Health Care and Social Service Providers Network (WHCSSPN) - This was a group of people representing the various health care and social services – education, health, social services, policing, Elder's centre, youth services, addictions services, mental health, and the clergy.

List of Figures

Figure 1 - Stepping Stones on My Journey – pg. xxviii

Figure 2: Average CWB Scores, First Nations and Non-Aboriginal Communities, 1981-2016 – pg. 19

Figure 3 – Canadian Collaborative Mental Health Initiative - Collaborative Mental Health Framework – pg. 26

Figure 4- Medicine Wheel - The Hub – adapted from Herb Nabigon-ba - pg.35

Figure 5 - Map of First Nations communities involved in the MWT Pilot Project - pg. 75

Figure 6 - The MWT Pilot Project Methodology – pg. 94

Figure 7 - Key areas impacting the MWTs relationships with First Nations – pg. 113

Figure 8 – Case Example from a Self-reflective Journal – pg.146

Figure 9 - Raising the Spirit MWT Organizational Structure – Original Vision – pg. 164

Figure 10 – Anishinabek Nation NgoDweWanngizid – pg. 165

Figure 11 - Raising the Spirit Mental Wellness Team Organizational Chart – pg. 166

Figure 12 -Medicine Wheel Diagram – pg. 194

List of Pictures

Picture 1 – Island on Whitefish River First Nation - pg. 2

Picture 2 – Photos of Violet and Art McGregor-ba - pg. 5

Picture 3 – Art and Violet McGregor-ba – pg. 8

Picture 4 – Elder Nmenhs (Arthur McGregor-ba) – pg. 9

Picture 5 – One Part of the Medicine Wheel – pg. 130

Picture 6 - The Wide-Open Road – pg.138

Picture 7 - Communication in the Midst of Chaos – pg.139

Picture 8 - The Importance of Culture – pg. 142

Picture 9 - Nurturing the Team to Life - pg. 149

Picture 10 – Walking Stick Received from George Martin – pg. 197

List of Tables

Table 1 - Interview and Focus Group Breakdown (2010) – pg. 101

Table 2 - Interview and Focus Group Breakdown (2012) – pg. 102

List of Appendix

Appendix 1 – MWAC Strategic Plan – 5 Pillars

Appendix 2 - CCMHI Collaborative Mental Health Framework

Appendix 3 – Mental Wellness Team Pilot Project – Program Coordinator

Appendix 4 - Mental Wellness Team Pilot Project – Concurrent Disorders Specialist

Appendix 5 - Mental Wellness Team Pilot Project – Traditional Counsellor/Coordinator

Appendix 6 – Letter of Introduction

Appendix 7 – Work plan – Mental Wellness Team Pilot Project –Evaluation of the engagement process with First Nations communities

Appendix 8 - Submission to National Network for Aboriginal Mental Health Research – NAMHR Small Research Award

Appendix 9 – Narrative Storytelling Interview – Participating Service Providers/Agencies

Appendix 10– Narrative Storytelling Interview Guide – Mental Wellness Team

Appendix 11 – Narrative Storytelling Interview – Mental Wellness Team – Steering Committee

Appendix 12 – Narrative Storytelling Interview –First Nations Leadership

Appendix 13 - Questions for Reflective Journaling

Appendix 14 - Gibb's Reflective Cycle

Appendix 15 - Consent Form – Participating Service Providers/Agencies

Appendix 16 – Consent Form for Health Directors

Appendix 17 – Guide for Leadership Interviews

Appendix 18 - Community Workers Focus Group Guide

Appendix 19 – Letter of Introduction to Health Directors – Second Round of Data Collection

Appendix 20 – Raising the Spirit Mental Wellness Team (MWT) Elders-in-Residence Program

Preface - Stepping-stones on My Journey

Figure 1 – Stepping-stones on My Journey

The above figure depicts my journey towards my PhD. This picture came to me as I was preparing for a presentation to the Supporting Aboriginal Graduate Education (SAGE) group at Laurentian University in November 2013. The topic of my presentation was "The path thus far - where did I come from, how did I get here and where am I going? A critical reflection on the journey towards acquiring my PhD in Rural and Northern Health". The SAGE group was established at Laurentian University to support Indigenous students through their graduate studies through peer support and mentoring. Each month a student would be asked to talk about where they were in their graduate work, identify issues/challenges as well as successes and share resources that they found helpful on their journey. In preparing for this presentation, I found it

helpful to reflect on where I was in my journey and how that experience provided the added push needed to continue my work.

It is important to have a vision of where you want to be. Equally important is to recognize the steps along the way to reach that vision. Sometimes when one is on a journey, the end seems to be far off and the end goal almost unattainable. This picture of the 'stepping-stones on my Journey' served as a constant reminder of where I was on that journey. In life we sometimes don't recognize how far we have come until we take a few moments to reflect on where we have come from. As I reached each step on my journey, I would look back to see where I came from. This provided me with the encouragement to continue on the journey. The stepping-stones are used in this thesis to describe the various stages along my PhD journey. In this thesis, these stepping-stones are used to indicate movement back and forth as I tell the story of the evaluation of the engagement process utilized by the mental wellness team pilot project. In each chapter I will identify where I am using these stepping-stones as a point of reference.

I have chosen to present my thesis in the form of a story. A storytelling format was chosen because of its characteristic as a universal language loaded with symbolism and significance. Stories are a framework through which one can seek out the mysteries of the world; discover meaning and purpose within the world; and investigate our experiences. Rooney, Lawlor and Rohan (2016) identify that there is an overlap of concepts and approaches in storytelling common to a narrative research methodology. A characteristic of storytelling is that the stories weave in and out and are sometimes repetitive often in an effort to emphasize certain points. This is something that I have attempted to do in the telling of the story of the engagement of the Mental Wellness Team (MWT) with First Nations communities. The repetition is also necessary when retelling the story from a different perspective in order to emphasize different aspects of

the story. Throughout this thesis certain themes are intentionally repeated because there represent important aspects of the story. The art of storytelling is more than just a temporal account of events, it requires that a back and forth movement in the relation of a narrative that is used to illustrate key points, key lessons and, more importantly, to keep the audience engaged in the storytelling.

Storytelling is also an important part of the research methodology that was chosen by the evaluation subcommittee, a subcommittee of the steering committee of the (MWT) that was established to oversee the pilot project. It was important that the research reflect the stories of the participants – the MWT members, the steering committee members, the frontline workers, the First Nations leadership and other key informants. Storytelling honours the words that the participants shared in their recount of their experiences with the MWT pilot project.

In this thesis, the reader will notice that elements of a story are interwoven with parts of the thesis requirements such as the literature review, methods, findings and analysis. In essence, the thesis is a story of my experience on the journey towards completing my PhD. There have been many twists and turns on my path, such as presenting parts of my thesis at the 5th biennial International Indigenous Development Research Conference that was held in Auckland in June 2012, hosted by Ngā Pae o te Māramatanga, New Zealand's Indigenous Centre of Research Excellence. Throughout this thesis I will also be drawing parallels between my personal experiences, my work in addictions and mental health and my research. Significant to this is the work I had done with elders, healers and ceremony, particularly the cedar bath and soul retrieval ceremonies.

According to Kovach (2009), reflexivity is often used in qualitative research to aid researchers in the meaning making process. Van Manen (2001) asserts that in exploring self-location we uncover beliefs about our lives that informs our truths and knowledge. Van Manen (2001) also states that phenomenological research emphasizes understanding lived experience and that it is through self-reflection that one begins to understand the significance of human experiences. I have found etymology a useful tool in weaving in and out between my personal philosophy; Anishinaabek worldview and way of life; and western academic thinking. Through self-reflection I came to realize that some of the struggles experienced by the MWT pilot project were similar to struggles faced by Indigenous peoples (in general) and myself as an Indigenous scholar. Many of these struggles seemed to be related to colonial history and the dominance of western society.

In this thesis I have chosen to use a literary device called ‘etymology’ which examines the various derivatives of a word and how their meanings have changed over time. Words can have different connotations attached to them at different points in time and depending on the context (Merriam-Webster, 2019). For example, the term ‘struggle’ has many origins. This term may have originated from the Old Norse word ‘strugr’ meaning ‘ill will’ or Dutch term “struikelen’ meaning "to stumble” (Harper 2019). In the late 14th Century, several meanings were attached to the word `struggle` such as ‘compare’, ‘trample,’ or ‘wrestle’ (Harper, 2019). According to Van Manen (2001), ordinary language holds incredible amounts of richness about human experience. Kovach (2009) asserts that qualitative research is interpretive therefore the stories of both the researcher and the researched are reflected in the meaning making process. Throughout this thesis, I explore the various meanings attributed to the word ‘struggle’ and their applications

to myself, the MWT and the various relationships that the team had through its service to the First Nations communities.

Each of the chapters presented in this thesis correlate to the stepping-stones illustrated above. Chapter one is entitled 'Beginning the Story'. This part of the thesis covers several of the Stepping-stones – the vision, the initial project, a new opportunity and how this led to a change in plan from the original vision. This chapter also contains a review of literature covering the following topic areas: Indigenous Aboriginal Health and Indigenous Mental Health; Collaborative (shared care) model; Cultural Safety; and Indigenous Knowledge – ways of knowing. This chapter begins to highlight personal struggles – knowing self, maintaining my identity, being an Anishinaabe-kwe within a western academic institution, and being a voice for other Anishinaabe women.

Chapter Two - The Mental Wellness Team Approach to Health and Addiction Services builds on the change in plan identified in chapter one. This chapter introduces the struggle facing Indigenous people in Canada with respect to access to mental health services. Mental health services for Indigenous people are affected: by the definitions attributed to mental health by Indigenous people and western society; the way in which statistics are gathered; the distinctions between urban and rural residency; as well as how services/programs are funded. This chapter also provides a historical perspective of the development of Aboriginal mental health services at the national, provincial, regional and local levels. Specific attention will be given to the development of mental health services on Manitoulin Island as well as the development of the "Raising the Spirit' MWT pilot project.

Chapter Three - Use of a Culturally Appropriate Evaluation Method describes the methodology chosen for this study including additional detail about the evaluation process used to assess the 'Raising the Spirit' MWT pilot project. The research for this project represents only a small portion of the overall evaluation of the MWT pilot project. In terms of the stepping-stones this chapter represents the data collection piece. In this chapter I discuss how I incorporated Anishinaabe teachings and practices into the evaluation of the engagement process between the 'Raising the Spirit' MWT pilot project and the First Nations communities served through this project. A culturally appropriate evaluation model that included the use of self-reflective journals, photovoice, storytelling interviews and focus groups was chosen because of their congruence with Anishinaabe traditional ways of knowing and being. While space is being made for methodologies that are based on traditional Anishinaabe ways of knowing and being these continue to be problematic since they are not widely accepted within western academic institutions.

Chapter Four: 'Raising the Spirit' Mental Wellness Team Engagement with First Nations Communities in the Manitoulin, North Shore and Bemwijaang Tribal Council Areas: Findings from the evaluation of this project represents the 'data analysis' and 'writing' steppingstone. This chapter takes an in-depth look at the findings of the evaluation and some of the recommendations with respect to the engagement of First Nations communities. The idea of the 'struggle' is explored further in this chapter.

Chapter Five: The Traditional Advisory Committee (TAC) of the Raising the Spirit Mental Wellness Team evolved out of the Elder's Advisory Committee. This group was tasked with providing information about the Elders-in-Residence (EIR) Program as well as providing advice and guidance to the MWT pilot project. A major focus of this chapter is about the Elders-in-

Residence program. This is included in this thesis because, as a PhD student, I applied for and was awarded a practicum through the Ontario Training Centre (OTC) which was designed to provide additional practical experience in health policy development. As a result of this practicum experience, I spent a significant amount of time building relationships with the TAC and EIR. My work with the TAC and the EIR was to help develop policies and procedures for the MWT for their TAC and EIR with respect to how they were to work with the First Nations communities involved with this project. This chapter explores the 'struggles' facing the EIR and the impact of these struggles on the ability of the MWT to engage with its partners. This chapter also represents the writing Stepping Stone on my journey.

Chapter Six: Conclusion: Completing the Journey concludes the writing stepping stone aspect, tying all chapters of this thesis together. This chapter is a reflection on my PhD journey. In this reflection, I relate significant events that encouraged me to continue on this journey. I also reflect on some of the struggles along the way involving the MWT pilot project, the Traditional Advisory Committee, specifically the EIR Program and my own personal struggles.

1. Chapter 1 - Beginning the Story

Boozhoo, Aanii, Kia Ora

Susan Manitowabi ndiznikaaz, Jidmoonh-kwe Ndezhnikaz, Wigwaskinaga miinwaa N'Swakamok ndoonjiibaa, Mkwa Doodem. This is translated as follows: "Hello, my name is Susan Manitowabi, I am squirrel woman. I come from Whitefish River First Nation and live in Sudbury. I am from the bear clan." Jidmoonh-kwe is the Anishinaabe name that I was given when I was a child, and it means 'squirrel woman". In my home community of Whitefish River First Nation naming ceremonies were a common practice when I was a child. I received my Anishinaabe name from my great uncle, Dan McGregor. The process for acquiring a name can vary depending on the teachings one follows. In my case, my great uncle was approached by my family to find an Anishinaabe name for me. This name was bestowed upon me at a community gathering, I believe it was at the Gimaa Gizhigaat (King's Day) feast. In my community, a day was chosen, usually once a year, where children would be welcomed into the community, and it was at that time that the children would be given their Anishinaabe names. The Anishinaabe name is significant as it indicates to the 'spirit world' who you are and it also describes what your role in life will be as well as your personal characteristics. I identify with the bear clan as this was my mother's clan and I choose to follow my matrilineal line. The bear clan represents the healers and protectors in Anishinaabe tradition.

1.1 Remembering who I am

Picture 1 – Island on Whitefish River First Nation

This picture represents the most important struggle as I embarked on this PhD journey. This picture comes from a small inland lake on Whitefish River First Nation. It serves as a reminder of my home, my family, my community and my connections. This is really important to me as it helps me to ground myself and to remember my roots.

As I started out my PhD journey, I was acutely aware that getting an education was important not only to myself but my family and community. Maina (1997), in conducting research on the education of First Nations and other minority group students found that schools which respect and support a child's culture demonstrate significantly better outcomes. This finding was corroborated by other Indigenous scholars who recommended that the educational system needed to respond better to the needs of First Nation children (Hamme, 1996; McCaleb, 1994). This included: respecting and supporting a child's culture; including culturally relevant curriculum; promoting an understanding of the relationship between First Nations and larger Canadian

society; as well as creating educational opportunities for children to participate successfully in larger society while maintaining their cultural identity (Maina, 1997). Kirkness (1992) argued that First Nations children must know the true history of their past in order to understand the present and plan for the future (p. 103). While these recommendations focus mainly on First Nations children, there is validity in extending these recommendations to Indigenous people attending post-secondary institutions. The announcement of the 'Calls to Action' by the Truth and Reconciliation Commission (2015) speak to the need for educational systems to improve education attainment levels and success rates as well as develop culturally appropriate curricula (p. 2) My experience with the PhD in Rural and Northern Health was one in which much of the responsibility for inclusion of Indigenous content fell on my shoulders.

I had been told early on by my parents that it was important to get an education. I was the first in my family to graduate from university and probably also one of the first in my community. I recall the, then, chief coming to my home to celebrate my accomplishment with me and my family. Since then, other community members have followed, and more are graduating from post-secondary educational institutes. I also grew up in an era where there were many people that did not have a good attitude towards the education system due to their involvement with the Indian Residential School System. People reacted in many ways. Some avoided sending their children to school and others viewed school as a means of survival as was the case with my parents. They (my parents) encouraged us (me, my brothers and sisters) to go to school.

The residential school system had a devastating impact on many Indigenous communities (Wilk, Maltby & Cooke, 2017: Kirmayer, Gone & Moses, 2014). In my family, our parents purposefully did not teach anything about our traditional ways hoping to save us from experiencing what they went through in residential school. It was not until my youngest brother

and sister were just entering their teenage years that they began to teach us more about our traditions and culture. My parents, particularly my mother, was very involved with the Ojibway Cultural Foundation and began attending many cultural and elder gatherings. My parents eventually became quite respected elders in our community and other communities throughout Northeast Ontario.

My parents were excellent role models for us and demonstrated what it was like to live life in a good way, following our teachings and engaging in cultural activities. As a young mom, I tried to follow in my parents footsteps and teach my children what I knew. This is what I carried with me into my doctoral studies.

I struggled with the notion of losing my sense of self within the academy. I had heard so many stories about people who had gone on to pursue their higher education who would then return home with an air of superiority simply because they possessed academic knowledge; or those who would never return to their communities seeking 'success' in the 'outside' world; or those who forgot about their traditions and cultural background and ultimately their connection to community. I vowed that this wouldn't happen to me. So, the picture above helps me to stay grounded. I also stay grounded by attending cultural gatherings, participating in ceremonies, drumming and trying to live life in a good way. Sometimes life can also get in the way of being successful in my academic studies. Having a reminder of why I pursue higher education helps me to maintain balance between my work, personal and academic life.

Early on in my studies I was intrigued by the concept of Indigenous ways of knowing. Indigenous ways of knowing involves knowing your identity, remembering where we come from and what we know so that we don't lose ourselves, honouring our ancestors and our knowledge,

ensuring that our voice and the voice of others are heard, making the invisible visible and "lifting up" Indigenous ways of knowing, being and doing (Kovack 2009; Absolon, 2005). In doing so, this helps to keep one grounded and connected to Indigenous roots. Reminding oneself of where one comes from ensures that one does not become lost. This re-affirmed for me the need to remember my heritage and where I came from. It also inspired me to pursue Indigenous ways of knowing as the basis for my PhD work, to build upon the work of other Indigenous scholars and to create space within the institutions for Indigenous knowledge.

1.2 My Inspiration

Picture 2 – Photos of Violet and Art McGregor

Violet McGregor-ba Art McGregor-ba

My inspiration for pursuing my PhD studies came from my parents, Violet McGregor-ba and Art McGregor-ba. Violet McGregor-ba greatly influenced my life decisions. She had gone to residential school and managed to survive those years but her experience there had a great

impact on her child-rearing practices. She came away from that experience with the resolve that none of us would experience what she endured there. She firmly believed that if we were to get ahead in this world and survive then we needed to be educated so that we could learn as much as possible about the 'Shoganosh' ways. She stated that "no matter what you decide to do in this world promise me that you will get an education" (McGregor, personal communication, 1977). Other reasons for pursuing my PhD are both personal and social: to be a role model for other Anishinaabe-kwe; to create a mental health resource; and, to acquire my credentials.

This brings me to another struggle that I faced. I grew up in an era where Anishinaabe women had no voice. I recall a visit to a dentist in Sudbury, Ontario. We made the trip by bus from our home community in Birch Island (now Whitefish River First Nation) to Espanola and then on to Sudbury. I had an appointment with a dentist there because of an abscessed tooth. Rather than fixing my tooth the dentist decided to pull it out. He froze my mouth but didn't wait long enough for the freezing to take. He came in to pull my tooth and it hurt so much that I began to cry. Rather than trying to soothe me or wait a little longer he simply slapped my face and told me that it didn't hurt that much and not to cry. My mother, who was in the waiting room, knew nothing of this event. I came out of that office still crying. I was offered a candy but refused and stated that I would never come back. After we left the dentist's office my mother asked me what happened. I told her but she did nothing. We kept walking down the street towards the Bonimart (now the Rainbow Centre) in Sudbury, Ontario.

I never thought about that experience again until much later in life when I started to learn about having a voice and being able to stand up for oneself and others. In trying to make sense of that experience I came to realize that during that time period (the 1960's) women did not have much voice and Aboriginal women had even less of a voice. It was not until the 1970's that the

women's movement took hold and people started advocating for women's rights. For example, The Ontario Native Women's Association (ONWA) was "established in 1971 to empower and support Indigenous women and their families throughout the province of Ontario" (ONWA, 2018) and the Native Women's Association of Canada (NWAC) were incorporated in 1974 with a "collective goal to enhance, promote, and foster the social, economic, cultural and political well-being of First Nations and Métis women within First Nation, Métis and Canadian societies" (NWAC, 2011, p.4).

Around about that same time, my mother became very active in the Aboriginal rights movement. One of my earliest memories of her was when we were at home huddled around our small black and white television set watching her march on Parliament Hill. My father stayed behind to care for us and made sure that we were able to see her on television. It was totally amazing for us as Anishinaabe children to see that our mother who was our primary caregiver, always at home, was now on the screen of our small television set. That was the beginning of her journey as an advocate for Aboriginal rights. Violet went on to serve in other areas as well. She was active in the Parish Council, the Espanola Board of Education, the Ojibwe Cultural Foundation, the United Chiefs and Councils of Manitoulin (UCCM) police commission, Anishinaabemowin Teg, the Great Lakes Water Advisory Committee just to name a few. As you can see, I had a wonderful mentor in my mother who encouraged me to stand up for what is right and to have the courage to speak up about those things in an effort to make things right.

My second greatest influence in my life was my father – Art McGregor-ba. "Archie" (Nmenhs-Little Sturgeon), as he was known, was always there wherever my mother went. He supported

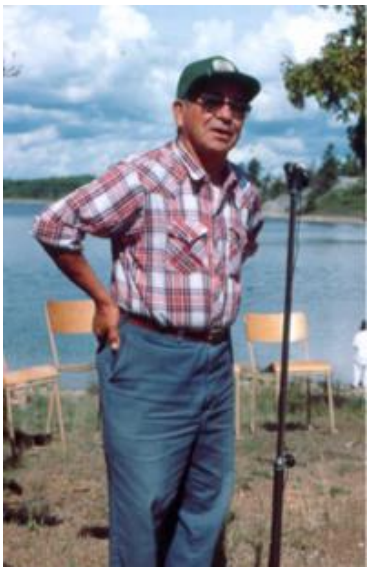
Picture 3 – Art and Violet McGregor-ba

Art McGregor-ba and Violet McGregor-ba

her in all her activities often driving her to meetings and quietly sitting in the background. Sometimes he wasn't so quiet because he was also known to be somewhat of a 'trickster' telling jokes and poking fun at people.

Archie was also a great supporter of getting an education. He was very proud of the fact that he graduated from "Guelph Agricultural College". Archie had to help his father with the farming so couldn't go away to school. Instead, he applied to Guelph Agricultural College and completed all his studies by correspondence. Archie never graduated from high school but was able to enrol in college. I recall a story he told about this. He was interviewing for a job with Ontario Hydro and when asked if he had a high school education, he responded that he didn't. However, he did say that he had a college diploma, and he was immediately put into a supervisory position. He was also very proud of all his children especially so at graduation ceremonies.

Picture 4 – Elder Nmenhs (Arthur McGregor)



Wigwaskinaga (Whitefish River) Elder Nmenhs (Arthur McGregor)

Art was a very active member of the Whitefish River First Nation community. He was the coach for the Birch Island Warriors hockey team for many years. He was the school bus driver for our community. He also supported the Little Native Hockey League and the local hockey club by driving youngsters to their hockey games, often times borrowing the community's bus to do so.

Art was a storyteller and an author of 'Wigwaskinaga' – stories of Dreamer's Rock, Bell Rocks, and the little people. Art was a keeper of traditional knowledge, and he shared that knowledge in his stories. My childhood was filled with his stories, he would tell us stories mainly about life lessons, cautionary tales, and family history. Art was also recognized as a traditional historian of the Whitefish River First Nation community. As described in the following quote, he was recognized for holding the oral history of the community that stretched back as far back as four hundred years.

> *"We talked at his home several times and at community gatherings. Nungess's (*In this article there was a misspelling of 'Nungess', it should read 'Nmenhs' which translates to Little Sturgeon, Art's Anishinaabe name) *style of storytelling introduced key characters with himself included in the dialogue, as if the characters were with us, sharing the present space and time. Nungess's stories when combined with other research descriptions (i.e., political history, field notes) provide a thicker description of the Wah Wha Skin Ah Gah exhumation. In particular, his interviews revealed a timeline that stretches back about four hundred years. This traditional history is from the WRFN oral tradition, about the WRFN on Wah Wha Skin Ah Gah before and just after European contact. It embellished the written histories of contact with others who came into the WRFN homeland for trade, war, tradition, research and discovery, during traditional and historic times" (Biron, 1998, p. 59).*

It was because of his influence as a storyteller that I chose to use a storytelling methodology in this PhD thesis. A spinoff effect of using storytelling is that stories, such as the stories held by my father (and other community elders and knowledge keepers) contributes to understanding the history of communities on Manitoulin Island. Storytelling is important because it allows people to make sense of their world, to learn about values, history, significant events, relationships, cultural beliefs and share sacred stories. According to Archibald (2008), stories are used to educate as well as heal the heart, mind, body, and spirit.

Storytelling allows storytellers to use their own voices to tell their stories on their own terms (Brown and Strega, 2005). According to Cruickshank (1998), storytelling has gained importance as a means of countering dominant discourse in which Indigenous voices have been systematically erased. Dominant society deems storytelling as illegitimate because of its

subjective nature (Brown and Strega, 2005). However, First Nations peoples (I use this term because I am First Nations) often use storytelling as a means of recording our histories, as is the case of my father's role in recounting the history of Whitefish River First Nation - 'Wigwaskinaga'.

What is igniting the movement towards Indigenous storytelling? Storytelling is a form of resistance to colonialism (Brown and Strega, 2005). For example, the Truth and Reconciliation Commission collected stories from residential school survivors allowing them to share about their experiences and how they were able to survive that era. Storytelling allows people to learn about culture, traditions and life lessons. This is important as Indigenous peoples reclaim what was lost due to colonization, imposition of residential schools, the Indian Act and child welfare systems. Storytelling allows us to gain access to information that is available through stories, legends and teachings. For example, the Anishinaabe governance system is based on the clan teachings (Anishinabek Nation, n.d.).

1.3 Reasons for pursuing my PhD

1.3.1 Inspiration for Others

As my journey continued in life, I found myself working in a number of fields. I started out working for the Federal Government in Employment and Immigration and later became employed as a clerk for Health Canada at the Wikwemikong Health centre in Wikwemikong, Ontario. After about ten years in this position, I switched roles and gained employment in the field of addictions as the Prevention Program Manager with Ngwaagan Recovery centre in Wikwemikong. Ten years later I transitioned into working in the mental health field as the Manager of Nadmadwin Mental Health Clinic and then as a member of the First Nations Mental

Health Development Initiative (FNMHDI) with Northeast Mental Health Centre (NEMHC). At this point I decided to pursue my Master of Social Work Degree at University of Toronto. Upon graduation, I returned to my role as the researcher for the FNMHDI at NEMHC only to find out that I was the only indigenous person employed at NEMHC on the FNMHDI team. This discouraged me so when I received the call that the Native Human Services – Bachelor of Social Work Program at Laurentian University in Sudbury, Ontario was looking to hire me as a professor I jumped at the opportunity.

As a professor in the Native Human Services Program (now School of Indigenous Relations) I found myself working with many students from the various communities where I had lived and worked in on Manitoulin Island and the surrounding areas. In reflecting on this, I realized that the people I was teaching were the same people that I lived with in my community, grew up with and worked with. What could I possibly teach to them that they didn't already know? Will they accept me as someone that can facilitate learning? I turned to my mother for advice. She simply related to me that I was not there by accident, that this was where I was supposed to be in life and that my role was to help facilitate that learning. She also told me that I could never know everything that there was to know and that I needed to be honest about that and let people know of my limitations. As time went on, I became comfortable with my new role. Several years went by. I had taught people who I had considered to be my peers from my communities, and they went on to work in their home communities. I was not quite prepared for what happened next. I began to notice a couple of things: some of the students that were coming into the program were the children of students that I had previously taught and, secondly, many of the students who came through the program were going on to pursue their master's degrees. The students, mainly the female students, who were seeking their master's degrees had told me that they were inspired

by me to continue on their educational paths. These students would often express that if I could do it - work, raise children and attend school - then they could as well. This brings me to one of my personal reasons for pursuing my PhD which is to demonstrate to other Anishinaabe-kwe that we (Anishinaabe-kwe) have the capacity to succeed in Western academic settings while remaining true to identities.

1.3.2 Documenting the History and Development of Mental Health Services on Manitoulin Island

One of the teachings that I grew up with was about how we are on this journey and that our path is pre-determined to a certain extent. Our life experiences prepare us for what lays ahead. In reflecting back on my life, I am not surprised that I chose to do my PhD in Rural and Northern Health. Everything that I had done up until that point was leading me towards that journey. This brings me to my second reason for pursing my PhD comes from my experience working in the field of mental health. My experience in the mental health system was an important motivator for my choice of thesis topic. This is something that was near and dear to my heart.

During my employment as a consultant for the FNMHDI, I had many conversations with my colleague, Daniel Manitowabi, about documenting the work we did as mental health professionals working in Aboriginal communities. Daniel Manitowabi was one of the first mental health workers hired to work at the Wikwemikong Counselling Program (later known as Nadmadwin mental health clinic). Daniel Manitowabi later became the clinical lead for the Nadmadwin Mental Health Clinic, and then went on to become a Clinic Manager with the North East Mental Health Centre in Sudbury, Ontario.

The Wikwemikong Counselling Program was developed in 1975 in response to a community crisis, a cluster of seven suicides that occurred between December 1974 and November 1975

(within the space of less than a year) (Smye & Mussell, 2001, Kirmayer et al. 1999, RCAP, 1995). Several other programs also developed in response to that suicide epidemic – Rainbow Lodge (an alcohol abuse treatment centre), the Wikwemikong Child and Family Centre and the Youth Centre (Kirmayer et al., 1999, RCAP, 1995).

Documenting the history of Nadmadwin Mental Health Clinic represents a number of firsts in First Nations mental health: this was the first Native mental health program to be developed in this Sudbury/Manitoulin area, it was one of the first to hire First Nation employees; and first to be delivered in a First Nation community. Nadmadwin Mental Health Clinic was also a leader in being able to braid Western and traditional healing approaches in order to provide culturally appropriate services for community members served by the mental health clinic. It has served as a model for the development of other First Nation mental health services across Manitoulin Island and Canada.

1.3.3 Advancing Indigenous Knowledge

Lastly, and probably the least important of my reasons for pursing this PhD was to acquire the credentials needed to progress through the ranks in the academic setting. In a Western view of the world, credibility comes from having the piece of paper that states that you have acquired the knowledge to be considered an 'expert'. In an Aboriginal understanding of the world, knowledge comes from life experience and is transmitted from one generation to another. According to Battiste (2002), Indigenous knowledge has always existed but has systematically been excluded from educational and Eurocentric knowledge systems. Battiste (2002) goes on to state that Indigenous knowledge is viewed as a form of empowerment by Indigenous people and that the task for Indigenous academics is to "affirm and activate the holistic paradigm of Indigenous knowledge" (4). My contribution to the academy is to aid in creating the 'ethical space' between

Western and Indigenous cultures so that Western and Indigenous knowledge systems can co-exist (Ermine, Sinclair, & Jeffery, 2004). In other words, to promote intellectual self-determination through the creation of new types of analyses and methodologies that contribute to the decolonization of ourselves, our communities and our institutions demonstrating that Indigenous knowledge systems can co-exist alongside Western scientific thought.

According to Wilson (2008), Indigenous knowledge is relational knowledge. This means that knowledge is shared with all of creation, the cosmos, the animals, the planets, the earth and individuals. Wilson states that "the concepts or ideas are not as important as the relationships that went into forming them" (Wilson, 2008, p. 71.) As Indigenous academics we are tasked with creating the space for Indigenous knowledge to exist within Western academic settings. This is probably the greater challenge associated with the pursuit of my PhD degree since Indigenous knowledge and Indigenous thought is not widely accepted although there are more Indigenous academics pushing the boundaries.

1.4 My vision

As mentioned earlier, my original intent of my PhD thesis was to write about the history and development of mental health services on Manitoulin Island. This was something that I and my colleague, Daniel Manitowabi, spoke about to each other many times. With that in mind I submitted my application along with an abstract entitled "An Analysis of the History and Development of Aboriginal Mental Health Services". The focus of my research was to document

the history and development of mental health services in Ontario, specifically as it related to the Sudbury/Manitoulin area. This was to include a discussion about how mental health policy development in Ontario and policy developments at the federal level had impacted mental health service delivery in Aboriginal communities and to highlight areas for development of culturally specific, relevant and safe mental health service delivery. My plan was to research how recent developments such as the formation of the Mental Health Commission and the Aboriginal Mental Health Framework were impacting the Aboriginal Mental Health Programs.

My project would also consist of a system level analysis of collaborative (shared care) models of service delivery. MacFarlane (2005) describes collaborative mental health care as a concept that emphasizes opportunities to strengthen the accessibility and delivery of mental health services in primary health care settings through interdisciplinary collaboration. Collaborative care models offer a range of services that involves consumers, families, and caregivers, as well as health care providers from mental health and primary health care settings—each with different experience, training, knowledge, and expertise working together for more coordinated and effective services for individuals with mental health needs. Examples that I would use as a comparison were: the Health Care and Social Service Providers Network in Wikwemikong; the Health and Social Service Providers in M'Jikaning (Rama); and the wrap around services with Noojmowin Teg and M'Namodzawin Health Services on Manitoulin Island.

At this point on my journey, I was very ambitious. I was eager to add to the body of knowledge about Indigenous research methodologies, I wanted to engage Aboriginal communities in research partnerships, I wanted to develop a culturally safe collaborative model of mental health care and create 'promising practices' for the delivery of Aboriginal mental health services. Looking back on this, this would be a huge undertaking, possibly one's life work. As I

progressed through my first year, I realized what a monumental task that would be. What had started out as a small idea morphed into a huge research project! Another challenge was to scale back this project or settle on another project that could be completed within a reasonable timeframe.

1.5 Literature Review

My literature review began as I was planning on documenting the history and development of mental health services on Manitoulin Island. This literature was expanded on when the original project transformed into this new project – evaluating the engagement of the Mental Wellness Teams with partnering First Nations Communities. Had I not done the original literature review I may not have realized the significance of the Mental Wellness Team project. With respect to the development of my initial project – a documentation of the history and development of mental health programs on Manitoulin Island - a literature review of the following themes was conducted:

- Indigenous Health and Indigenous Mental Health
- Challenges to Mental Health Care
- Collaborative (Shared Care) Model
- 'Cultural Safety' and Mental Health
- Indigenous Knowledge – Ways of Knowing

This previous literature review is still relevant to my new, refined project and so I am exploring these topics here.

1.5.1 Indigenous Health and Indigenous Mental Health

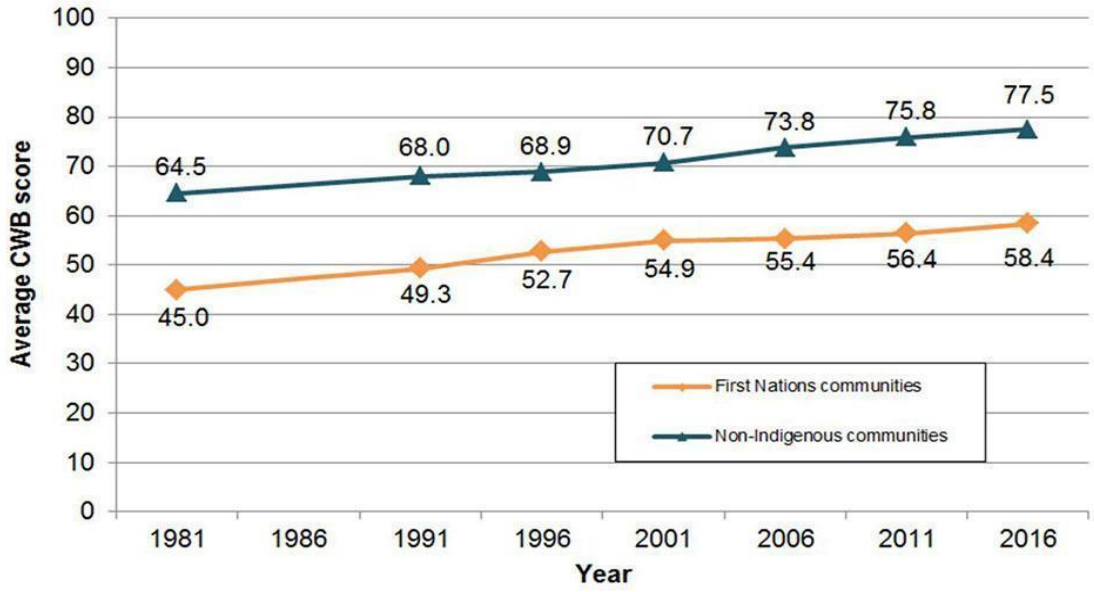
Indigenous Heath

The definition of health has changed over the years since the World Health Organization first attempted to define health in 1948 as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 1948, p.119). Sartorius (2006) identifies two other definitions of health in addition to the WHO definition of health – health as a state where the individual can adequately cope with all demands of daily life: and health as a state of balance or equilibrium between an individual and his/her social and physical environment. The latter definition fits well with an Indigenous perspective on health which views health from a holistic perspective often conceptualized through the medicine wheel including all aspects of the physical, emotional, mental and spiritual wellbeing (Mushquash, 2014; Mussel et al, 1993). To be healthy or achieve wellness then each of the four aspects of life must be in balance.

According to Romanow (2002), the general health status of Aboriginal peoples is better today than it was in the 1950s yet there remains a significant the gap in health and well-being between Aboriginal and non-Aboriginal peoples (National Collaborating Centre on Aboriginal Health, 2013; Minore & Katt, 2007; Mitchell & Maracle, 2005; RCAP 1996). According to RCAP (1996), while medical services were available to Aboriginal people even in the remotest parts of the country this did little to reduce the gap in health and wellbeing. The socio-economic status (SES) of Aboriginal peoples has improved slowly since the RCAP report but the gap in SES and the health and well-being of Aboriginal compared to non-Aboriginal people in Canada remains high (NCCAH, 2013; NCCIH, 2019). The following figure from Indigenous and Northern Affairs Canada (2015) indicates that the average Community Well-Being (CWB) scores for First

Nations and non-Aboriginal communities increased slowly between 1981 and 2011. A more recent report on CWB (2019) from Indigenous Services Canada reports that an increase from 56.4 in 2011 to 58.4 in 2016 yet the CWB gap remains substantial with the average CWB score for First Nations communities around 19 points lower than the average score for non-Aboriginal communities. Incidentally, there is very little change in the CWB report since 1981.

Figure 2: Average CWB Scores, First Nations and Non-Aboriginal Communities, 1981-2016



Source: Statistics Canada, Censuses of Population, 1981 to 2006, 2016 and National Household Survey, 2011.

Indigenous Mental Health

The First Peoples Wellness Circle (FPWC) (formerly the Native Mental Health Association of Canada (NMHAC)) joined with the National Native Addictions Partnership Foundation (NNAPF) on June 25, 2015 to form the Thunderbird Partnership Foundation (TPF). The aim of this new organization is to promote Indigenous holistic approaches to healing and wellness with the First Peoples of Canada. The NMHAC (2008) in its report *Charting the future of Native*

mental health in Canada: Ten-year strategic plan 2007–2017, defined mental health as a balance, harmony and connection between interior aspects of the being and the external world in which he or she lives. This definition above acknowledges that mental is not only affected by what is going on inside one's being but is influenced by the outside environment.

Warry (2000), states that while there are a few mental health programs in existence, such as the National Native Alcohol and Drug Addiction Program (NNADAP) and Aboriginal Healing and Wellness Strategy, Aboriginal mental health services remain seriously underdeveloped. It is important to note that this was written two decades ago yet Warry's observations are still pertinent in that other writers had and continue to have similar concerns about gaps in mental health programming. Mental health programming continues to be the largest single gap in services in mental health services for Aboriginal people (Warry, 2000; Boska et al., 2015). Although there is funding for human and financial resources for Aboriginal mental health programs and services, Aboriginal people continue to be at serious risk for mental health issues (Kirby, 2006; Boska, et al., 2015) due to a lack of culturally safe, culturally appropriate and engaging mental health services (Keilland & Simone, 2014).

Aboriginal people in Canada receive health care (including mental health services) through a variety of home and community care programs funded by Health Canada as well as through various other programs funded by provincial and territorial governments (Minore & Katt 2007, Minore et al 2007; Keilland & Simone, 2014)). The First Nations communities within the Manitoulin District of Northern Ontario receive health care and mental health care predominantly from the First Nations Inuit Health Branch (FNIHB) under Health Canada.

The federal government's announcement in March 2007 for the establishment of a Mental Health Commission of Canada was a first step towards the goal of a national strategy on mental illness. The establishment of the Mental Health Commission of Canada along with the development of an Aboriginal Mental Health Framework brought hope that additional funds would flow to Native communities for Native mental health programs (Kirby & Keon, 2006; Schizophrenia Society of Canada, 2016). More recently, the Truth and Reconciliation Commission of Canada (2016), calls for reconciliation and constructive action to address the destructive impacts that colonization has had on Aboriginal peoples' health as well as on education, cultures and languages, child welfare, the administration of justice, and economic opportunities. In Northeast Ontario, the Northeast Local Health Integration Network (NELHIN) developed an Aboriginal Health Care Reconciliation Action Plan aimed at closing health care gaps (which includes closing the gaps in mental health care) that was launched in May 2016 (LHIN, 2016).

Since the late 1980's, there has been a shift in the policies guiding and structuring health care delivery to Canada's Aboriginal people. The devolution of health services from Health Canada to First Nations communities has resulted in the transfer of decision making to First Nations peoples who must now develop, plan, manage and control their own health services (Minore & Katt, 2007). While self-determination can lead to better health outcomes in Aboriginal people's health (Chandler and Lalonde, 2007, 1998), transfer of health services is not sufficient in itself. Minore and Katt (2007), indicate a couple of challenges that cannot be addressed through the transfer of responsibilities. First, western society measures success through accountability based on standardization which fails to take into account local Aboriginal traditions and preferences. Secondly, self-determination can have little effect on factors that define health such as poverty, housing, contaminated environments, sanitation or even lifestyle choices. Self-determination

alone does not resolve underlying issues. Funding for programs and infrastructure can help but when funds are allocated to First Nations communities it is never enough to adequately address larger systemic and structural realities faced by First Nations communities.

Linklater (2014) writes that the impacts of colonization have severely altered Indigenous worldview including educational systems and community functioning. Littlebear (2000) asserts that colonization tries to maintain a single social order effectively suppressing diverse human worldviews. Battiste and Henderson (2000), speak about Indigenous knowledge as vibrant relationships between people, other living beings and spirit as well as ecosystems. Cajete (2000) asserts that understanding relationships and cultural connections help people to understand their place in the world. This cultural disruption as a result of settler colonial influences makes it difficult for First Nations communities to address health and social issues. Duran (2006) speaks about the 'soul wound', a profound wounding of the soul related to spiritual damage caused by colonization. Braveheart (2004) articulated that historical trauma responses include reactions to substance abuse, self-destructive behaviours, suicidal thoughts and gestures, depression, low self-esteem, anger and difficulty expressing emotions. Both Braveheart (2004) and Duran (2006), suggest that treatment approaches address historical issues. Linklater (2014) speaks to the importance of self-determination and community control with regards to healing stating that Aboriginal communities that do take control over health programs have the benefit of creating programs that meet the cultural needs of their members.

The First Nations Mental Wellness Continuum identifies 'mental wellness' as "state of well-being in which the individual realizes his or her own potential, can cope with the normal stresses of life, and is able to make a contribution to her or his own community" (First Nations Mental Wellness Continuum, 2015, p. 1). Mental wellness is achieved when there is a balance between

the mental, physical, spiritual, and emotional aspects of the being and is enriched when individuals have purpose in life, hope for the future, a sense of belonging and a sense of meaning (First Nations Mental Wellness Continuum, 2015, n.p.).

1.5.2 Challenges to Mental Health Care

There are many barriers to addressing the mental health needs of all Canadians. For example, there is a lack of necessary resources to meet the mental health care needs of all Canadians; language and cultural variations prevent access to mental health care services; intake procedures vary between service providers; health care provider attitudes and limited knowledge of respective roles, responsibilities and skills; geographical barriers prevent access to mental health services; poor coordination of primary health care and mental health care reform planning; and, stigma and discrimination associated with mental health problems (Gagne, 2005). In addition, First Nations peoples face a number of challenges related to Native mental health service delivery: a general mistrust of 'outsiders' providing health care in the community; lack of culturally sensitive care, lack of knowledge about issues relevant to the community, and lack of respect for traditional healing practices; confidentiality issues; stigma related to mental illness; as well as lack of consumer awareness regarding mental health, mental illness and available treatment and services (Wieman, 2009; Maar et al., 2009; Warry, 2000). Service delivery issues include achieving a balanced blend between 'Western" and 'Traditional" practices, a 'revolving door' syndrome (individuals with acute mental illnesses being admitted to hospital and discharged without follow-up services and then having to be re-admitted), and challenges to maintenance of self-care for mental health professionals (Wieman, 2009). The Health Council of Canada (HCC) (2012) reports that the "negative stereotypes about Aboriginal people are deeply rooted in Canadian society, and much of what Aboriginal people experience in the health care

system is an extension of this systemic racism" (p. 8). This is probably the main reason for the under-utilization of mainstream health care system among many First Nations, Inuit and Metis peoples. Simply put, the experience of many First Nations, Inuit and Metis peoples is one on being treated with disrespect, judged, overlooked, stereotyped, racialized, or minimized (Health Council of Canada, 2012).

In terms of what works in Aboriginal mental health service delivery, Ockenden et al. (2007) attribute the success of Aboriginal mental health and addiction services to strong collaborative relationships between agencies, service providers, and families (p.7). According to Maar (2009), the blending of collaborative and culturally competent services with traditional Aboriginal healing services have been identified as promising practices in Aboriginal mental health. Those who work in mental health within Aboriginal communities know this to be true. For example, in my role as the Clinic Manager for the Nadmadwin Mental Health Clinic in Wikwemikong, Ontario, I worked along with the Wikwemikong Health Care and Social Service Providers Network (WHCSSPN). This was a group of people representing the various health care and social services – health, addictions, mental health and social services, as well as education, policing, youth services, the clergy and local Elders. This group organized itself in an attempt to work together to address the health and social issues prevalent at the time. One of the first projects that we addressed was the issue of sexual abuse. The WHCSSPN pooled their resources together to bring in a specialist to provide training to the frontline workers to deal with sexual abuse issues and to assist service providers to develop programming for the community aimed at addressing sexual abuse. This approach seemed to work well so this group decided to tackle another issue - youth suicide. This group gained the respect of the chief and council and subsequently, any issues that the council felt needed to be addressed were referred to the

WHCSSPN. Later, I came to learn that this was an example of a Collaborative (Shared Care) Model of service delivery.

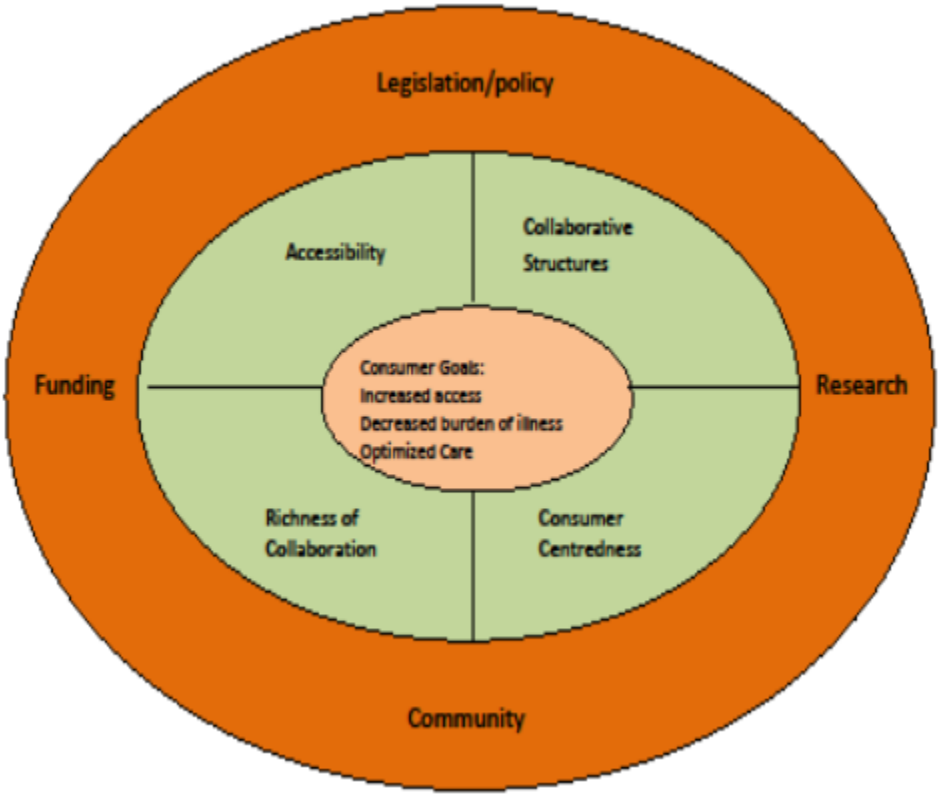
1.5.3 Collaborative (Shared Care) Models

"Collaborative mental health care is a concept that emphasizes the opportunities to strengthen the accessibility and delivery of mental health services in primary health care settings through interdisciplinary collaboration" (Gagne, M.A. 2005, p.1). There is no one way of providing collaborative mental health care. Rather, there are a range of practice models that involve consumers, families, and caregivers, as well as mental health care providers from mental health and primary health care settings that recognize the unique experiences, training, knowledge, and expertise that each individual possesses. Collaborative care promotes mental health and provides coordinated and effective mental health services in a range of setting that varies according to individual needs and preferences and the knowledge, training, and skills of the providers (ibid).

The Canadian Collaborative Mental Health Initiative (CCMHI) Collaborative Mental Health Framework (Figure 3) places the consumer at the centre (see appendix 2). The goals of collaborative mental health care are identified as "increased access, decreased burden of illness and optimal care" (MacFarlane, 2005, p 1, 2). Four key factors influence the implementation of collaborative mental health care: Government policy and legislation; funding; research-based practices; and community needs (MacFarlane, 2005, p. 2). Four key elements define collaborative mental health care: accessibility, collaborative structures, "richness of collaboration, consumer-centredness" (MacFarlane, 2005, p. 2). According to MacFarlane's model, accessibility refers to that ability of consumers to access mental health services in primary health care settings; richness of collaboration is measured in terms of numbers involved in care, numbers of disciplines involved and the ability to transfer knowledge among

collaborative partners; and collaborative structures include style of management, formal evaluation protocols, and/or memorandums of understanding. Most important is the placement of the consumer at the centre of the planning, evaluation, governance and treatment decision-making processes (MacFarlane, 2005.)

Figure 3 – Canadian Collaborative Mental Health Initiative - Collaborative Mental Health Framework



Elements of this model were evident with the WHCSSPN. For example, the collaborative structures and the richness of the collaboration helped this group to create a common vision for the health and wellness of the community. Sharing resources, time and energy helped this group to tackle some complex issues and design a response that best met the community needs. For example, this group addressed family violence and sexual abuse by providing the frontline

workers with training necessary to work with their clients. This group also undertook a consultation process with the community to develop a sexual abuse prevention program which later become known as the Naandwedidaa (Helping each other heal) Program. This program went through many developmental phases in its 22year history and is now known as the Community Wellness Program. The original coordinator of the Naandwedidaa program is now the Community Wellness Worker (Personal communication, 2017).

My interest in collaborative care stemmed from this experience. Part of what I wanted to do with my PhD was to research other programs and compare them to the WHCSSPN. My idea was to develop some Aboriginal specific practices that would be viewed as 'promising practices' and could help to inform the development of other Aboriginal mental health programs.

1.5.4 Cultural Safety and Mental Health

I had been interested in the concept of cultural safety since beginning my work at the Indigenous Social Work Program at Laurentian University. My first encounter with (or lack of) cultural safety was when I was researching Cedar Baths as a treatment modality. The Research Ethics Board (REB) did not fully understand what Cedar Bath was about so denied the ethics proposal. The REB asked questions like: How deep was the water; how hot was the water; how many people in the bath at the same time; and did they have clothes on? This was both very devastating and humorous at the same time. We (me, my colleagues and the traditional healers) put together some information on Cedar Bath and answered the questions. Fortunately, we were able to convince the REB that Cedar Bath was not an intrusive procedure and that there would be minimal harm from engaging in this ceremonial practice. This struggle is one that many Indigenous peoples face regularly due to lack of understanding of cultural practices. It requires additional time and effort to explain ceremonies (that have been conducted from time

immemorial) in a way that protects the sacredness of the ceremony while providing enough context for non-Indigenous people to grasp the concepts behinds these ceremonies. For example, there are four sacred medicines that are used in traditional ceremonies by Anishinaabe people - cedar, sage, sweet grass and tobacco. Cedar and sage are considered the women's medicines and sweet grass and tobacco are the men's medicines. Cedar is used in cleansing and purification ceremonies. One ceremony where cedar is used is in the cedar bath. Among its many applications, cedar bath can be used to welcome a baby into this world, to purify and protect the body, to help in inner-child work and in death to prepare the body for its journey back to the spirit world. Cedar bath is also used in the healing of all types of trauma (family violence sexual abuse, verbal abuse, mental abuse, emotional abuse, physical abuse and spiritual abuse) (Manitowabi & Gauthier-Frohlick, 2012).

The Cedar Bath, as used in this project, was a symbolic cleansing of the body. For the participants, this involved washing away of all the hurts and pains that they carried, letting go of past traumas and replacing traumatic experiences with forgiveness and self-affirming behaviours. Cedar Bath allows the person to begin the change process, to move forward thus creating a sense of empowerment that leads them to take charge of their own recovery and growth. During this process, participants re-live trauma head-on so it is essential to establish a safe, nurturing environment (Manitowabi & Gauthier-Frohlick, 2012).

The idea of cultural safety originated with the Maori nursing program in Aetearoa (New Zealand) (Ramsden, 2003: Ramsden, 1993). Cultural safety provides a framework to examine unequal power relations from the perspective of the patient/client and the social and historical processes that organize these relationships (Koptie, 2009: Ramsden, 2003; Smye & Brown, 2002; Ramsden 1993). By doing this, discussions can occur about whether the current health

system benefits or places Aboriginal people at greater risk. Since its inception in the early 1990s, the concept of cultural safety has gained momentum in Canada and is used in a variety of settings such as education, medicine, child welfare, corrections, and mental health.

Cultural safety, a term that originated with nursing students in Aotearoa (New Zealand), recognizes the social, economic, and political position of certain groups within a society (Smye & Brown 2002). Cultural safety reminds us that we need to reflect on the ways in which policies, research and practices may recreate trauma. According to Smye and Brown (2002), the concept of cultural safety is used to inform moral questions about the 'rightness' of policy decisions and actions initiated in the dominant health sector as they relate to Aboriginal populations.

Cultural safety provides a framework for examining unequal power relations and the social and historical processes that organize these relationships (Smye & Brown, 2002). For example, how is the notion of culture used to address meanings that Aboriginal people give to mental health? How does the current health system benefit Aboriginal peoples or does it place them at greater risk? Cultural safety allows for a critique of issues of institutional racism and discrimination to occur with respect to the health care system.

The notion of cultural safety challenges researchers to use reflexivity in the research process so that moral, ethical questions are answered, and that research is conducted in a manner that does not create a culturally unsafe situation (situations that diminish, demean or disempower people) (Cooney, 1994). For research to be effective, participants need to feel safe to participate. In designing programs for Aboriginal people, it would also be important to incorporate cultural safety so that the programs can be effective in addressing the issues faced by Aboriginal people.

Cultural safety alone does not ensure safe service delivery. Indigenous people understand that in order to build good relationships with people they must operate from a place of cultural humility. According to Chavez (2012) cultural humility is a multi-dimensional concept that recognizes lifelong learning, critical self reflection, mitigates power imbalances and challenges institutions to do better. Key to cultural humility is the notion of humility and through self reflection realizing that one doesn't know everything there is to know and the best way to address this is to ask appropriate questions. Institutions also need to be self reflective and respond appropriately (FNHA, n.d.). Anishinaabek people respond well to the concept of cultural humility since humility is one of the seven grandfather teachings that provides guidance for how to live life. Benton-Banai (1988) describes humility as knowing your place as a sacred part of creation. Being humble means to live life selflessly, respecting your place, carrying yourself with pride, lifting others up through praise, and finding balance in life. One demonstrates humility by recognizing the importance of all life and showing compassion, care and concern for all of creation.

In the dominant society, the focus of mental health policy and programs is on serious mental illness (SMI) with mental health problems being thought of as medically defined disorders. Many Aboriginal care givers and policy analysts feel it is more appropriate to focus on mental health issues which are posing the most serious threat to the survival and health of Aboriginal communities such as alcohol and drug abuse and family violence. Root causes of mental health issues need to be adequately addressed. Spiritual and traditional ways of life need to be fully explored.

Evidence exists that Aboriginal peoples struggle with accessing culturally safe and appropriate mental health care. In my view, western therapeutic concepts of mental health and mental illnesses are largely ineffective in responding to the needs of Aboriginal people as the mental health system

remains aligned with an illness service delivery model (Smye & Brown, 2002) which does not fully reflect the holistic approaches of Aboriginal traditions and ignores Aboriginal perspectives and knowledge. Many Aboriginal individuals do not access the dominant society's mental health services (Marsh et al., 2015) and out of those who do, approximately 50% drop out (Smye & Mussell, 2001; Sue, 1981). This is because mental health programs and services are designed in keeping with the dominant cultural views of mental health and mental illness and ignore the unique cultural identities, histories, and sociopolitical contexts of Aboriginal people's everyday lives (Smylie et al, 2011; Poonwassie & Charter, 2005; Hill, 2003; Smye & Mussel, 2001). This puts them as risk of not having their mental health needs met. According to Hummeel (2001), culture is an important component of health thus it is also important that health care be culturally appropriate. While culturally appropriate care is important, it is equally important to provide a balance of Western and traditional mental health care for the simple reason that due to colonial history some First Nations individuals/communities still require/want Western mental health services. Culturally appropriate care means that care providers are responding to the diverse care needs of clients and their families by becoming aware of their culture, including their traditions, history, values, and family systems (Webb, 2008).

Is settling for culturally appropriate the right thing to do? It is a step in the right direction. But are there other ways of working in health care with culturally diverse groups and communities that are respectful and avoids stereotyping? How does one balance western and traditional care given that many First Nation communities have similar colonial histories yet the degree to which each community is integrated into western varies from one community to the next? How does one accomplish the need to provide a balance of Western and traditional mental health care? One way to do this is through culturally connected care. Culturally connected care means that the principles

and techniques of health literacy are combined with cultural humility allowing care providers to work together with their clients to develop a shared understanding of each other's values, beliefs, needs, and priorities (Population Health Promotion BC Women's Hospital, n.d.).

What is needed is the development of culturally relevant/safe, integrated mental health services which are strengths based that complete the "circle of care" (Smye & Mussell, 2001). Mental health services need to be respectful of the diverse 'cultures' of individuals, families and communities. Within and across Aboriginal communities there exists diversity in terms of language, values, beliefs and way of life that is a result of the impacts of colonization and assimilationist policies. There exists a cultural continuum upon which Aboriginal peoples may identify with that ranges from very contemporary to very traditional. Mental health programs need to attend to this issue of cultural diversity. The consumer must be actively involved in defining the services that they receive (Richardson & Carryer 2005).

In terms of policy development, steps need to be taken to prepare practitioners (Aboriginal and non-Aboriginal) with the knowledge and skills needed to promote holistic wellness for individuals, families and communities. Kirby (2006), in his report, "Out of the Shadows at Last," highlighted the need for accredited frontline workers in Aboriginal communities. Both the Mental Health Commission and the Aboriginal Mental Health Framework for Alberta (Alberta Health Services, 2006) highlighted the need to partner with educational institutes to provide accredited, specialized training programs to prepare frontline workers to work in Aboriginal communities. For example, the Indigenous Social Work Program offered through the School of Indigenous Relations at Laurentian University in Sudbury has been preparing social work students to work in Aboriginal communities since 1988. Students enrolled in this program learn a blend of Indigenous healing methods and western theoretical approaches to healing that prepare them to work with Indigenous

clients wherever they are on the continuum from being very traditional to being very contemporary in their belief systems. Other universities are following suit such as the University of Manitoba that offer a Master of Social Work in Indigenous Knowledge (MSW-IK) and Wilfred Laurier University that offers a Masters and PhD program that focuses on Indigenous pedagogy.

Jurisdictional debates by federal and provincial governments affect the ability of communities to offer integrated services and programs blocking forward movements on mental health concerns. Integration supports the retention of cultural distinctiveness and uniqueness. The Kirby Report, called for "more integrated models of funding between federal departments to support more comprehensive programs that could be sustained over the long term" (2006, 13.1.3.2). It should be noted that while additional funds are needed to create these integrated services and programs, what governments fail to recognize and address are the real issues underlying the need for said services.

1.5.5 Indigenous Knowledge

I grew up at Wigwaskinaga, Whitefish River First Nation on Manitoulin Island. My first memories were about the community gatherings/celebration and community meetings. My grandfather had been chief of the community for 35 years. I recall sitting on the floor listening to the deliberations of the chief and council and the community members. It was a very peaceful, protected place to be, to know that the community was taking care of us. Much later, in my adult life, I recalled this memory, thinking that it was now my turn to look after the community. Such is the circle of life. I mention this because of the relationships that Aboriginal peoples have with themselves, their community and all that is around them which brings me to my point. Indigenous knowledge is very much about relationships – it is relational in nature.

Western academics have a difficult time acknowledging Indigenous ways of knowing as equally valid and therefore don't fully accept that there are alternate ways of knowing (Stewart, 2009). Indigenous knowledge comes from the people and the relationship that people have to their environment and all that surrounds them – seen and unseen. Knowledge is transmitted from one person to another, one generation to the next. There are lessons in every tree, plant, water, insect, animal life and the elements. Knowledge comes from everywhere - it comes from experiences, teachings, ceremonies, dreams, and visions.

To take this further, Indigenous methodologies are often not perceived as valid forms of knowledge production within western science. Indigenous academics are challenging this notion. For example, Smith (1999) states that communities' values, beliefs, practices and customs are regarded as 'barriers' to research or as "exotic customs" that one needs to become familiar with so that research can occur without creating offence (p. 15). Aboriginal researchers see the cultural protocols, values and behaviours as an integral part of the methodology (Stewart 2009, Kenny et al 2004, Smith 1999). Smith (1999) states that 'reporting back' to the people and 'sharing knowledge' assumes a principle of reciprocity and feedback that acknowledges the contributions of the people who were part of the research (p. 15) which contributes to a relational methodology.

1.5.6 Relational Worldview

The term worldview refers to the collective thought process of a people or culture (Teaching Treaties, n.d.). Authors such as Cross (2010) and Blackstock (2011) refer to a 'relational worldview' which views life as a harmonious relationship between many interrelating factors in one's circle of life.

One way to understand Indigenous worldview is through the Medicine Wheel teachings. The Medicine Wheel teachings provide guidance about how one should live their life. The Medicine Wheel is made up of 4 directions – Waabaanong (East), Zhawaanong (South), Epingiishmag (West) and Giiwedinong (North). Each of these four directions contain teachings about life and the need to balance all four aspects of the being – mental, emotional, physical and spiritual.

On the Medicine Wheel, Waabaanong (the east) represents new beginnings, new life, birth, food and spring (Nabigon, 2006). Beginning to know and understand one another is reflected in the eastern direction.

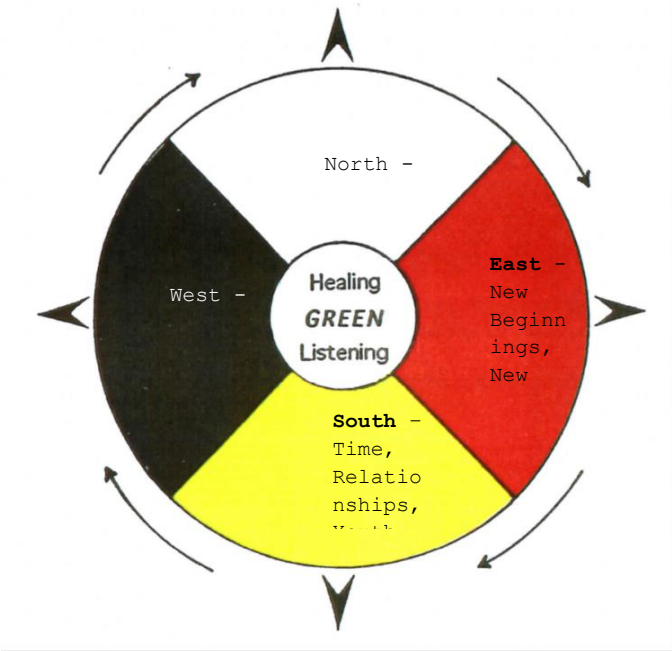


Figure 4 - Medicine Wheel - The Hub – adapted from Herb Nabigon-ba

The teachings of Zhawaanong (the south) includes time, relationships, youth, and patience. Time is needed to engage the community as full participants in the research process. The scope of the project that I had intended to undertake would have taken considerable time to develop. I would have needed to visit the community agencies and discuss the idea with them and then garner support from the chief and council to undertake this project. Time would have been needed to

develop the ideas behind this project. Time is represented in the southern direction on the Medicine Wheel. Time takes patience. It takes patience to build relationships (Nabigon, 2006).

The teaching that lies in Epingiishmag (the western) direction is one of respect (Nabigon, 2006). According to Nabigon (2006), respect comes from the English language, and it is made up of two words – 're' meaning again and 'spect' meaning to look at. So, in order to have 'respect' one must be able to look a second time. The first time we meet someone there are always first impressions, these may or may not be positive. Getting to know someone means setting aside our first impressions of them. Thus, in order to respect the community, it is important to get to know them and to understand what their needs are. This is where a discussion about the appropriateness of the research question comes into play. The community needs to be the one that drives the research process.

The teaching of Giiwedinong (the North) is one of caring (Nabigon, 2006). It matters that the community sees the research as having some importance. Again, to discover whether the research matters to the community takes time and effort.

The teachings shared above were related to me from Herb Nabigon-ba. Although his teachings describe the Cree concept of the Medicine Wheel the core values underlying this version of the Medicine Wheel are similar for Ojibwa people (of which I am one). This version of the Medicine Wheel describes one way in which people are to conduct their lives. There are many teachings that are in existence. The important lesson is that the core foundational values are similar and that the ultimate goal is to achieve mino-bimaadiziwin (the good life), which is a balance of all aspects of the being and of the inner and outer environment. This is really about the relational worldview that I referred to at the beginning of this section.

After taking time to consider this relational worldview I came to realize that the documentation of the history and development of mental health programs on Manitoulin Island would be a huge undertaking, one that couldn't possibly fit into the timelines for doing my PhD research. I would have to reconsider the proposed project that I would undertake.

1.6 A new opportunity presents itself

Earlier in this chapter I reflected on how I came to start on my journey towards getting my PhD in Rural and Northern Health and that it was not by accident that I came to be enrolled in the program. As I started out on this journey, I was pretty sure that my goal was to document the history and development of the Nadmadwin Mental Health Program, but something happened during that year that would change the research that I was to undertake. To explain this, I need to take us back to the year 2001 and describe some of the events that occurred at that time with respect to First Nations mental health services in the Sudbury area and the communities serviced by the Northeast Mental Health Centre

In 2001, myself, Daniel Manitowabi (Clinic Manager of the First Nation Mental Health Development Initiative, Northeast Mental Health Centre) Dr. Brenda Restoule (Psychologist – First Mental Health Development Initiative) put together a proposal for a Community Resource Team which, unfortunately, did not get funded. In 2008, Health Canada approached Dr. Restoule about putting together a Mental Wellness Team proposal based on the Community

Resource Team proposal that had previously been submitted. Both Daniel Manitowabi and I were invited to be part of the planning team for this Mental Wellness Team project.

The Mental Wellness Team Project was approved and officially launched in March 2010. Since this was a pilot project the steering committee decided that the project needed to have an evaluation component. It was about the same time that I had finished my course work in the Rural and Northern Health PhD program so I approached the team and asked if there was something that I could do to assist with the evaluation. It was suggested that I do some work on the engagement process as this is an area that Health Canada seemed to be interested in. I had to remove myself from the steering committee and re-establish a relationship with this group as a researcher.

I prepared a brief report outlining what I proposed to do with my research and presented it to an evaluation subcommittee of the MWT steering committee. The main goals for this research project were to utilize a culturally appropriate evaluation framework to evaluate how the MWT pilot project maintains the engagement process and support of the participating First Nations communities. The research examined four aspects of the Mental Wellness Team pilot project engagement process:

1. How the MWT pilot project maintains the engagement and support of the 10 participating First Nation communities,
2. Collaboration within and across communities and with key partners,
3. The integration of mainstream and traditional approaches by the Mental Wellness Team (MWT) pilot project, and,

4. The impact on the capacity building and knowledge at the community level.

The work plan for this project is presented in Appendix 7.

This evaluation subcommittee provided some feedback which I used to help with my submission to ethics. And we were off… I had to submit an ethics application to both the Laurentian Research Ethics Board and to the Manitoulin Anishinaabek Research Review Committee (MARRC). The application to MARRC was necessary since the proposed project involved several First Nations communities from Manitoulin Island, the North Shore and Waabnoong Bemwijaang Tribal Council. I also submitted a proposal to the Network for Aboriginal Mental Health Research (NAMHR) and received a small grant of $5000 for this project (see appendix 8). This covered travel during my first year and transcription of data.

For the purposes of this research the following are key concepts: engagement, support, collaboration, mainstream, traditional, capacity building and knowledge will be defined here.

Engagement

The term engage can have many different meanings but for the purposes of this thesis the term will be used as a verb – to involve (Merriam-Webster, 2019). For example, how is the MWT involved with the First Nation communities, the leadership, and the frontline workers? According to Meriam-Webster (2019), engagement refers to a state of being engaged. In other words, how does the MWT establish meaningful contact or connection with the First Nation communities, the leadership, and the frontline workers? (Meriam-Webster, 2019).

Support

Meriam-Webster (2019) describes support as "to promote the interests or cause of" (n.p.), to advocate, assist, help, etc. Support is reciprocal in nature. At the start of the MWT project, the First Nations communities indicated their support for the project by providing Band Council Resolutions. The MWT team needed to work to ensure that the First Nations communities continued in their commitment and participation in the project by engaging in relationship building activities.

Collaboration

The word collaborate has several meanings: "to work jointly with others or together" (Meriam-Webster, 2019, n.p.) or "to cooperate with an agency or instrumentality with which one is not immediately connected" (Meriam-Webster, 2019, n.p.). For the MWT pilot project, there were many collaborators – the First Nation leadership, the frontline workers, the steering committee, the MWT staff, other First Nation agencies as well as other health authorities (Noojmowin-Teg and M'Namodzawin Health Services). Although the First Nations communities supported the project through Band Council Resolutions, the MWT staff were tasked with further building the relationship with each of these communities.

Mainstream

The term 'mainstream', as used in this thesis refers to mainstream healing approaches. 'Mainstream' is often used to describe the current dominant paradigm operating in the North American context. Wilson (2008) describes a paradigm as a set of values or beliefs that guide one's actions in the world. According to Stewart (2007), the current dominant paradigm is based on specific social norms, ethical values, customs, artefacts and technologies of European settlers

and their descendants which then inform various aspects of historical and contemporary North American tradition, custom, practice, and thought. So, for this thesis, mainstream healing approaches are based on western, scientific concepts.

Traditional

The term 'traditional' as used in this thesis refers to traditional healing approaches. The Royal Commission on Aboriginal Peoples (1996) summarizes some of principal elements associated with the term and practice of traditional healing approaches: traditional practices are designed to promote mental, physical, emotional and spiritual well-being; these practices are based on Indigenous beliefs which pre-existed western 'scientific' biomedicine; healing practices include a wide range of activities, from physical cures to use of ceremony, traditional counselling and access to elders.

Capacity Building

The Government of Ontario (2015) states that capacity building forms the foundation for economic development. Building capacity means that the community has the economic development institutions, tools and staff needed to achieve its community economic development goals. With respect to the MWT pilot project, capacity building refers to the skills and resources that the community needs to be able to manage their own mental health and addictions programs. This can refer to professional development and access to specialized services.

Knowledge

In this thesis, the term knowledge refers to Indigenous ways of knowing. Brant-Castellano (2000) describes three different sources of Aboriginal knowledge - traditional, empirical, and

revealed knowledge. Traditional knowledge is knowledge that has been passed down from one generation to another that teach about creation stories, genealogies, ancestral rights, and a nation's values and beliefs. Empirical knowledge is gained through observation whereas revealed knowledge is more spiritual in nature being received through dreams, visions, and intuition. According to Brant-Castellano (2000), "Aboriginal knowledge is said to be personal, oral, experiential, holistic, and conveyed in narrative or metaphorical language" (p. 25) and, more importantly, unique to the individual. Aboriginal knowledge recognizes that there are many ways of knowing and there are diverse ways of creating and obtaining knowledge. Further, Wilson (2008) asserts that knowledge is relational meaning that it is created in relationship with other entities (other than humans, animal and plant life, the ancestors, the spirits and the cosmos) and because of this knowledge cannot be owned, only shared. In contrast, Western scientific notions of knowledge are based on the search and acquisition of objective truth. For the purposes of this thesis, knowledge refers to all sources of knowledge gained through the established relationships between the MWT and partnering communities.

1.7 A Change in Plan

After the first year of data collection, a second round of focus groups was proposed. There were two reasons for this. The first round of focus groups did not generate enough data and, secondly, the community-based researchers hired to conduct the overall review of the project required further data that could be collected most efficiently through the use of focus groups. The community-based researchers and I met with the evaluation subcommittee to discuss how best to

accomplish this. It was decided that I would partner with the community-based researchers and we would co-facilitate the focus group sessions. In order to have both our needs met with the focus groups we had to re-design the focus group questions to ensure that we were both capturing the information that we required. It was a great experience working with the community-based researchers. This did not change the overall research goal but rather it was a new approach to collecting the research data than was originally established,

1.8 Conclusion

This chapter highlighted some of the struggles (personal and otherwise) that I encountered on my PhD journey. One of the biggest struggles was maintaining my sense of identity as an Anishinaabe-Kwe within a western academic institution. Another struggle was finding my voice as an Anishinaabe-kwe and paving the way for other Indigenous women to pursue higher education. The next struggle was paring down what had become a huge project into something that was manageable while staying true to my original vision for what I wanted to accomplish on my journey. This chapter also highlighted some struggles related to Aboriginal mental health – how mental health is defined, challenges related to lack of resources, culturally inappropriate services that increase difficulty in access, geographical issues, poor coordination and planning as well as stigma and discrimination. Lastly, this journey is about challenging western academic traditions through the use of Indigenous methodologies such as storytelling, the Medicine Wheel and relational worldview.

Upon reflection, this journey towards my PhD has started out years ago. I am coming complete circle around the Medicine Wheel. As a child I knew and understood the safety of being in a loving community even though we did not have many material possessions. We had the love and caring of our families and communities. Our encounters with the colonial government with

actions such as the imposition of the Indian Act, the residential school system and the changes to welfare legislation allowing for children's aid society workers to enter Aboriginal communities and remove Aboriginal children from their families and communities have had a devastating effect on the mental health and wellness of Aboriginal communities.

My family was not exempt from these devastating effects. My mother having attended residential school, refused to speak about that incident but it forever had a lasting impression on her. She was wise in insisting that we go to school. She viewed this as one way to counter the negative effects of her experience. Being educated and being able to speak English would give us a leg up and help us to survive in this world, so she thought. Missing from this was our language and culture, two important pieces that form our identity. But all was not lost because as a family we picked these up before they were totally lost from us.

As a young mother I dreamt about standing before a group of people and sharing with them the knowledge that I carried. It was not in a circle but in a large classroom. For many years I worked in health, then the addictions field and then in mental health. I thought that my ultimate goal was to become a health promotion educator. While working in mental health, I realized that I needed to return to school to get my social work degree. I have a degree in sociology and a minor in Native Studies, but I didn't feel that those degrees had prepared me for my work in the mental health field. I completed my degree in social work while working for Northeast Mental Health Centre as the Aboriginal Mental Health Development Initiative Researcher. I took a leave from my work with Northeast Mental Health Centre to complete my Master's in Social Work at University of Toronto. Upon my return, I learned that I was the last member of the Aboriginal Mental Health Development Initiative and that I was to be the point person. Not sure of what a point person was or if I even liked the idea, I asked Creator "If I get a call in the next few

minutes from someone offering me a job, I will take it". Just as I finished that thought, my phone rang, and it was my partner saying to me that someone from Laurentian University called to see if I would be interested in teaching. I called back and went for an interview and was successful in landing the position. That fulfilled my dream about speaking in front of the group of people sharing my knowledge.

In many respects, Anishinaabe-Kweok, like myself, are still challenged within western academic institutions. I also believe that my experiences in life have led me to this place. I have been fortunate to work in the fields of health, addictions and mental health. All these experiences have helped to prepare me for my next leg of my journey. It is these experiences that I am building upon that have informed my PhD thesis. I am also incorporating personal learnings about life, ceremonies, teachings, and stories into the thesis. I hope that the findings from this work will help benefit my community in some way.

Chapter Two: The Mental Wellness Team Approach to Mental Health and Addiction Services.

This chapter examines the development of mental health services in the Sudbury/Manitoulin First Nations Area and, in particular, the vision of a First Nations approach to mental health and addictions for Sudbury/Manitoulin that led to the development of the Mental Wellness Team Pilot Project. Further, this chapter begins with a literature review that explores the historical experiences that have contributed to the current situations that Indigenous peoples find themselves in and the connection of these situations to the mental health and addictions issues that are reflective of current reality in Indigenous communities. Interwoven in this chapter are the struggles that First Nations communities have experienced in self determining what mental health services are appropriate to address their specific needs. The chapter ends with an overview of the Raising the Spirit MWT.

2.1 Introduction

The significant mental health disparities that exist between Indigenous and non-Indigenous Canadians are best understood through the examination of the unique historical experiences of Indigenous communities. Indigenous peoples have experienced collective trauma and cultural disruption as a result of colonial policies that systematically dispossessed them from their land and weakened their social and political institutions (Keilland & Simeone, 2014) and have eroded traditional cultural practices, family structures, and community support networks (Mussell, Cardiff, & White (2004). This has contributed to the social and economic marginalization of Indigenous people, who have long experienced poorer mental health outcomes – such as high rates of depression, anxiety, substance abuse, and suicide that can be many times greater than the rates in the general population (Keilland & Simeone, 2014; Mussell, Cardiff and White, 2004).

The most visible impacts of colonization are seen in the multi-generational effects of the residential school system (Keilland & Simeone, 2014).

According to the Truth and Reconciliation Commission of Canada (TRCC), Indian Residential Schools (IRS) operated in Canada from the late 1800s through to the late 1960s, with the last school closing in 1996. The residential schools were developed with the purpose of removing and isolating First Nations, Inuit and Métis children from their families and communities in order to assimilate them into the dominant culture. Bull (1991) indicates that the widespread exposure to physical, sexual and emotional abuse to Indigenous children while in the residential schools was perpetuated on their own community members upon return to their communities. This served to undermine the safety and security of traditional cultural and community organization, and in particular the role of elders. The residential school system also resulted in intense cultural suppression (Haig-Brown, 1988; Grant, 1996; Chrisjohn and Young, 1997). Children were punished for speaking their language or practicing their traditions resulting in the loss of culture and language which made it difficult for children to connect with family and community upon their return home and to participate in traditional activities. Many children found themselves in marginalized positions neither fully accepted in their own communities nor in mainstream society (Kirmayer et al, 2007). The emotional, physical and sexual abuse, the internalized behaviours and the racism and discrimination that Aboriginal people were subjected to have all had lasting effects on the collective sense of identity and belonging of Aboriginal people (Kirmayer et al, 2007) and, in particular, the youth who find it difficult to form a positive identity and to find their way in the world. Browne, McDonald and Elliott (2009) attributed mental health issues to the erosion of Aboriginal culture and values contributing to socio-economic marginalization and loss of self-esteem.

Indigenous peoples in Canada are countering these poor mental health outcomes by creating innovative approaches to healing and wellness that promote the importance of cultural identity and self-determination while braiding traditional knowledge systems and the wisdom of elders with non-indigenous approaches. Indigenous mental health programs also recognize the close relationship between mental health, addictions, and inter-generational trauma. More recently, Indigenous mental health programs have adapted the concept and practice of cultural safety. The concept of cultural safety, an educational framework that analyzes power relationships, originated in New Zealand among Maori nurses who were dissatisfied with the way in which nursing services were delivered (Health Canada, 2015; Koptie, 2009: Ramsden, 2003). Cultural safety moves beyond cultural awareness and sensitivity to cultural competence to focus on the skills, knowledge and attitudes of practitioners (Ramsden, 2003) allowing the client to determine what culturally safe service is for them. The concept of cultural safety not only helps to improve the health outcomes of Indigenous peoples but can also transform the broader health system to respond more appropriately to the diverse cultural needs by drawing attention to the need to critically assess approaches to mental health and mental illness and to find ways to address power imbalances and inequities.

The factors that influence mental health are complex and are further complicated by the legacy of colonization (Keilland & Simeone, 2014). It is difficult to disentangle the impact of colonization on health and mental health especially when one considers these issues from an intersectionality point of view. Health, including mental health is determined by what is commonly referred to as the social determinants of health - contextual factors that interact with social and economic factors, the physical environment and individual behaviour (Keilland & Simeone, 2014) which influence health outcomes and help to determine an individual's overall

health status. Community infrastructure, access to resources, political context as well as the social environment in which the people live all influence an individual's mental health (Keilland & Simeone, 2014). While the federal government continues to play a key role in the health and mental health of Indigenous peoples, Indigenous communities and organizations are exerting greater control over the delivery of mental health services in their respective areas.

2.2 The Mental Health of Indigenous People in Canada

The World Health Organization defines health as "a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity…" (WHO, 1978, n.p.). The Declaration of Alma-Ata prompted the movement towards a focus on the social determinants of health that characterizes the health care system as we know it in Canada. This view of health is not so different from how Indigenous people view health. For Indigenous people, health is viewed from a holistic perspective often conceptualized through the Medicine Wheel including all aspects of the physical, emotional, mental and spiritual wellbeing (Mushquash, C. 2014; Mussel et al., 1993). In order to achieve a state of health, the individual must be balanced in all aspects of their being. It should be noted that mainstream society has been moving toward adopting a more holistic perspective.

Mental health and mental wellness are often viewed as being the same, however, there are some distinct differences between these terms. The World Health Organization definition of mental health is as follows:

> "a state of well-being in which the individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his own community" (WHO, 2014).

According to Keyes (2002), mental health is not simply the absence of mental illness nor does it refer to merely the presence of high levels of subjective well-being. Keyes views mental health as a "complete state consisting of the presence or absence of mental illness and mental health symptoms" (p. 210). Mental health exists across a continuum of complete or ***flourishing*** (high levels of well-being) and incomplete or ***languishing*** (low levels of well-being) levels of mental health (Keyes, 2002). Viewed in this manner, mental health is a broader, positive term associated with wellbeing, inherent strengths, and functioning in life.

Indigenous peoples understand mental health and wellness from a holistic perspective. Mental health is viewed as a lifelong journey towards a state of mental well-being. The First Nation Mental Wellness Continuum Framework (FNMWCF) (2015) identifies that mental wellness is achieved when there is a balance between each of the four aspects of life - mental, physical, emotional and spiritual (p. 4). According to Dell et al (2011), in addition to the focus on achieving balance of spirit, heart, mind and physical being, the incorporation of community relations is key to development of mental wellness. Mental wellness includes belief in one's connection to language, land, and beings of creation, as well as ancestry, and being supported by a caring family and environment (Restoule, Hopkins, Robinson & Wiebe, 2015). The key task for mental wellness is facilitating connections across individual, family and community levels and across the four aspects of life (p.4). The balance between the four aspects of life is enriched when people have purpose, hope, belonging and meaning (Restoule, Hopkins, Robinson & Wiebe, 2015). This allows them the ability to function effectively, deal with new challenges, realize potential, cope with normal stresses, and are able to contribute to their community (Minister of Health, 2015).

The report by Romanow (2002), *Building on Values: The Future of Health Care in Canada* reaffirmed what many health status reports indicated that "the general health status of Aboriginal peoples is better today than it was 50 or even 10 years ago primarily because of the noticeable improvements in living conditions and continued investment in disease prevention and public health (p. 218). However, Aboriginal Canadians fare more poorly than the general population and chronic disease is significantly higher (National Collaborating Centre on Aboriginal Health, 2013; Minore & Katt, 2007; Mitchell & Maracle, 2005). Kirby (2006) acknowledged that even though there are multiple reports and funding provided for human and financial resources, Aboriginal people continue to be at serious risk for mental health issues. Even though mental health programs such as National Native Alcohol and Drug Addiction Programs (NNADAP) and the Aboriginal Healing and Wellness Strategy (AHWS) exist even in the remotest Aboriginal communities, significant gaps in mental health and addictions programming between Aboriginal and non-Aboriginal peoples continues to exist and remain seriously under-developed. (NELHIN, 2011: Warry, 2000; RCAP 1996).

More recently, the Truth and Reconciliation Commission of Canada (TRCC) (2015), compared First Nation people to the general population, and found that First Nations people were six times more likely to suffer alcohol-related deaths, more than three times more likely to suffer drug-induced deaths and the overall suicide rate being about twice that of the total Canadian population. Suicide rates for Aboriginal youth ages ten to twenty-nine are five to six times greater than non-Aboriginal youth. The TRCC and recent actions by the Liberal Government have instilled a sense of hope in Indigenous peoples throughout Canada as there seems to be more action directed at closing the social, health and economic gaps between Aboriginal and non-Aboriginal Canadians (TRCC, 2015, p 125).

Over the last 20 years, there has been a shift in the policies guiding and structuring health care delivery to Indigenous people in Canada. First Nations communities apply for and renegotiate their health transfer agreements every 5 years. This has increased the decision-making capacity at the community level as First Nations communities are more actively engaged in the design, management and control of their own health services (Minore & Katt, 2007). According to Chandler and Lalonde (1998) First Nation communities that have exercised their rights to self-government by taking control over education, police, fire and health services have taken steps to secure aboriginal title to their traditional lands; and have officially recognized "cultural facilities" to help preserve and enrich their cultural lives saw reduction in their communities' overall suicide rates.

According to Manitowabi and Maar (2018), First Nations communities are under the false impression that they control how services are managed in their communities when in reality the government maintains indirect control over services by stipulating how programs should operate. In effect, First Nations communities remain at a loss in terms of self-determination and economic dependence. Nevertheless, First Nations must continue to advocate for more control of their political and social circumstances if they are going to address the ongoing colonialism perpetuated by current government policies. Having stated that, it is not sufficient to just have control over the delivery of services in First Nations communities, greater structural change is required at all levels of government.

The federal government's announcement in March 2007 for the establishment of a Mental Health Commission of Canada was a first step towards the goal of a national strategy on mental illness. The establishment of the Mental Health Commission of Canada along with the development of an Aboriginal Mental Health Framework brought hope for the flow of additional funds to First

Nations communities for mental health programming (IIMHL Conference 2006, Kirby & Keon 2006, Schizophrenia Society of Canada, 2016). More recently, the Truth and Reconciliation Commission of Canada (2016), calls for reconciliation and constructive action to address the destructive impacts that colonization has had on Indigenous peoples' health as well as on education, cultures and languages, child welfare, the administration of justice, and economic opportunities. The announcement of the national strategy, the influx of funding for mental health programming and the calls to action from the Truth and Reconciliation Commission are all good but these are not sufficient to deal with the mental health crises facing Indigenous peoples. These words need to be put into action.

2.3 The Demography of Indigenous People in Canada (Statistics Canada, 2006)

How does the demography affect the delivery of Indigenous mental health service? This section describes some of the challenges faced with respect to collection of data.

There has been a significant increase in the quantity and quality of Aboriginal health data over the last several decades, yet gaps and challenges still exist in the reporting of Aboriginal health data. For example, Statistics Canada routinely surveys on a wide variety of health issues. Until 2006, Statistics Canada collected census data on Indigenous people through the census long form which provided Indigenous data on almost all census subdivisions, some census divisions and some census metropolitan areas (Smylie and Firestone, 2015). Although this information contained many gaps in information it was a reliable source of information that could be used to track demographics on First Nations people and the information collected was consistent from census to census. The Aboriginal Peoples Survey (APS), introduced in 1991 by Statistics Canada, was a significant step forward in collection of health data for the off-reserve Aboriginal population. The First Nations Regional Longitudinal Health Survey (FNRLHS) has provided a

wealth of new information for the on-reserve population but did not collect data on First Nations people off reserve, Inuit or Métis people.

When the census long form was discontinued by the Harper Government in 2006, information on Aboriginal peoples was collected using the First Nations Regional Longitudinal Health Survey (RHS) (Kilpatrick, 2017). Initially, the RHS only collected data on First Nations people but when the census long form was discontinued, the RHS was adapted to collect data on all Aboriginal peoples. The issue with that was that there was no consistent data collection source that could be used to compare data. The Census long form was reinstated in 2016 (Kilpatrick, 2017).

First Nations communities are recognizing the importance of data collected through the census as a planning and development tool to aid in raising awareness of pressing social needs (Globe and Mail, 2016). More First Nations communities are participating in the Census, but others are still leery about the reasons the government is collecting information and whether the information collected will result in benefits for their people. Other First Nations stand by the position that they are sovereign Indigenous nations who do not derive their citizenship from Canada.

> "Many community members simply don't believe they are part of Canada and therefore didn't feel comfortable participating in a Canadian census. However, as a council and organization, we understand the relationship between accurate statistics and funding for programs, services and infrastructure ... so we have educated our membership on those positive benefits." (Grand Chief Abram Benedict – Globe and Mail, 2016)

The under-reporting of people living off-reserve makes it difficult for detailed analysis since the numbers are too insignificant (Loppie, Reading, & Wein, 2009). The gaps in the survey

information are due to differences in surveys, methodologies, terminology, Aboriginal affiliation/ethnicity, jurisdictional issues, reporting standards, mobility and relocation between communities (northern and southern communities) and failure to include culturally relevant health measures that reflect Indigenous perspectives. This makes it is difficult to report comparable data on all the different Indigenous groups since no organized health data collection system for Indigenous peoples in Canada and no way to provide a complete picture of all their health care issues (National Collaborating Centre for Health, 2013). Mobility between communities makes it difficult to track the care and health status of individuals who need to receive acute care needs outside of their communities.

The movement towards Indigenous data sovereignty attempts to address the issues highlighted above. According to Walker et.al. (2018), Indigenous data sovereignty "highlights the importance of data governance and research processes that are Indigenous led" (n.p.) In Ontario, the Chiefs of Ontario (COO) and the Institute for Clinical Evaluative Sciences (ICES) worked collaboratively to develop a data governance agreement (DGA) to facilitate First Nations-engaged research that utilizes Indigenous data sovereignty principles as defined by Ownership, Control, Access and Possession (OCAP) principles. These principles were established in the early 1990s by First Nations communities to ensure that their collective rights to control the collection, use and storage of data about their populations and communities were protected. The ICES is an independent, not for profit research institute responsible for stewardship of health data in Ontario (Walker et.al., 2018). The DGA facilitates the linkage between data collected from the Indian Register (IR) and the data at ICES for use by First Nations organizations and communities.

There are approximately 1.4 million (4.3% of the Canadian population) Aboriginal people in Canada (Statistics Canada, 2015: National Household Survey 2011). Out of this Aboriginal population, 851,560 (60.8%) identify as a First Nations person; 451,795 (32.2%) identify as Métis; and 59,445 (4.2%) identify as Inuit (p.3, 4). The majority (301,425 or 79%) of Aboriginal people in Canada reside in Ontario and the western provinces with the largest population of Aboriginal people living in Ontario. Of those Aboriginal people living in Ontario (21.5%) live in rural and northern Ontario (Minore & Katt, 2007). Given that there is a significant number of Aboriginal people living in rural and northern Ontario it makes sense to review the scope and effectiveness of mental health services directed towards this population.

More than one half of the Aboriginal population in Canada live in rural communities (Ministerial Advisory Council on Rural Health, 2002). According to the Ministerial Advisory Council on Rural Health (2002), people living in rural, remote, Northern and Aboriginal communities experience poor health (shorter life expectancies, higher death rates and higher infant mortality rates) than their urban counterparts. Health status also declines the further away people are from urban centres (Ministerial Advisory Council on Rural Health, 2002). The poor health status in rural areas is linked to the social determinants of health – income, employment, working conditions, health practices, environment, and education. The health status of rural Aboriginal people tends to be the poorest. In addition to a high prevalence of all major chronic diseases, Aboriginal people have higher rates of suicide, fatal injuries, as well as smoking and alcohol consumption. Health status is further affected by low incomes, low levels of education, chronic unemployment, inadequate housing, exposure to environmental contaminants as well as to the intergenerational effects of the residential school era (Ministerial Advisory Council on Rural Health, 2002).

Aboriginal people tend to circulate between rural and urban, and between reserve and non-reserve communities. This mobility between communities must be considered when studying the causes and transmission of health issues within this population and in coming to an understanding of the significant stressors, help-seeking, resources, and supports related to Aboriginal peoples. However, we should not rely only on the rural versus urban distinction since it is not that fact that one lives in a rural community that only affects health, it is the level of immersion in the community, the variations between communities and how well one adapts to these differences that impacts on health. For example, an individual can thrive in an isolated rural community with few healthcare resources, high unemployment while another individual will struggle in this same type of environment and experience more health challenges than the other. Therefore, we need to be cognizant that health can be dependent on more than just the location of community.

What is the significance of all of this on the mental health of Indigenous people? Mental health cannot and should not be separated from health. The social determinants of health also have a great impact on mental health. According to the Medicine Wheel, the four aspects of the being must be in balance if one is to achieve a state of health, this includes mental health. If there is a deficit in one area, that will affect all other aspects of the being. Therefore, what adversely affects health will also adversely affect mental health.

The need for accurate statistics (culturally and community defined) is an important aspect of community development. First Nations leadership are beginning to realize that the collection of accurate statistics is needed to create mental health programs that best address needs of First Nations communities (Globe and Mail, 2016).

2.4 Historical Perspective – The Role of the Federal Government in the Health of Indigenous Peoples

How does the involvement of the federal government help or hinder self-determination? According to Kirby and Keon (2006), both Health Canada and Aboriginal Affairs and Northern Development Canada (AANDC) (formerly Indigenous and Northern Affairs Canada) are responsible for health care, mental health services, addiction treatment and social services and supports to First Nations on reserve and Inuit people. Under the Constitution Act, 1867, section 91(24) federal parliament has allocated exclusive legislative responsibility over "Indians and Lands reserved for the Indians". In addition, the Indian Act of 1876 established the criteria for a "status Indian" along with a framework for federal jurisdictional responsibilities. In 1939, a Supreme Court ruling determined that Inuit (then called Eskimos) were Indians for the purposes of section 91(24). Under these legislations, the federal government provides certain federal programs and services to status Indians (also known as Registered Indians and First Nations) and some federal programs and services have been extended to Inuit. Under these legislations federal programs and services were usually not extended to non-status Indians or to Métis peoples.

Indigenous and Northern Affairs Canada (INAC) maintains fiduciary responsibility for the constitutional and statutory obligations and responsibilities of the federal government to Indian and Inuit people. INAC covers basic services for First Nations on-reserve and in Inuit communities including education, income assistance, housing, and family violence prevention for registered Indians and certain Inuit peoples. Recent developments between INAC and Aboriginal peoples are exploring extension of federal responsibility to non-status Indians and Metis (INAC, 2013). This will have significant impact on services offered through Health Canada, First Nations and Inuit Health Branch.

Health Canada, First Nations and Inuit Health Branch's (FNIHB) current mandate is derived from the 1979 Indian Health Policy and its primary responsibility is to support the delivery of health services to First Nations and Inuit peoples including community-based mental health care for First Nations on-reserve; non-insured drugs and short-term mental health crisis counseling for registered First Nations and recognized Inuit; and addiction treatment centres. While FNIHB's health policy has not changed substantively since its inception, it is clear that this policy needs to adapt to manage new opportunities and challenges emerging in the relationship with Aboriginal peoples (First Nations and Inuit Health Branch Strategic Plan, 2012).

2.5 Mental Health and Addiction Services in Ontario

2.5.1 The Federal Level

In Ontario, First Nations and Inuit communities' access mental health and addictions services through both the federal and provincial governments. At the federal level, First Nations and Inuit communities can access the NNADAP program, Brighter Futures program and Building Healthy Communities program.

The National Native Alcohol and Drug Abuse Program (NNADAP) was jointly created by Health Canada, Indian and Northern Affairs and the National Indian Brotherhood was created in 1973 for the exclusive treatment of First Nations drug and alcohol abuse victims (Ontario Region Addictions Partnership Committee (ORAPC) NNADAP Worker Guidebook 2011). This program was formally established in 1979 and received permanent funding through Health Canada in 1982. The goal of the NNADAP is as follows:

> "to support community designed and operated projects in the areas of alcohol abuse prevention, treatment and rehabilitation in order to arrest and reverse the present

destructive physical, mental, social and economic trends" (Government of Canada, 2005, p. 4).

A review of the NNADAP in 1998 identified the need for the development of Partnership Committees between First Nations and Health Canada to enhance coordination of services. In Ontario, the Ontario Regional Addictions Partnership Committee (ORAPC) is mandated to provide advice/ guidance/ recommendations to leadership through the Chiefs of Ontario office and the First Nations and Inuit Health Branch on issues of addictions and holistic healing approaches as part of an ongoing review process (OPRAC, 2011).

The Brighter Futures program was introduced in 1992 to help First Nations and Inuit communities to develop community-based programs, services and activities aimed at achieving better health (Health Canada, 2013). The mental health component of this program promotes the development of healthy communities through community-based mental health programs, services and/or activities such as information and awareness activities, counselling services and wellness activities. The aim of this program is to increase awareness, change attitudes, build knowledge and enhance skills in order to promote healthy communities.

The Building Healthy Communities program, introduced in 1994, assists First Nations and Inuit communities to address youth solvent abuse and mental health crises. The solvent abuse component allows First Nations and Inuit communities the ability to develop solvent abuse prevention programs and/or intervention programs such as residential treatment. This program also funds training-related activities to deliver such programs (Health Canada, 2013). The mental health component of the Building Healthy Communities program is designed to complement the Brighter Futures program in that it enables First Nations and Inuit communities to respond to mental health crises through crisis-related training or programs to heal from crises (Health

Canada, 2013). According to Health Canada (2013), the majority of First Nation and Inuit communities are accessing either one or both of the Brighter Futures and Building Healthy Communities programs.

2.5.2 The Provincial Level

At the provincial level, there has been significant progress being made in Aboriginal health and mental health since the early 1990s. It was during this time that the Ontario government began collaborating with Aboriginal, First Nations and Metis leaders and organizations to develop Ontario's first Aboriginal Health Policy. The Aboriginal Health Policy, still in effect today, was intended to improve Aboriginal health through better access to care, better standards of care and more culturally appropriate care (New Directions, 1994). Through this policy the Ontario government marked its commitment to health services designed, developed and delivered in partnership with Aboriginal people (ibid).

In 1994 the province created the Aboriginal Healing and Wellness Strategy (AHWS), a joint program between the Ontario government and First Nations and Aboriginal organizations, to help improve Aboriginal health and reduce family violence (Government of Ontario, 2016). This program was made available to Aboriginal people living on-reserve as well as those in urban and rural communities. Included under this strategy are the Aboriginal Health Access Centers (AHACs), Aboriginal community-led, primary health care organizations providing "a combination of traditional healing, primary care, cultural programs, health promotion programs, community development initiatives, and social support services to First Nations, Métis and Inuit communities" (Ontario Aboriginal Health Access Centres, n.d., p. 7). The AHWS offers a range of services from community wellness, children and youth services, counselling services, crisis intervention services, healing lodges, health promotion and

education, shelters and safe houses, pre- and post-natal care as well as solvent abuse treatment centres. The strategy has a strong focus on Aboriginal worldview and integrates an Aboriginal understanding of health, traditional healing and community partnerships in the development of programs. This strategy offers an indirect approach to dealing with mental health and addiction issues. In 2010, the Ontario government developed a renewed Aboriginal Healing and Wellness Strategy that would allow greater Aboriginal oversight and control of AHWS programs and services in order strengthen Aboriginal health services (Government of Ontario, 2012).

In 2008, the Ministry of Health – Long Term Care made a commitment to improved mental health and addictions services and established a Minister's Advisory Group to develop a comprehensive mental health and addiction strategy that would transform mental health and addictions services leading to better services for Ontarians (Minister of Health, 2010). The goals of this 10-year strategy were to improve health and well-being for all Ontarians; reduce incidence of mental illnesses and addictions, early and appropriate intervention and high quality, effective, integrated, culturally competent, person-directed services and supports. This was a generic mental health and addiction strategy aimed at all Ontarians. Clearly missing from this strategy was any specific mention of the unique and compelling needs of the Aboriginal population in Ontario.

2.5.3 The Regional Level

At the regional level, The North East Local Health Integration Network (NELHIN) funds a range of mental health services: housing and residential care for people with mental illness; mental health courts, diversion, and forensic programs; mental health services for children and youth, people with intellectual difficulties and seniors; community mental health programs; hospital

mental health programs as well as recreational and social programs for people with mental illness (NELHIN, 2016). The main provider of mental health services for the northeast region of Northern Ontario is the Northeast Mental Health Centre (NEMHC) which is a specialized mental health centre that provides service to people with severe and persistent mental illness (North Bay Regional Health Centre, n.d.). Programs provided by NEMHC include specialized adult mental health, senior's mental health, forensic psychiatry, outreach programs, a regional children's psychiatric service. As well, regional specialized mental health beds are provided at NEMHC's Sudbury campus.

Mental health services for Aboriginal people in Northeast Ontario, specifically the Sudbury/Manitoulin and North Shore Tribal Council areas are provided either through the First Nation community itself or through AHACs. Shkagamik-kwe Health Centre provides mental health case management (NELHIN, 2016). Noojmowin Teg Health Centre provides psychological services (child, youth and family consultations, and psychological assessments) to the seven First Nation and off-reserve Aboriginal populations within the Manitoulin Island District (NELHIN, 2016). In the North Shore Tribal Council area, mental health services are provided by N' Mninoeyaa Community Aboriginal Health Access Centre (NELHIN, 2016).

2.6 The Development of Mental Health Services in the Sudbury/Manitoulin First Nations Area

Much of the information contained in this section comes directly from my experience as the Clinic Manager of Nadmadwin mental health clinic. In essence I am a knowledge keeper of that part of the history of Nadmadwin. My original vision in undertaking this PhD program was to document history of mental health services provided by Nadmadwin mental health clinic on Manitoulin Island since that had not currently been documented since the initial reports produced

in 1977 by Ward and Fox (1977). When I examine the history of mental health service development it appears that there did not seem to be much focus on mental health at the federal level until the late 1970s. At the provincial level, it was not until the 1990s with the development of the Aboriginal health policy that there was much attention given to health and mental health of Aboriginal peoples. Incidentally, Wikwemikong Unceded Indian Reserve was already delivering mental health services to its community members through its relationship with the Queen's University and Sudbury Algoma Hospital (now known as Kirkwood Place, a division of North Bay Regional Health Centre).

2.6.1 Development of Nadmadwin Mental Health Clinic

The First Nations communities within the Manitoulin District of Northern Ontario receive health care and mental health care predominantly from the First Nations Inuit Health (FNIH) under Health Canada. Wikwemikong Unceded Indian Reserve was the first Aboriginal community on Manitoulin Island to develop a mental health program. The Wikwemikong Counselling program was initiated in January 1976 in response to the Wikwemikong suicide crisis in 1974-75 in which there was a cluster of suicides within the space of less than a year (Ward & Fox, 1977; Royal Commission on Aboriginal Peoples, 1995; Smye and Mussell, 2001).

The Wikwemikong Counselling Program was a joint venture between Queen's University and Sudbury Algoma Hospital. Two Native mental health counsellors, Daniel Manitowabi and Joseph Fox, were hired by the Sudbury Algoma Hospital to provide mental health services in the Wikwemikong Community. These two mental health counsellors received clinical supervision from Dr. Richardson from Queen's University and psychiatric support from Dr. J.A. Ward who was a member of the Sudbury Algoma Hospital Travelling clinic. The Sudbury Algoma

travelling clinic provided monthly psychiatric clinics in Wikwemikong (Northeast Mental Health Centre – Native Services, 2001).

In July 1983, Sudbury Algoma Hospital took over sole sponsorship of the program. The name of the program changed from Wikwemikong Counselling Program to Nadmadwin ("People working together") Clinic. This name was, in part, a result of the change in service delivery from providing mental health services only to Wikwemikong to expansion of mental services to five additional First Nation Communities in the Manitoulin area – Sheguiandah, Sheshegwaning, Sucker Creek (now Aundeck Omni Kaning First Nation), West Bay (now M'Chigeeng First Nation) and Whitefish River First Nation. The expansion of services to these five additional First Nations communities increased the population served to approximately 5,000 people thus an additional mental health worker was required as well as a secretary/receptionist. Nadmadwin Clinic's mandate was to provide direct and indirect mental health services to these five First Nations communities as well as to the Wikwemikong community. Direct services included: treatment and assessment services for children, youth and adults; psychiatric and psychological assessment and consultation; individual, family and group therapy; and referrals to other agencies, practitioners, and specialized assessment and treatment services. Indirect services included community development and public education (Northeast Mental Health Centre – Native Services, 2001). What started out as a small counselling program evolved into a comprehensive mental health program servicing six First Nations communities. This was the first Native mental health program to be developed in this area, it has served as a model for the development of other First Nation mental health services across Manitoulin Island and Canada.

Another change occurred in 1989 when the Sudbury Algoma Hospital changed its name to Network North – The Community Mental Health Group. All eight mental health clinics

including Nadmadwin Clinic (the only Native clinic) reported to the Community Clinics Department of Network North. This department was administered by a Community Clinics Director and supported by a professional resource team consisting of a Clinical Program Coordinator, Community Development Coordinator and a Consulting Psychiatrist. Nadmadwin Clinic received several benefits from its relationship with Network North. The staff were able to access administrative and clinical support; education and staff development; clinical supervision; evaluation and training; access to Network North's inpatient programs; and, received liability protection through Network North's policies and procedures (Northeast Mental Health Centre – Native Services, 2001).

2.6.2 The Significance of the Nadmadwin Mental Health Clinic to Aboriginal Mental Health Care

Nadmadwin clinic was among the first Native community-based mental health programs in Canada to provide quality, culturally appropriate mental health services to First Nations communities. This clinic was also able to provide a continuum of mental health care. At the primary level, native mental health workers provided counselling to individuals and families. At the secondary level of care, the clinic was able to access clinical consultation and supervision. At the tertiary levels, they were able to access Network North's inpatient programs as well as participate in public education and community development activities. This program was unique in that First Nation mental health workers familiar with the culture and language of the communities were employed to provide mental health services in the First Nations communities that Nadmadwin Clinic serviced (Northeast Mental Health Centre – Native Services, 2001).

2.6.3 Development of Service Agreements with Network North

The first service agreement with Network North since the establishment of Nadmadwin Clinic was with Sagamok Anishinabek in the fall of 1993. Under this agreement, Network North

provided clinic management, a clinician and secretary/receptionist to the Sagamok mental health clinic.

In 1995, Nadmadwin Clinic was forced to restructure their existing services in response to changes in the federal funding for mental health. In April 1994, Medical Services Branch – Health and Welfare Canada introduced the "Building Healthy Communities" initiative, a new mental health initiative that transferred all funding for mental health service delivery to First Nations communities a move which allowed communities more input and control over funding allocations. This created a crisis situation for Nadmadwin Clinic as the funding arrangements for their program was going to change and along with it the existing service agreement with Network North. Prior to the introduction of this initiative, all funds for mental health programming for Nadmadwin Clinic were allocated to Network North through a service agreement between the federal government and Network North. Under this new initiative mental health funds were allocated to each individual First Nation community. Another change was that health transfer agreements could be made with groups of First Nations or individual First Nations. This meant that for Nadmadwin Clinic to maintain the existing service agreement with Network North they would have to find a way to convince each of the First Nations communities to pool their resources.

In response to the Building Healthy Communities initiative and partly in an effort to maintain the existing service agreement, Nadmadwin Clinic undertook an operational review and consulted with the First Nation communities who accessed services through the clinic about their desire to continue the existing arrangement. What ended up happening is that four of the seven First Nations communities (Wikwemikong, Sheguiandah, Whitefish River and Sucker Creek (now Aundeck Omni Kaning) that accessed services through Nadmadwin Clinic agreed to continue

their partnership and negotiated a separate service agreement with Network North. Another separate tripartite agreement was negotiated between West Bay (now M'Chigeeng First Nation), Sheshegwaning and Cockburn Island (now Zhiibiihaasing First Nation).

From 1996 to 1999 there was much activity in the development of service agreements with Network North. In August of 1996, a new mental health service agreement was negotiated between Network North and Whitefish Lake First Nation. The tripartite service agreement with West Bay, Sheshegwaning and Cockburn Island fell apart in 1997. At that time West Bay Mental Health Clinic pursued its own service agreement with Network North. The other two First Nation communities accessed mental health services through Noojmowin Teg Health Access Centre in Sheguiandah, Ontario. In November 1998, Noojmowin Teg Health Access Centre entered into a service agreement with Network North to hire its first Aboriginal psychologist. In 1999, an agreement was negotiated between Nipissing First Nation and Network North for the provision of a Clinical Program/Consultation Agreement for the Right Path Counselling Services. In February of 1999, the agreement was amended to add half-time psychological services to the Right Path Counselling Services. During this time period, Network North changed its name to Northeast Mental Health Centre.

2.7 The Development of the Mental Wellness Team Pilot Project

2.7.1 Development of the Mental Wellness Advisory Committee

The Kirby Report (2006) was mandated to examine mental health and mental illness issues in the Canadian population and noted that drastic changes to programs and services related to addressing the determinants of health for all First Nations and Inuit people were needed in order to improve health outcomes. This report identified a highly fragmented health system with little collaboration between different levels of government, different departments, and/or various

departmental directorates or divisions. It also recognized that involvement of Aboriginal peoples in the development of their own solutions would result in the development of more culturally appropriate and therefore more effective services and supports (Kirby and Keon, 2006, Chandler and Lalonde, 1998). Further, the report identified a need for adequately trained Aboriginal mental health and addiction professionals. Finally, it was recognized that federal programs for Aboriginal mental health on or off reserve be integrated into province-wide mental health strategies. This was the beginning of the discussion for coordinated programs that would maximize the effective use of available resources. In response to the Kirby Report, Canada developed a mental health strategy for all Canadians.

2.7.2 The First Nations and Inuit Mental Wellness Strategic Action Plan

In 2005, the First Nations and Inuit Mental Wellness Advisory Committee (MWAC) was established and was comprised of partners from the Assembly of First Nations, Inuit Tapiriit Kanatami, Federal/Provincial/Territorial networks, non-governmental and Aboriginal organizations (Health Canada, 2014). The MWAC sought representatives with specialized expertise in the mental health and addictions fields to provide strategic direction to Health Canada on issues related to mental wellness, including mental health, mental illness, suicide prevention, and substance abuse/addictions. The MWAC committee developed five goals for a First Nations and Inuit Mental Wellness Strategic Action Plan (FNIMWSAP):

1. Coordinated continuum of mental wellness services,

2. Disseminate and share knowledge,

3. Support and recognize community as its own best resource,

4. Enhance mental wellness and allied services workforce,

5. Clarify and strengthen collaborative relationships (Health Canada, 2014).

The focus of the First Nations and Inuit Mental Wellness Strategic Action Plan was to address core mental health and addictions issues utilizing both strengths based and cultural approaches. This strategy also recognized that on-going support was necessary if community-based approaches towards mental wellness were to evolve in a culturally congruent way (Wiebe, Manitowabi & McNulty, 2009). Eight pilot initiatives were implemented in several Aboriginal communities across the country with a primary goal of integrating these programs with provincial services. A key priority of this mental health strategy for Aboriginal communities was to establish a coordinated continuum of mental wellness services (mental health and addictions) inclusive of traditional, cultural, and mainstream approaches (Mental Health Commission of Canada, 2012, First Nations stream, priority 5.1).

In 2011-2012, First Nations Inuit Health Branch (FNIHB) put a strategic plan in place that would respond to and transform health services directed at First Nations and Inuit groups. This strategic plan recognized the intersection between First Nations and Inuit health issues and other government priorities as well as the many challenges facing Health Canada in delivering health services such as fiscal pressures, demographic challenges, new and emerging health technologies and increased expectations from First Nations and Inuit groups (Minister of Health, 2012). This strategic plan demonstrated Health Canada's commission to ensuring access to quality health services for Aboriginal peoples which included continuous support of the mental wellness teams and the need for culturally safe mental health and addictions services that span the continuum of care (Minister of Health, 2012).

2.7.3 First Nations Resource Team Proposal

The idea for a mental wellness team originated with the First Nations Mental Health Development Initiative team members, Dr. Brenda Restoule, Daniel Manitowabi, and Susan Manitowabi, members of the Native Services Team at Northeast Mental Health Centre (NEMHC). In 2001, the Native Services Team (NST) held a retreat with all the First Nations communities that held service agreements with NEMHC. A major recommendation resulting from the retreat was the need for specialized services to complement and support the existing mental health and addiction services. In response to this identified gap, the NST, headed by Daniel Manitowabi put together a proposal for "The Development of a First Nations Resource Team" to enhance mental health and addictions services in First Nations communities in the Sudbury/Manitoulin region. This proposal was submitted to First Nation Inuit Health Branch (FNIHB) but was not funded at the time.

2.7.4 The "Raising the Spirit" Mental Wellness Team (MWT) Pilot Project

Several years later, in 2006, Dr. Brenda Restoule was approached by Medical Services Branch of Health Canada about the possibility of exploring the proposal previously submitted by NEMHC as a pilot project for the Mental Wellness Advisory Committee (MWAC) Strategy. The proposal for the First Nations Resource Team was revised and submitted to Health Canada. By 2007, Health Canada was looking for ways to fill gaps in the continuum of mental health care. The concept of mental wellness teams was one way to create comprehensive, client-centred, culturally safe, community-based mental health and addictions services in First Nation communities (Health Canada, 2014). Incidentally, the First Nations Resource Team proposal was one of the first programs to be considered a under the "Mental Wellness Team" concept (Health Canada, 2014).

In 2007, the National Anti-Drug Strategy (NADS) provided the opportunity for Health Canada for continued funding of the mental wellness team project. The core planning team consisted of Daniel Manitowabi, Dr. Brenda Restoule, Susan Manitowabi, and Frank McNulty (Ontario Region, Health Canada). From July through to September 2008, the planning team undertook a community engagement process with each First Nation community to assess need and interest for the project and to obtain Band Council Resolutions for both the community consultation process and to support the development of the MWT pilot project (Health Canada, 2014; Sutherland, 2013).

In 2008, Health Canada committed funds for the planning team to conduct a community engagement strategy consisting of information sessions, interviews, as well as meetings with leadership and potential partners. Consultations began in the September of 2008 and finished in March 2009. As a result of this community engagement process, ten (10) communities decided to participate in the project and one (1) community declined the opportunity. Results of the consultation indicated significant gaps in mental health and addictions services within these First Nations communities and confirmed the need for specialized services, capacity building among the frontline mental health staff and some sort of accredited training.

By November 2008, representatives from each of the First Nations communities came together to develop a Terms of Reference (TOR) for their steering committee. The TOR was finalized in March of 2009. According to the TOR, steering committee representatives were to be appointed by each of the participating First Nations communities. On April 17, 2009, the inaugural meeting of the MWT steering committee was held in Whitefish Lake First Nation.

The steering committee began recruiting for the MWT in May 2009. By January 2010, the first two MWT staff were hired. By March 2010, two more staff were hired and the office opened.

The official launch of the 'Raising the Spirit' MWT occurred in March 2010 at the Knowledge Symposium "Raising the Spirit: A Balanced Approach to Mental Wellness".

In the initial phase of the MWT pilot project, First Nations and Inuit Health asked M'Chigeeng Health Centre to act as the secretariat to the project. The rationale behind this decision was in part due to Danny Manitowabi's relationship with First Nations Inuit Health Branch, his relationship as a mental health leader in many First Nations communities, his long-standing reputation as a leader in mental health locally, provincially, nationally and internationally, as well as his position as chair of the steering committee and role as clinic manager for M'Chigeeng's mental health program. As the secretariat, First Nations Inuit Health Branch would flow the funds for the pilot project through M'Chigeeng Health Centre. M'Chigeeng Health Centre provided a lot of administrative support in the initial stages of development of the MWT pilot project. There was a lot of administrative work such developing the policies and procedures for the team, developing the partnership agreements with the other First Nations, getting the BCR's in place, setting up the office, and recruitment. There was a lot of work that the secretariat had to compile before the doors of the MWT pilot project could officially open. Once the policies and procedures were in place, the administration of the project was transferred to the "Raising the Spirit" MWT.

The "Raising the Spirit" (MWT) pilot project based in Sudbury, Ontario, Canada was funded by the federal government under the Mental Wellness Advisory Committee (MWAC) Strategy. The pilot project partnered with ten First Nations communities from the Manitoulin Island, North Shore and Waabnoong Bemwijaang Tribal Council with the goals of improving access to specialized services; enhancing knowledge, skills and capacities of community workers; providing support, consultation, clinical supervision, coaching and mentoring, and; braiding of

traditional and Western approaches to wellness. Interestingly, these goals were consistent with the goals of a collaborative care (shared care) model of program delivery that were gaining increased recognition as effective service delivery models. The overall goal of this pilot program was to enhance capacity at the First Nations community level to address needs associated with addictions, mental health and concurrent disorders in ways that reflect the culture, attitudes and philosophies of the participating communities.

There is much evidence for the support for the Mental Wellness Team concept. Mussell, Cardiff and White (2004), identified six main opportunities for actions to improve the mental health and well-being of Aboriginal children and youth: recognize the role that culture plays in determining health; focus on implementing ecological, community-level interventions; promote local leadership and develop high quality training; provide mentoring and support; foster links within and between communities as well as support ongoing capacity building (p.3). This report emphasized that the best approach that offered the greatest opportunity for change was one that that was collaborative in nature and built on the strengths and unique contributions of each of its players (Mussell et al, 2004). The North East Local Health Integration Network (NELHIN) (2011) stresses that Aboriginal communities are accepting of culturally relevant, community-driven mental health care that blends clinical and traditional Aboriginal healing services.

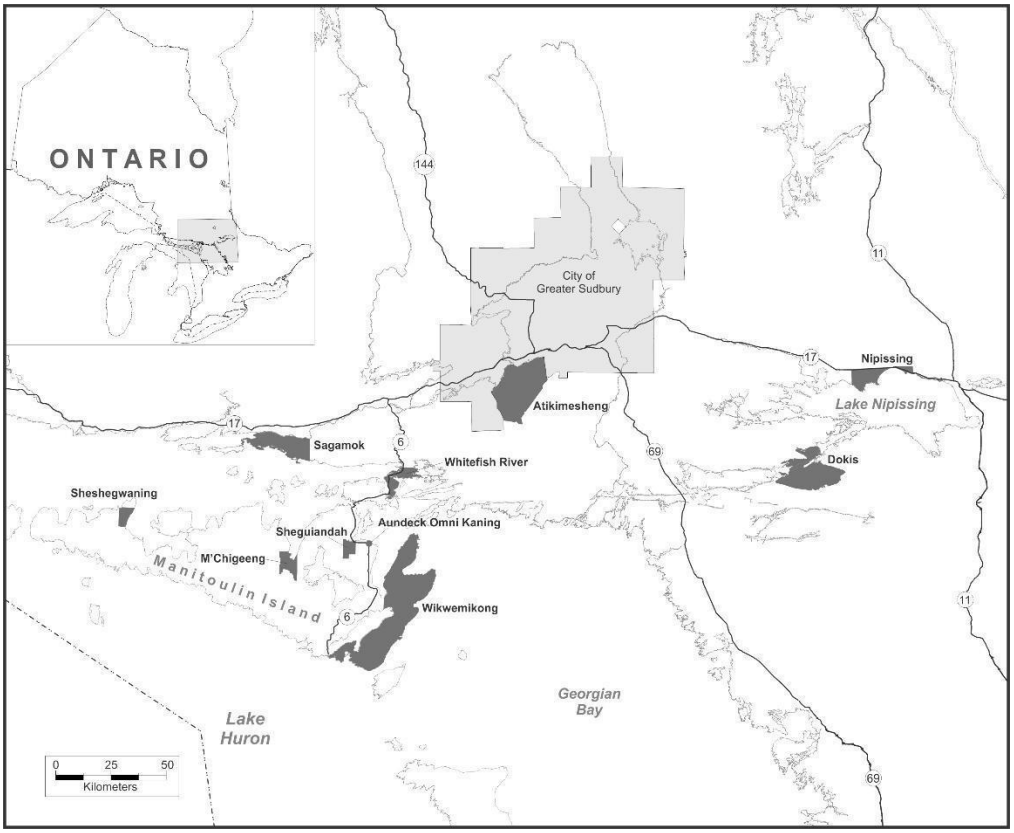
The Six Nations reserve in Ontario provides a community-based mental health and psychiatric clinic for its community members that has been in existence since 1997 (Vukic, Gregory, Martin-Misener & Etowa, 2011). The clinic's "shared care" model promotes a mutually respectful collaborative working relationship between traditional healers and agencies to deliver culturally relevant programs and services within the community. According to Wieman (2009), this "shared-care" model has provided the community with balanced mental health care service that

has resulted in reduced hospital readmissions. The strength of this model is the ability of mental health staff to provide holistic care for community members.

2.8 Geographical Location of the "Raising the Spirit" Mental Wellness Team Pilot Project

The "Raising the Spirit" pilot was different from the other seven pilot projects in that this was a new initiative that had to be built from the ground up whereas the other pilot projects were comprised of services that were previously in existence. This was a significant difference since much effort was expended to build the service which impacted on the ability of the MWT to provide the promised services to the First Nations communities that were party to this project.

Figure 5 - Map of First Nations communities involved in the MWT Pilot Project



Lariviere, 2012

As you can see from the map provided the distance between the ten participating First Nations is significant. The main office for the MWT project was located in Sudbury, Ontario. This seemed like the most logical place for this office since it was centrally located. Whitefish Lake First Nation was also considered as a site for the main office because it was centrally located but there was no office space available in that First Nation community around that time. This distance between the farthest community to the west (Sheshegwaning First Nation) is about two and a half (2 ½) hours travel time. The distance from Sudbury to Wikwemikong Unceded Indian Reserve is about two (2) hours travel time. Travelling to Dokis First Nation from Sudbury could take as long as one and three-quarter (1 ¾) hours. Sudbury to Nipissing First Nation takes about an hour. The geographical distance between these First Nation communities and the MWT office posed some interesting challenges that affected the engagement between the mental wellness team and the participating First Nations communities.

2.9 Overview of the MWT Pilot Program

The Mental Wellness Team (MWT) Pilot Project, funded by the federal government under the Mental Wellness Advisory Committee (MWAC) Strategy, involved ten First Nations communities in Northeastern Ontario (Manitoulin Island, North Shore and Waabnoong Bemjiwang Tribal Council areas). Support for the project was indicated by Band Council Resolutions (BCRs) from each of the ten First Nations communities involved in this project. Each community designated a representative to sit on the steering committee. At the outset of this project, the "Raising the Spirit' MWT was one of three pilot projects across Canada which eventually grew to eight pilot projects each different in design. Some pilot projects comprised services that had previously been in existence whereas the "Raising the Spirit" pilot was a new initiative.

The idea behind the development of the mental wellness team concept was to enhance collaboration among clinical and community experts to increase and improve culturally safe mental health and addiction services; to offer a full spectrum of services ranging from prevention to post-treatment follow-up; to promote community engagement and self-determination with respect to mental wellness; and, to support community development in order to help improve health outcomes (Health Canada, 2014). Several goals were identified for the MWT: to establish collaborative working relationships with community mental health and addictions workers and other service providers; to improve access to needed specialized services; to enhance knowledge, skills and capacities of community workers; to provide support, consultation, clinical supervision, coaching and mentoring, and; to build and strengthen bridges between traditional and mainstream approaches to wellness. A defining feature of this project was its multi-disciplinary team approach to mental health care.

At the start of the project, the MWT was comprised of a program coordinator, a concurrent disorders specialist, a traditional coordinator and an administrative assistant. This objective of this pilot project was to connect communities, to facilitate the sharing of information and resources as well as to provide support, capacity building and training to community frontline workers. As the project developed the Traditional Advisory Circle (TAC) and the Elder-In-Residence (EIR) program were established to provide cultural support to the team. Other professional services (psychologist, psychiatrist, and clinical consultant) were secured through funds made available through the specialized services enhancement funds. A description of these positions are provided below.

2.8.1 Program Coordinator

The role of the Program Coordinator (PC) evolved as the MWT pilot project unfolded. In the beginning the PC was involved in the implementation of the recommendations from the community consultations and establishment of the office and administrative structures (policies, procedures, job descriptions, service protocols and continuous quality improvement processes) (see Appendix 3). As the project progressed the PC's role shifted several times. At the start of the project, the PC's role was to establish and maintain formal partnerships with the participating First Nations communities, federal and provincial stakeholders, as well as academic/educational institutions. Once the project was established, the role shifted to recruitment, development and implementation of the specialized Mental Wellness Team; provision of support to the MWT team; ensuring that the MWT was being responsive to community needs. As the project continued to evolve the role of the PC expanded to oversee the development of a culturally appropriate evaluation process, ensure the provision of culturally appropriate clinical consultation services/training, ensure access to educational/training services, as well as the incorporation of traditional and western healing practices and building capacity.

2.8.2 Concurrent Disorder Specialist

The role of the Concurrent Disorders Specialist (CDS) was to provide information, training/education, and consultation/supervision to frontline workers with respect to concurrent disorder issues. Major tasks included: providing clinical consultation and guidance regarding treating and supporting individuals with a concurrent disorder; promoting and coordinating training/educational initiatives in order to build the capacity of community frontline workers to respond to and deal with concurrent disorders; participate in planning and knowledge exchange opportunities; ensure the braiding of clinical with traditional wellness approaches; as well as

participate in team planning, quality improvement processes and research/evaluation endeavors (see Appendix 4).

2.8.3 Traditional Coordinator

The primary role of the Traditional Coordinator (TC) was to work collaboratively with all stakeholders to develop community designed programs, services, and policies that encouraged and supported traditional wellness approaches to mental health and addictions (see Appendix 5). In addition, other roles included assisting in coordination of knowledge exchange opportunities around traditional wellness approaches, sharing teachings, facilitating sharing circles, and assisting in community activities such as ceremonies, feasts, etc. Another important aspect of the role was to support access to traditional counselling and/or healing services. The braiding of western and traditional approaches to healing was a major task for the TC who undertook "consultative rounds" with service providers and frontline workers in order to facilitate their capacity to offer more culturally appropriate services.

2.8.4 Traditional Advisory Circle

One of the main tasks of the TC was to establish and coordinate a Traditional Advisory Circle (TAC). The purpose of the TAC was to advise and support the Mental Wellness Team in their capacity building efforts with the community workers and program managers. The TAC was comprised of traditional knowledge holders and community cultural resource people who were non-voting ex-officio members of the MWT Steering Committee who shared their advice and recommendations with them. In addition, the TAC was tasked with overseeing the MWT "Elder-in-Residence" program.

2.8.5 Elder-in-Residence (EIR) Program

The MWT recognized the importance of braiding traditional Anishinabek teachings & practices with western knowledge & techniques as well as the need to nurture this balance in order to empower First Nations in healing themselves. Towards this end, the MWT established an EIR program that functioned both as a support to frontline workers in their own wellness and a way to build confidence in the application of traditional wellness approaches. The EIR program provided First Nations communities with access to visiting elders, provided one to one or group support to community frontline workers, assisted workers to learn about Anishinaabe Kinomaadwin healing approaches, provided traditionally based counselling and debriefing support, and act as a traditional resource to assist in community development initiatives.

2.10 Conclusion

In many respects the development of Nadmadwin Mental Health Clinic represented an innovative approach to mental health with Aboriginal peoples that was ahead of its time. Nadmadwin Mental Health Clinic was one of the first mental health clinics in Canada to employ Aboriginal mental health workers. Nadmadwin Mental Health Clinic was one of the leaders in Aboriginal mental health to blend traditional healing approaches with western healing approaches. The report from the North East Local Health Integration Network (NELHIN) cites M'Namodzawin Health Services Inc. and Noojmowin Teg Health Access Centre as mental health care providers that have contributed significantly to the blending of traditional and western approaches to healing. What the report from the NELHIN fails to mention is that a long-time former chief of Wikwemikong and traditional healer, Ron Wakegijig and Dr. Jack Bailey both worked tirelessly at bridging traditional and western approaches to healing (Manitoulin

Expositor, May 2012). Much of this work was done during the early 1980s. Both individuals had a significant effect on the health services offered through Nahndahweh Tchigehgamig Wikwemikong Health Centre as well as the services offered through Nadmadwin Mental health Clinic. The visiting psychiatrists and the mental health workers at Nadmadwin Mental Health Clinic had a mutually beneficial relationship where they were able learn from each other thereby enhancing capacity of each to work with Aboriginal clients.

The service agreements made with Nadmadwin became a model upon which service agreements were established with other First Nations Communities within the Sudbury-Manitoulin and North Shore areas. The relationships established with the First Nations communities in these areas led to the regional gathering where the idea for a central resource team was first discussed. It is evident by the growth and expansion of the mental health services that the need for continual improvement in mental health service delivery for Aboriginal peoples in this area was at the forefront. Mental health service providers and government officials at both the provincial and federal level looked to the mental health leaders such as Danny Manitowabi and Dr. Brenda Restoule for advice and consultation on mental health services for Aboriginal peoples.

The development of mental health services in the Sudbury-Manitoulin area was a significant contributing factor to the development of the mental wellness team pilot project for this area. The initial resource team proposal put forth by the Native Services team at Northeast Mental Health Centre became the foundation for the mental wellness team pilot project proposal for this area. The mental wellness team concept represents one way in which the mental health disparities that exist between Aboriginal and non-Aboriginal Canadians can be addressed. There is no dispute that the colonial policies of the Canadian government and the resultant collective trauma and cultural disruption have dispossessed Aboriginal peoples from their land and weakened their

social and political institutions. The recent findings of the Truth and Reconciliation Commission have validated this and have recommended a path towards reconciliation involving both parties keeping in mind the key role that the federal government plays in the health and mental health of Indigenous peoples and the desire of Indigenous communities and organizations to exercise greater control over their own health and mental health service delivery.

Chapter Three – Evaluation of the "Raising the Spirit" Mental Wellness Team Pilot Project

This chapter focuses on the evaluation of the pilot project. In the early stages of development of the "Raising the Spirit" Mental Wellness Team pilot project, the Steering Committee members decided that it would be wise to engage in an evaluation of the project. This was an important move given that the pilot project needed to demonstrate that it was meeting its mandate. This chapter describes the rationale for the evaluations and the method of evaluation are described. A unique feature of this research project is the use of a culturally appropriate methodology that integrates Indigenous methodologies and epistemology. I will be using a literary device called etymology as part of my methodology to explore the relationships that emerged throughout this thesis. This was not part of the original methodology but one that materialized through the data analysis process.

3.1 Rationale for the Evaluation

Early on, the MWT Steering Committee identified a need to evaluate this pilot project. The steering committee was interested in doing this evaluation for several reasons: to demonstrate that the MWT concept as a culturally appropriate method for working with First Nations communities; to document the development of the MWT model; to highlight its unique relationship with First Nations communities; to highlight successes, and challenges; to improve upon and strengthen the service, as well as; to build a rationale for continued funding.

The overall evaluation of this project was contracted out to a group of community-based researchers. As part of my PhD research the evaluation sub-committee of the MWT steering committee granted me a small piece of this overall evaluation. The main focus of my research

was on the engagement process between the MWT and the ten participating First Nations communities. In doing this piece of the evaluation the sub-committee was interested in learning more about the collaboration within and across communities and with key partners; the integration of western and traditional approaches; and the impact on the capacity building and knowledge at the community level.

This research was developed in conjunction with evaluation subcommittee of the steering committee and Elders connected with the pilot project. This research received approval from two research ethics boards – the Laurentian University Research Ethics Board and the Manitoulin Anishinaabek Research Review Committee on Manitoulin Island. For the evaluation of this project, I drew on Anishinaabe teachings and practices to create a culturally appropriate model. The methodology will be described later in this chapter.

3.2 Indigenous Methodologies

The academy is often antagonistic and resistant towards attempts to 'Indigenize' our research methodologies (Lambert, 2014; Chilisa, 2012; Lavallee, 2009; Kovach, 2009: Absolon, 2005; Smith, 1999). Those Aboriginal writers who speak from a "traditional" Aboriginal viewpoint are criticized because they don't make sense to Western thinkers. Indigenous voices are often dismissed as naive, contradictory and illogical (Smith 1999). Although others (Kovach, 2009; Archibald, 2008; Brown & Strega, 2005) have begun to 'pave' the way by advocating for the 'space' for Indigenous research within the academy, Western academics have difficulty acknowledging Indigenous ways of knowing as equally valid and therefore don't fully accept that there are alternate ways of knowing (Stewart, 2009). Personally, I have felt this resistance, as an academic doing my research on Cedar Bath receiving questions about ceremony and having to explain myself and the work of the healers. It was almost as if the not knowing about

ceremony raised ethical issues for the ethics review board. Duran (2012), states that when Indigenous people try to implement Indigenous ideas they are met with resistance. That is because western academic institutions insist that Indigenous ideas must be filtered through western academic lenses (Duran (2012) cited in Lambert (2014, p. xii)). In addition, as a student in the PhD in Rural and Northern Health Program I felt that my instructors were ill-equipped to challenge any of the teachings that I shared within the classroom, possibly for fear that they would be perceived as unknowledgeable or that I would question their feedback.

Many Indigenous scholars (Chilisa, 2012; Kovack, 2010, Smith, 1999; Wilson, 2008) are making concerted efforts to clearly explain the differences between Indigenous methodologies and the methods used in Indigenous research. According to Linda Smith (1999) in her book *Decolonizing Methodologies,* western research methodologies tend to view Indigenous peoples as being less than human, needing to be 'civilized". Indigenous methodologies offer a way of countering the colonizing role of western research methodologies by offering a paradigmatic approach that allows one to choose alternative methods or approaches to achieve the research goals (McGregor et al., 2018; Lambert, 2014; Chilisa, 2012; Kovach, 2010). As I began my research in 2011/2012, there appeared to be support from Indigenous communities for culturally congruent research methodologies – research that fit with Indigenous worldview, particularly among the evaluation sub-committee of the MWT steering committee. This support was also apparent at Indigenous research conferences occurring locally (Manitoulin Research Ethics Conference 2013), nationally (Aboriginal Education Research Forum 2015, Winnipeg, Manitoba) and internationally (at Healing Our Spirits Worldwide 2015, Hamilton, New Zealand and International Indigenous Development Research Conference 2012 in Auckland, New

Zealand). More recently, there seems to be an increase in the number of resources that talk about Indigenous methodologies (McGregor et al, 2018; Lambert, 2014; Chilisa, 2012).

What are Indigenous methodologies, why are they important and how are they different from other methodologies? Methodologies are premised on a belief that there is a knowledge belief system (ontology and epistemology), and the actual methods must both work in tandem (Kovach, 2009). Indigenous methodologies keep tribal epistemologies at the centre, rather than the typical academic expert-subject and objective models currently espoused by mainstream research thus making them distinct from western qualitative approaches (Lambert, 2014, Chilisa, 2012) Kovack, 2009), Wilson, 2008; Brown and Stegra, 2005). Aboriginal researchers see the cultural protocols, values and behaviours as an integral part of the methodology (Stewart, 2009; Baskin, 2005; Smith 1999). Indigenous methodologies involve understanding the historical, political, social, economic contexts of Aboriginal peoples' lives (Lambert, 2014) as well as the intimate relationships that Aboriginal people have to all of creation and how these relationships are interrelated. It is about knowing your place in creation and operating from that place. It requires one to think reflexively about that relationship and how it becomes the cornerstone for knowing, being and doing (Kovach, 2009; Wilson, 2008).

Methodology refers to the study about how research needs to be done, how we learn and how knowledge is gained (understanding the why and the way we do research) (Datta, 2017). Inherent in an Indigenous methodology is a relational accountability meaning that the researcher has a responsibility to learn about how individual knowledge systems operate and how knowledge is expressed (Kovach, 2009; Wilson, 2008). Relational accountability, an important concept for Indigenous researchers, grounded in Indigenous epistemologies, allows researchers to position themselves in relation to their environment and research partners (Kovach, 2009; Hart, 2010;

Macdougall, 2011) According to Wilson (2008), relational accountability is more than human relationships, it is built upon the interconnection and interrelationships that binds the group (collective, community) together. It acknowledges the relationship and spiritual connection that Indigenous people have to the land (Wilson, 2008). All of these Indigenous principles are incorporated into the research methodology so that research practices contribute to Indigenous people's rights and sovereignty (Wilson, 2008).

Research methods refer to the tools, techniques and processes used in research (surveys, interviews, focus groups, etc.). According to Kovach (2010) Indigenous research methods differ from western research methods in several ways: connect to Indigenous knowledge, located in an Indigenous paradigm, relational in nature, protocols reflect Indigenous knowledge, and are flexible, collaborative and reflexive in nature. Indigenous research methods are purposefully selected to help preserve indigenous voices, build integrity and strengthen community while resisting dominant discourses.

3.2.1 The importance of locating oneself in the Research

According to Kovach (2009), it is good practice for researchers conducting research with, in and for Indigenous communities to expose their motivation and purpose as a way of countering the history of unethical and exploitive research that has occurred with Indigenous peoples (Baker, 2009; Menzies, 2001; Smith, 1999). Because the ontology of Indigenous epistemologies is relational (Wilson, 2007), a deeper explanation of who the researcher is (personally, professionally, emotionally and spiritually) helps to build the relationship between the researcher and the community.

Two people that had a huge influence on me were my parents, Violet McGregor-ba and Art McGregor-ba. From my mother, I learned the importance of getting an education. This is what

drives me to pursue my PhD. From my father, I learned how to be a storyteller. This is what influenced me to utilize a storytelling methodology in my thesis.

I was also very connected to the mental health system, having worked alongside many of the players who were part of this journey. When this journey began, I started out as a colleague but when the direction of my research changed, I had to let go one role (member of the Native Advisory Committee, visionaries of the MWT pilot project) and adopt a new role as a researcher. This meant that my relationship with these individuals also changed. I was no longer a member of the group driving the pilot project. Instead, I was taking direction from the MWT via the evaluation subcommittee and reporting back to the steering committee. What hadn't changed was my desire to create a mental health system that was culturally appropriate and responsive to the mental health needs of Anishinaabek communities in the Manitoulin, North Shore and Bemwijaang Tribal Council areas.

3.2.2 Locating Indigenous Methodologies alongside Qualitative Landscapes

Situating Indigenous methodologies alongside the qualitative landscape is mutually comparative because they encompass characteristics congruent with other relational qualitative approaches such as grounded theory, case studies and participatory action research to name a few. However, it should be noted that in some cases quantitative research can also be congruent with Indigenous values and beliefs, based on tribal epistemologies. For example, Dr. Malcom King is actively engaged in scientific research yet at the same time he is concerned about how his research is guided by what Cora Weber-Pillwax, (2001) refers to as the three Rs – Respect, Reciprocity and Relationality as guiding principles for Indigenous research. Building on Weber-Pillwax's work, McGregor et al (2018) have added two other guiding principles - relationships and relevance.

Qualitative research is increasingly being selected by Aboriginal/Indigenous scholars as a result of this congruence. Qualitative research allows for a range of interpretations to be analysed and understood, in this regard, it is interpretive. Therefore, for Indigenous scholars there is a wider capacity to understand the stories and the meaning of these stories on behalf of their research participants in a much more holistic way which gives more breadth and depth to Indigenous ways of knowing and being (Kovach, 2009). Through this the researchers can give more power to Aboriginal and Indigenous populations to control their own agendas for wellness and well-being thus leading to ongoing improvement in their lives for future generations.

3.2.3. Articulating a Relational Methodology

Using the concept of 'relational' and my experience with the Cedar Bath project, I thought that I could adapt the concept of 'relational worldview' and apply it to the research process, thus the idea of a 'relational methodology'. The relational quality of Indigenous research has also been articulated by several Indigenous researchers (Kovach, 2009, Wilson, 2008, Brown & Strega, 2005).

The Medicine Wheel is an ancient concept that is used to describe the different ways in which we are related with the world, the cosmos and the universe. Further exploration of the Cedar Bath research project led me to the understanding that a "relational methodology" requires time, time to build relationships. In my work with the traditional healers on the Cedar Bath Project, it took about six months of getting to know one another before we even got to the point of discussing the research idea around the project. The traditional healers wanted to know more about me as a researcher. They wanted to know if I understood the teachings, the ceremonies and what they hoped to achieve in undertaking this project. They also wanted me to participate in a Cedar Bath before beginning this work. This became an important aspect of this work since if I

knew at a personal level what the Cedar Bath was about then I would understand what others who were going through this ceremony might be experiencing. The relationship building process also allowed me to learn more about the traditional healers and what they hoped to achieve by engaging in this research project.

3.3 The MWT Pilot Project Methodology

This qualitative research project consisted of a storytelling methodology based on a conceptual framework of Indigenous ways of knowing that included concepts of ethical space, and cultural safety. Since the start of my research project there have been many advancements in thinking about Indigenous research methodologies. A major shift in Indigenous research has been from viewing research from an Indigenous perspective to viewing Indigenous research from an Indigenous paradigm (Wilson, 2001). A perspective is a way of looking at something (the lens we view the world through). A paradigm is a set of beliefs that go together to guide our actions (Wilson, 2001) so it flows that a research paradigm is a set of beliefs about the world and knowledge gathering that informs how you are going to do your research (Wilson, 2001). Wilson (2001) describes a research paradigm as being made up of four aspects: ontology (what you believe is real in the world), epistemology (how you think about that reality), methodology (how you use your way of thinking to gain more knowledge of your reality, and axiology (the ethics and judgement of which research is worthy of doing).

There are some similarities and differences between an Indigenous paradigm and non-Indigenous paradigm. For example, like social constructivism, Indigenous ontology believes that there is more than one reality but beyond this there are many differences. The social constructivist paradigm is based on the fundamental belief that knowledge is an entity and that researchers in search of that knowledge gains that knowledge and therefore owns that knowledge (Wilson,

2001). The Indigenous paradigm is based on the fundamental belief that knowledge is relational (shared with all of creation – the cosmos, the animals, the plants, and the earth) and that knowledge cannot be owned or discovered (Wilson, 2001).

Besides this distinction between the social constructivism paradigm and Indigenous paradigms there are other differences when it comes to Indigenous research methodologies. Indigenous research methodologies are based on tribal epistemology (Smith, 1977; Kovach, 2009, Lambert, 2014). Tribal epistemology is "interactional, inter-relational, broad-based, whole, inclusive, animate, cyclical, fluid and spiritual" (Kovach, 2009, pg. 56). Kovach (2009) also states that "tribal knowledge is pragmatic and ceremonial, physical and metaphysica"l (pg. 56). This combined with sophisticated and complex cultural practices, makes it difficult to "define, deconstruct and compartmentalize" (pg.56) as is often the case with western-based research.

A dilemma facing Indigenous researchers is the tension between the notion that empirical evidence (intellectual knowledge) is superior to cultural knowledge (Meyer, 2001). However, Tafoya (1995) (cited in Wilson, 2001) indicates that the western notion of objectivity doesn't fit an Indigenous paradigm because it requires one to separate (break down) stories and then piece them together again. This sort of analysis is in opposition to an Indigenous methodology which involves relational accountability meaning that the researcher is obliged to answering to "all your relations" during the research process (Wilson, 2001). Further, a relational methodology is grounded in the understanding that the researcher is knowingly involved in the lives of real people and thus, needs to be concerned about fulfilling his/her role in this relationship and the obligation to gain knowledge needed to fulfil that relationship (Wilson 2001).

Aspects of Indigenous epistemologies that consistently emerge are its non-fragmented, holistic nature that focuses on "the metaphysical and pragmatic, on language and place, and on values and relationships" (Kovach, 2009, pg. 57). Building relationships requires time - time to engage community as full participants in the research process, to discuss the appropriateness of the research questions and to determine whether the community sees the research as important (Roberts, 2005). This is one aspect of an Indigenous methodology that appears like community-based action research. However, there are several other distinctions that set Indigenous methodologies apart from Western qualitative approaches: there is a relationship with the source of the research data (the person who knows and tells the story); the relationship that the researcher has with the story (how it is told), and the relationship between the researcher and the knower (how the story is interpreted) (Kovach, 2009).

The methodology for the evaluation of the engagement process was jointly developed between me and the evaluation sub-committee of the MWT. An Indigenous storytelling methodology was utilized for this research. Storytelling is a preferred method of imparting knowledge for Indigenous peoples. What I have come to know about storytelling is that a storyteller does not give a universal answer at the end of the story. It is up to the listener/reader to interpret the story for their context/situation. Each time a story or teaching is provided, the way one interprets that story or teaching is dependent on the individual. For example, you can hear the same story everyday but because individuals change based on their experience/context, the person will take a different lesson from that story or teaching. Storytelling is relational at its core thus allowing deep meaning and connections to be shared (Archibald, 2008; Thomas, 2005; Absolon &Willett, 2005; Bishop, 1999; Bishop and Glynn, 1999). Storytelling involves getting into a relationship with someone, being able to tell both sides of the story through its analysis (Wilson, 2001).

A challenge for Indigenous researchers is how to write research participant's stories without "othering", exploiting or leaving them voiceless in the telling of their own stories (Liamputtong, 2007: pg. 165, cited in Kovach, 2009). How stories are interpreted depends on the researcher's belief about how to accurately represent the voice of the research participant and choices for data gathering and interpretation. Indigenous methodologies include a requirement for the researcher to give back to the community in a meaningful way and having a relationship with the community that allows the community to determine what is relevant. Storytelling allowed participants to describe their journey and relationship to the pilot project. Stories were captured by a variety of means – storytelling interviews, self-reflective journals, photovoice and focus groups. These methods will be further described in Section 3.4. Data Collection.

The research participants included members of the Mental Wellness Team, Mental Wellness Steering Committee members and key informants from the community partners/community services (10 First Nations communities from the Manitoulin Island, North Shore and Waabnoong Bemjiwang Tribal Council areas).

Recruitment was done through a purposeful sampling. Some participants such as the MWT, the steering committee, and the participating First Nations communities were already involved with the pilot project. Others such as First Nations agencies and service providers were recruited through the Health Directors from the participating First Nation communities. The Health Directors were provided with a script/letter of introduction to aid in recruitment (Appendix 6).

My research for this project focused on the following areas:

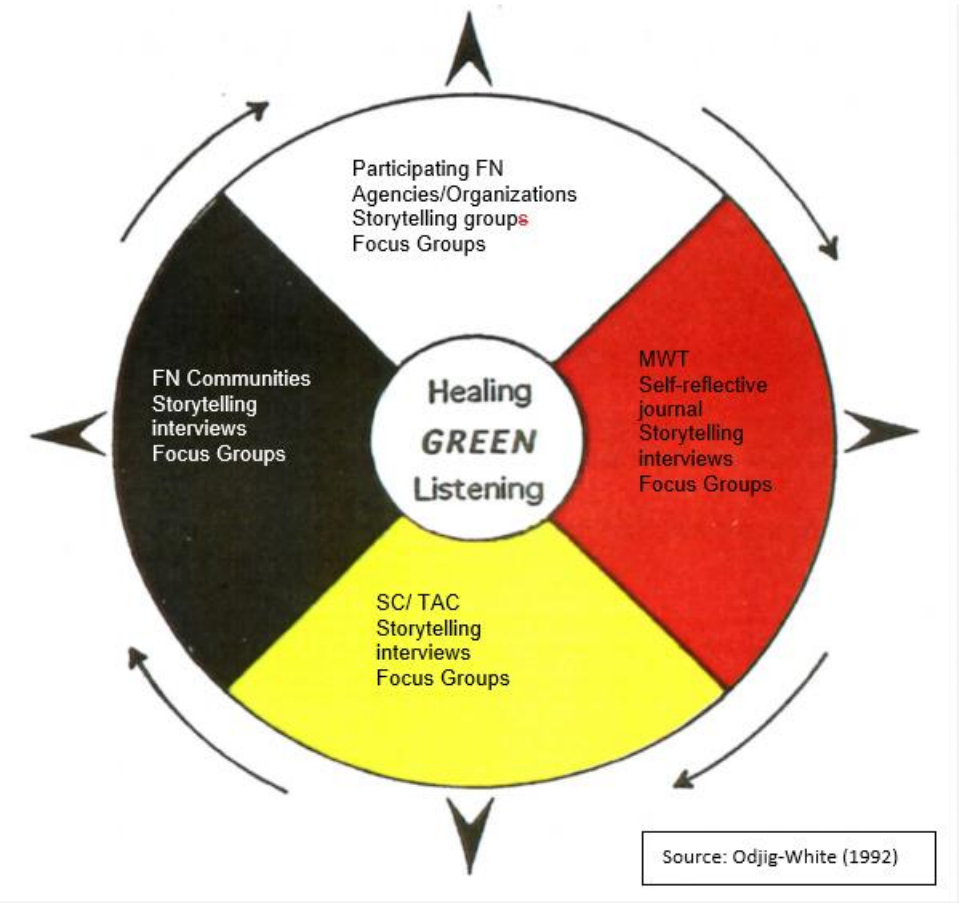
- How the MWT pilot project maintains the engagement and support of the 10 participating First Nation communities,

- Collaboration within and across communities and with key partners,
- The integration of mainstream and traditional approaches by the MWT pilot project and,
- The impact on the capacity building and knowledge at the community level.

An Indigenous storytelling methodology guided by the medicine wheel was chosen for the pilot project. This would allow for the in-depth exploration of the involvement of the MWT Steering Committee, MWT staff, First Nation leadership and frontline workers.

Working with the evaluation subcommittee we came up with an evaluation process based on the Medicine Wheel framework involving the steering committee and MWT staff, the frontline workers and the First Nations leadership and several data collection methods – storytelling interviews, focus groups, photovoice and self-reflective journals. These methods were chosen specifically because they were consistent with Aboriginal oral tradition, respectful of Aboriginal protocols and worldview (values, beliefs, traditions) and consistent with traditional ways of knowing and being. Figure 6 shows the MWT pilot project methodology depicted using the Medicine Wheel, an ancient symbol used by almost Native people of North and South America (Lane, Bopp, Bopp & Brown, 1984) to help people understand concepts that cannot be seen physically (Hart 2002). Appendices 11 and12 contain sample interview guides and focus group questions that were devised in consultation with the evaluation subcommittee of the steering committee for the MWT.

Figure 6. The MWT Pilot Project Methodology



Four groups were included in this evaluation: Service Providers/Agencies, MWT, Steering Committee, and First Nation Communities (see appendices 9,10,11, and 12). All four groups were invited to participate in the storytelling interviews. The MWT members were also invited to participate in self-reflective journaling as well as a Photovoice activity. Each of these methods are described in more detail below.

3.4 Data Collection

3.4.1 Storytelling Interviews

Indigenous knowledge comprises a specific way of knowing based upon oral tradition of sharing knowledge - akin to what different Indigenous researchers refer to as storytelling (Thomas, 2005; Absolon &Willett, 2005; Bishop, 1999). Storytelling can be viewed as conversational method of gathering knowledge and a culturally preferred method of imparting knowledge (Bishop & Glynn, 1999). Conversational knowledge gathering based on an oral storytelling tradition is compatible with an Indigenous worldview. A storytelling methodology is relational at its core, a quality that has great meaning for Aboriginal peoples that allows deep meaning and connections to be shared with one another (Archibald, 2008).

According to Bishop (1999), there are different versions of stories, and each version of the story contains truth and meaning. With that in mind, storytelling interviews were conducted with the MWT staff, the Steering Committee, the Traditional Advisory Circle, the First Nation leadership as well as the service providers/agencies so that they each could describe their journey and relationship to the pilot project, highlighting successes and challenges, offer recommendations for improving the services and suggestions for improving the relationship between the pilot project and its partners.

The storytelling interviews were held one on one with the MWT staff, the Steering Committee members, the Traditional Advisory Committee and in a group with First Nations agencies/organizations. Some interviews were held by telephone interview depending on the availability and preference of the participant. The bulk of the storytelling interviews occurred in

2010. A total of 21 storytelling interviews were conducted with the steering committee members, the traditional advisory committee members, the MWT staff and First Nation leadership. An interview guide was provided to the participants for their reference. The interview guide (see appendix 9 - 12) was not strictly adhered to. Rather, in telling their stories, the participants could refer to this guide as prompts for their stories. The remainder of the interviews conducted with First Nations leadership were completed in 2011. There was a total of 28 interviews conducted. Data was audio recorded and stored on an encrypted laptop that only the researcher had access to.

3.4.2 Focus Groups

Focus groups (consisting of about 12-15 participants) are often used when collecting program evaluation data (Rubin and Babbie, 2001). Focus groups provide a convenient way of gathering information about specific topics through group discussion. Focus groups were chosen as part of the data collection methods because of its fit with the concept of the sharing/talking circle. Lavallee (2009) makes the distinction between focus groups and sharing circles. While both sharing circles and focus groups gather information on a particular topic, sharing circles differ in that there is sacred meaning attached to the activity often with a healing component that can result in the growth and transformation for the participants (Lavallee, 2009). Further, Wilson (2001) indicates that talking circles (sometimes referred to as focus groups) are relational in nature. The focus group process was modified to make it more culturally relevant by the offering of tobacco and utilizing traditional circle protocols. Focus groups were held with the service providers/agencies in the First Nations communities to seek their opinions on the services provided through the mental wellness team pilot project and to ascertain whether the pilot project was having an impact in their communities.

Focus groups were held with seven First Nations community social service providers with a total of 48 participants. These focus groups took place in their respective First Nation communities. One focus group was held with the five MWT staff at their office in Sudbury, Ontario. In total there were 53 participants who participated in the focus groups.

3.4.3 Self –Reflective Journaling

Self-reflective practice can be a catalyst for change; create spiritual awareness; and contribute to the development of self-discovery, self-awareness and empathy (Argyris & Schön, 1974; Nabigon, 2006). Anishinaabek in the Sudbury/Manitoulin area use the Medicine Wheel teachings, Seven Grandfather teachings and teachings on Mino-Pimatisiwin to reflect their understanding of themselves and their relationship with all of Creation (Nabigon, 2006; Hart, 2002; Benton-Banai, 1988) which leads to growth and self- discovery and knowledge in a positive direction deepening and expanded one's practice.

The MWT staff members were invited to participate in a half-day training session on self-reflective journaling. The MWT staff received training on how to use Gibb's reflective cycle in their self-reflective journals in order to track their activities, critically reflect on their current practice and provide recommendations for change. Using Gibb's reflective cycle, participants were asked to: Describe what happened; what were you thinking and feeling; what was good or bad about the experience; what sense can you make of the situation; what else could have been done; and, if it rose again, what would you do? (Gibbs, 1988) The questions for self-reflection are included in Appendix13. Self-reflective journals allowed the MWT staff to track their activities, critically reflect on their current practice and provide recommendations for change. Gibb's Reflective Cycle is described in Appendix 14. The MWT staff were instructed to keep a

self-reflective journal of their activities with all the people they engaged with as part of the MWT pilot project.

There were 5 MWT staff members that participated in the self-reflective journaling training. Only one of the MWT staff actually completed the journal activity. Thus, it was decided that this portion of the evaluation be discontinued. Examples of consent forms are provided in appendices 15 and 16.

3.4.4 Photovoice

Photovoice is a form of storytelling that allows deep meaning to be shared with others. It is a method of gathering knowledge that is congruent with an Indigenous paradigm. Photo voice is a participatory action research method that uses photography and group dialogue to help individuals deepen their understanding of a community issue or concern. Photovoice is a non-threatening method that can be used to tell a story; to promote critical dialogue on a topic; and, to identify important real-life issues while allowing deep meaning to be shared with others (Wang & Burris 1997). Visual images and accompanying stories are used to draw attention to conditions experienced at the community level. The analysis of images, critical dialogue, and self-reflection are ways to identify themes and important issues.

The photovoice training included background information about photo voice, introduction to the focus topic, ethics and safety as well as instruction on taking photographs. The MWT staff were asked to take pictures that represented the strengths and challenges around their engagement with the participating First Nation communities and then they were then asked to record, name & reflect on what these photos represented with respect to their engagement with the community.

3.4.5 A Second Round of Interviews

Concerns were raised over the lack of data from both the photo voice activity and the self-reflective journaling. To compensate for this a second round of interviews was required to ensure the saturation of data. A community-based research team had just been hired to complete a summative evaluation and had just begun to work with the evaluation sub-committee on the approach to take for this evaluation. A recommendation was made for me to collaborate with the community-based research team in order to avoid duplication of information gathering. I met with the community-based research team to collaborate on the reviewing and finalizing the evaluation framework, the data collection tools and focus group questions (see appendices 17 and 18). This second round of data collection involved a focus group for MWT staff and several regional focus groups that would be co-facilitated by myself and a member of the community-based research team with information collected being shared between myself and the research team. Since this was a second round of data collection a letter of introduction (appendix19) was drawn up to explain to the partnering communities the need for further interviews and focus groups.

Partnering with the community-based research team was a very interesting experience. The way in which they worked with the First Nation communities differed significantly from my approach. My interaction with the First Nation communities was based on a relational worldview in which the establishing of relationships with community was of paramount importance. Establishing a relationship takes time and effort and cannot be rushed. Thus, my approach emphasized the building of relationships with all participants – mental wellness team, the steering committee, the First Nation leadership, and the frontline workers. For example, my approach to focus groups with the community workers would involve greeting them with hugs

and catching up on what has happened since we last saw each other. This constituted a more culturally appropriate way of connecting with community workers whereas working with community-based researchers there was some connecting happening but not to the extent that I was used to.

The data collection methods for the first round of data collection are summarized in Table 1. The data collection methods for the second round of data collection are summarized in Table 2.

Table 1 - Interview and Focus Group Breakdown (2010)

METHOD	SCHEDULED LENGTH OF SESSION	GROUP	# OF PARTICIPANTS
Photovoice	No specified time frame	Mental Wellness Team Staff	3
Self-reflective journals	No specified time frame	Mental Wellness Team Staff	2
Community Focus Groups	2 hours	First Nations Mental Health and Addiction and other frontline workers (5 groups interviewed)	48
		Mental Wellness Team Staff (One meeting)	5
Storytelling Interviews	1 – 1 ½ hours	Mental Wellness Team Staff	5
		Leadership/Health Directors	5
		Steering Committee Members	9
		Traditional Advisory Circle	2
Total number of participants			**79**

The approach taken by the community-based research team was purposeful yet at the same time respectful of community, but it was clear that their intention was to gather information. I, too, was interested in gathering information but the way I approached community was different. I was used to having conversation, catching up on news and maybe having coffee before we got down to the business. As Anishinaabe people this is what we do when we meet each other. I decided to follow the lead of the community-based researchers for this second round of focus groups because I was aware that having to conduct these focus groups again can be an imposition which had the potential to create hard feelings among participants. I also noticed as they were conducting the focus group that attention was focused on how they would frame their evaluation report. I was focused on remembering important information that was needed to be included in the final report.

Table 2 - Interview and Focus Group Breakdown (2012)

METHOD	SCHEDULED LENGTH OF SESSION	GROUP	# OF PARTICIPANTS
Regional Focus Groups	2 hours	4 regional focus groups with community agencies 1 focus group with Mental Wellness Team Staff	28
Interviews	1 hour	Chiefs/Health Directors	7
Total number of participants			**35**

There was much consideration given to the data collection methods for this project. Each method was adapted to be more culturally relevant and fit within an Indigenous worldview. Each method

allowed the participants to share ideas about their relationship with their partners involved with the pilot project. The research participants were able to share information about the successes and challenges that were experienced during the pilot project and identify recommendations for improving the relationship between the pilot project and its partners.

3.5 Data Analysis

Once the data from the storytelling interviews and focus groups were transcribed, I used the N'Vivo 10 software, a qualitative data analysis tool, to help me to organize and code data. In the process of coding, related information is gathered and placed into a container called a node. Opening a node allowed me to see all the references coded to that node. Nodes can be organized according to themes. I was able to do some queries to do text searches which helped to identify key words. From this I was also able to develop word trees that helped to identify themes. Coding in this way allowed me to see broad headings and from this I was able to organize into subheadings. This formed my initial analysis.

While N'Vivo can be a valuable tool for data analysis, I found this a difficult program to work with particularly because it requires one to break down the data and then rebuild it up again. For myself as an Anishinaabe-kwe this was a process that didn't fit well with my worldview and at times felt awkward and the idea of dissecting the stories to identify themes seemed unnatural.

However, it was still necessary to make sense of the information provided through the storytelling.

According to Wilson (2001), there is a relationship that is established between the teller and the listener of a story. I felt honoured that the research participants willingly shared their lives with me, and I wanted to ensure that I fulfilled my obligation to represent their stories as accurately as possible. The question then becomes – how did I identify and name themes? I spend a lot of time reflecting on what was told to me. I read and re-read the transcripts looking for ideas that came up many times. I shared what I was learning with the Steering Committee throughout the process. The last presentation back to the Steering Committee occurred Feb 2016 at M'Chigeeng First Nation. It was fortunate that we were able to do a second round of data collection. This provided an opportunity to re-connect with community and present information about what had been learned to date.

In addition, I sought feedback on my work with the MWT pilot project by presenting at several conferences:

- Healing Our Spirits Worldwide Conference - 2015, Hamilton, New Zealand
- Aboriginal Education Research Forum – May 2015, Winnipeg, Manitoba
- Manitoulin Anishinabek Research Review Committee (MARRC) Research Conference - February 2013, Whitefish River First Nation, Manitoulin Island, Ontario
- Mental Wellness Team Annual Gathering - Oct 2011, Victoria B.C.
- SAGE Meeting - Oct 2011, Laurentian University, Sudbury, On.
- Ontario Training Centre - Poster Presentation – Oct 2010
- Healing Our Spirit Worldwide – Sept 2010, Honolulu, Hawaii, USA

- PhD Presentation, School of Rural and Northern Health – July 2010

Feedback from these conference presentations provided validation for the stories.

I was able to share my findings with my supervisor who would often ask pointed questions about what I was learning. In addition, there were opportunities to meet with people who had been part of the MWT pilot project and how had moved on to other work. When asking about the MWT pilot project I was able to relate some of the finding which were confirmed by these individuals. This happened with previous MWT coordinators and Steering Committee members. In addition, the sharing of where I was at with the project with Elders and community people allowed me to further refine my thinking on the information gathered.

3.8 Conclusion

The evaluation of the MWT pilot project afforded the opportunity to use an Indigenous research methodology and research methods congruent with traditional practices. All techniques used in the data gathering for this were relational and are respectful of Anishinaabe protocols. This project required the researcher to situate herself in relationship to the community and with the MTW pilot project team. As is evidenced from above, the MTW pilot project took the time to be inclusive of meaningful relationships, which included reflective practice, choosing appropriate research methods, ensuring traditions were respected, honouring voices and having an open circle for ideas and opinions to ebb and flow.

Use of reflective practice provided the MWT with the opportunity to take a realistic look at where they were and where they could go from here. This component of the evaluation for the MWT adds to the overall evaluation of the project and builds a case for justification of continuation of the project by demonstrating worthiness. Recommendations from this evaluation

can provide information for other mental wellness team projects about how to engage with their First Nations communities. The findings from this evaluation as well as recommendations will be discussed in the next chapter.

Chapter Four: Findings from the Evaluation of the Raising the Spirit Mental Wellness Team Engagement with First Nations Communities in the Manitoulin, North Shore and Bemwijaang Tribal Council Areas

4.1 Evaluation of the "Raising the Spirit" Mental Wellness Team Pilot Project

The Raising the Spirit Mental Wellness Team in the Manitoulin, North Shore and Bemwijaang Tribal Council areas of Ontario, Canada areas is an example of how Aboriginal communities are implementing the mental wellness team concept to address mental health and addiction issues. The aim of this chapter is to highlight the findings from the evaluation of the engagement process between the MWT and the First Nations communities involved in this pilot project.

Early on in the development of this project, the MWT steering committee recognized the need to develop an evaluative component to this project. A community-based research team was hired in the fall of 2011 to conduct a process evaluation and to conduct a final summative evaluation of the pilot phase in 2012 (Health Canada, 2014). As part of my PhD research, I was responsible for completing a portion of the overall evaluation. My research used a culturally appropriate framework based on the medicine wheel to evaluate the engagement process between the MWT and the participating First Nations communities. The main research question was "How does the MWT pilot project maintain the engagement and support of the 10 participating First Nation communities? Other research questions included: How does the MWT pilot project maintain collaboration within and across communities and with key partners? How does the MWT pilot project integrate mainstream and traditional helping approaches? And what is the impact of capacity building and knowledge at the community level? An outcome of this research was to highlight the successes and challenges of the engagement between the MWT and the First Nations communities. Lessons learned from this project can be used to help inform the development of other mental wellness team projects across Canada.

In keeping with the theme of ‘struggle’, this chapter also highlights some of the struggles that the MWT pilot project encountered throughout the evaluation process. In this chapter I use the word scramble to describe the early development of the MWT Pilot project. According to Etymology Online, the word scramble has several meanings: "to struggle, to scrape quickly", "to stir or toss together randomly", "to make unintelligible" (as used in broadcasting or as in scrambled eggs) (Harper, 2019). The word ‘scramble’ describes the work that the planning committee did when they learned that the project had received funding but the level of funding that was received was lower than expected. The planning committee scrambled to work with First Nations Band Councils to select representatives for the steering committee. Once established, the steering committee scrambled to hire a project coordinator and staff to work on the pilot project. The MWT coordinator scrambled to make connections with the First Nations leadership and mental health programs and to come up with a service delivery plan. A key aspect of all these activities is the need to develop relationships which takes time, requires respect and reason and is complicated by a number of challenges (geography, number of communities involved in the project, seasons, change overs in MWT staff, changes in Band Councils, etc.).

Elaborate is a verb that is related to the word ‘struggle’. The word elaborate originates from the Latin term ‘elaboratus’ which means to "to labor, endeavor, struggle, work out" (Harper 2019). There are many meanings to the word ‘elaborate’. Two meanings: "to build up from simple elements," or "to work out in detail" have significance for the MWT pilot project. The MWT pilot project experienced many challenges right from the start. This project was different from the other pilot projects in that the other projects were already firmly established in their service delivery models. The Raising the Spirit Mental Wellness Team pilot project was a new project, just past the idea stage, there was no infrastructure in place and the program required further

development. The steering committee was responsible for hiring the project coordinator as well as the staff before the project could be implemented.

Another term related to ‘struggle’ is ‘tension’ The word has roots in Middle French (a stretched condition) as well as the Latin term ‘tensionem’ (a stretching or a struggle or contest) (Harper, 2019). This chapter also explores the tensions that developed between the MWT, the staff, the frontline workers, the First Nation leadership, and other collateral agencies in relation to this pilot project.

The word reluctance originates with the Latin tem ‘reluctari’ which is actually two words: re ‘against’ and luctari ‘to wrestle, struggle’. Reluctance is a verb that refers to the "act of struggling against" and more recently means ‘unwillingness’ (Harper, 2019).

Perhaps one of the biggest challenges was in relation to the reluctance of the Federal and Provincial governments to properly fund this project. The project as envisioned by the planning team (Danny Manitowabi, Dr. Brenda Restoule and me) required a certain level of funding for it to run effectively. First Nations and Inuit Health Branch did not fund the project as requested so the project had to move ahead with a scaled back budget. The MWT had to find ways to pare down the project yet still meet the needs of all ten First Nations communities that had signed on the project. This meant that this team would not be able to deliver all of the services that had been envisioned.

4.2 Background

During the consultation phase of the MWT pilot project, the planning committee conducted a needs assessment with the First Nations communities to determine the level of skills and training that were in existence in the communities. The needs assessment found that although the

frontline workers were highly skilled, they lacked post-secondary training. Many of the frontline workers identified that they could benefit from additional skills enhancement training that would allow them to upgrade from a college diploma to a university degree. Community workers were enthusiastic about the prospect of having an accredited training program. This was identified as an important component of the services that would be provided by the MWT pilot project.

In addition, a meeting was held with representatives from the education sector to discuss how to best address the need for an accredited education program. Several options by which the MWT could make available that accredited training to the communities were identified: the mental wellness team could partner with local educational institutions to offer accredited social work programs; a laddering process could be introduced that would allow the workers to continue to work while obtaining their advanced credentials; and the idea of developing certificate programs were also discussed. The findings from the needs assessment was supported be the Kirby Report (2006) which also identified a need for accredited training for First Nations mental health workers.

However, the accredited training aspect of the MWT project never materialized mainly due to lack of funding available from Health Canada. With the scaled back funding received from the Federal Government, this was one aspect of the project that had to be let go. *"What was envisioned, mammoth idea, huge apple, one bite at a time, some of the goals, beyond, human and financial resources, trying to pare down" (FG, 2011-01).*

Instead of giving up on the training aspect of this project, the MWT focused on delivery of capacity building and the blending of traditional and Western approaches to service delivery. The traditional teaching series was one of the more successful components of the pilot project that

appeared to contribute to the development of good relationships between the MWT and the First Nations communities.

One tension that emerged early in the development of the pilot project occurred between the steering committee and other health services in existence on Manitoulin Island. For example, two other health service providers, Noojmowin Teg and M'Namodzawin Health services felt that funding for the MWT pilot project had been diverted from mental health funding intended for their organizations. In order to clarify funding issues, a meeting was held in August 2011 between the steering committee, First Nations leadership, these two health authorities and Medical Services Branch of Health Canada.

Another tension was related to representation on the steering committee. The two health authorities on Manitoulin serviced the same First Nations communities that were part of this pilot project with the exception of the communities in the North Shore and Bemwijaang Tribal Council areas. These two health authorities felt that they were entitled to have representation and a vote on the steering committee. However, membership on the steering committee was comprised of representatives from the First Nations communities that had signed on to the project had indicated their support and participation through Band Council Resolutions (BCRs). A meeting was held with Health Canada representatives, Tribal Council representatives, Chief and Councils of participating communities, health boards and health access centres to address the membership concerns. In the end, it was agreed that both Noojmowin Teg and M'Namodzawin Health Services would be ex-officio members of the steering committee for the purposes of networking and information sharing. They would be privy to the activities of the project but would have no vote on the steering committee since the communities that they served already had representation on the steering committee.

The MWT project was designed in such a way as to avoid the potential for political interference. While there was support from the First Nations communities in the form of BCRs there was also acknowledgement that there was a direct reporting relationship between the steering committee members and the First Nations communities, with the steering committee members reporting back either directly to the chief and council or a designated committee such as the health committees. The steering committee members' role was to provide guidance to the MWT staff which was especially important during the start-up of the project.

> *"… when the mental wellness team was created the whole idea was that direct relationship from the project to the First Nation. And they didn't want any middle. So, the tribal councils weren't really part of it … but we always concentrated on the direct relationship with the First Nation" (HD 2011-02).*

Tensions were also evident in terms of community characteristics. The needs of larger, well-resourced communities differed from smaller First Nation communities. Mental health workers in larger First Nations communities seemed to be more experienced in providing mental health services so increased access to specialized services, consultation on complex cases as well as increased capacity-building in terms of traditional and cultural competencies were identified as needs. Smaller, less experienced communities were more interested in acquiring additional training in mental health and addictions as well as in traditional healing approaches.

4.3 Findings from the Evaluation of the Mental Wellness Team Pilot Project

The key focus of this evaluation was on the relationship between the MWT and the First Nation communities. Four topics emerged from the evaluation that impacted this relationship: 1) Communication and communication challenges; 2) the commitment to the project; 3)

collaborative relationships; and 4) capacity building efforts (see Figure 7). Challenges that affected the ability of the MWT to engage with the First Nations communities included: geography, location, funding and jurisdictional issues. The MWT pilot project realized many successes such as skills enhancement training, the bridging of western and traditional helping approaches, access to specialized services including the Elders-in-Residence Program, and crisis response. Access to these services and activities served to enhance the relationship between the MWT and the First Nation communities.

4.3.1 Communication and Communication Challenges

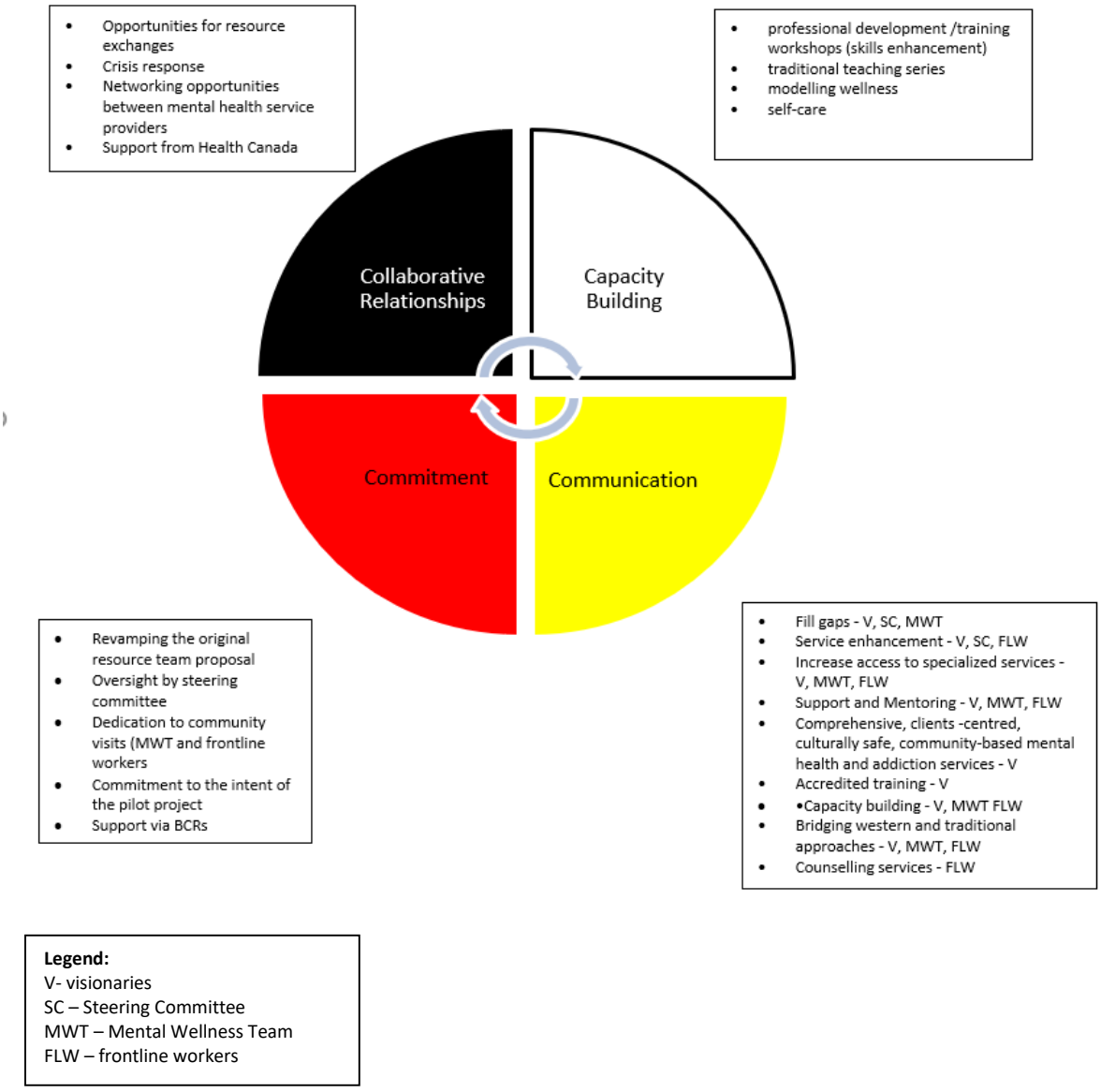
Each of the groups involved in the MWT pilot project – the visionaries, the steering committee, the MWT team, the First Nations leadership and the frontline workers – had a different understanding of what the original intent of the "Raising the Spirit" Mental Wellness Team Project was.

4.3.1.1 The Visionaries View

The visionaries were the employees of Northeast Mental Health Centre employed through the First Nation Mental Health Development Initiative, specifically Daniel Manitowabi, Dr. Brenda Restoule and me. These individuals plus Frank McNulty (Ontario Region, Health Canada) developed the Mental Wellness Team proposal, based on a previous proposal submission, the Development of a First Nations Resource Team that was designed to enhance mental health and addictions services in First Nations communities in the Sudbury/Manitoulin region. The Mental Wellness Team proposal built upon this original submission and incorporated key components related to the mental wellness team goals of filling in gaps in the continuum of mental health care and the creation of comprehensive, client-centred, culturally safe, community-based mental health and addictions services in First Nations communities (Health Canada, 2014). In addition,

after a community engagement process with the ten (10) First Nation communities, this group envisioned inclusion of accredited training that would enhance the capacity building of frontline mental health staff (Sutherland, 2013; Wellness Team Pilot Project Meeting minutes, July 16, 2007).

Figure 7 - Key Areas Impacting the MWTs Relationships with First Nations



4.3.1.2 The Steering Committee View

The steering committee members viewed the pilot project as a service enhancement that would fill in mental health service gaps, which would aid people to lead better lives. As the project evolved it was important for the steering committee to not lose sight of the original intention of the project.

> *"I think that the intent of the Mental Wellness Team and the steering committee- when the proposal was put together- the whole ideas before it even came to be needs to remain the same" (SCM 2012-01).*

4.3.1.3 The MWT Team Staff

It took some time for the MWT Team staff to fully understand their role in working with the First Nations communities. At the outset of the project, the MWT Team staff consulted widely with the First Nations communities to discuss the nature of the services that they would be providing. According to the job descriptions for the MWT staff, these staff members were tasked with "improving access to needed specialized services where gaps exist; enhancing knowledge, skills and capacities of community workers; providing support via a team approach of consultation, clinical supervision, coaching and mentoring; and, building and/or strengthening bridges between traditional and mainstream approaches to wellness" (Appendix 3, 4, & 5. - Job Descriptions). In addition, it was made clear to them that their role was not to provide direct services in the First Nations communities. The MWT staff consistently had to redirect community frontline workers about the scope of their duties as demonstrated in the following quotes:

> *"I was asked to do their counselling for them – No I can't do that. I was able to sit in and listen and talk to you after the client left." (MWT 2011-01)*

"What does case consultation mean – we see our role – we will help you determine what could be done." (MWT 2011-01)

"We tried one time to do mock scenarios - they wanted us to do the work. Discuss it, find solutions." (MWT2011-01)

4.3.1.4 The Frontline Workers View

Frontline workers were confused about who the MWT was supposed to be providing services for – the community members or the frontline workers.

"I think when they introduced the pilot project to us, we all had the understanding that it was for the community members, it wasn't to be working with the staff. We were confused as to why they were always here." (FG, 2012-02)

The frontline workers had envisioned that the MWT would provide counselling services. The enhancement of counselling services was of particular interest to the smaller First Nations communities as they were not as well-resourced as the larger First Nations communities that had well-established mental health services. These smaller First Nation communities were relying on the mental wellness team to provide counselling services for their community members since they were limited in their scope of practice to prevention and promotion activities. However, when crisis situations arose the frontline workers in these smaller communities felt obligated to provide counselling services.

Frontline workers were interested in the in-service and capacity building as well as the opportunity for consultation. Most of those involved were attracted to the increased access to specialized services like psychiatry and psychology. They also saw that the traditional piece as being of equal importance in building capacity and supporting workers in a culturally safe way.

Most communities were under the impression that the MWT could offer additional resources that would enhance their programs. For example, the need for a central resource repository was identified:

> *"… initially I was looking at this group to be resource, a resource group. If I wanted some resources instead of seeing or talking to them directly, going to some place where they have this information, I'm thinking if we had more of a computerized library or a site where we can connect with the professionals would have been good, know what their expertise are. If we had a common thing within our communities that we deal with, you know, grief and loss, all the resources that we could utilize with that, that kind of a structure, that's what I was looking for" (FG 2011-02).*

4.3.1.5 The First Nations Leadership View

Originally, First Nation leadership *"envisioned that it would be an opportunity for knowledge exchange so the transfer of knowledge"* (FNL 2011-01). First Nations leadership saw that the goal of the mental wellness team was to integrate traditional healing practices into mental health service delivery.

> *"… what I saw as its intent or its goal was to really try to integrate some traditional pieces into the work that we do as services providers" (FNL 2011-01).*

4.3.1.6 Summary

All participant groups in the project had the similar understanding about the original intent of the pilot project which was to enhance mental health and addictions services as well as to fill in gaps in the mental health care continuum (Health Canada, 2014). However, the differing expectations such as providing direct services, an accredited training program, and lack of clarity over

purpose behind the community visits left the stakeholders confused and frustrated about the process. Although each of the participant groups realized the benefits of the MWT pilot project, a well thought out roll out strategy may have helped to clarify the purpose behind the project and address concerns over the scope of duties of the MWT staff. It was suggested that having a vision for the project or referring back to the original intent of the project would aid in keeping the project on track.

A good communication plan may have been able to bridge the lack of understanding between the various groups and provide them with a common understanding. The logistics of the hiring of staff and retention issues made the communication between the parties difficult. Each time a new person was hired there was a need to orientate the individual to the project. Orientation was problematic since the person tasked with providing the orientation may have only been there a short while and was fairly new to the project. In addition, the project had several different program managers in a short time frame particularly at the start of the pilot project. Each time a new project manager came on board, it was necessary for them to orientate themselves to the community partners. The program managers would introduce what they thought was the intent of the project to the communities adding to the misunderstanding around purpose.

4.3.2 Commitment to the Project

Commitment to the project was evident throughout all stages of the project and with all the stakeholders – the visionaries, the steering committee (SC), the MWT, the frontline workers, community partners, as well as the Traditional Advisory Committee (TAC).

There was commitment from the visionaries to revamp the resource team proposal and resubmit it to Health Canada and then to work with Health Canada on further development in line with the

MWT concept put forth by the MWAC strategy. The visionaries worked to coordinate the community consultations and then to develop the Steering Committee (SC).

The SC then continued to develop the MWT project. Being on the SC was a time-consuming process. In the beginning stages of the project, the SC needed to meet frequently, and their role was expanded to include oversight of the project since there was no full-time coordinator in place. The SC members really took their appointments seriously. One SC member spoke about her experience on the hiring committee in this way:

> *"We have to look at what skills they have. So that is why I was tough on the hiring process because I saw what they needed to provide to the staff, to the frontline workers so I was really tough…. But we need to be tough because we want to make sure we have the right people in place" (SCM 2011-01).*

This demonstrated the commitment to ensure that the right people were in place on the MWT.

The MWT staff were committed to the community visits often times travelling in inclement and unpredictable weather. Although there was much turn-over in staff, when there was finally a full complement, the community partners recognized the commitment of the MWT. *"The commitment that the team has now to the project that they are staying with it, working hard, and making the best of it" (FG, 2011-03).* The MWT staff were also committed to the intent of the project and worked to the best of their abilities to ensure that the goals and objectives of the project were being met. "*That the team is moving forward, a committed group, even the staff are committed to the intention of the project, community wellness, and capacity building" (FG 2011-01).*

The frontline workers showed their commitment by adjusting their schedules to make time for the visits from the MWT. First Nations communities demonstrated their commitment to the project by way of Band Council Resolutions (BCRs) and through ensuring representation on the steering committee.

Although there were varying views on the original intent of the project, there was evidence that all the parties involved were accepting of the partnership.

> *"Looking at the whole time line of the project, certainly the initial priority was met, 10 participating First Nation communities, significant effort on the part of the chair and program coordinator, significant effort in the beginning to do community presentations in being able to launch the project, its intention and meeting… [it is] evident that there has been acceptance of the partnership" (FG, 2011-01).*

4.3.3 Collaborative Relationships

Many of the First Nation communities involved with the MWT pilot project felt that this project could offer opportunities for collaboration.

> *"I think what would have been nice to see, is not only what we can get from the team but what do the communities have to offer each other and have the team be the hub for that."* (FG, 2011-01).

For example, if a community had a really strong program for seniors, then other communities could benefit from their experience. First Nations communities viewed this as an opportunity to exchange resources.

There were a couple of First Nation communities that were reluctant to sign onto the project. These communities did not see the benefits of this collaborative relationship at first; this was only realized when their communities experienced crisis situations. The crisis response component was not part of the original vision for the MWT pilot project nor was it identified as a need during the needs assessment process. This is something that evolved out of necessity. In an effort to build relationships with the First Nations communities the MWT would respond to crisis calls from the First Nations communities. One of the first crisis situations occurred in one of the smaller First Nations communities. The MWT received a call from the community to provide assistance to community workers who were dealing with the suicide of a youth. The MWT responded by sending the traditional coordinator, the concurrent disorders specialist and the program coordinator to provide assistance and support to the frontline workers in that community. This set a precedent and an expectation that the MWT could offer additional supports to communities in times of crisis. Frontline workers, other service providers and First Nation leadership came to appreciate this support from the MWT. The following quote recognized that in times of crisis even the mental health workers were affected by the situation.

> *"It's additional support because a lot of times when there's a crisis in the community your mental health workers are probably from the community and they may have a direct impact from that crisis so it's very difficult for them to provide services in some situations. So having access to an external resource to bring them in, it really relieves the burden from our team in many situations. So that is a key component"* (*FNL 2012-03)*

The MWT was able to offer additional resources especially in times of crisis. They were able to take the pressure off community workers who were *"impacted just as much as the people that are directly involved. It's our families as well" (FG, 2012-04).* It added a sense of peace

knowing that they (the frontline workers) didn't have to be the ones to respond and that they could rely on the mental wellness team.

> *"Crisis situations or death in the community per se then they've been there as far as providing additional support groups and fire- keeping and the traditional components of the grieving process. I would say it's helped our services there. It's kind of lessened the bit of the stress maybe or the strain that comes with that because it's a 24/7 thing" (FG, 2012-02)).*

It was great to have workers from the MWT and other First Nations communities to step in and provide that support in those communities experiencing the crisis.

> *"Those are ways to collaborate with the mental wellness team; the resource sharing and networking, information sharing, coming together, sharing ideas, finding out where you get funds, that kind of stuff"* (FG, 2011-01).

The relationships formed between the MWT and First Nations communities created an opportunity for networking – *"It brings that collaboration amongst First Nation workers and communities"* (FG, 2011-01).

The SC members were the direct connection between the MWT and the First Nations communities and organizations. Information about the MWT project was shared with the First Nations communities as well as M'Nidoo Mnissing mental health and addictions mental health partnership network. The MWT, at the SC level, had also partnered with other services on Manitoulin such as Noojmowin Teg Health Centre and M'Namodzawin Health Services. Both these organizations were identified as ex-officio to the MWT which provided them with the

opportunity to sit at the table so that they could be aware of the work that was being done by the MWT which in turn created the opportunity for collaboration.

With respect to Health Canada, Frank McNulty from Ontario Region must be acknowledged for the role he played in this project. He firmly believed in the resource team concept and felt that the people best suited to deliver mental health services were those who were right from the community. Mr. McNulty was a huge advocate for the MWT pilot project.

Collaboration and engagement go hand in hand. The MWT worked diligently to form collaborative relationships with their First Nation partners, the steering committee members, other mental health and addiction agencies, and funders. Although challenges were experienced along the way, the commitment of the MWT staff aided in the engagement process with their partners.

4.3.4 Capacity Building

The MWT excelled in the area of capacity development. First Nation leadership noted that staff who had access to workshops and training benefitted through enhanced skill development.

> *"…providing the workshops and training so that our staff have access so that they can upgrade their skills…" (FNL, 2012-01).*

Capacity building efforts were most noticeable in knowledge transfer and skills enhancement that resulted from the traditional teaching series, training sessions (Knowledge Symposium and Jane Middleton-Moz workshop) and access to specialized services. The training that seemed to be most helpful was the addictions training, cognitive behavioral therapy (CBT), and motivational interviewing. Workers expressed that *"…I've received more training through them in the last six months than I have in years" (FLW, 2012-02).* The frontline workers identified that

the workshops offered by the MWT allowed them the opportunity to attend conferences away from their communities and to gain skills and knowledge that would enhance their ability to perform their roles.

> *"I appreciate those little, the perks that they kind of offer when we go to the conferences or whatever, like the sitting massage, yeah, that's nice. I think what I find helpful there is that it's a chance to be out of the office. It's a chance to be learning, which is good and it's a chance to be kind of somewhere else where you're still working, but you're not necessarily client focused at that point. Then there is an opportunity to do other things that you enjoy while you're there. In that way I find it a form of self-care" (FLW, 2012-01).*

At first the frontline workers were reluctant to work with the traditional coordinator and the concurrent disorder specialist. They would have preferred that the MWT staff work directly with community members as they (the frontline workers) were either not skilled enough to service their clients using traditional methods or lacked the specific knowledge base around concurrent mental health and addictions issues. However, the one-on-one support offered by the MWT staff helped the frontline workers to develop their individual skills. *"It allows us to reflect on what we're doing, so sometimes maybe we've been doing something not as good as we can be, so it helps us self-evaluate what we're doing" (FLW, 2012-02).*

4.3.4.1 Traditional Teaching Series

The traditional teachings series allowed frontline workers the opportunity to learn more about traditional teachings, ceremonies and protocols or reinforce their own knowledge of the teachings. The traditional teaching series increased the confidence level of the frontline workers

to be able to use traditional methods with their clients; practical application of traditional healing approaches in their practice; and increased their personal knowledge.

Feeling ill equipped to be able to use their own knowledge of traditional ceremonies, teaching and protocols with their clients, the frontline workers welcomed the opportunity to learn from the traditional coordinator and to co-facilitate sessions. *"Demystifying the approach, I think" (FLW, 2012-01).*

The frontline workers seemed to be particularly interested in the practical application of how to use the traditional teachings with their clients. *"...we talked about what's in a bundle and the significance of a bundle and what do we do with that bundle, because we're looking at of course bringing that more into what we do" (FLW, 2012-02).*

The frontline workers benefitted personally from the traditional teaching series. *"We have found traditional teaching series invaluable to increase personal knowledge" (FLW, 2012-02).* The frontline workers were able to use what they learned for their own personal healing and to help deal with their own family issues. For example, the teachings of the cedar bath are one way in which the individual can care for self as well as perform the ceremony with their own family members.

There was a strong element of self-care embedded in the approach taken by the MWT as the frontline workers had one on one time to debrief with the traditional coordinator. *"I think that is a lot of what we were asking for from the traditional coordinator program was the self-care element because we're always forgetting that" (FLW, 2011-01).* Having access to the support from the MWT was beneficial in that it lessened the risk of developing burn out amongst the frontline workers.

> *"I guess one of the things that people always say is burn out, burn out, burn out and if you know what's coming, chances of burnout are less likely. I think that was a really positive thing is that they're able to assist with that. You have that vision where you can see what is potentially problematic and deal with it" (FLW, 2012-02).*

Frontline workers as well as steering committee members noted that the traditional teaching series was one way in which they could improve service provision to their clients. While reluctant at first to participate in the healing circles offered through the traditional teaching series, the frontline workers quickly came to realize that the traditional teachings series was a form of capacity building.

The frontline workers' reluctance to participate could be related to a number of factors. According to Goodleaf and Gabriel (2009), frontline workers are impacted by a number of factors that affect their ability as helpers. These factors include: the impact of historical trauma on personal and professional identity; the value placed on culture and the expectation to super cede this expectation; community and personal expectation to respond to crisis; the expectation to be perfect, flawless and problemless; and being immune to social malaise. Because the frontline workers viewed the healing circles as something that was supposed to be offered to their clients, they didn't see the need to be part of that healing. Support mechanisms for frontline workers are often inadequate (Goodleaf and Gabriel, 2009). When support services are offered frontline workers may not feel that they should be taking advantage of such services. And that these services are much better directed at individuals accessing services. The frontline workers didn't understand that part of the services offered by the MWT pilot project was directed at providing them with support through healing circles and the traditional teaching series. Perhaps, the frontline workers felt embarrassment due to their lack of knowledge and experience with

traditional healing methods. Perhaps, they were worried about how they would be perceived having to participate in healing circles when they were supposed to be the helpers. Perhaps, they were afraid of the unknown, afraid of what they would learn about themselves during the traditional healing sessions. Were they prepared to do their own healing in order to be helpful to their clients? Perhaps, they struggled with being cared for since they were hired to provide services to people with mental health problems.

> *"By providing more services, building our capacity and it improves the service we provide, opportunity for self-care, to debrief one on one with traditional coordinator. Our services are also improved that way." (FLW, 2012-03).*

> *Well, I think the capacity building is more with my front-line workers. By building capacity with our worker, we are better able to deliver services to our people here (SCM, 2012-02).*

4.3.4.2 Crisis Response Training

Some of the training that was provided by the MWT came about in response to community crisis. The MWT was able to secure suicide survivor training for community members.

> *"And just recently, after a community crisis in one of the communities, we were able to provide suicide survivor training for 8 individuals in different communities so these survivors of suicide would be able to help communities if there's a suicide in their own communities and help out. So that's one good thing about the training, because often when a crisis occurs in a community, workers are often impacted (SCM, 2012-03).*

4.3.4.3. Professional Development Training

Frontline workers capitalized on the visits made by the MWT and used the sessions with staff members as a professional development opportunity.

> *"We utilized the mental wellness team as a staff group for professional development. We have them come in once a month and we rotate like a traditional self-care where we have a little group, and everyone gets to debrief and then we flip over to technical skills. Like we have had workshops or sessions on case notes, writing case notes and that kind of thing. So, it's an added service for our staff. Where, it almost like an employee assistance program. If they have problems they meet with the traditional coordinator or the concurrent disorders specialist when Danny was here" (FG, 2011-03).*

4.3.4.4 Modelling Wellness

In terms of capacity building, the MWT staff found it necessary to model for the communities how to maintain a sense of wellness. The following picture served as a reminder for the MWT staff to be mindful of maintaining a balance in their emotional, spiritual, physical and mental aspects of their being. The work that they do could easily throw them off balance.

Picture 5, on the following page, shows one quadrant of the medicine wheel. The picture represents the work that was done by the MWT staff and that much of the work originated in the office. In the picture you can see that the inviting landscape of the trees and grass through the window are in stark contrast to the sterile environment of the office. The connection to the land is clearly missing from the work that was being done in the office. This also served as a reminder for the MWT staff to be cognizant of maintaining that connection to land so that they could model that for community.

Much of the work that the MWT was doing, particularly at the start of the project, was confined to the office in Sudbury. Some of the MWT staff members were not connecting physically to the people in the community. The lack of use of the sacred medicines is indicative of this lack of connection to the land. Around the time that this picture was taken, it was fortunate that new MWT staff members were hired who were also traditional knowledge holders and a more concerted effort was made to connect with the First Nation communities. Communities were looking to the MWT team to be role models in terms of providing traditional healing services.

There has been an increase in the number of mental wellness programs and services that are promoting the resurgence of cultural practices including the healing that comes from being on and connecting to the land. Currently, there is an emphasis on land-based activities, a term used to describe cultural-based activities that facilitate healing and wellness (Redvers, 2016). There is evidence that spending time in the outdoors has many healing benefits such as improved cognition, and mood is supported by biomedical research (Redver, 2016; Luig, et.al., 2011). The initial MWT proposal was put together prior to the notion of connection to the land or to the development of land-based activities became popular. Land-based activities aimed at healing and wellness is a fairly new concept gaining importance in health, education and social services. Maintaining balance in one's life is important to building good relationships. If someone is unwell in any of the four quadrants of their being then this affects their ability to function effectively. Engagement is about being able to work well as a team, and with other partners. It is also, about demonstrating to others – SC members, frontline workers, First Nations leadership, colleagues - how to maintain this wellness so that they too can model a way of being for the people they work with.

Picture 5 – One Part of the Medicine Wheel

"The Mental Wellness Team is located in an urban setting away from the 10 partnering communities. You can see in the background the buildings representative of the city. You can also see the trees, which represent 'honesty' to stand straight and tall, the connection to nature. If you look at the window it looks like one quadrant of the medicine wheel. This is our reminder that we are still connected to the community even though we are not located there." (Photovoice participant)

4.4 Ability to Engage with Communities

There were a number of issues that interfered with the MWTs ability to engage with communities that include: consultations; the project infrastructure; varying service needs; funding and resourcing; communication issues and issues related to geography.

4.4.1 Consultations

The frontline workers identified that the consultation process undertaken by the MWT staff could have been better coordinated. It appeared that there was very little consultation with communities about decisions being made.

> *"When I think about when we work with the project staff, too, that there are decisions that are made and I'm not sure exactly where the consultation piece really comes in. And the example I think I'll use is a more recent one, so the traditional program, now the communities are going to be responsible to pay and get reimbursement. So that is sort of the logistical financial piece that we can sort out. But there wasn't too much of a consultation with the community. It went to the steering committee. They would be presented with some information, but no one really came back to the community and ask is this okay for your community. Can your community pay somebody and wait to be reimbursed? Is your community okay with this?" (FLW, 2011-02).*

Frontline workers felt that some of the decisions made by the steering committee could have used more consultation with the communities especially when there were financial or legal implications for the First Nations communities.

4.4.2 Project Infrastructure

Perhaps the largest factor that affected the MWT's ability to engage with the First Nations communities was the lack of infrastructure prior to the start of the project. The MWT staff - the project coordinator, the concurrent disorder specialist, traditional coordinator and administrative assistant positions were filled just prior to the grand opening of the project. Their first task was to consult with communities about their needs and to design and implement the project in consultation with the First Nations communities. A community needs assessment was done in

each of the First Nations communities. The recruitment of staff took a long time, and this affected the ability of the MWT to provide services.

> *"Well, the other thing that I kind of get from what you are saying is that the process as far as recruiting really took a long time therefore it impacted the service delivery at a community level" (FLW, 2011-03).*

The recruitment and retention of the MWT staff also proved to be challenging. There was a high turn-over at the start of the project that led to a great deal of frustration. It was difficult to move the project forward because each new worker that was hired had to be oriented to what had happened with the project which consumed a large portion of their time. One frontline worker expressed: *"this big turn-over with the workers and they are spending time just trying to figure things out" (FLW, 2011-02).* The turn-over in MWT staff resulted in inconsistency in visits to the First Nations communities which in turn affected the communities' commitment to the project.

With respect to recruitment, the skill set that was needed was very specific to meet the needs of both the MWT pilot project and the commitment of the project to the First Nations communities.

> *"… it became a real challenge for the administrative and the advisory committee to kind of balance the needs of staff, their staff and meet the needs of the community…it doesn't become all administrative, but it maintains the focus of providing the services to the communities as originally intended. It doesn't become about recruiting staff, it's maintaining staff" (FNL, 2012-01).*

It is one thing to recruit staff but another to create an environment where MWT staff want to remain. For the MWT staff, this being a pilot project, there was no incentive to stay since there is

no security in the position. It may be a great experience, but most people want to know that they will have employment past two or three years.

4.4.3 Service Needs

The service needs of each of the First Nations communities varied due to their size and location, the skill levels of the frontline workers as well as the level of resourcing each community had. A needs assessment conducted at the outset of the project identified some of the service needs of the participating First Nations communities. However, concerns were expressed from the smaller communities that the services provided by the MWT may not have been what they wanted. The smaller communities felt that *"It's just the majority of whatever they tabulated, the majority of what the needs were, that's what they went with" (FG, 2011-03).* Smaller communities were concerned that their needs may have gotten lost in the overall project and that because they were smaller perhaps then they were overlooked. But the understanding is that the MWT was supposed to service each of the communities equally.

Scheduling visits to First Nations communities was problematic. A major issue with the scheduling was having consistent visits with communities. There were times when the scheduling required changes either due to inclement weather or crisis situations in other First Nations communities that required attention. This caused frustration on the part of the frontline workers who would adjust their schedules for the MWT visit only to find out that the visit had been cancelled.

Frontline workers struggled with idea of the community visits. In some instances, the frontline workers felt that the community visits were being imposed on them. This might have been interpreted as lack of trust in their (the frontline workers) to deliver services or that they were being spied upon. This did little to strengthen the relationship between the MWT staff and the

frontline workers. In addition, the frontline workers were also confused about how the MWT was supposed to enhance their services that were already in existence within their First Nations communities. In particular, how were the supports to the frontline workers supposed to translate into the delivery of more services or better services for their community members?

> *"It was my misunderstanding that they had developed the community visit as a visit to meet with the health service providers and provide them with support. And it was almost felt as though, to be frank, that it was being imposed on us. It wasn't very clear what the purpose was just that they were going to come in and somehow provide support and the staff would meet for three hours with a couple of the mental wellness team staff" (FG, 2012-01).*

The First Nation leadership was also confused about the purpose behind the community visits. Although designed to provide one on one support for frontline staff, the confusion could have been alleviated by clearly identifying the purpose of the visits at the start of the pilot project.

> *"They thought that the mental wellness team would provide that kind of service (counselling) but as it turns out what they thought and what is actually happening is two different things" (FG, 2011-2).*

> *"We would prefer to have the team to come in and work with our community members, for MWT worker to see clients…" (FNL, 2011-01).*

> *"When this project started a lot of First Nations were under the understanding that this team would offer services to the community members. It was the way it was presented, there was a misunderstanding" (FNL, 2011-01).*

Some communities held back with a lot of program support because there was no consistency in follow through. For example, even though communities were aware of the scheduled visits ahead of time they would sometimes plan other activities within their communities just in case there were changes to the scheduling. This sometimes caused a conflict in appointment scheduling on the part of the frontline workers who would then respond to the MWT staff that they were busy and couldn't accommodate their visits.

4.4.4. Funding Issues

The level of funding available from the Federal and Provincial governments had a huge impact on the relationships that the MWT were able to establish with the First Nations communities. There were ten First Nations communities that were part of this project. These communities covered a wide geographical area; were at different levels of development in being able to deliver mental health programming in their communities; and may or may not have had their own traditional resource people. The funds allocated to the MWT project were not sufficient to address specific needs of each First Nation community. The result was that the MWT had to provide services on a regional basis. It is likely that the First Nations communities felt disappointment because what was viewed as a project that would enhance services really became a project that was using a generic approach to address specific community needs.

Health organizations on Manitoulin Island were concerned about the perceived encroachment of the MWT into services that these health organizations provided and, in particular, the duplication of specialized mental health services such as access to psychiatric and psychological consultation. The competition for resources may be indicative of settler colonialism's divide and conquer tactic that pits communities against each other. The steering committee members were

aware of this misperception and understood how these two health organizations could feel threatened by the increased access to specialized services as offered by the MWT., *"So then here comes the Mental Wellness Team to provide specialized services and to fill gaps and also to enhance frontline workers and I think they are doing it very effectively" (SCM, 2011-01).* The MWT pilot project was not intended to compete with the health organizations rather to enhance access to specialized services that these First Nations communities would otherwise not realize.

The two health organizations on Manitoulin were under the impression that Health Canada had redirected mental health funds to the MWT and that this funding should have supported their programs instead. To address this issue, the steering committee held a community consultation meeting with all the First Nations in the Manitoulin, North Shore and Bemwijaang Tribal Council Areas who were part of this initiative and the two health organizations to clarify the funding concerns and re-assure these groups that the funding targeted for their organizations had not been accessed.

4.4.5 Geography

The fact that the MWT project was located in Sudbury raised a number of concerns the greatest of which was "Why would they base it in Sudbury?" Sudbury, at first, seemed like the ideal location since it was central to all the First Nations communities involved in the project. However, as the project progressed questions were raised about locating the project in a First Nation community. *"We kind of thought because it's a service for First Nations communities we thought it would be, I remember our discussion, kind of be more appropriate to be located in a First Nation community"* (SCM-2011-02). Many arguments made for changing the location included isolation from communities, lack of technical support available in communities, lack of

ownership and a sense that being located on the reserve feeds into the stereotypes that reserve life is not good enough.

> *"I think when it's in Sudbury it's very isolated and it's isolated from a lot of technical support that you would get in a community, as well as the human resources, different things like that.". (FG 2012-02)*

> *"Yeah, it's not really ours. It's not something that we can feel … when you first walk in its more city and commercial, then like what they stand for … I think it's important for it to be more close to home for the communities." (FG 2012-02)*

The distance between communities was also a challenge. The following picture (see picture 6) describes the conditions that the MWT staff had to deal with to be able to make it to the First Nations communities in the wintertime. The travel in winter was often lonely and isolated like this picture, not knowing what was around the bend. This speaks to the uncertainty about road and weather conditions. In this picture you can see that the roads are fairly clear but at the end of the day the driving conditions may be more hazardous due to snow, freezing rain or ice. In one of the interviews with a TAC member, that person talked about the challenges of servicing ten First Nations communities. This person talked about an incident where the MWT staff members were stranded due to weather and had to find a motel to stay at. These members had no corporate credit card and had to use their own credit card to book the room.

Communication was another challenge. The MWT staff were often on the road to one of the partner First Nations communities. There would be no access to internet and in some cases cell

phone service was sporadic until the MWT staff reached their destinations (see picture 7). The MWT staff

Picture 6 – The Wide Open Road

"This photo is of a wide open road, like so many I traveled over during the months I worked in this position. There are no other people anywhere to be seen. The photo represents the journey I have been on and it has been a long and isolating journey. This is the most isolating job I have ever had! In my mind I know there have been times on this road where I have had wonderful experiences and learned a lot and I feel like I have traveled a far distance, gone places, accomplished some things, but never made it across the bridge. I'm satisfied now that it's time to get off this road and find my own roads to travel and bridges to cross – leave other roads and bridges behind. (Photovoice participant)

traveled with their laptop computers and their personal belongings since they might have to stay overnight somewhere especially during the winter months when road conditions might deteriorate causing travel delays or dangerous driving conditions. Maintaining communication between the Project Manager and the First Nations partners could be challenging. Often times, the internet would be the only connection that the MWT staff would have.

Picture 7 – Communication in the Midst of Chaos

This picture talks about the resourcefulness of the MWT to meeting the challenges in providing service to the 10 partner communities – the Internet and computer are essential resources as well as the connection to traditional teachings.

4.5 Successes

4.5.1 Braiding Mainstream and Traditional Approaches

The term "Braiding" versus blending (mixing) was used to describe the approach that the MWT staff used in integrating Western and traditional approaches. The sweet grass braid is significant for Anishinaabe in that the braid represents the interconnectedness of the mind, body and spirit. For the MWT project, the braiding represented working together but still separate. The MWT team felt that the communities were very receptive to the idea of balance between Western and traditional approaches. The First Nation leadership liked the combination of both clinical and traditional approaches indicating that there was a good balance between the two approaches.

The SC members identified that the traditional programming offered by the traditional coordinator was the area in which they were most successful. *"At the steering committee level traditional services is what they have had most consistently"* (SCM, 2011-01). The SC members recognized the benefits of creating opportunities where the blending of traditional and western

approaches could occur. *"We need continual ongoing examples of the two collaborating together just because of where we live and how everybody interacts" (SCM, 2011-01).*

First Nation leadership were aware of and acknowledged that the MWT was able to bring a blended mental health care approach to the communities through in-service training for their mental health staff. The blending of traditional and western approaches is very similar to the two-eyed seeing perspective which proposes that both Indigenous and Western ways of knowing are important for knowledge and understanding. Two-eyed seeing is very much about a collaboration between Western and traditional approaches that avoids domination of one over the other (Bartlett, Marshall and Marshall, 2012).

> *We utilize both traditional and Western approaches to mental health and we have brought in their traditional program. Some in-service was provided for staff, and we brought him [Perry or Godfrey] in for services as requested by the community (FNL, 2012-02)*

First Nations communities appreciated that the MWT was able to deal with mental health issues from a cultural approach and that they were able to transfer these skills to the frontline workers. The mainstream way of working with clients is very clinical and does not necessarily take into consideration the traditional approaches for working with mental health issues.

> *"In 2009 we had a community member in an institute in southern Ontario. He was a young man who faced various problems and there weren't any services geared for a younger population. Our front-line workers weren't adequately trained to deal with those kinds of issues and I advocated on their behalf to build capacity. It was brought to a band meeting for support for the project. In mainstream there is only one way of dealing with*

mental health, that is through counselling but there wasn't a cultural approach to dealing with mental health. Once this was noticed they changed the way they dealt with his situation. I can see it happening here today – that traditional perspective needs to come to the forefront" (FNL, 2012-02).

Some communities are just now embracing traditional approaches to healing. Indigenous peoples have been socialized into thinking that culture is "voodoo", an idea that is slowly being dispelled. "*Culture in my community is just starting to come back; more people are now attending sessions and are open to traditions (FG, 2012-01).* There is a trend towards acceptance of traditional approaches to health that includes family and community particularly among the young generations. The older generation still believe in mainstream ways of healing. Therefore, there is recognition that dealing with mental health issues in Indigenous communities need to incorporate both traditional and mainstream clinical approaches.

4.5.2 Cultural Safety

A defining feature of the MWT pilot project was its focus on culture, specifically the traditional teaching series and the braiding of traditional and western approaches. Sometimes people can get wrapped up in the everyday tasks and lose focus on what is really important, in this case, the importance of culture. Picture 8 – The Importance of Culture, served as a reminder to the MWT staff that culture needed to remain at the forefront of the work that they were doing.

Generally, respondents felt that the MWT offered culturally safe services. Focus group participants felt that the traditional coordinator and the concurrent disorder specialist both created a sense of safety and acknowledged that cultural safety was practiced within the MWT.

The MWT staff were able to connect with frontline workers and create an environment where the frontline workers felt 'safe' to share.

> *"…both are also knowledgeable and open minded, that makes it safe to share without worry of discrimination. Safe to be able to communicate and share, maybe one person's knowledge is at the same level, so my own understanding of the culture is respected and we can ask questions..." (FG, 2011-01).*

Picture 8 – The Importance of Culture

I had a dream one night about the mental wellness team. I dreamt that we had a basket with the medicine in it. I told my co-workers about this dream and the next day there were 4 baskets with the medicines in it arranged on a quilt on the table. The Traditional Coordinator immediately went out after me telling him about my dream and brought these baskets in This is really important for the work that we do because it helps to ground us and remind us of the important work we are doing and that we can't forget why we are here.

However, some communities felt that they weren't receiving services in a culturally safe manner, they weren't sure if it was lack of service provision or lack of cultural safety. For example, there were some difficulties with payment for elder services provided by the EIR program. This may

have been attributed to having a secretariat controlling the funds. The inability to pay the elders in a timely fashion may have been interpreted as contributing to a lack of cultural safety.

> *"There's a reluctance to pay traditional people; some people think they should do it for free, but that controversy has been going on forever. In old times they (elders) would be provided for. They don't mind paying shoganosh big bucks but not our own people. People with traditional knowledge don't come by that easily – it takes a long time to learn it and it's a way of life." (FNL, 2012-02).*

4.5.3 Access to Specialized Services

Increasing access to specialized services was one area in which the MWT excelled. The MWT was able to access funds for specialized services such as psychiatric, psychological and social work consultation which contributed to the ability of First Nation communities to engage in case management as well provide opportunities for clinical specialists to participate in community development initiatives (e.g., seniors' health nurse during mental health week). Included in the specialized services was the access to traditional healers and elders offered through the Elder in Residence (EIR) program.

> *The other component of the project was specialized services. I think that's where the Elder's advisory circle came into place because we acknowledge that Elder and spiritual people are specialized people as well (FG, 2012-03).*

Each First Nation community was allocated $9000.00 per year for specialized services (regardless of the size of the community), and it was up to their discretion how the funds were to be utilized in their communities. An argument can be made that the amount of funding can and should be proportional to community size but that was not how the funds were allocated. On the

one hand, smaller, less resourced communities would be complaining that they are not resourced to the same level as the larger, more highly resourced communities and this certainly would have an impact on the type and amounts of services that they would be able to access and deliver. The larger communities could claim that they needed extra funds to pay for specialized services because the need was there. In an effort to provide equitable services it was decided that each community received the same amount of funding, and they could then allocate the funds to where there was most need.

The specialized services that each First Nation community received varied. Some of the well-established mental health programs accessed these funds to increase their number of psychiatric, psychological and social work consultation visits for case consultation and to provide their frontline workers with in-service training on how to work with difficult client issues. While team consultations did happen on occasion, frontline workers saw that there was definite benefit to having clinical case reviews and would have preferred for this to happen on a more consistent basis. Smaller less established communities were limited in their scope of duties to offering prevention activities therefore were not interested in case consultation and preferred to have direct psychiatric or psychological services for their community members.

Early on in the project, not all of the communities were aware of the funds available through the specialized services, so the MWT ended up with surplus funds that had to be re-allocated. The communities that had accessed the specialized services funds purchased clinical consultation for their mental health clinics. Those communities who were unaware of the available funds were dismayed when they learned that the additional funds were used by the well-established mental health programs to enhance their mental health resources. This caused a bit of controversy when the other First Nation communities became aware of this and may have interpreted as being an

unfair process. However, requests had been sent to all community partners about the availability of the funds and for some unexplained reason (perhaps the messages had not been passed along) the MWT had to spend the money by a certain date otherwise lose the funding so allocated the funds to those communities that had responded to the request. In hindsight, perhaps the MWT could have been more vigilant with the community partners and followed up with each community to ensure that each received their fair share of the allocated funds.

4.6 Impact on Relationships

4.6.1 Relationships with First Nations Communities

Initially, the First Nation leadership were actively engaged with the project through the consultation process and with providing BCR's in support of the project. One focus group member expressed "I recall, who is now the grand Chief saying, *'It's our responsibility to advocate for more funding'" (FG, 2011-1).* However, as the project unfolded, the level of support from the leadership dwindled. Perhaps this was reflective of the communication back and forth between the MWT and the First Nation leadership. Each First Nation community had different reporting mechanisms. Some communities had strong processes in place via the steering committee members who may have held several roles (being on the health committee, being portfolio holders for the chief and council, or being expected to report back regularly to the First Nation community) that set the protocols in place for reporting back to the community on the status of the pilot project. In other First Nation communities these linkages were not as firmly established.

At the outset of the MWT pilot project there was a clear understanding by the Chief and Councils, Tribal Councils and other health boards and health organizations that the MWT would have a direct relationship with the communities that were part of this pilot.

"… And, it was always maintained from the get-go that it was a direct relationship with the First Nation, and not another organization that they might work under. The Chiefs made it very clear. We want that direct relationship, and we'll appoint our steering committee members. And they are accountable to us" (HD 2011-02).

While there was a concerted effort to keep political interference at a distance, it is not to say that the actions of the MWT Coordinator were not political in nature. For example, a decision made by the MWT Coordinator to help a community in crisis was viewed as a strategic move that could potentially strengthen the relationship between the MWT and the First Nation community.

Figure 8 – Case Example from a Self-reflective Journal

Case example from a self-reflective journal: In response to a community suicide

What was I thinking or feeling?

"It was difficult to mentally grasp the complexity of the event as many other teens were impacted in many communities".

Evaluation

"I question the appropriateness of committing the total resources of the MWTP & of all the staff to one community in a crisis response"

Analysis

"This was a political move on the part of our coordinator to commit the whole MWTP for the whole time in order to present a "show of force", to appease a political leader in the community, and to strengthen the MWTP position in a relationship to First Nation leadership" (MWT, 2011-02).

4.6.2 Relationship between the Steering Committee and the Communities

There appeared to be some misunderstanding of the relationship between the MWT and the participating First Nations. Some of this was attributed to the dual roles that some of the steering committee members carried such as being both the steering committee representative and a

health board representative. This could be beneficial as there was always a way to ensure that decisions made at the steering committee level were being communicated back to the community. The downside of this was that the optics of the dual roles may have been interpreted as preference being given to certain communities, particularly the larger communities who were better serviced.

Communication between the steering committee and the First Nations communities varied from community to community. For example, one community had a system set up in place where the steering committee member provided regular updates to the health committee. The steering committee was viewed as the link between the MWT and the First Nations communities. They were *"…the driving force behind the project. They give them the guidance and direction and what's required". (HD, 2011-01).*

The level of interaction between the steering committee member and the community varied from one community to another. Some communities had very active representatives on the steering committee. *"our rep on the board is very active" (HD, 2011-01).* In some other communities, the link between the steering committee representative and the First Nation was tenuous with little information going back and forth to the community.

The communities recognised the key role played by the steering committee in the success of this pilot project. The expertise of the steering committee members was noted;

> *"All the appointed members from the steering committee had direct relationship with mental health. So that's a key component we leave it up to them to bring those initiatives or ideas forward on what's needed, where are the gaps in mental health in First Nations"* (FNL 2011-01).

4.6.3 Relationship between the Steering Committee and the MWT Staff

For the most part, the steering committee members were actively engaged with the MWT staff. However, as with any relationship, there were growing pains. *"Perceptions raised by (MWT) staff that steering committee was not communicating as well as they should and they don't know because it is not brought to their attention"* (MWT 2011-06). MWT staff needed to find a way to bring issues/concerns to the steering committee. This was done through the MWT coordinator. The MWT program coordinator took direction from the steering committee. Much discussion occurred between the steering committee members about the best approach to balance the identified needs of the First Nations communities with the ability of the MWT staff to meet those needs given the geographical area covered by the project.

As far as the First Nation leadership was concerned, they seemed to be of the impression that the relationship between the steering committee and the MWT staff was a positive one.

> *"It was a two-way street there, they were very respectable to the staff and the staff were very respectable to the steering committee. So, I think as far as I could see there's a pretty good relationship." (HD, 2011-01)*

4.6.4 Relationship with Project Manager and the MWT staff

A key figure in the relationship between the steering committee and the MWT staff was the MWT Project Manager whose role was to provide leadership and support to the MWT staff. The focus of the picture below (see picture 9) is the dead, dried out plants on the floor. At the grand opening of the "Raising the Spirit" MWT office many gifts of plants and flowers were presented to the team. At first the MWT staff took good care of the plants and flowers, watering them on a daily basis. As the work of the team picked up momentum and the team became busy

Picture 9 – Nurturing the Team to Life

"This picture is reflective of the 'Raising the Spirit' mental wellness team when I first arrived. You can see all the dead leaves and the green leaves in the midst of the dead ones. The individual who cared for the plant was going through some personal difficulties and didn't have the dedication or energy to look after the plant. The personal difficulties that this person was going through also had an impact on the rest of the team. This combined with the frustration of having no leadership is reflective of the dead leaves. But with time and nurturing, weeding out the dead leaves and taking care of the plant, the plant slowly returned to life" (Photovoice participant, 2011).

with their community visits, they forgot to care for the plants. The plants were moved off their tables and onto the floor to clear up workspace. In the move the plants were forgotten and they began to dry up.

This picture that was taken served as a reminder to the MWT project manager to take time to nurture the team. Just like the plants need love and attention so do the members of the MWT staff. The work of the MWT team can be frustrating especially trying to balance the needs of ten First Nations communities. There is extensive travel involved and a lot of time away from family

and friends. It became necessary for the project manager and the steering committee to support the staff in the work that needed to be done.

4.7 Recommendations

The following recommendations address some of the challenges experienced by the MWT with respect to the engagement of the team with the First Nations communities. These include:

- Proper Infrastructure
- Establishment of Service Agreements
- Communication Strategy
- Provision of Regional Services
- Ongoing Evaluation of the Project.

4.7.1 Proper Infrastructure

The MWT project experienced a lot of challenges right from the start of the project. Some of these challenges were related to not having the proper infrastructure in place. A fully developed project would have allowed the MWT the ability to focus more on their relationships with community and to carry out the identified tasks rather than taking time to establish those relationships. Suggestions to improve infrastructure include:

- A clear terms of reference for the steering committee
- Vision, mission and value statement that clearly identified the intent of the project
- Service agreements and work plans in place
- Office location on reserve
- Financial policies and procedures established
- Proper technology must be in place

Part of the infrastructure included development of policies around case consultations. For example, procedures for case consultations need to be identified such as how case consultations are going to be done, how to maintain confidentiality (whether to include names or not, use of pseudonyms), and dealing with consent, etc.

> *"You didn't have a policy set up as far as confidentiality, so when we're doing these case reviews it was like what ... I forget what we had to do, keep out names and just whatever. There wasn't like a process in place to do that, so it just kind of made things a little bit awkward I think as far as getting it done" (FLW 2012-02).*

4.7.2 Establishment of Service Agreements

Although BCRs were in place that demonstrated support and commitment for the project, First Nations communities felt the need for service agreements that would formalize the services that were to be provided. Service agreements would add more clarity about the relationship between the First Nation communities and the MWT. These agreements would provide the communities with a sense what to expect from the MWT team, the services that would be provided and information on how access those services. The service agreements would also outline what the MWT could expect from the communities. There are several benefits to having a service agreement in place: it would provide clarity about what each partner is to expect in the relationship; it would help in transition if and when new people came on board either from the MWT or from the community; it would help to keep focus on the initial goals/intent of the project; it would provide guidance for the steering committee and aid in decision making; and, it would aid in the ongoing evaluation of the project when you can review the progress or lack of with respect to the goals. In essence the service agreements would provide a road map for the project.

4.7.3 Communication Strategy

A communication strategy that dealt with important issues such as project mandate, terms of reference for the steering committee, and updates to communities about project activities, etc. would have enhanced the ability of the MWT to connect with the First Nations communities that were part of this project. A well-developed roll out strategy would have also helped to engage other organizations that were not part of the project to work more collaboratively and alleviate some of the concerns coming from those outside agencies in terms of overlapping mandates and issues around funding.

> *"I think it's vital that the project keep the communities informed as well as the leadership informed because if you're going to want that continued support, they should be informed on a regular basis as to the progress and what's happening with the project." (HD 2012-02).*

Specific suggestions to improve communication include having a mechanism in place that would allow for proper flow of information. For example, providing an agenda for the community visits a few days ahead of time to allow the mental health workers enough time prepare for the visit. Another suggestion was that there would be a presence on social media such as a web page that would allow frontline workers to access resources. This website could include a drop-down menu with options such as library resources which would be available to frontline workers and others so that they could connect to these needed resources. The website could also provide community partners with information on the project such as details related to project development, funding and contact information. This would create better awareness of what the project was about and provide a venue to address issues and concerns.

4.7.4 Provision of Regional Services

The MWT was challenged in being able to provide enhanced mental health services to the ten participating First Nations communities involved in this project. That is a fairly large group and covering a fairly substantial area. Questions were raised about whether it was reasonable for the team to be able to manage all of that given that there were only three or four staff on board at any given time. The travel issue is complicated by unpredictable weather and road conditions during the winter season, by road construction during the spring, summer and fall months and by the geographical distance to each First Nation community (some being about two and a half hours away from the Sudbury office). This makes it difficult to arrange for on-site attendance in the First Nations communities. Provision of regional site visits would alleviate some of the travel issues as well as enhance the ability of the MWT staff to ensure that they were able to fulfill their commitments to the First Nations communities. Regional visits might be divided into the following areas: the Northshore Tribal Council area (Whitefish Lake and Sagamok), the Bemwijaang Tribal Council Area (Nipissing and Dokis) and the Manitoulin communities (Wikwemikong, Sheguiandah, Whitefish River, Aundeck Omni Kaning, M'Chigeeng, and Sheshegwaning). The Manitoulin communities could be split so that there would be two regional visits.

4.7.5 On-going Evaluation of the Project

The MWT seemed to be in a constant reactionary mode rather than being able to strategically plan their course of action. A service agreement and/or a work plan would allow the team the opportunity to stop and reflect on their progress. Initiating a 'stop and start process' would allow the MWT the time to evaluate whether what they were doing was working or not and the

opportunity to do some creative problem solving rather than wait until the issue became too large to handle.

With respect to the consistency of staff turnovers, it would be wise to determine major factors for leaving (Morris, 2017) which in turn could lead to better delivery of service. This could be done through exit interviews. An issue with a pilot project is that there is no security beyond the duration of the project. According to MacLaine et al. (2019) there are three top reasons Indigenous employees voluntarily leave their jobs: family/personal reasons; other/better opportunity; and lack awareness of Indigenous culture. It would not be prudent to assume that the turnover in staff is due to this factor alone. However, if we were to be able to understand the reason for staff turnover it may help in recruitment and retention of staff. Plans could be put in place to ensure that the work environment was attractive so that the organization would not have to be constantly recruiting new staff.

4.8 Limitations

The results of this evaluation are not generalizable to other populations or other mental wellness team projects. This evaluation represents a case study of one mental wellness team project. This project is different in shape, size and context as compared to other mental wellness team projects.

The evaluation for this project was done in two phases simply because the first phase did not reach a point of saturation of data. Secondly, the way in which the data was collected through the second phase changed slightly. The second phase of data collection was a collaborative effort between this researcher and a community-based research team. In an effort to ensure that the evaluation was meeting the needs of both the research and the community-based research team,

the evaluation subcommittee of the steering committee worked with both the researcher and the community-based research team to develop a new interview guide that would capture all of the data that needed to be gathered.

The self-reflective journaling and photovoice aspects of the project were dropped after the first year of the project. There were a number of reasons for this decision: There was constant change-over in staffing that impacted participation in the self-reflective journaling and photovoice activities; there was a constant need to provide training on photo voice and self-reflective journaling with each new hire; there was a lack of motivation on the part of newly hired staff to participate in this activity; and the new hires felt pressure to orient themselves to the project rather than engage in training on self-reflective journaling and photovoice. This meant that these two components of the data collection could not be completed as envisioned.

Despite this setback, there were some great results from the photovoice activity by some of the staff that were part of the original MWT staff team. The photos taken by the MWT staff really emphasized some of the challenges that the team was experiencing and was a great addition to the data collection. But this was not done consistently enough to meet the criteria for saturation of information that is a necessary part of the rigour of qualitative research.

4.9 Future Directions

This research project examined on aspect of the evaluation of the pilot project, specifically the engagement of MWT to First Nation communities. Looking at this project from an Indigenous perspective, it is difficult to examine only one aspect of a project without considering all other factors.

Are there other forms of research that could be done? Certainly, the traditional teaching series seemed to have a great impact with the frontline workers both at the service delivery level as well as on a personal level. Perhaps one can examine how frontline workers are integrating what they have learned through the traditional teaching series into their practice and how the teachings affect their personal lives.

This research project focused on the MWT, the steering committees, the frontline workers, and First Nations leadership. This project did not attempt to get the perspective of community members. It would be interesting to see what the community members thought about the MWT project, whether they noticed improvements in the quality of services being delivered or even whether services were being made more culturally safe as a result of training that the frontline workers were receiving.

There were other pilot projects that had been funded across Canada. This project focused only on the services provided by the Raising the Spirit MWT. Another research project might draw comparisons between how the other projects were looking at engagement with their own First Nation communities. Were they having similar struggles? How did they resolve those struggles? Were there lessons learned that could be shared with other mental wellness teams?

The needs assessment done by the MWT project was very specific to the ten First Nations communities that were part of this project. Now that the project is complete, perhaps there is need for another assessment to determine what needs to happen in those communities in the future. Is there still a need for access to specialized services? Is there a need for specific services in the community? For example, crisis response to deal with the increasing opioid use, the legalization of cannabis or with youth or senior mental health issues. What currently exists in

the community that can fill the void left by the MWT since funding for this program has ended and the program no longer exists?

4.10 Conclusion

The MWT had seen success in a number of areas, the knowledge exchange opportunities, the symposium, traditional medicine, and the traditional teaching series. These successes have had a positive impact on the ability of the MWT to engage with the First Nation community partners, However, The MWT fell short in meeting individual First Nation community needs. Geographical and other challenges contributed to the shift from responding to the individual First nation community needs to providing the same sort of services in all communities.

In terms of building strong collaborative relationships, the MWT was particularly successful in the knowledge exchange symposium and the traditional teaching series. The traditional teaching series was one of the services offered by the MWT that was done well. Each month there was an elder or knowledge keeper available to share teachings to the staff in the First Nation community. The consistency in being able to deliver the traditional teaching series contributed to the building of strong relationships between the traditional coordinator and the First Nation community which in turn contributed to the reputation of the MWT.

Having a strong foundation and a shared vision for the project contributes to the meaningful engagement. The proper infrastructure, including human and financial resources, needs to be in place. Although this project started without a solid foundation, there were some advantages that helped move this project along such as the support of the participating First Nation communities, the support and commitment from the steering committee, the Traditional Advisory committee and Frank McNulty, the Health Canada, Ontario Region representative who was a strong advocate for this project right from the start.

There were many challenges that affected the ability of the MWT to engage with First Nations communities but through the persistence of dedicated steering committee members and a strong belief in the project by the participating First Nations communities the MWT was able to realize many successes. Successes included the ability of the MWT to provide services that were grounded in Traditional /Western approaches as well as the provision of training and capacity building initiative that were responsive to specific community needs.

Storytelling interview, self-reflective journals and photovoice were all extremely powerful means of telling the story of the relationship between the MWT and the First Nations communities involved in this project. The storytelling interviews allowed participants to tell their story of the engagement with the MWT and the contributions and benefits to their communities. The self-reflective journals contained information about the challenges and successes that the MWT has had in carrying out their mandate. Photovoice allowed the use of visuals to assist participants to convey their stories, sometimes containing sensitive issues, in a more befitting way. It was unfortunate that the photovoice and self-reflective journaling components of the project did not proceed as planned especially since the visual images and accompanying stories are the tools that are used to draw attention to conditions experienced at the community level. It is important to note that photovoice and self-reflecting journaling had the potential to elicit different reactions that would draw on different ways of knowing and forms of Indigenous knowledge. This would have been a value-added dimension to the evaluation had the conditions been right to proceed.

This research project demonstrated that Indigenous ways of being and doing and choosing congruent research methods proves that there is an (in)credible way of employing appropriate research evaluations. Despite not being able to complete the evaluation using the photovoice and

self-reflective journals, the storytelling interviews were extremely powerful in telling the story of the relationship between the MWT and the partnering First Nations.

Lessons learned through this pilot project was that for the MWT to provide programs and services that were relevant to the First Nations community they must be meaningful engagement with the communities. Community needs for service must be respected and communities must be appropriately involved in the decision making. Programs must be culturally relevant. A major lesson was that the proper infrastructure be in place prior to the start of the project.

Chapter Five: The Elder's Advisory Committee and Role of the Elders in Residence Program

The Mental Wellness Team (MWT) steering committee recognized the need to ensure that elders were involved in the MWT pilot project right from the start. In May of 2011, the MWT pilot project invited local elders to a planning meeting with the intent of developing the elders' advisory group. These elders were also invited to the MWT strategic planning as advisors to share their ideas, knowledge and teachings to incorporate into service delivery. This was a beginning step to the formalization of the braiding of traditional Anishinabek teachings and practices with western knowledge and techniques. The Elders Advisory Circle (EAC) was established to ensure active engagement of elders in the pilot project.

In the beginning stages of the pilot project the EAC served as advisors to the steering committee. As the pilot project continued to develop, the MWT's role evolved to include provision of professional and personal wellness support to mental wellness, addictions and traditional health workers to the First Nation communities participating in the pilot project. The EAC's role also evolved to support this goal. The role of the EAC was to help nurture the balance between traditional Anishinabek teachings and practices with western knowledge and techniques and in doing so would empower member First Nations in healing themselves. This was accomplished by providing access to a visiting elder program otherwise known as the Elders-in-Residence (EIR) Program.

Eventually the name of the EAC was changed to the Traditional Advisory Circle (TAC) as this was a more encompassing term that better described the services that the participating First Nations communities had access to. The TAC was made up of traditional knowledge holders

and community cultural resource people who oversaw the EIR program and provided advice as needed to the MWT project. The Traditional Coordinator (TC) played a key role in working with the TAC: maintaining communication between the TAC and the MWT steering committee and ensuring advice and recommendations shared by the TAC were incorporated in the EIR program.

This chapter will examine the role that the TAC played with the MWT pilot project. In particular, it is important to understand how the TAC and EIR program functioned and how these groups were able to negotiate the tension between Indigenous/non-Indigenous worldviews and funding requirements.

5.1. Background

5.1.1 Ontario Training Centre in Health Services and Policy Research

As part of my PhD program, I applied to and was selected to participate in a policy practicum through the Ontario Training Centre in Health Services and Policy Research (OTC). The Ontario Training Centre in Health Services and Policy Research was a consortium of six Ontario Universities that offered graduate training that led to a Diploma in Health Services and Policy Research (Ontario Training Centre in Health Services and Policy Research, 2007-2012). The policy practicum provided an opportunity for OTC students to interact with policy makers or shapers with a major goal of understanding the policy-making environment and learning about policy development. It was an opportunity to gain experience and skills working with policy makers as well as developing the competencies needed to become health services researchers.

My OTC policy practicum involved working with the TAC of the MWT. My main goal was to work with the TAC to develop the EIR program. This included reviewing the various policies

that the MWT needed to be aware of; ensuring clarity of the policies; ensuring that financial policies were in line with M'Chigeeng's (secretariat) policies; ensuring the braiding of western and traditional philosophies; and operating from a non-oppressive stance.

In working with the TAC we reviewed the organizational structure of the 'Raising the Spirit' MWT and developed a draft policy document for the EIR program. A copy of this policy document is included in the appendix 15. The EIR policy document is still in draft form since it was never formally adopted by the MWT steering committee. Reasons for this will be explained further in this chapter of the thesis.

5.2. Definition of Elders and Healers

In this chapter, the terms elders and healers appear together because both are considered as service providers in the EIR program but there are significant differences between these terms. The MWT identified elders are those individuals who are acknowledged and respected within their communities for spiritual and cultural leadership and who are traditional knowledge holders. These elders are respected for the knowledge and experience gained throughout their life's journey and are often called upon for advice, help and support to teach others about, culture, traditions and about living a healthy lifestyle ((Hart, 2014; Manitowabi, 2014; Raising the Spirit Mental Wellness Team, 2010).

Healers are often associated with providing some sort of traditional treatment. The World Health Organization defines traditional medicine as

> *"the sum total of the knowledge, skill, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment*

of physical and mental illness."

(http://www.who.int/medicines/areas/traditional/definitions/en/)

Traditional medicine knowledge is gained over an extensive period of time and is passed down from generation to generation. Each healer has their own gifts whether it be the gift of touch, doctoring, energy work, midwifery, and/or a variety of healing methods (Antone & Hill, 1990; Martin-Hill, 2003, Hill 2008).). Healers provide a wide range of services: spiritualist (faith keeper, holy person), herbalist, diagnosis specialist (seer, referral source), and medicine man/woman (bundle keepers, song keepers, pipe carriers, lodge keepers, etc.) who use their gifts to provide help and guidance for those seeking holistic health (Antone & Hill, 1990; Martin-Hill, 2003).

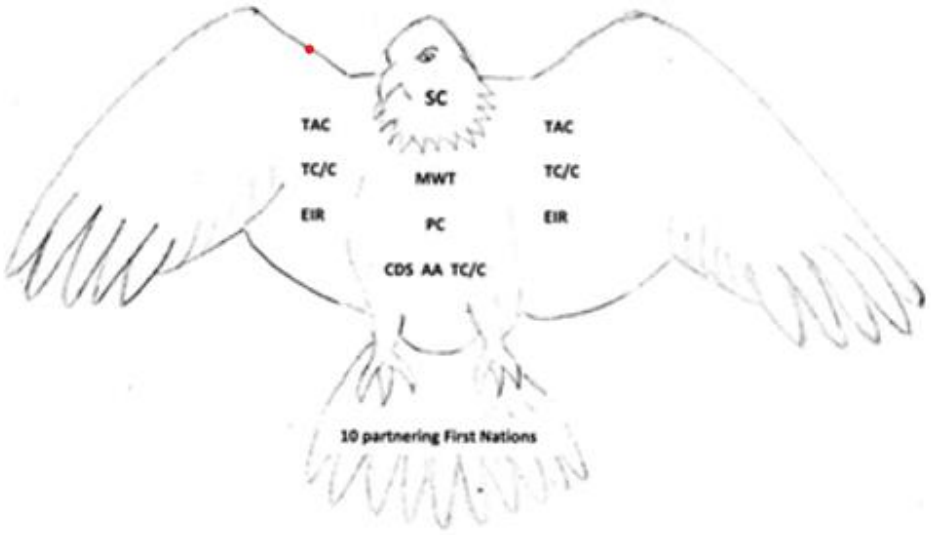
5.3. "Raising the Spirit" MWT Organizational Structure

The TAC wanted to develop an organizational structure that made sense to them, so they chose the symbol of an eagle to depict the organizational structure for the MWT (Figure 9). The eagle is one of the most sacred symbols for Indigenous people, including the Indigenous peoples of the Manitoulin, North Shore and Bemwijaang tribal council areas.

Depicting the organizational chart in the form of an 'eagle' challenges western, mainstream thinking about organizational structures and in doing so the TAC was treading on new grounds and in many respects were ahead of other organizations in using culturally appropriate symbols, fitting with Indigenous worldviews. It should be noted that First Nations organizations such as the Union of Ontario Indians have begun to reclaim traditional ways of organization. For example, the Anishinabek Nation Government uses the following diagram (Figure 10) of the seven sacred gifts as their guiding principles and way of life (Anishinaabek Nation, 2016).

Figure 9 – Raising the Spirit MWT Organizational Structure – Original Vision

"Raising the Spirit" Organizational Structure



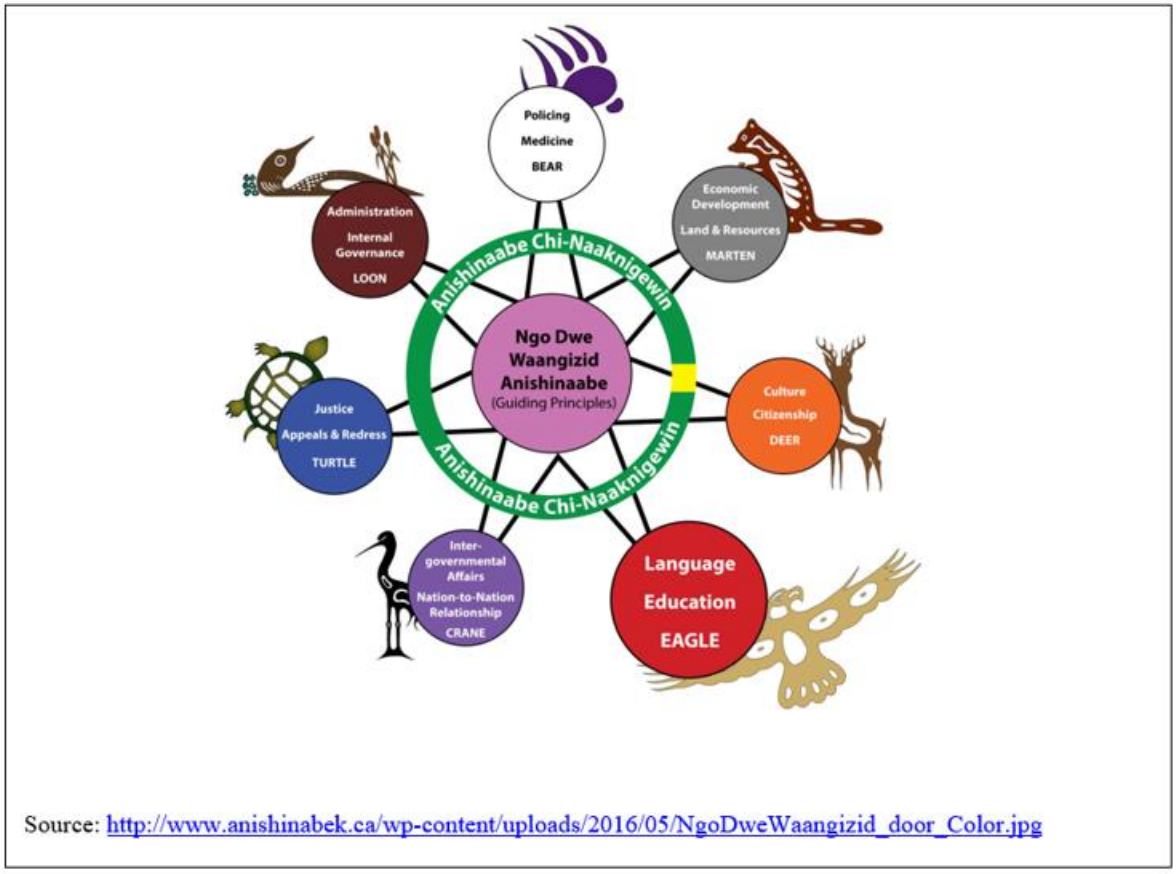
Traditional Advisory Committee (TAC) – Is represented by the wings of the Eagle that encircle the entire "Raising the Spirit" MWT project. The TAC provides advice and recommendations to the MWT's steering committee, the MWT and the Elders-In-Residence (EIR) program. The TAC oversees the Traditional Coordinator/Counsellor who oversees the EIR program. A representative from the TAC also sits on the steering committee (SC).

Steering committee (SC) – The Eagles uses its tail feather for steering. The steering committee is made up of representatives from the 10 partnering First Nations. Each tail feather represents each of the First Nations communities involved in this partnership agreement. The steering committee oversees the Program Coordinator.

The Mental Wellness Team (MWT) - The MWT is represented by the body of the Eagle. The Program Coordinator (PC) oversees the Concurrent Disorders Specialist, the Administrative Assistant; the Traditional Coordinator/Counsellor as well as the Contracted Service Providers.

Contracted Service Providers - Contracted Service Providers provide enhanced specialized services to the 10 partnering First Nation communities. Services may include psychological consultation, psychiatric consultation, social work consultation or traditional healer/helper services.

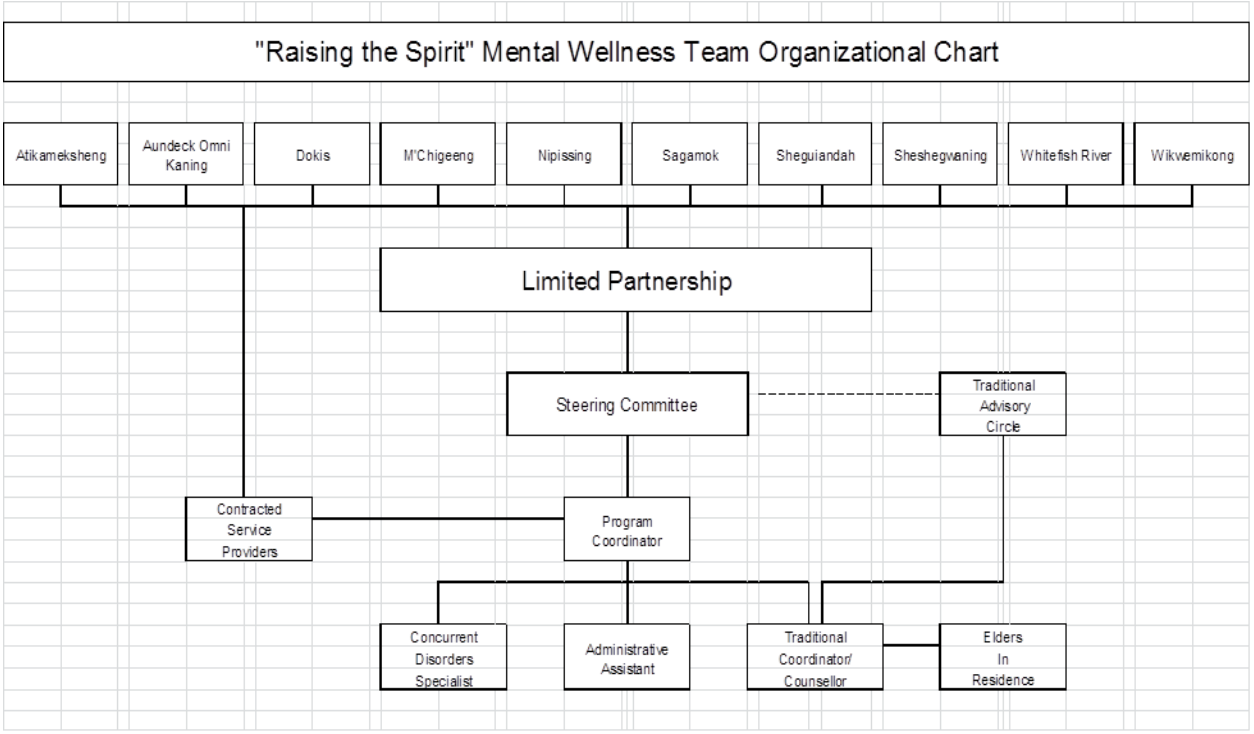
Figure 10 – Anishinabek Nation NgoDweWanngizid



Source: http://www.anishinabek.ca/wp-content/uploads/2016/05/NgoDweWaangizid_door_Color.jpg

Some members of the TAC were concerned that depicting the organizational chart using the symbol of the 'eagle' would jeopardize funding for the project. In the end, the TAC resorted to a more standardized organizational chart that the government funders would know and understand. *"This is what the government expects, and this is how we have to present ourselves*" (TAC-01-2010). The organizational chart that the MWT adopted is depicted in figure 11.

Figure 11 - Raising the Spirit Mental Wellness Team Organizational Chart



It was a risky move to present the organizational chart as the eagle. I began to realize that there was still a huge reluctance among Indigenous people to not 'rock the boat`. Even though they might want to return to traditional ways of organizing themselves, the fear of being misunderstood or not taken seriously or of losing funding if they should not follow the rules was still a great deterrent.

5.4. Elders-in-Residence (EIR) Program

The EIR program (see appendix 20)was developed to support the MWTs mission to provide professional and personal wellness support to the ten (10) member First Nations communities. The EIR program was overseen by the Traditional Advisory Circle (TAC), a committee comprised of traditional knowledge holders and community cultural resource people. The TAC

had a dual role: to provide advice and guidance to the steering committee; and, to ensure recommendations received from the steering committee were incorporated in the EIR program.

Each community was at different stages in the development of their mental health programs. Some communities had well established, highly skilled mental health workers. Other communities had fairly new mental health programs with mental health workers that were just gaining experience in the mental health field. Thus, each community had differing needs and levels of service provision. This meant that the type of elder visits would vary from one community to another. In some cases, depending on need, the First Nation community might request more than one elder visit in any given month. One of the issues that had been raised by the member First Nation communities is that they were limited to 10 elder visits in a given year. The need for elder visits was often much greater than the amount of services they were eligible for.

The EIR program was provided as a service to mental wellness, addictions and traditional health workers of the ten participating First Nations. The function of the EIR program was two-fold: to support to workers in their own wellness needs and to aid in building confidence by expanding frontline worker knowledge of Anishinaabe Kinomaadwin (traditional) wellness approaches. Services offered by the EIR program included:

- One to one or group support to community mental health and additions workers
- Sharing teachings about traditional wellness, mentoring traditional practices such as smudging, sharing circles and the spirit journey to assist community workers to expand their knowledge and build skills and confidence.

- Traditionally based counselling and debriefing support to help workers impacted by crisis in their communities.
- Traditional resources to assist in community development initiatives.

(Raising the Spirit Mental Wellness Team, 2010)

The MWT project was designed to provide support for the frontline workers and for communities to access specialized services. The communities involved in the MWT pilot project were under the impression that this project would enhance the existing services so when the MWT indicated that the EIR program was a service for frontline workers only the First Nation communities were not pleased.

> *"I guess the other component that evolved, I guess, was the elder's advisory circles. I think that evolved too not long after we got started. The advice of having elders on board as well to be utilized in the communities… So, I know that they were drafting up a term of reference and identifying elders from those 10 communities. I think they play an important role, but I think their role is more for capacity for frontline workers as well. And I think we always need to stress that to make sure that even the MWT staff or the elders are not doing the work in the community that they are there for the staff. We always have to make sure that we stay on track with what was in our mandate" (FG, 2012-02).*

In order to maximize the benefit for the First Nation communities, the MWT agreed to expand the EIR services other community services providers (addictions workers, children and youth services, health services, etc.) in the community. *"This program is now extended to communities to receive teachings – isolated, not involved, don't know where to connect with elders" (MWT,*

2012-01). This move had the added benefit of outreach to service providers who may or may not have been familiar with how to access elder resources.

This provided all frontline workers with the opportunity to learn about teachings that they could use both at a personal level (with themselves and their families) and at a community level (with their clients). *"and you see with the traditional sessions that we have been having and providing those teachings to our frontline staff, that's the beginning because we open the door to the rest of the staff to participate" (MHL,2012-01).*

5.4.1 Establishment of a Roster of Elders

As mentioned at the start of this chapter, a meeting was held with a group of elders in May 2011. At this meeting, the elders in attendance identified a listing of elders (along with qualifications and specializations) who could be approached to participate in the Elder's Advisory Committee (EAC) for the pilot project.

The TC was tasked with further developing this roster of elders and maintaining a portfolio listing the specific qualifications and specializations on each of the elders. Once the elders had been vetted by the TAC (formerly the EAC) their names could then be provided to the communities as potential resource people. This was the starting point for the development of the EIR program.

The TAC was also mindful of the fact that not all older people are elders and that not all elders had the specific qualities that would work to enhance the skills, knowledge and confidence of community workers. Keeping in mind that each elder possess their own specific gifts that make them valued for their spiritual and cultural leadership; knowledge about culture, tradition and

ceremonies; and life experiences (Hart, 2014; Manitowabi, 2014), a roster of elders was developed that considered the following desirable qualifications:

- Acknowledged/Respected within their own and area communities for their wisdom and abilities to help
- Demonstrate a commitment to "living" the traditional teachings and to helping and improving the quality of life of communities
- Carry a diversity of life experiences
- Have knowledge of mental health and addictions healing journey
- Have knowledge of an aptitude for teaching/sharing traditions, ceremonies, cultural identity, teachings
- Able to listen and communicate effectively and to interact with people of all ages, walks and levels of understanding
- Are ideally, fluent in Anishinaabemowin
- Non-judgemental, patient, able to interpret needs of individuals
- Able to travel and undertake a consistent commitment to visiting and working within communities.

(Raising the Spirit Mental Wellness Team, 2010)

The MWT recognized that each First Nation community participating in this pilot project had their own elders, natural healers and helpers (each with their own special gifts and knowledge). While the MWT encouraged communities to use their own resources, they also recognized that in some cases there was a need for outside resources. For example, in the case where there was a suicide in the community the resources available within the community would be so greatly

impacted by the event that it was preferable to have outside resources support the community. In these instances, a participating First Nation community might request an elder from outside their territory. The MWT kept an ongoing list of internal and external elders that the participating First Nations communities could refer to when they required elder services in their communities.

5.4.2 Honorariums

According to Anishinaabe protocol with respect to services received from an elder, it is customary to provide an honorarium to the elder (Manitowabi, 2014; Maar & Shawande, 2010). It is common practice for elders to accept semma (tobacco) which signifies their commitment to the services that are being requested of them (Maar & Shawande, 2013). This is a timeless practice that recognizes Anishinaabe worldview and honours the teachings that the elders follow and has served Anishinaabe people for countless generations. Elders use the semma to ask for prayers, to help to call the spirits in and/or to give thanks for the help and guidance that is received from the spirits (Bell, 2012, personal communication). The honorarium is a representation of the gift that is given in acknowledgement of the special, knowledge, skills and gifts that the elder possesses. Traditional healers/elders are not paid for their services. Instead, they are offered practical gifts (Maar & Shawande, 2010) and often times an honorarium that is used by the elder/healer to enable them to provide their services (gas money, to pay their driver or helper, to purchase supplies) (Bell 2012, personal communication). A special relationship is established between the person/community making the request and the elder through the giving of the ‘semma’ and the ‘honorarium’. Failure to offer the semma and/or the honorarium disrespects the meaning and intent behind the special relationship between the individual making the request, the elder and the relationship between the elder and the spirits that are being called in.

The process for accessing honorariums for the elders was complicated. Honorariums would be provided only to those elders who had been approved to be on the roster. Payment advances were not authorized. Payment for elder services would be processed at the end of the scheduled community visit. The elders expected that they would be paid for their services upon completion of their day. This would be upsetting for the elders as they used their honorarium to pay their drivers, helpers, expenses and supplies.

The funding for the MWT was set up in such a way that payments for services were processed through the secretariat which happened to be M'Chigeeng Health Services. The MWT had developed a flow through arrangement with M'Chigeeng First Nation as the federal government could not flow the funds directly to the MWT project. This extra layer of administration was an added step that slowed down the processing of payment.

First Nations communities were not pleased with this arrangement for a couple of reasons. Smaller communities did not always have the funds on hand to wait for a re-imbursement. It was also inappropriate to make an elder/healer wait for payment. Individual First Nations could provide a check to the elders and be reimbursed by the MWT, but this was not an ideal situation since these First Nations would have to use funds that were dedicated for other purposes and wait for the re-imbursement which could take several weeks. *"Because of the way finances were set up – thought that communities should pay and then be reimbursed – for some communities it was a challenge" (FG2012-02).*

5.4.3 Elder in Residence (EIR) Program Screening/Approval Process

The MWT recognized that there are many elders in the community who are not healthy and that accessing the services of certain elders may put community members at risk. This comes from

Anishinaabe history of intergenerational trauma and the fact that there are many people who are still dealing with the effects of this colonial history (the impacts of the Indian Act, the policies of assimilation, segregation and integration, the residential school system, the sixties scoop (Duran, 2006). Thus, it was important that screening guidelines were developed for the EIR program to ensure the credibility of the elders providing services in the First Nations communities.

The screening process was very thorough and involved several steps. Participating First Nation communities could request that an elder be added to the roster or the elder could ask to be put on the roster. Elders wanting to be on the roster had to provide their name, phone number, band number, date of birth, area of specialty, knowledge or special gifts, three references and a Criminal Police Information Check (CPIC) to the TC. Once this information was received the TC must contact the references, complete a reference form and make a recommendation about whether or not the individual may be added to the roster. The TAC would make the final decision whether approve the elder's request to be on the roster.

The EIR program experienced a number of challenges with the development of a roster of elders. For example, community members were not clear on how the elders/healers were recruited to be on this list. *"And the list, they have to have, they don't even know if they were actually asked to be put on that list. And that is another thing. They haven't clarified that with the healers." (FG, 2012-01).* Some the elder/healers did not realize that they were on the roster nor were they aware of what their role was with the EIR program.

First Nation communities wanted to have greater involvement in the decision making on who was added to the roster and felt that it would be preferable to add their own traditional resource

people to the list. *"We don't know half the people on the list but we have people we are comfortable with and so why not use our own"* (FG, 2012-01).

5.4.4 Access to the Elders-in-Residence (EIR) Program

The services provided through the EIR Program were based on the individual member First Nation community's needs and request. An elder may provide up to six (6) individual staff consultations or sessions per day or the community may organize a group session or circle. Under normal circumstances the First Nation would contact the TC to request the services of an elder. The TC would then contact the elder to provide date(s) and start time(s). In exceptional circumstances such as when there is a community crisis (suicide, critical incident, etc.) that urgently warrant the services of an elder, the TAC and MWT staff would review the case on an individual basis and make the necessary arrangements.

Participating First Nation communities wishing to access the services of an elder on the roster would coordinate the visits with the TC. The TC was responsible for:

- Obtaining the MWT staff schedule before the visit;
- Ensuring that the elder visit not exceed the maximum of six (6) hours per day (included 2 hours for evaluation and documentation);
- Confirmed the elder visit with the staff of the participating First Nation;
- Complete evaluation form(s) and other community visit documentation (brief summary of services provided and follow up notes);
- Make reservations for accommodations, if required;
- Accompany the elder on community visits, if required; and,
- Communicating any necessary follow up.

The elder visit was limited to a maximum six hours per day to allow ample time for travel in day light hours, as well as to complete their evaluation and document the visit. In cases where the services of the elder were required for longer than six hours, the First Nation community was not eligible for further compensation/payment by MWT program resources and would have to fund these activities on their own.

Through the EIR program the MWT was able to track how communities were able to use of their traditional resources. *"Elders called back frequently gives a record of teachings, tracking services and track what communities have and don't have"* (FG, 2012-01). Feedback from the elders/healers was provided to the MWT who could then record the visit and the nature of the services provided.

There were a number of issues with respect to accessing services of the EIR program. For example, participating First Nation communities could request a specific elder but they would have to provide a rationale to the TC that included describing the nature of the issue(s) that needed to be addressed. The participating First Nations could also access the services of elders/healers or helpers with whom they had previous relationships. However, if the TAC felt that a particular elder posed a community safety issue the MWT reserved the right to decline a community's request. First Nation communities were not happy with this arrangement since their relationship with a specific elder who had previously been providing services to their community could be discontinued by the TC. This also meant that the TC could potentially interfere in previously established relationships.

The process established for elders to apply to be on the roster did not take into consideration that *"Some community Elders were only comfortable in their community and not another list"*

(SCFG, 2011-01). In order for a community to access funds to pay for their elder resources, the elders would have to apply to be on the roster and be approved by the TC and the TAC. *"They (the elders) had to be on their list in order to be funded"* (FG, 2012-01). First Nation communities were told *"we could use whoever so because not on the list couldn't pay them"* (FG, 2012-02). In order for First Nations communities to access their knowledge keepers they encouraged them to get on the list. *"They sent their info to be put on the list but all were denied"* (FG, 2012-02). One community that felt uncomfortable about the process for getting their knowledge keepers on the list and then being denied asked their health director and steering committee to address the issue with the steering committee. This First Nation community had their own internal list but because their knowledge keepers were not on the roster they *"would have to pay them first" (FG, 2012-02).*

There was an unspoken expectation that in order to be on the roster elders would have to make themselves available to other communities. This could deter some elders from applying to be on the roster. First Nation communities were not pleased with the process for getting their elder/healers and/or knowledge keepers on the roster. The process, rather than being a help for First Nations communities to access traditional services became a hindrance in that they were limited by who was on the roster, how to get their traditional resource people recognized on the roster and access to funds to pay their traditional resource people.

The application process was also problematic for some elders. It was a very intrusive process to be asked for personal information and then be subject to a criminal reference check. Many of the elders did not have access to a computer and to complicate matters further they are not computer literate, so this meant that they had to ask someone to do the application for them.

Another issue with the recruitment of elders on the roster had to deal with the conflict of interest that resulted when these elders were also on the TAC. *"Some of the elders were on the TAC but also providing services" (SCFG, 2011-01).* This served to blur the lines of responsibility for these elders especially when the process to appoint elders to the roster had to be approved by the TAC. The optics of this served to discredit some of the elders if they were selected to provide a service to a particular community. It would appear that they were receiving preferential treatment in terms of being asked to go into a community.

5.4.5 Elder's Services as Specialized Services

Specialized mental health services are often thought of in terms of access to psychiatric and psychological consultation as well as clinical mental health services such as diagnostic assessment and treatment. For example, according to the Ontario Ministry of Health, Mental Health Reform (1999), people with serious mental health illness can access specialized mental health care consisting of treatment, rehabilitation and support services usually through a multi-disciplinary team approach either in community or hospital settings.

While funding provided by the MWT for specialized services was expanded to include access to elders, it should be noted that this did not constitute a policy change for OHIP, or other Ministry funded access to specialized services. This was a significant move for First Nations communities in that notion of specialized knowledge was expanded to include the knowledge and gifts that the elders possessed. Recognition was given to the fact that many of these elders spend a great deal of time learning about their area of speciality and being able to practice that with the people seeking their help.

5.4.6 Staff Eligibility

The MWT team pilot project was designed to provide support to frontline workers. Thus, priority for the EIR program was given to all mental wellness, addictions and traditional health staff of the participating First Nations including non-band members and/or non-registered persons on staff. Should a staff member want to see an elder that staff member would have to contact the TC and indicate that they would like to see the elder. The MWT project would pay for the elder visit, but staff would be responsible for providing their own meals, beverages and donations to feasts and/or any offering such as tobacco/giveaways. The frontline workers felt that the EIR Program would be more beneficial for their clients especially since many of the communities were lacking access to specialized services.

5.4.7 Other Issues Related to the EIR Program

Initially, there were some questions raised by the TAC about the scope of duties of the EIR Program. For example, was the EIR program supposed to service 'clients' or 'professionals'? Servicing clients meant that the elders would see clients on an individual basis. Service to professionals meant that the elder would work with a group of frontline workers to provide cultural teachings to them so that they in turn could work with their clients. In the end it was decided that in keeping with the mandate of the MWT team that the elders would work with the "professionals" to offer indirect services to the clients. This meant that they would co-facilitate along with the frontline workers thereby increasing the confidence level of the frontline worker to do sharing/healing circles or share teachings with their clients. It was preferable that the elder not work alone when providing support and guidance to the frontline workers. A member of the MWT staff would co-facilitate and/or co-supervise with the elder throughout the session.

5.4.8 Discontinuation of the Elders- in-Residence Program

In the end, the steering committee decided to dissolve the TAC due to the multitude of issues related to the membership on the roster, access to resources and funding issues. As a result of the dissolution of the TAC there was nobody to oversee the EIR program so this program was discontinued.

> *"Dissolved the TAC at the last strategic planning session. That part of it doesn't work. What we were saying is that the communities were their own best providers of that service. Rather than having a committee over who is providing their service. It is an option for the communities to select from the elder-in-residence list, the communities would also have their own list so they would have the option of selecting from their list." (FG, ST, 2012)*

The steering committee recognized that the First Nation communities each had their own traditional resources that they were familiar with and when they needed elder/healers with a specific expertise they could refer to people who had originally agreed to be on the roster. Funds were allocated to each First Nation community to access these traditional resource people. This alleviated some of the funding issues as the First Nations communities did not need to seek re-imbursement for payment of honorariums and had the funds on hand to pay for their traditional resource people.

5.5. Negotiating the tension between Indigenous/non-Indigenous worldviews

The visionaries of the pilot project had the foresight to realize the necessity of engaging elders as advisors. Their attempt to engage elders early on was a movement in the right direction. Elders when properly used have the potential to be the buffers between Indigenous and Non-Indigenous

worldviews. There were many points at which the elders could have made significant difference in the outcomes of TAC, the EIR program and the engagement of the MWT with the First Nations communities.

The first opportunity to negotiate the tension between Indigenous and non-Indigenous worldviews occurred when the elders were invited to that first meeting in May 2011. The elders present agreed that having a council of elders would be advisable and that there should be greater representation from other elders for the Manitoulin, North Shore and Bemwijaang Tribal Council areas. The brainstorming session was one way in which elders could be identified to be invited onto this council. The brainstorming session seemed to fit into an Indigenous way of identifying elders in that the elders were selected based on reputation in their communities.

The terms of reference for the TAC were an important component that bridged both worldviews. On the one hand, the terms of reference provided the guidance that the TAC needed to follow in order to operate. This is a procedure that comes from mainstream society and while useful doesn't necessarily fit into an Indigenous worldview. The TAC attempted to braid traditional Anishinabek teachings & practices with western knowledge & techniques by developing their terms of reference. The TAC included a consensus model of decision-making and utilized traditional talking, decision-making and conflict resolution methods in their deliberations.

The role of the TAC was to advise and provide guidance to the EIR program and to the MWT through the steering committee on issues related to traditional customs, traditional healing methods, and culturally appropriate methods for information gathering, research, analysis, reporting and dissemination. The advice and guidance from elders were one way to ensure

meaningful and respectful integration of culturally safe traditional healing as well as culturally approaches to community consultations.

The EIR program struggled with balancing Indigenous and non-Indigenous worldviews. The idea of an EIR program was great but perhaps relied too heavily on non-Indigenous ways of operating. The reliance on western-based methods for screening made it difficult for elders to be added to the roster and this impacted on who the communities could access services from. A more culturally appropriate method of screening based on traditional practices probably would have resulted in less discord and may have contributed to greater participation by the elders.

It was unfortunate that the payment arrangements for elders was so complicated. This had to do with the way in which money flowed to the MWT project through the secretariat as prescribed by the federal government and not so much having to do with being disrespectful of the community protocols around payment of honorariums. In the end, the MWT just decided that the communities would be given funds that were allocated to the EIR program, and they could manage the funds how they (the First Nations communities) saw fit. Perhaps this is how it should have been from the start of the project. Yet, First Nations communities (an organizations) still struggle with achieving their own autonomy when it comes to funding arrangements. This is probably an area that needs further exploration when designing programs in First Nations communities and organizations that receive outside funding. In this case, the elders probably did not have much input into how honorariums were to be paid.

Perhaps the issue was not one that dealt with the role of the elders per se but rather with the timing of the pilot project and the culture of the environment. With respect to the organizational chart, the elders recognized and acknowledged that using the symbol of the eagle was more

culturally appropriate and made complete sense to them, they struggled with the notion that dominant society that may or may not understand the symbolism. Even though other Indigenous organizations were incorporating traditional teachings and guiding principles into their programming and organizational structures, this was still a fairly new idea area that, at the time of the pilot project, was not widely accepted.

5.6. Areas for further discussion

The EIR program seemed to have most success in concert with the traditional teaching series and providing support and training to the frontline workers. This project did not explore how the elders felt about providing that training to the frontline workers since this was not in the scope of this project.

Due to the nature of the work they do mental health workers are likely to be traumatized especially dealing with the high rates of suicide, family violence, and addictions issues within First Nations communities. The frontline workers mentioned that the traditional teaching series was one that benefitted them both on a professional and personal level and that what they learned from the elders/healers was beneficial in their practice and with their own self-care and care of their families. The pilot project did not explore how the elders were able to help with this except that they did provide that support and training. If the frontline workers found themselves in need of help, where would they go? How did the frontline workers feel about having the support from the EIR program?

Another area for discussion might be around the inclusion of the elders. Although the elders were invited to that first meeting in May 2011, could there have been more discussion with elders about the TAC? How invested were the elders in the TAC? How did the elders feel about the

whole program falling apart at the end? Perhaps there could been an evaluative component that dealt with the involvement of the elders in the pilot project. This was something that wasn't considered in the development of the pilot project.

5.7. Conclusion

Although not part of the original vision for the MWT project, the EIR program was viewed as beneficial. The EIR program provided community workers with access to a pool of elders who were able to share their teachings and special gifts (e.g. knowledge about Berry Fast teachings) with community workers. In addition, the EIR program functioned to connect elders/healers with community workers.

The EIR program had the potential to enhance traditional specialized services in addition to the services provided by the TC. Many details needed to be worked out with respect to the EIR program right from the recruitment process, the application process, the screening and approval process and the details of the services to be provided.

First Nations communities recognized the importance of having elder resources and viewed these resources in much the same light as "specialized" mental health services. Specialized services offered through mainstream services do not necessarily take into consideration the cultural context of the First Nations community members. Having access to elders helps to provide frontline workers with the needed knowledge and expertise to service clients that are seeking a more culturally appropriate, wholistic way to address mental health and addiction issues.

The Elders-in-Residence program was a wonderful idea for promoting the work that traditional elders, healers and helper do in our communities. Unfortunately, this portion of the project was discontinued. There were numerous challenges with this program so another research project

might focus on policy development around recruitment, compensation and development of elders.

In my view, the EIR program could have been an excellent resource for the MWT project. Unfortunately, much more thought and attention needed to be put into the details of the services that would be provided through the EIR program. Having a solid foundation in place that addressed the many issues identified in this paper would have set this program up for success. Perhaps more consultation with the First Nations communities and the elders would have been beneficial.

Chapter Six: Conclusion: Completing the Journey

6.1 Introduction

Figure 1 – Stepping-stones on my PhD Journey

As mentioned at the start of this thesis, there were several steppingstones along this journey – the vision; the initial project; new opportunities; change in plan; data collection; data analysis; and, the writing all represented by the stones shown above (See Figure 1). This chapter represents the last of those stepping-stones. It is noted that the writing stepping-stone is something that occurs at every point along this journey but for the purpose of this thesis it is represented in this last chapter.

In completing the journey, the first part of this chapter will summarize the research findings as they relate to the Mental Wellness Team pilot project. This chapter also identifies limitations of

this research as well as future directions for the study. A summary will be provided about how the MWT project maintained the engagement and support of FN communities, how collaboration was facilitated among partners, the integration of mainstream and traditional approaches as well as the impact engagement and support had on capacity building in the First Nation communities participating in this project.

This chapter is a reflection on my PhD journey. Looking back over my experience I realized that there was a common struggle that was happening with the MWT pilot project, the Traditional Advisory Committee, particularly the Elders-in-Residence Program, funding issues and my own personal struggle. I will simply call this ‘the struggle’. The last section of this chapter is my personal reflections on my PhD journey. In this reflection, I relate significant events that encouraged me to continue on this journey. I will also provide recommendations for others on a similar journey.

6.2 My Personal Struggle - Writing

6.2.1 Floundering

The term flounder has many meanings – to "struggle awkwardly and impotently," especially when hampered or "to flop about” (Harper 2019). It can also be used as a noun referring to the “act of struggling" (Harper 2019). The idea of flounder represents a great part of my PhD journey was the writing. Upon reflection, it appeared that there was something that was blocking my writing, like there was a huge piece missing. I was at the point of complete and utter

frustration, not knowing what to do or where to turn. Just at this point of desperation a number of events occurred one after another.

I have been a committee member with the Manitoulin Anishinaabek Research Review Committee (MARRC) since the committee was formed in 2003. The main purpose of this committee was to review ethics applications on behalf of the First Nations communities on Manitoulin Island. The MARRC had developed some guidelines – Guidelines for Ethical Aboriginal Research (GEAR) – that the committee followed in reviewing ethics applications. Up until recently, this committee reviewed applications that dealt with health and social issues. However, there had been some inquiries into whether we would review applications that involved biological sampling. Our committee felt that we did not have the capacity to do this and felt that the responsibility would be too great since biological sampling involved collecting samples from the human body. Within Anishinaabe traditional teachings the body is considered a sacred vessel. For this reason, we felt ill-equipped to handle these sorts of reviews.

For this reason, the MARRC committee commissioned a researcher to write a paper on biological sampling outlining some of the considerations for First Nations communities with regards to that area. Further, the MARRCC committee applied for and received funding from the Secretariat on Responsible Conduct of Research to consult First Nations communities in the Manitoulin area on the issue of biological sampling.

These consultations were scheduled for January 29, 2016, and Feb 4, 2016. At the first consultation session I walked into the room and was in awe since there were a great number of elders from the Manitoulin Island First Nations communities. It was very humbling to be in the presence of such reputable Indigenous knowledge holders. I took this to mean that the topic of

discussion must have great importance. The second consultation the following week also had a great number of community elders, many of the same people who had been there the week before. Again, this re-iterated for me the importance of the topic of discussion.

At these consultations a great many teachings were shared mostly about the sacredness of the body and our need to properly care for the body through ceremony. Also shared were some teachings around the seven generations which loosely interpreted meant that we need to be cognizant of where we come from, where we are and the future and that any decisions that are being made must to consider the implications on future generations. We also heard that communities wanted to be the ones directing the research agendas as well as maintaining control over the collection of the biological samples including how are they cared for, secondary use of data, ownership of data, and proper care following appropriate protocols and ceremony. Finally, the community insisted that researchers coming into the community learn about the community and be familiar with concepts contained within the Preamble to the United Chiefs and Councils of M'Nidoo Mnising's (UCCMM) constitution (UCCMM, 2013) and the meaning and intent behind this Preamble, it wasn't enough to just reference the Seven Grandfather teachings.

The next event that occurred happened on the same evening of that second day of consultation. I had a friend come stay at my home because she was going to attend the Anishinaabewin Conference. Anishinaabewin loosely translated refers to teachings about life. During our visit that evening, she asked me about how my PhD was coming. She asked me to explain to her where I was at. I explained that I had become 'stuck'. She offered a few suggestions such as going out on a fast and doing a 'bear feast' with my family. This is something that I knew about and recognized the significance of but had not done. I told her that I would do that.

The next morning, I went to the elder's teachings at the University of Sudbury. Our drum group, 'Wabiski Mkwa' had been asked to drum at the opening and closing of the gathering. At this gathering, I met up with Daniel Manitowabi who inquired about my thesis. I had mentioned that I had lost touch with the group. He provided an update about the MWT – there were a few changes in the coordinator position and the steering committee was still in existence. My plan was to touch base with the steering committee and provide an update on the findings from my research. I realized at this time that perhaps part of the reason for not being able to go forward was because of that loss of connection. I felt very hopeful after this encounter. I came to realize that part of the reason I was floundering is that I had lost my connection to the MWT.

Brian Nootchtai, an elder from Atikameksheng First Nation and a former colleague, was giving a teaching at this elder's gathering. This was another pivotal moment for me on my PhD journey. Brian began by talking about how everything is alive and that it has a spirit. He said 'we are never alone, we always have out spirit helpers'. 'Everything has a spirit even the markers. We just need to be open to the teachings". He also said that one spirit is not greater than another. "The tobacco isn't greater than the markers.' In reflecting on this I became aware that this is another important piece that I was floundering with. I had forgotten the spiritual aspect of the work that I was doing. I had forgotten that the writing I was doing also had a life and that it was alive. Up until then my dissertation did not have a life, I needed to breathe that life into it, to make it come alive.

I contacted the Chair of the MWT steering committee to make arrangements to do a presentation about the findings from my research and to seek feedback on the findings. The meeting was arranged for March 20, 2016, at the MWT office in M'Chigeeng, Ontario. Upon my arrival I learned that had to be re-scheduled but not all was lost. A couple of steering committee members

and a few staff were there and so I did my presentation. The steering committee members and the staff present seemed to enjoy the presentation and appreciated the fact that I was able to re-tell the story of the development of the MWT pilot project. The MWT staff were fairly new in their positions so were appreciative of the presentation as it helped them to better understand the history of the organization. It was unfortunate that not all the steering committee members were there. We had some good discussion about the findings from the project.

Up until this point, I struggled with finding time to do my fast. I did arrange for my brother to take me out on the fast but family issues arose for him and we never did connect. Needless to say, I still struggled with my writing. However, another series of events occurred that helped to put me back on track. I met up with my friend Bill Sayers and he seemed very interested in how I was progressing with my PhD work. At that time, I thought that I would be ready to defend my thesis in the fall so invited him to my thesis defence. He said that he would be happy to attend. At the same time he disclosed to me that he was not well. He passed away in February 2017. I went to his funeral and talked with his family and shared stories with them. It was at this time I learned about how seriously he had taken my invitation to attend my defence. His family members shared with me that he was excited about attending and that he talked a lot about me. I felt very honoured that he thought so highly of that invitation.

I mention these events for a specific reason and that reason that within Indigenous ways of being and understanding the world there is a belief that our paths are laid out for us and that along these paths are helpers that when called upon will walk with us on our journeys. The consultations on Manitoulin with the elders; the encounter with my friend; being invited to drum and meeting up Daniel Manitowabi and Brian Nootchtai; meeting with the steering committee;

and the passing of a dear friend were all events that provided the motivation that I needed to move forward with this thesis. At that point I further resolved to complete this journey.

6.2.2 Agonize

The verb agonize originates from Middle French and translated means "to torture" (Harper, 2019). Over time, the meaning of this word has shifted. For example, in Medieval Latin, the word ‘agonizare’ meant "to labor, strive, contend," as well as "be at the point of death" and in the 1660s, this word shifted meaning "to worry intensely" is from 1853. The word ‘agony’ is a derivative from the verb ‘antagonize’. One definition of this verb means to "act in opposition to, struggle against continuously" (Harper, 2019).

The word ‘agonize’ describes my struggle with western academic writing. Around about the same time I reconnected with one of the previous MWT program coordinators who asked about the outcome of my research. I had to let her know that I was still working on it. I was able to relate to her some of the findings from the research which helped with my motivation to complete this thesis. When people ask me about the project, I have no difficulty sharing what I learned through the process. The difficulty that I had was in the writing. In the words, of my brother, all the words were contained in the wood drive (the head) and there was difficulty transferring the information to the hard drive and software and ultimately down on paper. Upon reflection I was certain that this had more to do with coming from an oral storytelling tradition rather than coming from a Western academic tradition (which promotes being able to write academically).

In many ways the writing of this thesis challenged Western academic traditions and pushed the boundary for considering other ways of knowing. As mentioned in Chapter three, storytelling

continues to be a culturally preferred form of knowledge transmission for Indigenous peoples. Storytelling challenges the notion that there is only one way of knowing, in fact there are many ways of knowing. Indigenous people across the world have well-developed knowledge systems. Mainstream society has looked to Indigenous peoples for their knowledge of ecology, medicines and healing techniques. Often times, Indigenous knowledge systems are not given appropriate credit. This is the continuous struggle that I have had on my PhD journey.

Another challenge encountered along the way was to develop research questions that would guide the research process. I found that the questions were useful as guiding questions that helped with some of my reflection that contributed to my data analysis and writing but in the end the research did not provide specific answers to the questions. Instead, these questions found some usefulness in shaping my recommendations for the Raising the Spirit MWT.

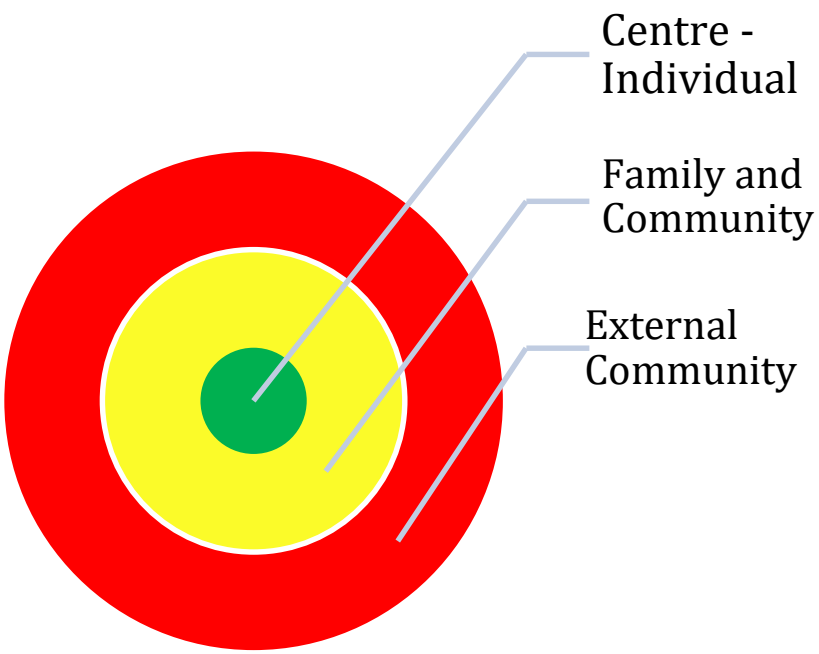
6.2.3 Overcoming my struggle

I had mentioned at the start of the PhD program that I was concerned that I would lose my sense of self within the western academic institution. For much of this journey I relied on the teachings from my family and community, particularly my parents, Art McGregor-ba and Violet McGregor-ba. I had also attended cultural events in my community and surrounding communities. This all helped to keep me grounded yet there was still a void in my being that prevented me from moving forward. The events that I related above reminded me that there were still other helpers that would be there for me on my journey – the elders whose knowledge about life and traditional Anishinaabek teaching; the importance of feasting, or sweat lodges and other ceremonies that help one connect with the ancestors and contributes to the resolve to move forward knowing that you are not alone; realizing that as time passes we lose connections to important supports along the way; a belief in sacred items and the power contained within that

helps with our tasks or roles that we take on; and most importantly, the people who are relying upon you to complete the work that will ultimately aid the community.

I came to realize that my struggle is not one that I must endure alone. I am once again reminded of the teachings of the medicine wheel, which has guided the research process and which when applied can provide guidance for much more in life. In this case, it is the struggle. The medicine wheel can be depicted as concentric circles moving out from the centre (Figure 12 – Medicine Wheel diagram). The individual is represented in the center (referred to as the spirit or inner fire). Sometimes the fire within is strong and bright and sometimes it is dim, depends on how we feed the fire. On my journey the fire went through many ups and downs being very bright to being dim. When my fire was dim, it was because I wasn't feeding it, meaning that I had lost connection by not attending feasts and ceremonies or even taking care of myself. Other times my fire was bright. These were the times that I embraced the ceremonies, attended sweats, connected with people who had an interest in this project and connected with the ancestors through prayer or ceremony. These were the motivators.

Figure 12 -Medicine Wheel diagram



The second circle is family and community. Many of my teachings come from family and community and my community. For instance, my father wrote about Dreamer's Rock, the Bell Rocks and the little people. He also shared stories about Shawanossowe (a great chief in my community of Whitefish River First Nation). Lillian Pitawanakwat was an elder from my community who shared traditional teachings specifically from our area. She taught about the Medicine Wheel and the strawberry. Medicine wheel teachings vary from community to community but there are core lessons contained within these teachings. At this level, are the supports such as the elders and family members that encourage and provide guidance on one's journey through life.

The third circle is the external community represented by health and social services, political organizations, bureaucracies, etc. The MWT pilot project grew out of a vision that several individuals (including myself) had about creating improved access to culturally appropriate,

community-based mental health services. This vision was part of the inspiration that helped to keep me on track. It was the commitment of the steering committee, the support of the First Nation leadership, and the belief of the funding bodies in concept of the MWT that provided the motivation for the MWT to stay the course. The meeting with the steering committee members and the MWT staff in March 2016, demonstrated to me that, even though it had been a while since I had connected with the MWT, they were appreciative of knowing the history of the project. This also re-affirmed for them the importance of the work they were doing. The First Nation leadership believed in the project and saw this a much-needed service that community organizations could benefit from. Reflecting on the findings of the project, the community frontline workers also realized the benefit of this project. Last, but not least, Health Canada, specifically Frank McNulty from Ontario Region, also recognized the importance of capacity building and that the community's best resource were the community members. His belief in the project was also a great motivator.

My only regret is that this journey was a slow one, fraught with many challenges. I often wonder why there were so many challenges along the way. Was it because of the imposition of working within a western academic institution and the need to create ethical space where Indigenous knowledge systems are equally valued? Was it a journey that was reflective of life and the life lessons that one encounters along the way? Was this reflective of the reality of the journey that Indigenous people continue to experience in their relationships with western society? Perhaps, it is all of the above.

6.2.4. The Tug

The word 'tug' has also undergone changes over time. In the mid-14 century, a tug referred to a part of a harness; in the 1500 century it referred to the "act of pulling or dragging"; it also

referred to a tugboat (a small, powerful vessel for towing other vessels) (Harper, 2019). Upon reflection about my struggles with writing I came to realize that what was missing from this work is my connection to the 'spirit' and to asking the ancestors to help me on my journey. I was fortunate to meet an elder from the United States, George Martin, a veteran who makes walking sticks. I received a walking stick from him (see picture10). Upon presentation of this walking stick I could feel the energy in the stick, it appeared to be vibrating. In speaking with this elder about the walking stick, I explained that I was working on my PhD and was having challenges with my writing. I told him that I felt that the walking stick had come at the right moment and that it would help with the spiritual piece that was missing. He told me that the ancestors would be with me on my journey and that that they would help me see it through.

In May 2017, I attended the Canadian Network for Innovation in Education conference in Banff, Alberta. My sister and her family live in Maskwacis, Alberta, about an hour outside Edmonton so I took this opportunity to spend time with them before and after the conference. Upon arrival in Maskwacis, my brother-in-law had arranged for a sweat lodge ceremony for me. He also arranged for a second sweat lodge ceremony before I left Alberta. My brother-in-law who was conducting the sweat told me two things afterwards: that the spirits of our ancestors had come in

Picture 10 – Walking Stick received from George Martin

"This is what it means to be Ojibway, I said to myself. To be human. The effortless, almost mindless mending of the nets we cast across the currents of time." (Richard Wagamese. Posted on December 2, 2014 In News, Opinions, Anishinaabek News).

and that I would be so "holy that I could walk on water". We laughed about the walking on water comment, but I believe that this is just what I had been waiting for. I was able to connect spiritually through the sweat lodge ceremonies and felt a renewed sense of encouragement to pick up my writing once again, this was the tug that was needed.

6.3 Conclusion

What did I learn, what I would do differently and what were some of the limitations of this project? The storytelling interviews were probably the most successful method to collect the data needed for this project. There were some challenges with the self-reflective journals and the photovoice particularly because these two methods of data collection required additional training about how to do the journaling and take the photos. The self-reflective journaling and photovoice activity required additional time on the part of the participants which made the activities less

feasible given that there was a huge learning curve for the MWT staff being new to the positions and the newness of the project itself. These activities were also complicated by the turnover in staff and the enormity of the project covering ten First Nations community in a huge geographical area.

What would I do differently? I would probably narrow down my choice of evaluation methods rather than trying to incorporate all four – focus groups, storytelling interview, reflective journaling and photovoice. While all are valuable methods that are congruent with traditional oral tradition, I would focus on one or two methods possibly the storytelling interviews and the focus groups. The other two, the self-reflective journals and photovoice, I would do with a smaller participant group that had a closer more stable working relationship so that I would not have to continually train on how to do the journaling or the photovoice activity. Alternately, this method could be used with a group that was more firmly established rather than one that was just building their foundation.

Limitations of the project – there are many but upon reflection I will choose two to focus on. The First is that this was a huge project that covered a wide geographical area and tried to accommodate the needs of ten different communities with a small number of team members. Clearly this was too large of a project from that small team. The second issue with this project is that the infrastructure was non-existent at the start of the project. There was no team in place, there was no office, and the project has not been fully developed. This was work that had to be completed as the project moved along. These two issues were challenging enough on its own but the MWT, despite these challenges, were able to maintain the engagement and support of the First Nations partners throughout this project. Why? I would say that it was because of the commitment to and belief in the project by all partners. There was great support from the First

Nation leadership who felt that this was an essential service that could potentially create better range of mental health services for community members. It was the belief that the visionaries had that a mental wellness team could provide culturally appropriate community-based mental health services with increased access to specialized services. Having that support and belief in the work that needed to be done provided the motivation for the MWT to do what they could to live up to the original vision of this project.

Lastly, I would like to remind readers that this is my version of the story of the Raising the Spirit MWT. I have made some recommendations based on my analysis corroborated by the individuals involved in this story. The beauty of storytelling is that the readers are free to draw their own conclusions. And remember, the story is not static, it changes with each iteration and by the experience and context of the individual.

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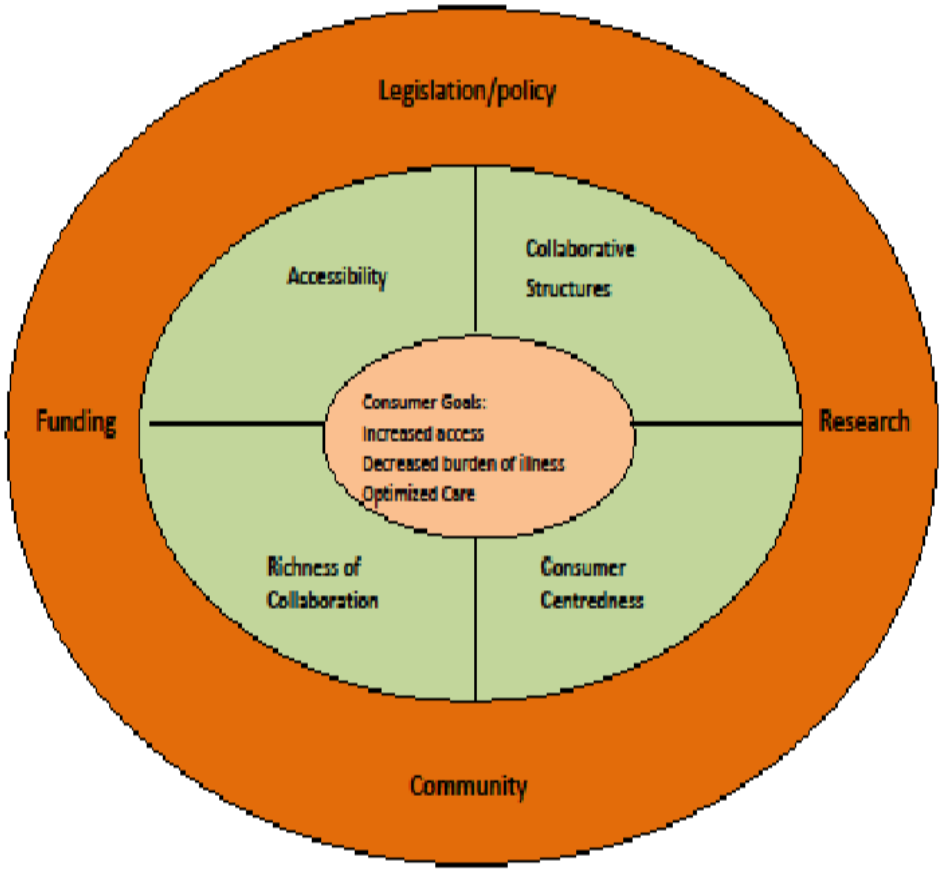
Appendix 1 – MWAC Strategic Plan – 5 Pillars

1. To support the development of a coordinated continuum of mental wellness services for and by First Nations and Inuit including traditional, cultural and mainstream approaches.
2. To disseminate and share knowledge about promising traditional, cultural and mainstream approaches to mental wellness.
3. To support and recognize the community as its own best resource by acknowledging diverse ways of knowing, and by developing community capacity to improve mental wellness.
4. To enhance the knowledge, skills, recruitment and retention of a mental wellness and allied services workforce able to provide effective and culturally safe services and supports for First Nations and Inuit.
5. To clarify and strengthen collaborative relationships between mental health, addictions and related human services and between federal, provincial, territorial and First Nations and Inuit delivered programs and services.

Appendix 2 - CCMHI Collaborative Mental Health Framework



Accessibility can refer to how consumers can access mental health services in primary health care settings.
Richness of their collaboration can refer to numbers involves in care or numbers of disciplines involved as well as ability to transfer knowledge among collaborative partners.
Collaborative structures may refer variations in style of management, whether there is a formal evaluation protocol, and/or memorandums of understanding with their partners.
The ***consumer is at the centre*** of the planning, evaluation, governance and treatment decision-making process. (MacFarlane, 2005)

Appendix 3 – Mental Wellness Team Pilot Project – Program Coordinator

The Mental Wellness Team Pilot Project is an innovative 2.5-year project involving the formation of a specialized consultative team of professionals from social work, psychology, traditional knowledge and healing, concurrent disorders and psychiatry. The team will work with community mental health and addictions workers in addressing complex needs in addictions and mental health in ten area First Nations. The goals of the project are as follows:

a) Improving access to needed specialized services where gaps exist
b) Enhancing knowledge, skills and capacities of community workers
c) Providing support via a team approach of consultation, clinical supervision, coaching and mentoring.
d) Building and/or strengthening bridges between traditional and mainstream approaches to wellness.

The Mental Wellness Team Pilot Project seeks an experienced Program Coordinator to provide leadership in the development of the Mental Wellness Team Pilot Project as follows:

Responsibilities:

The Coordinator of the Mental Wellness Team Pilot Project in the implementation phase of the project will:

1. Implement the recommendations from the community consultation:

a) Establish and maintain formal partnerships with the ten participating First Nations communities in the Sudbury, Nipissing and Manitoulin Districts
b) Establish formal partnerships with academic institutions (educational institutions)
c) Based on the community consultation results and in coordination with the Steering Committee, define partnerships with federal and provincial stakeholders (i.e., FNIHB, provincial ministries, etc.)
d) Foster community collaboration, involvement and support and ensure the team is responsive to community needs and strengths as these evolve.
e) Participate in the recruitment, development and implementation of the specialized Mental Wellness Team.
f) Establish in collaboration with the Steering Committee, the office and administrative structures (policies, procedures, job descriptions, service protocols and continuous quality improvement processes) to implement the Mental Wellness Team.
g) Oversee the development of a culturally appropriate evaluation process.

2. Ensure clinical consultation services are provided to First Nation communities' program managers and frontline workers to build capacity in incorporating traditional and western healing practices.

Specific Duties:

1. Collaborate with the Steering Committee to ensure that culturally appropriate service needs are being met for the Anishinabek in the local area of Nipissing/Sudbury/Manitoulin

2. Coordinate and provide leadership in the implementation and delivery of the Mental Wellness Team Pilot Project.

3. Ensure culturally appropriate clinical consultation/training is provided to frontline staff working in the ten participating First Nation communities and First Nation organizations that would lead to enhanced knowledge and skills

4. Facilitate access to educational/training programs/services for First Nation front line workers as identified through the consultation process.

5. Collaborate with the Steering Committee and M'Chigeeng Health Services to develop and manage the financial resources of the Mental Wellness Team Pilot Project by monitoring the financial records, developing and adhering to a project budget, ensuring expenditures conform with the approved budget and seeking and obtaining available additional resources as needed

6. Develop and maintain partnerships with educational institutes/academic programs to assist in the training capacity of frontline workers

7. Define, in collaboration with the Steering Committee, partnerships with provincial stakeholders, educational institutes and academic programs and community stakeholders (health managers, team leaders, frontline workers, health board members, community leadership and consumers)

Specific accountabilities

1. To generate timely preparation of all monthly, quarterly and yearly program and financial reports for the funding agencies, for the affiliated First Nation communities, and other stakeholders i.e., Educational Institutions

2. Accountable to the participating First Nation communities, funding agencies and stakeholder groups

3. Ensures confidentiality of all health information by monitoring the development, maintenance and auditing of a comprehensive system of records for the Mental Wellness Team Pilot Project

4. Maintain and develop professional competence and quality assurance through appropriate continuing education methods

Qualifications

1. Master's level degree from a recognized university in Health Human Services or Health Administration and registration in a recognized professional association in the Province of Ontario

2. Three years management and administration experience in First Nations' health services/mental health and addictions services working with First Nations' communities

3. Knowledge in working with First Nation, provincial and federal government systems of health

4. Excellent communication, interpersonal and leadership skills

5. An intimate understanding of the lived experience of Anishinaabe people

6. Travel is a requirement of this position – applicants must possess a valid Ontario Driver's License and have access to a reliable vehicle

7. Current clear criminal reference check

Salary:

The salary will range from $60,000 - $66,000 based on qualifications and experience.

Appendix 4 - Mental Wellness Team Pilot Project – Concurrent Disorders Specialist

The Mental Wellness Team Pilot Project is an innovative 2.5-year project involving the formation of a specialized consultative team of professionals from social work, psychology, traditional knowledge and healing, concurrent disorders and psychiatry. The team will work with community mental health and addictions workers in addressing complex needs in addictions and mental health in ten area First Nations. The goals of the project are as follows:

e) Improving access to needed specialized services where gaps exist
f) Enhancing knowledge, skills and capacities of community workers
g) Providing support via a team approach of consultation, clinical supervision, coaching and mentoring.
h) Building and/or strengthening bridges between traditional and mainstream approaches to wellness.

The Mental Wellness Team Pilot Project seeks an experienced clinician who has in-depth knowledge of current best practices in mental health and substance abuse and traditional wellness approaches (or willingness to learn about traditional wellness approaches).

Working in a First Nation community setting as a member of a multi-disciplinary care team, the Concurrent Disorders Specialist will provide advanced clinical practice and interventions relating to intake, assessment, intervention, education, treatment, consultation and referral for clients experiencing mental health, addiction and/or concurrent disorder problems and their caregivers/families. This position consults extensively with community resources and participates in the training and supervision of community workers.

Qualities:

1. Experience in working within a recovery directed service philosophy and in community-based mental health
2. A strong community development advocate
3. Clinical expertise: assessment, planning and intervention including treatment related to mental health, substance abuse and concurrent disorders; knowledge of mental health/addictions assessments, treatment methodologies, intervention strategies, the change process and community dynamics
4. System knowledge: mental health and substance abuse service delivery systems applicable to Manitoulin, Sudbury and Nipissing District First Nations settings as well as all applicable legislation; knowledge of First Nation community dynamics
5. Service knowledge: local and regional providers of general and specialized services
6. Minimum 5 years clinical expertise in working with Aboriginal populations and minimum of 2 years of experience in community development/knowledge transfer
7. Masters level degree in health care or social sciences or equivalent
8. Membership or membership qualification in a recognized provincial regulatory body
9. Travel is a requirement of this position – applicants must possess a valid driver's license and have access to a reliable vehicle
10. Current clear criminal reference check

Responsibilities:

1. Developing and supporting a consultative approach to service delivery in collaboration with local First Nations program managers and community workers to coordinate supports for individuals with a concurrent disorder

2. Clinical consultation and guidance regarding treating and supporting individuals with a concurrent disorder

3. Promoting and coordinating training and educational initiatives that will build capacity in concurrent disorders with local communities

4. Participate in planning and knowledge exchange opportunities aimed at ensuring clinical approaches work hand in hand with traditional wellness approaches

5. Participate in team planning and quality improvement processes; research and evaluation endeavors in support of the Mental Wellness Team Pilot Projects aims and objectives

Salary Range:

$58,000 to $65,000

Appendix 5 - Mental Wellness Team Pilot Project – Traditional Counsellor/Coordinator

The Mental Wellness Team Pilot Project is an innovative 2.5-year project involving the formation of a specialized consultative team of professionals from social work, psychology, traditional knowledge and healing, concurrent disorders and psychiatry. The team will work with community mental health and addictions workers in addressing complex needs in addictions and mental health in ten area First Nations. The goals of the project are as follows:

i) Improving access to needed specialized services where gaps exist
j) Enhancing knowledge, skills and capacities of community workers
k) Providing support via a team approach of consultation, clinical supervision, coaching and mentoring.
l) Building and/or strengthening bridges between traditional and mainstream approaches to wellness.

Our concept of wellness recognizes a balance between physical, mental, emotional and spiritual dimensions of health. The Traditional Counsellor/Coordinator is someone who reflects this philosophy in their understanding and approach. Some of the desired qualities and expected responsibilities would thus include:

Qualities:

1. Degree or diploma or qualifications in one of the helping disciplines
2. Background and work experience in mental health and addictions issues/healing pathways
3. Understanding/Knowledge of cultural safety and traditional approaches to healing and wellness
4. Aptitude for community development/teaching/sharing
5. Superior communications skills
6. Recognized qualifications in counselling
7. Anishinaabemowin an essential asset
11. Travel is a requirement of this position – applicants must possess a valid driver's license and have access to a reliable vehicle
12. Current clear criminal reference check

Responsibilities:

Work with Steering Committee, program managers, community workers, Traditional Advisory Circle and Elder in Residence to develop community designed programs, services, policies to encourage and support traditional wellness approaches to mental health and addictions by:

1. Establishing and coordinating a Traditional Advisory Circle to advise and support the Mental Wellness Team in contributing to capacity building of community workers and program managers

2. Assist in coordinating knowledge exchange opportunities for Mental Wellness Team members and community workers around traditional wellness approaches

3. Enhance community development in this area in collaboration with communities including facilitating and presenting workshops, sharing teachings, facilitating sharing circles, assisting in community activities such as ceremonies, feasts, etc.

4. Supporting additional access to traditional counselling and/or healing services and facilitate inter-disciplinary sharing of approaches; Assist local community workers in accessing or linking them with traditional healers for fasts, ceremonies, circles, etc.

5. Providing appropriate mechanisms to share information about resources in this area, best practices, and a source of referrals for traditional resource people.

6. Coordinating access to an "Elder in Residence" to assist community workers with advice, support, and counselling as needed, and support the learning of the Mental Wellness Team through mentoring and dialogue.

7. Ensuring close collaboration between mainstream and traditional approaches via:
    1. common intake and case management ensuring that intake processes reflect the ability to offer traditional wellness approaches, and
    2. regular "consultative rounds" involving both mainstream and traditional approaches with a discussion on how they can be mutually supportive.

8. Facilitating planning opportunities to develop a common lexicon; an appropriate mission and vision; policies and procedures, committee terms of reference; evaluation frameworks etc. which are reflective of both aspects of care.

9. Helping guide culturally appropriate planning, evaluation, research, quality improvement and capacity building efforts.

10. Identifying and seeking additional financial resources to support project initiatives

Salary Range:

$58,000 to $65,000

Appendix 6 - Letter of Introduction

NISHNAABE KINOOMAAWIN

HONOURS B.S.W. (NATIVE HUMAN SERVICES)

Letter of Introduction

Study Title: A Culturally Appropriate Way of Evaluating the Engagement Processes utilized by the Mental Wellness Team Pilot Project

Investigator: Susan Manitowabi, MSW, PhD student

This research will document a culturally appropriate way of evaluating the engagement processes used by the Mental Wellness Team (MWT) pilot project. The research will focus on four aspects of the MWT pilot project:

1. The engagement process and support of the 10 participating First Nation communities,
2. Collaboration within and across communities and with key partners,
3. The integration of mainstream and traditional approaches by the MWT pilot project and,
4. The impact on the capacity building and knowledge at the community level.

This research will document the journey of the pilot project, highlighting the successes and challenges so that the MWT concept can be copied and inform the development of other mental wellness teams. This research project will also help to build a rationale for continued funding for the Mental Wellness Team project and to provide recommendations that will improve upon and strengthen the project. The research will use Indigenous research methodologies and research methods together with traditional practices thereby adding to the body of knowledge around Indigenous research methodologies.

Methodology

This qualitative research will use a case study methodology. This case study uses a combination of self-reflective journaling, photovoice and storytelling (narrative) approaches to tell the story of the engagement process of the Mental Wellness Team with the participating First Nations communities involved with the pilot project.

Laurentian University/University of Sudbury
Ramsey Lake Road, Sudbury, Ontario P3E 2C6
(705) 675-1151, ext. 5082 FAX (705) 675-4817

Recruitment

All participants will already be involved with the pilot project and will include members of the Mental Wellness Team, Mental Wellness Steering Committee members and First Nations leadership (Health Directors) and key informants from the community partners/community services (10 First Nations communities from the Manitoulin Island, North Shore and the Waabnoong Bemjiwang Tribal Council areas). The service providers/agencies will be recruited through the Health Directors representing the 10 participating First Nations communities involved in this pilot project.

The activities that each group will participate in are outlined below:

Target Group	Activities	Timeframe
Mental Wellness Team	Self-reflective journal of their activities ● Training on self-reflective journaling Storytelling interview Photo-voice ● photovoice training ● Group discussion	Ongoing – Dec 2010 - ½ hr/ wk. ½ day session - July 1hour every three months – July 2010, Oct 2010, Dec 2010 Ongoing – when activities have been planned with the community ½ day session – July 2 sessions – Aug 2010 Oct 2010
MWT Steering Committee	Storytelling interview	1 hour - Nov 2010
First Nations Leadership	Storytelling interview	1 hour – Nov 2010
Service Providers/Agencies	Storytelling interview Focus group activity	1 hour – Nov 2010 Aug 2010 Dec 2010 Each session will take approximately 1- 2 hours.

If you have any questions or concerns about the study or about being a subject, you can call me at 1-877-674-7626 or the Research Officer at (705) 675-1151, ext. 3213 for information.

Laurentian University/University of Sudbury
Ramsey Lake Road, Sudbury, Ontario P3E 2C6
(705) 675-1151, ext. 5082 FAX (705) 675-4817

Appendix 7 – Work plan – Mental Wellness Team Pilot Project –Evaluation of the Engagement Process with First Nations Communities

Target Group	Activities	Timeframe
Mental Wellness Team	Self-reflective journal of their activities ● Training on self-reflective journaling Storytelling interview Photo-voice ● photovoice training ● Group discussion	Ongoing – Dec 2010 - ½ hr/ wk. ½ day session - July 1hour every three months – July 2010, Oct 2010, Dec 2010 Ongoing – when activities have been planned with the community ½ day session – July 2 sessions – Aug 2010 Oct 2010
MWT Steering Committee	Storytelling interview	1 hour - Nov 2010
First Nations Leadership	Storytelling interview	1 hour – Nov 2010
Service Providers/Agencies	Storytelling interview Focus group activity	1 hour – Nov 2010 Aug 2010 Dec 2010 Each session will take approximately 1- 2 hours.

Other activities related to this research:
Completion date for data collection activities – December 2010
Data Analysis – Ongoing
Member Checking – Ongoing once each activity has been completed
Draft Report – January 2011
Final Report – March 2011

Appendix 8 - Submission to National Network for Aboriginal Mental Health Research – NAMHR Small Research Award

National Network for Aboriginal Mental Health Research NAMHR Small Research Award	
	Total Request of Funding
Expenditures	
Equipment and supplies	
Paper – questionnaires and ink cartridges	$250.00
Printing costs – reports, data collection tools, e-journal articles, user manuals, self –reflective journals, and research related paper documents (pamphlets, posters, focus group materials)	$1,000.00
Travel Expenses	
Travel for field work (10 First Nations communities)	$1,000.00
Computer and Electronic Communications	
Data analysis software	$1,000.00
Internet charges ($50.00/month X 12 months)	$600.00
Dissemination of Research Results	
Audio and video equipment	$750.00
Prepare manuscript for publication	
CD-ROMS	
Services and Miscellaneous Expenses	
Workshops related to use of research tools (self-reflective journals, photo-voice instructions)	$400.00
TOTAL	**$5,000.00**

Appendix 9 - Narrative Storytelling Interview – Participating Service Providers/Agencies

1. Tell me about your role in the community. What position do you hold in the community? How long have you been in that position? What is your relationship to the Mental Wellness Team?

2. Tell me about the role that the Mental Wellness Team plays in working with the Mental Wellness Steering committee, the participating First Nations leadership and the participating service providers/agencies. What services and programs does the Mental Wellness Team provide to the community? With whom do they interact with at the community level? How would you describe their working relationship with the Steering Committee, the First Nations leadership and participating service providers/agencies?

3. Describe how the Mental Wellness Team works in collaboratively within and across the communities and with key partners? Describe how effective this collaborative relationship has this been? What would strengthen the relationship with participating First Nation leadership and service providers/agencies?
4. Describe how the Mental Wellness Team (MWT) pilot project has been able to integrate mainstream and traditional approaches in their work with the participating First Nation communities and service providers/agencies.

5. Describe the challenges that the Mental Wellness Team has experienced in maintaining the engagement and support of the 10 participating First Nation Communities.

6. Describe the successes that the Mental Wellness Team has experienced in maintaining the engagement and support of the 10 participating First Nation communities.

7. Describe the impact that the Mental Wellness Team pilot project has had on the capacity building and knowledge at the community level.

Appendix 10 - Narrative Storytelling Interview Guide – Mental Wellness Team

1. Tell me about your role on the Mental Wellness Team. What the services and programs do you provide to the community? With whom do you interact at the community level? What is your working relationship like?

2. Describe how you work in collaboratively within and across the communities and with key partners? Describe how effective this collaborative relationship has this been? What would strengthen this?

3. Describe how the Mental Wellness Team (MWT) pilot project has been able to integrate mainstream and traditional approaches in their work with the participating First Nation communities and service providers/agencies.

4. Describe the challenges you have experienced in maintaining the engagement and support of the 10 participating First Nation Communities.

5. Describe the successes you have experienced in maintaining the engagement and support of the 10 participating First Nation communities.

6. Describe the impact that the Mental Wellness Team pilot project has had on the capacity building and knowledge at the community level.

Appendix 11 - Narrative Storytelling Interview – Mental Wellness Team Steering Committee

1. Tell me about your role on the Mental Wellness Team Steering Committee.

2. Tell me about the role that the Mental Wellness Team plays in working with the Mental Wellness Steering committee, the participating First Nations leadership and the participating service providers/agencies. What the services and programs do the Mental Wellness Team provide to the community? With whom do they interact with at the community level? How would you describe their working relationship with the Steering Committee, the First Nations leadership and participating service providers/agencies?

3. Describe how the Mental Wellness Team works in collaboratively within and across the communities and with key partners? Describe how effective this collaborative relationship has this been? What would strengthen the relationship with participating First Nation leadership and service providers/agencies?

4. Describe how the Mental Wellness Team (MWT) pilot project has been able to integrate mainstream and traditional approaches in their work with the participating First Nation communities and service providers/agencies.

5. Describe the challenges that the Mental Wellness Team has experienced in maintaining the engagement and support of the 10 participating First Nation Communities.

6. Describe the successes that the Mental Wellness Team has experienced in maintaining the engagement and support of the 10 participating First Nation communities.

7. Describe the impact that the Mental Wellness Team pilot project has had on the capacity building and knowledge at the community level.

Appendix 12- Narrative Storytelling Interview – First Nations Leadership

1. Tell me about your role in the community. What position do you hold in the community? How long have you been in that position? What is your relationship to the Mental Wellness Team?

2. Tell me about the role that the Mental Wellness Team plays in working with the Mental Wellness Steering committee, the participating First Nations leadership and the participating service providers/agencies. What services and programs do the Mental Wellness Team provide to the community? With whom do they interact with at the community level? How would you describe their working relationship with the Steering Committee, the First Nations leadership and participating service providers/agencies?

3. Describe how the Mental Wellness Team works in collaboratively within and across the communities and with key partners? Describe how effective this collaborative relationship has this been? What would strengthen the relationship with participating First Nation leadership and service providers/agencies?

4. Describe how the Mental Wellness Team (MWT) pilot project has been able to integrate mainstream and traditional approaches in their work with the participating First Nation communities and service providers/agencies.

5. Describe the challenges that the Mental Wellness Team has experienced in maintaining the engagement and support of the 10 participating First Nation Communities.

6. Describe the successes that the Mental Wellness Team has experienced in maintaining the engagement and support of the 10 participating First Nation communities.

7. Describe the impact that the Mental Wellness Team pilot project has had on the capacity building and knowledge at the community level.

Appendix 13: Questions for Reflective Journaling

- Describe what happened
- What were you thinking and feeling?
- What was good or bad about the experience?
- What sense can you make of the situation?
- What else could you have done?
- If the situation arose again, what would you do?

(Adapted from: Gibb's reflective cycle. Taken from: Gibbs, G. *Learning by Doing: A Guide to Teaching and Learning Methods*. London: Further Education Unit, 1988.9)

Successes

- What were the successful features of this engagement activity?
- What do you think helped make the activity a success?

Difficulties

- What proved difficult or did not succeed as well as you would have wished?
- Why do you think this was the case?

Changes

- What changes would you like to introduce the next time you run a similar activity?
- How do you think these changes might help make the activity more effective?

Appendix 14 - Gibb's Reflective Cycle

Taken from: Gibbs, G. *Learning by Doing: A Guide to Teaching and Learning Methods*. London: Further Education Unit, 1988.9

Appendix 15 – Consent Form – Participating Service Providers/Agencies

CONSENT FORM
Participating Service Providers/Agencies

Study Title: A Culturally Appropriate Way of Evaluating the Engagement Processes utilized by the Mental Wellness Team Pilot Project

Investigator: Susan Manitowabi, MSW, PhD student

I am a PhD student in the School of Rural and Northern Health at Laurentian University. My research will document a culturally appropriate way of evaluating the engagement processes used by the Mental Wellness Team (MWT) pilot project. The research will focus on four aspects of the MWT pilot project:

1. How the MWT pilot project maintains the engagement and support of the 10 participating First Nation communities,
2. Collaboration within and across communities and with key partners,
3. The integration of mainstream and traditional approaches by the MWT pilot project and,
4. The impact on the capacity building and knowledge at the community level.

This research will help to develop a road map that documents the journey of the pilot project that highlights the successes and challenges so that the MWT concept can be copied and inform the development of other mental wellness teams. This research project will also help to build a rationale for continued funding for the Mental Wellness Team project and to provide recommendations that will improve upon and strengthen the project. The research will use Indigenous research methodologies and research methods together with traditional practices and will therefore add to the body of knowledge around Indigenous research methodologies. The risk for participating in this study is minimal or no different than what the participants would experience in their everyday lives.

Participating service providers/agencies will be asked to participate in a focus group activity near the beginning and at the end of the research project to share their experiences and knowledge about the Mental Wellness Team pilot project. There will be two focus group sessions that will take approximately 1-2 hours each and will be audiotaped with your permission.

Your participation in this study is strictly voluntary. You have the right to withdraw at any time without penalty. Information gathered through this research project will be coded to protect personal information, but it will be difficult to guarantee that your identity will not be revealed since the participating First Nations Communities are known to one another.

The information gathered from this research study will be stored at Laurentian University in the School of Native Human Services in a locked file cabinet. The raw data will be destroyed once the PhD program requirements are completed. All reports generated and evaluation frameworks developed will be given to the Mental Wellness Team pilot project upon completion of the PhD program requirements. The evaluation framework will be presented back to the Evaluation Advisory Committee and information disseminated back to the participating communities at the annual knowledge symposium.

If you have any questions about the study or about being a subject, you can call me at 1-705-675-1151 ext. 5049 or if you have any ethical concerns, you can contact the Research Officer at (705) 675-1151, ext. 3213 for information.

.

I agree to participate in the following activities related to this study:

Focus groups ☐

I agree to be audio-taped ☐

I have received a copy of this consent form. ☐

_____ _____

Subject's Signature Date

Appendix 16 – Consent Form – Health Directors

CONSENT FORM
Health Directors

Study Title: A Culturally Appropriate Way of Evaluating the Engagement Processes utilized by the Mental Wellness Team Pilot Project

Investigator: Susan Manitowabi, MSW, PhD student

I am a PhD student in the School of Rural and Northern Health at Laurentian University. My research will document a culturally appropriate way of evaluating the engagement processes used by the Mental Wellness Team (MWT) pilot project. The research will focus on four aspects of the MWT pilot project:

1. How the MWT pilot project maintains the engagement and support of the 10 participating First Nation communities,
2. Collaboration within and across communities and with key partners,
3. The integration of mainstream and traditional approaches by the MWT pilot project and,
4. The impact on the capacity building and knowledge at the community level.

This research will help to develop a road map that documents the journey of the pilot project that highlights the successes and challenges so that the MWT concept can be copied and inform the development of other mental wellness teams. This research project will also help to build a rationale for continued funding for the Mental Wellness Team project and to provide recommendations that will improve upon and strengthen the project. The research will use Indigenous research methodologies and research methods together with traditional practices and will therefore add to the body of knowledge around Indigenous research methodologies. The risk for participating in this study is minimal or no different than what the participants would experience in their everyday lives.

Health Directors will be asked to participate in a storytelling interview to share their experiences and knowledge about the Mental Wellness Team pilot project. This interview will take approximately 1 hour and will be audiotaped with your permission.

Your participation in this study is strictly voluntary. You have the right to withdraw at any time without penalty. Information gathered through this research project will be coded to protect personal information, but it will be difficult to guarantee that your identity will not be revealed since the participating First Nations Communities are known to one another.

The information gathered from this research study will be stored at Laurentian University in the School of Native Human Services in a locked file cabinet. The raw data will be destroyed once the PhD program requirements are completed. All reports generated and evaluation frameworks developed will be given to the Mental Wellness Team pilot project upon completion of the PhD program requirements. The evaluation framework will be presented back to the Evaluation Advisory Committee and information disseminated back to the participating communities at the annual knowledge symposium.

If you have any questions about the study or about being a subject, you can call me at 1-705-675-1151 ext. 5049 or if you have any ethical concerns, you can contact the Research Officer at (705) 675-1151, ext. 3213 for information.

.

I agree to participate in the following activities related to this study:

Focus groups ☐

I agree to be audio-taped ☐

I have received a copy of this consent form. ☐

_____ _____

Subject's Signature Date

Appendix 17 – Guide for Leadership Interviews

Guide for Leadership Interviews
2012 MWT Evaluation

[Interview preamble: intro to the evaluation, purpose of the interview, etc., 5 mins]

Questions:

1. Please tell me about your understanding of the MWT pilot project. What kind of services do they provide in your community? What kind of services can they provide? What services would you like them to provide? Were you part of the project throughout the history? (If no, how were you briefed on the project if you got into your position after the project had already started?)

2. Please tell me about the flow of communication between the MWT and local community stakeholders. (Is there a formal process for your community's MWT representatives on the SC to communicate back to local leaders? Is this process working well?)

3. How much awareness is there currently in your community for the services of the MWT team? (probes: Among workers? Among C&C?) What has worked to create awareness? Can you share any ideas of how awareness can be further increased? Have you ever advocated for the MWT team services in your community?

4. Do you feel the community perspective and needs were usually addressed in the development of the MWT services (keeping in mind that this small team provides services to 10 communities)? Do you think the direction of the MWT is in line with what your community needs are with respect to this team?

5. What has been the response of your local health team to the MWT team? Do you think solid working relationships are developing? Do you think that an effective balance between traditional and western approaches to mental health are being developed?

6. Overall, do you think the administration is working effectively? Is the governance working effectively? (Steering Committee and administration in M'Chigeeng) Is there appropriate accountability related to budgeting?

7. What do you see as your role with respect to the MWT now and in the future? What is your role in advocating for funding? What about advocating for sustainability?

8. What is your long-term vision of the MWT project? Are you willing to commit to supporting the services as a viable long-term project?

9. Do you have any other comments you would like to share?

Appendix 18 - Community Workers Focus Group Guide

Community Workers Focus Group
2012 MWT Evaluation

[Preamble: introductions, intro to the evaluation, purpose of the focus group, informed consent]

Questions:

1. What kind of services has your community accessed through the 'Raising the Spirit' Mental Wellness Team (MWT)?

2. How would you describe your working relationship with the MWT? (Probes: Has the MWT been in close contact with your community? Has the MWT had a noticeable presence in your community? Have you collaborated with the MWT team in delivering clinical and traditional services? Has there been much collaboration among MWT staff, community health staff and external providers to provide shared care? What are the factors that facilitate service integration? What are the barriers to service integration? How does geography impact service delivery?)

3. Has the MWT increased your community's ability to provide additional clinical and traditional services? (Probe: Would you say that these additional services are 'culturally safe'? How effectively has the MWT project braided together both mainstream and traditional approaches to mental wellness? Would you say that is there improved access to mental health care in your community as a result of the MWT? Are communities better able to respond to mental health issues as a result of the MWT?)

4. *The Specialized Services Program of the Raising the Spirit Mental Wellness Team is intended to fill in gaps in mental wellness services within the 10 partner First Nation communities*. What do you understand 'Specialized Services' to include? What type of 'Specialized Services' have been used in your community? What has been the demand been like for these 'Specialized Services'? Should the scope of 'Specialized Services' be changed or expanded? What are the challenges of accessing Specialized Services? What are some different ways of delivering specialized services in your community that would improve accessibility?

5. *This Specialized Services Program is also intended to enhance the skills of the mental health/addiction community workers to assist them in increasing their knowledge and skills through shadowing, consultation or participation in counselling sessions*. How effective has this been?

6. Do you have any other comments you would like to share?

Appendix 19 – Letter of Introduction to Health Directors – Second Round of Data Collection

Dear Health Director,

The 'Raising the Spirit' Mental Wellness Team (MWT) was established in 2009 to enhance capacity at the First Nations community level to address needs associated with addictions, mental health and concurrent disorders in ways that reflect the culture, attitudes and philosophies of the participating communities.

During the next few months an external evaluation of the MWT will be taking place. Input from you and your staff is essential to ensuring that this evaluation reflects the experiences of the participating communities. The firm called *Community-based Research* has been contracted to complete the external evaluation with Lorrilee McGregor and Marion Maar doing the research.

The MWT has also been the focus of a study by Susan Manitowabi, a PhD student at Laurentian University. Susan Manitowabi is a PhD student in the Rural and Northern Health Program at Laurentian University. Susan has agreed to assist the Raising the Spirit Metal Wellness Team Pilot Project with the evaluative component of our project. The overall evaluation of this project is beyond the scope of what would be reasonably expected for a PhD research project so she will assist by conducting an evaluation of the engagement process utilized by the Raising the Spirit Mental Wellness Team Pilot Project. This research project will involve 10 First Nations communities from the Manitoulin Island, North Shore and Waabnoong Bemjiwang Tribal Councils. Susan conducted some meetings between May and August 2011 regarding the engagement process between the MWT and the participating First Nation communities.

In order to minimize the disruption to your schedule, we are proposing to conduct one meeting with you and your staff, rather than two separate meetings. Information gathered during this meeting will feed into both the external evaluation and the PhD study by Susan Manitowabi.

Susan will be contacting you during the next week to set up a meeting that is convenient to you and your staff. If you have any questions about the external evaluation, you may contact either myself or Lorrilee McGregor at (705) 285-4141. If you have any questions about the PhD study, you may contact Susan Manitowabi at (705) 675-1151 ext. 5049.

Sincerely,

Sharon Wabegijig

Appendix 20 – Raising the Spirit Mental Wellness Team (MWT) Elders-in-Residence Program

"Raising the Spirit" Mental Wellness Team (MWT) - Elders-in-Residence Program - Program Description - Aug 8, 2011 (Draft)

PREAMBLE

The "Raising the Spirit" Mental Wellness Team (MWT) is committed to providing professional and personal wellness support to Mental Wellness, Addictions and Traditional Health Workers of our 10-member First Nation communities of Dokis, Nipissing, Atikameksheng Anishnawbek, Whitefish River First Nation, Aundeck Omni Kaning, Sheguiandah, Wikwemikong Unceded Indian Reserve, M'Chigeeng, Sheshegwaning and Sagamok Anishnawbek.

The "Raising the Spirit" Mental Wellness Team (MWT) recognizes the importance of braiding traditional Anishinabek teachings & practices with western knowledge & techniques. MWT strives to nurture this balance to empower member First Nations in healing themselves. Towards this end, the MWT will provide access to a Visiting Elder Initiative and "Elders-In-Residence Program" as a service to promote mental wellness.

The Traditional Advisory Circle (TAC) which is made up of Traditional Knowledge Holders and community cultural resource people will oversee the MWT "Elders-in-Residence" program and provide advice as needed. The TAC non-voting ex-officio member will ensure such advice and recommendations are shared with the Raising the Spirit Mental Wellness Team's Steering Committee and are incorporated in the Elders-in-Residence Program.

Elders-in-Residence Program

In this program we refer to an "Elder" as someone who is acknowledged within the First Nation community for spiritual and cultural leadership and knowledge of a healing tradition. An Elder is someone who throughout their life's journey has gained specific knowledge and gifts and is respected for what they have learned and experienced. They are often asked to teach others about culture, tradition and mino-bimaadziwin based upon their experiences and are often called on for help and support.

The Elders- in- Residence Program is intended to function as both a support to community frontline workers in their own wellness and as an avenue to build confidence by expanding their knowledge of traditional wellness approaches:

1. Provide one to one or group support to community frontline workers
2. Assisting community workers to learn about Anishinaabe Kinomaadwin healing approaches.
3. Provide traditionally based counselling and debriefing support to community frontline workers who may be impacted by crisis in their communities.

4. In keeping with their particular gifts and knowledge, will enable and act as a traditional resource to assist in community development initiatives.

Based on the recommendations of the 10 First Nations, the Traditional Advisory Circle will approve Elders who are:

- Acknowledged/Respected within their own and area communities for their wisdom and abilities to help
- Demonstrate a commitment to "living" the traditional teachings and to helping and improving the quality of life for communities
- Carry a diversity of life experiences
- Have knowledge of mental health and addictions healing journey
- Have knowledge of an aptitude for teaching/sharing traditions, ceremonies, cultural identity, teachings
- Able to listen and communicate effectively and to interact with people of all ages, walks of life and levels of understanding
- Are ideally, fluent in Anishinaabemowin
- Non-judgemental, patient, able to interpret needs of individuals
- Able to travel and undertake a consistent commitment to visiting and working within communities

Member First Nations are encouraged to recognize and utilize their community's own Elder, Natural Healers and Helpers within the program however the MWT will also respect the request of each member First Nation should they recommend an Elder from outside their Anishinabek territory.

MWT has an ongoing list of Elders who the member First Nations can draw on to request Elder visits. The list of Elders will give the member First Nations a diverse pool of traditional resources to meet their needs.

The MWT will cover the expenses for the Elders-in-Residence Program six times per year per community. First Nation communities can negotiate hours and honorariums with Elders however the cost for honorarium covered by MWT cannot exceed $3000.00 annually per community.

Mileage will be covered up to $1200.00 per year per community. Any services beyond what is covered by the MWT program resources can be funded by each individual First Nation. Community visits can take the form of individual staff consultations, group sessions or circles.

Should a community not be able to utilize all their allotted funds for the Elders-in-Residence Program and for mileage before December 31 of each fiscal year a notice will be sent to all communities indicating that the MWT needs to be notified within two weeks as to how these funds will be utilized. If by Mid-January a plan is not submitted, then the MWT will reallocate the funds to other venues.

Purpose of Honorarium

It is important to understand the meaning behind the offering of the 'semma' (tobacco) and the honorarium. There is a relationship established between the community, the Elder and the spirit through the giving of the 'semma' and the 'honorarium'. The 'semma' is a representation of the gift of the offering to the spirit while the honorarium is a gift to the Elder. Once the offering has been made you enter into a relationship with the spirit through the person you have made the request to.

The semma that is given is used by the Elder to communicate with the spirit and to give thanks for the help and guidance s/he will receive. When we fail to offer the semma (and/or the honorarium) what we are doing is taking away the meaning behind the relationship.

Honoraria can be explained by the following:

1. Elders' expenses may include a helper, gas and a driver; or to purchase supplies.
2. As an acknowledgement of the special knowledge, skills and gifts of the Elder.

Screening/Approval Process - Elder

The Traditional Coordinator will ensure that each Elder to be selected for the program is screened and recommended by the Traditional Advisory Circle.

- Communities wishing to add Elders to the MWT list of Elders must provide the name of the Elder, phone number, band number, date of birth and area of specialty, knowledge or gifts to the Traditional Coordinator.
- The Traditional Coordinator will contact the Elder to request names of and contact information for 3 references. A Criminal Police Information Check (CPIC) will also be requested.
- The Traditional Coordinator will interview the Elder (TC will have to develop some interview questions to ensure that the Elder is a suitable candidate for the list of Elders).
- The Traditional Coordinator will contact and interview the references provided by the Elder and complete a MWT reference form. Once the MWT reference form is completed, the TAC will review the request and make the final decision to add or not add the individual to the list.
- A minimum of 3 Elders from the TAC will be involved in this decision-making process.
- The TAC has the right to decline a community's request for a particular Elder should they feel a community safety issue may be involved.

MWT Traditional Coordinator Responsibilities for Coordination of Visits

- Once the TAC has approved the Elder, the Traditional Coordinator will contact the Elder to notify her or him that s/he has been added to the Elders-in-Residence list.
- The Traditional Coordinator will:

- develop a portfolio of the Elder and keep reports on file of each visit.
- assist the community contact person to set up the scheduled appointments for the visit (if required).
- obtain the Elder visit schedule before the scheduled day.
    - ensure that the visit by the Elder is confirmed with the community contact person of the member First Nation.
    - ensure the completion of evaluation form(s) and other appropriate community visit documentation such as Request for Elders-in-Residence form, Elders-in-Residence Activity Form and follow up notes.
    - ensure close communication with the community contact person in regard to services provided and any follow up necessary.

Urgent Requests

- The MWT understands urgent situations sometimes arise (i.e. A crisis that puts enormous stress on the community) and that the process of screening and arranging for an Elder as outlined above will need to be adjusted to address the need if required.
- Urgent situations will be reviewed on an individual basis by the program coordinator. The program coordinator will communicate to members of the TAC the nature of the urgent situation and the decision. The program coordinator will provide an update to the TAC at the next scheduled meeting.

Contact Person Responsibilities

The community contact person will:

- Offer tobacco to the Elder immediately upon arrival.

1. Make reservations for accommodations (if required) for the Elder.
2. Set up the scheduled appointments for the visit and allow ample time for travel in day light hours.
3. Prepare an invoice for the Elder visit (sample to be provided) for re-imbursement.
4. Complete the Elders-in-Residence Activity form.
5. Forward both the invoice and the Elders-in-Residence Activity form to the Administrative Assistance at the MWT office.

Elder Responsibilities during the Visit

- Elders will provide services as outlined in this program description based on the individual First Nation community's needs and request.
- Services are to be provided in a manner that observes the "Elders Policy and Procedure" for "Raising the Spirit" – Elders-in-Residence Code of Ethics for Elders.

Community Frontline Worker Eligibility for Elder Services

- All Mental Wellness, Addictions and Traditional Health staff of the member First Nations are eligible to access the "Raising the Spirit" Elders-in-Residence services and will be given priority with respect to the scheduling of appointments.
- Non-band members and/or non-registered persons on staff are also eligible to access Elder services.
- The Community Frontline Worker will:

1. Advise the community contact person and/or Traditional Coordinator that s/he would like to see an Elder.
1. Be responsible to provide his/her meals, beverages and donations to feasts and/or any offering such as tobacco/giveaways.

Payment for Elders-in-Residence Services

1. The MWT program will reimburse the First Nation community for the Elder's honorarium, mileage and meals at the end of the scheduled community visit.
2. Payment advances will not be authorized.
3. The MWT will not provide honorarium for Elder who have not been approved by the TAC.
4. In the event that an Elder attends an appointment and the individual requesting or referred for services does not attend, the Elder must still be compensated for the visit.

“Raising the Spirit” Mental Wellness Team

888 Regent Street ▪ Suite #308 ▪ Sudbury, ON ▪ P3E 6C6 ▪ Tel: (705) 586-3071 ▪ Fax: (705) 586-3073

Procedure for Elder Services:

First Nation Health department contracts for services with the provider.

- F.N. Health department pays for services and submits an invoice to MWT. It is critical to submit the invoice to the Administrative Assistant, MWT in a timely manner to ensure that expenses are reimbursed efficiently, as there is a two-week processing period.

- MWT will reimburse communities $500.00 for Elder honorarium and a maximum $200.00 to cover mileage expenses.

- MWT will cover the above expenses for the Elders-in-Residence Program six times per year per community.

- Our partnering First Nations can choose the Elder they would like to utilize however the MWT has a list of Elder resources and can offer support in this process for those who do not have access to the Elder.

- Our Elder Advisory Council have identified that the Elders-in-Residence Elders need to have a staff member with them at all times while they are providing services in communities.

- Statistical Information needed by MWT is number of days of service, number of participants in attendance, and the purpose of the session (e.g., full name of Elder, individual, group or community support, ceremony, introduction to ceremony and culture, presenting condition, series of teachings or, follow-up).

- Expenses are authorized by Program Coordinator at RSMWT, and then submitted to M’Chigeeng First Nation to issue the reimbursement.

Updated: April 14, 2011

Traditional Advisory Circle - Terms of Reference

Purpose

The "Raising the Spirit" Mental Wellness Team (MWT) recognizes the importance of braiding traditional Anishinabek teachings & practices with western knowledge & techniques. Towards this end, the "Raising the Spirit" Mental Wellness Team (MWT) has developed a Traditional Advisory Circle (TAC) which is made up of Traditional Knowledge Holders and community cultural resource people. The Traditional Advisory Circle will provide advice and recommendations as needed to the "Raising the Spirit" Mental Wellness Team's Steering Committee, the MWT and the Elders-in-Residence Program.

Goal

The Traditional Advisory Circle will work collaboratively with the "Raising the Spirit" Mental Wellness Team to develop and nurture the balance of traditional Anishinabek teachings & practices with western knowledge & clinical techniques.

Duties

- To function as a support to community frontline workers in their own wellness needs and assist community frontline workers to expand their knowledge of traditional wellness approaches
- To maintain the "Elders-in-Residence" program
- To identify Traditional Healers including herbalists, spiritual teachers and Elder Knowledge Keepers for the "Elders-in-Residence" program
- To maintain a list of active and approved Traditional Healers for the "Elders-in-Residence" program
- To recruit and approve Traditional Healers for the "Elders-in-Residence" program
- To oversee the MWT "Elders-in-Residence" program and provide guidance as needed.
- To provide meaningful input, feedback, guidance and recommendations to the Raising the Spirit Mental Wellness Team
- To provide guidance on issues related to traditional customs, methods and approaches to ensure meaningful and respectful integration of culturally safe traditional healing for the 10 partnering First Nations communities
- To assist in the promotion of the "Elders-in-Residence" program locally and regionally
- To provide guidance on culturally appropriate traditional healing information gathering, research, analysis, reporting and dissemination
- Provide guidance on appropriate approaches to community consultations

Roles and Responsibilities

Mental Wellness Team

1. Coordinate and respond appropriately to the recommendations of the Traditional Advisory Committee to develop the Elders-in-Residence program
2. Provide Coordination, technical and administrative support to the Traditional Advisory Committee through the MWT Program Coordinator
3. Solicit Federal and Provincial funding partners and develop proposals for the financial stability of a comprehensive Elders-in-Residence program
4. Advocate and raise the profile of the Elders-in-Residence program within the 10 partnering First Nations

Mental Wellness Steering Committee

1. Advocate and raise the profile of the "Raising the Spirit" Mental Wellness Team (MWT) program

Traditional Coordinator

1. Build Traditional Helper capacity within the 10 partnering First Nations
2. Maintain accurate and validated Elders-in-Residence program list for the "Raising the Spirit" Mental Wellness Team (MWT) program
3. Maintain Accurate Traditional healing resources inventory
4. Advocate and raise the profile of the "Raising the Spirit" Mental Wellness Team (MWT) program

Membership

The Traditional Coordinator will submit names to the Program Coordinator for appointment to the Traditional Advisory Circle. The Traditional Advisory Circle will consist of seven members made up of Traditional Knowledge Holders and community cultural resource people from the ten partnering First Nation communities.

A letter must be submitted from their First Nation community stating that they support the application to the Traditional Advisory Circle. However, if selected the Traditional Advisory Circle member will not represent that particular First Nation community but brings the perspective of the First Nations community as a whole.

Term of Office

Members of the Traditional Advisory Circle are appointed for a two (2) year term, with the opportunity to renew membership for an additional two (2) year term. The Traditional Advisory Circle membership will be staggered so that no more than half of the member of the Committee will change in a calendar year.

New members may be recruited at any time to fill vacancies.

To be appointed for a second consecutive term, the Traditional Advisory Circle member must submit in writing his/her willingness to serve a second term as well as a letter from his/her First Nation community. This appointment must be ratified and reaffirmed by the Traditional Advisory Circle and the Program Coordinator. A Traditional Advisory Circle member may not be re-nominated or re-appointed until a full year has been elapsed after completing two consecutive terms.

Quorum

Quorum consists of a simple majority of voting members. Discussions on priorities may occur without quorum and decisions tabled to future meetings when quorum can be reached.

Chair

The Traditional Advisory Circle is responsible for choosing a chair.

Meetings

The Traditional Advisory Circle will meet 4 to 6 times annually with additional meetings as required in the initial stage of development and called at the discretion of the Chair. An agenda and the minutes of the last meeting will be provided one week prior to the scheduled meeting.

Decision - Making Process

The Traditional Advisory Circle members will work towards a consensus model of decision-making. The Traditional Advisory Circle will utilize traditional talking, decision-making and conflict resolution methods and approaches before calling a vote. In the event that consensus

cannot be reached during a meeting, a decision will be made according to the majority. All votes, including abstentions and oppositions, will be duly recorded.

Policy and Procedure

Declaration of conflict of interest

Conflict of Interest on the Elders-in-Residence Program which would include that a member of the Elders-in-Residence is closely related to one of the employees, Steering Committee members, or other stakeholders who are in a position of decision making and or authority.

Relations in this document refers to in this document is included in this document would include a life partner, wife, husband, brother, sister, son or daughter.