

# First Peoples Child & Family Review

An Interdisciplinary Journal

*Honouring the Voices, Perspectives and Knowledges  
of First Peoples through Research, Critical  
Analyses, Stories, Standpoints and Media Reviews*

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**NICWA**

National Indian Child Welfare Association  
*Protecting Our Children • Preserving Our Culture*



**First Nations Child & Family  
Caring Society of Canada**

## An Interdisciplinary Journal

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## First Peoples Child & Family Review

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## An Interdisciplinary Journal

*Honouring the Voices, Perspectives and Knowledges of First Peoples through Research, Critical Analyses, Stories, Standpoints and Media Reviews*

## Foreword

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Dear readers,

It is my great pleasure to introduce the Special Edition for the 10th Anniversary of the Touchstones of Hope, in partnership with the National Indian Child Welfare Association (NICWA). Thank you to NICWA for partnering with us on this issue. I would also like to thank all of the authors in this edition for their valuable contributions as well as the peer reviewers for their thoughtful feedback for authors.

In June 2015, the Truth and Reconciliation Commission of Canada released 94 recommendations to improve outcomes for Indigenous peoples.<sup>1</sup> Since that time, reconciliation has come to the forefront of media, touching the minds and hearts of people in Canada who knew about the impacts of residential schools and also those who were learning about them for the first time. Many want change for Indigenous people in Canada and have asked for directions on how to do this respectfully. There has perhaps not been a better time for reconciliation and for ensuring that everyone has the same opportunities to succeed and to realize their dreams. I am hopeful for the changing reconciliation landscape in Canada.

For us at the Caring Society, we see reconciliation as being a movement that involves all of us. It also means respecting the *Touchstones of Hope for Indigenous Children, Youth and Families* principles and process in order to effectively ensure that all First Nations children and youth have access to what others in Canada have. The Touchstones of Hope reconciliation process includes a process of truth telling, acknowledging, restoring and relating and is guided by core principles: culture and language, self-determination, holistic approach, structural interventions, and non discrimination. The aim of the movement is for communities and nations to create visions and action plans for healthy children and families and to interpret the principles reflecting their unique values, culture, languages and traditions. Although these the Touchstones of Hope were originally intended for those working in child welfare, these principles and this process are applicable to other organizations who work with Indigenous communities.

For this Special Edition, we asked for submissions from Canada and abroad that touched on the Touchstones of Hope core principles (culture and language, self-determination, holistic approach,

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<sup>1</sup> Release of full report December 15, 2015, available at: <http://www.trc.ca/websites/trcinstitution/index.php?p=890>.

structural interventions, and non discrimination) and Indigenous peoples. We are pleased to have submissions from both Canada and the US as well as a number of guest authors including: Commissioner Marie Wilson from the Truth and Reconciliation Commission, a youth named Hannah Battiste, as well as the authors of the Touchstones of Hope document, Cindy Blackstock, Terry Cross, John George, Ivan Brown and Jocelyn Formsma.<sup>2</sup>

We hope you enjoy the publications in this Special Edition! Happy reading!

In good spirit,

Andrea Auger

Coordinating Editor

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<sup>2</sup> Blackstock, C., Cross, T., George, J., Brown, I., & Formsma, J. (2006). Reconciliation in child welfare: Touchstones of Hope for Indigenous children, youth and families. Ottawa, ON, Canada: First Nations Child & Family Caring Society of Canada/Portland, OR: National Indian Child Welfare Association.

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## Editorial: Touchstones of Hope: Still the best guide for Indigenous child welfare

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### Origins of the Touchstones of Hope

In 2000, the authors of this editorial, along with a group of child welfare experts and allies, initiated a series of meetings and one conference as part of a project sponsored by the Centre of Excellence for Child Welfare, based at the University of Toronto in Canada. As a group, we represented the principal national child welfare organizations in the United States and Canada: NICWA (National Indian Child Welfare Association), CWLA (Child Welfare League of America), FNCFCS (First Nations Child and Family Caring Society), and CECW (Centre of Excellence for Child Welfare). The purpose of our gatherings was to conceptualize and develop a new perspective on child welfare that would be more appropriate for Indigenous children, their families, and their communities. The Touchstones of Hope was a document we produced in 2006 to share our new perspective.

In the sections that follow, we revisit the origins and development of our thinking. Ten years after the publication of the Touchstones document, we look at how far we have come, at what we have accomplished, and at the difficulties we have encountered. We also look to the future, and to how Touchstones might continue to influence what we think and what we do. Using the analogy of a journey down a river, we look at the waters behind us, beside us, and in front of us.

### Finding the headwaters

When a system fundamentally fails over many years to meet the needs of Indigenous children, you don't try to make it culturally appropriate – you build a new system. The imposition of the mainstream child welfare system on Indigenous families in Canada and the United States has resulted in the mass removals of Indigenous children from their communities, while failing to improve the safety and well-being of the children or their families.

A small group of Indigenous and non-Indigenous allies banded together in the year 2000 to develop a strategy to create a new child welfare framework for Indigenous children, because we were tired of the tragic stories from children who were removed from families only to be placed in a system that too often failed to give them the childhood they deserved. This small group, many of whom are authors of this editorial, quickly realized that this new child welfare framework needed to be a process that Indigenous and non-Indigenous peoples could engage in together based on reconciliation principles that were drawn from the collective wisdom of traditional knowledge keepers, community members, young people, experts, policy makers, and service providers. These principles also needed to be capable of adapting to various contexts and cultures. The group decided to bring together key knowledge holders to ask them what a new child welfare system would look like. The group was challenged by an enriching but complicated task of deciphering how to draw out the collective wisdom to develop the reconciliation principles and process once we had brought them all together. In our initial small group planning meetings, we realized that we really did not understand reconciliation well enough, and if we were going to host a gathering with reconciliation as the theme, then we would have to undergo the process ourselves. This involved courageously talking about colonization, working through our differences in worldview and more than one bout of tears. Processing these struggles provided us with clarity of thought and closeness of relationship that none of us have ever experienced in an event process before. Our own experience of reconciliation helped us realize that truth telling, an essential feature for reconciliation, is not just about putting facts on paper, it is hearing multiple interpretations of the truth, struggling for meaning, and then situating our joint learning in a new relationship.

Our reconciliation experience was like a river, sometimes curvy and slow, sometimes straight and quick, sometimes turbulent, and sometimes calm, but it all began with the headwaters of the truth. The river analogy became the running analogy for the 2005 gathering of 220 Indigenous and non-Indigenous Elders, youth, child-welfare professionals, stakeholders, and leaders from American and Canadian child welfare who were brought together to design a new child welfare framework. More specifically, the participants were challenged to create principles to guide child welfare for Indigenous children and families and a process of reconciliation to strip child welfare from its colonial roots. This was accomplished by critically examining child welfare in pre-colonial, and historical and contemporary colonial times. This would require acknowledging the colonial dichotomy cloaking child welfare, which gives preference to “civilized” western practices whilst relegating Indigenous practices to nihilism or irrelevance.

Consistent with Indigenous worldviews and practices, symbolism was integrated into the event with each participant bringing a small stone from their territory as a symbol of inclusiveness and connection with the community back home. The gathering anticipated conflict and different interpretations of the role of social work in the harms experienced by Indigenous children and families, but instead of backing away from this conflict we embraced it as a necessary step in truth telling to prepare for a shared journey of reconciliation down a metaphoric river.

The stones that people brought became symbols of the brief time we spent together along the river to share the truth of what had happened up river, acknowledge that past and the consequences of that time apparent today, and together to find a path that could restore Indigenous peoples to wholeness and heal the relationships between mainstream and Indigenous child welfare. Through a process of truth

telling and reconciliation, the participants collectively articulated a set of principles and a process for reconciliation in child welfare that became known as the Touchstones of Hope.

This event was a unique cross-border collaboration dedicated to finding common ground to reinvent child welfare for Indigenous people and moving it from a source of oppression to a catalyst for hope. Ten years ago when we wrote the Touchstones document, we closed by saying that we were paddling on a new stream. So, how has the journey gone so far? How far have we come? Have we reached our goal, or are we held up behind a logjam? This editorial and this issue of the Journal address these questions and call on the field to do more because we have learned that our journey down this river is longer and harder than we could ever have imagined. We have also learned that principles are not enough.

## Navigating the waters

To say that the Touchstones came only from the 2005 gathering would be misleading. To be sure, the gathering was a game changer, forever changing the dynamic in Indigenous child welfare, at least for those who attended. The status quo of using children as a vehicle of colonial control and assimilation is no longer acceptable at the macro policy level, as a program objective, or in practice standards. However, the vestiges of the post-colonial era are still alive and operating by default at every level of the system. In terms of how the process of reconciliation in child welfare is doing: the truth telling is incomplete, acknowledging the past lags behind, restoring is yet a dream, and relating is not yet foreseeable. The general map provided by the Touchstones is still relevant and true, yet the goal remains elusive.

The event did lay the groundwork for a decade of work and resulting progress. It did this by naming child welfare as an ongoing colonial undertaking, forging key relationships, opening lines of communication and articulating the Touchstones principle and reconciliation process. At the public policy level in the United States, the major national child welfare advocacy organizations forged an alliance that would together lead to key legislation to fund tribally operated child welfare technical assistance to support tribal programs. The Fostering Connections Act of 2009, which opened access to federal foster care funding for tribes, would not have been possible without this broad coalition. In 2013, 23 non-Indian child welfare advocacy organizations came together to file an amicus brief with the Supreme Court defending the Indian Child Welfare Act in the *Adoptive Couple v Baby Girl* case. This unprecedented move can be directly traced to commitments made to uphold the Touchstones. Also, in the United States projects to reinvent child welfare to align with the Touchstones – including the Western and Pacific Implementation Center Disproportionality Reduction Project in Alaska – and several tribal child welfare redesign projects have reduced the use of foster care, increased structural support for tribal families, and decreased state court roles with tribal children. Despite these efforts, long-needed changes have only just started to take shape.

Apologies occurred on both sides of the border, one in the United States from the Child Welfare League of America and in Canada with the Prime Minister's apology for the residential schools. These apologies raised awareness and marked a point where perhaps non-Indigenous peoples were willing to learn more about their pasts, but the apologies on their own are not enough to create the necessary systemic change. In many ways, apologies only signal intent to set things right – the meaningfulness of the apology is borne out in the actions that follow. A set of guiding principles would be needed as a foundation for a reconciliation movement within child welfare. This movement would require a deep



respect for the rich diversity across various states, provinces, Tribes and First Nations, necessitating cross-cutting principles that could be interpreted locally to reflect distinct Indigenous cultures, languages, and traditions. The principles would also have to apply to non-Indigenous child welfare systems and social work education providing guidance for both healing and equity.

In the United States, the Touchstones were imbedded under “decolonization” and disproportionality reduction projects. In these projects, Tribes worked to implement the Touchstones to reinvent their own services. One tribe dramatically reduced its foster care placement rate by taking over their own services.

In Canada, the Touchstones were embraced with enthusiasm in several regions of the country. For example, five First Nations in northern British Columbia partnered with that province’s government to re-vision child welfare delivery for Indigenous children and build implementation plans based on the Touchstones principles. The undertaking was evaluated by the University of Toronto and noted significant and positive changes in levels of understanding about colonialism and the ability of social workers to make better decisions with and for families. The evaluation also described the germination of fundamental policy and funding shifts in the mainstream child welfare community that were substantially improving practice. Unfortunately, despite the positive evaluation, a new provincial deputy minister cut funding for the Touchstones of Hope support team, replacing it with a regime of western organizational reorganization strategies. The latter failed and, while participating communities continued to implement the Touchstones of Hope strategic visions in their communities, their capacity to do so was fettered by the reduced support levels.

The First Nations Child and Family Caring Society of Canada (FNCFCS) embeds the Touchstones of Hope as a guiding philosophy for its work. On a practical level, this has translated into building a social movement for culturally based equity around a human rights case filed against the Canadian government for its flawed and inequitable child welfare funding on reserve. The case is filed with the authority of all First Nations in Canada and aims to ensure First Nations children receive culturally based services that target the structural causes of the over-representation of First Nations children in child welfare care. The social movement also embeds the Touchstones principles in the “I am a witness” campaign. The Canadian Human Rights Tribunal is expected to rule on this historic case shortly.

The FNCFCS also developed and implemented training using curriculum based on the Touchstones document – one for workers and one for youth. There was a very positive reception from both groups of trainees. The train-the-trainer sessions were popular and participants showed enthusiasm for this approach. The training was also offered to trainees in the United States but, unfortunately, few trainees were actually able to do their own training in their communities. Where they did, the momentum dwindled once people were left on their own. The lesson on both sides of the border was that there was an important need to have a champion to continue the work, coaches to support and motivate trainers, as well as dedicated resources to support the practice changes necessary to change the system. Change does not come easily. Looking back on the training, presentations, and projects, it became apparent that, despite the relevance of the values, many could not see the end. Even using the DREAM process of facilitation (where people put their ideal notions first and built their plans and systems towards that, it was a challenge to imagine a world where the new vision provided for in the Touchstones was possible or realistic to achieve.

In Canada the Touchstones also gave structure under the theme of “reconciliation” between Indigenous people and mainstream Canadians thanks to the work of the Truth and Reconciliation Commission of Canada (TRC). The TRC collected statements from over 7,000 witnesses regarding Canada’s residential school system that aimed to assimilate Indigenous children into mainstream society. In its final report released in 2015, the TRC said the prolific loss of culture and language, coupled with the preventable deaths of thousands of children and the horrible abuse of many others, amounted to cultural genocide. The schools operated for over 100 years with the last one closing in 1996. It is important to note that the top call for action issued by the TRC was equity and reform in Indigenous child welfare – the same goal the Touchstones aimed for in 2005. However, as one of the Touchstones authors points out, reconciliation is like a “unicorn” – people talk about it as if it exists, but it’s currently a fiction and will remain so not only until the mainstream engages with the material, but also when the necessary structural changes and interventions follow.

On both sides of the border, the Touchstones gathering fostered decolonization thinking and strategies among Indigenous peoples engaged in child welfare. We realized we needed to move alone if mainstream child welfare was not ready to move with us and we could not let the struggle to move them consume all of the energy. We realized we need champions to embed the philosophy of the Touchstones. That meant that as Indigenous leaders we needed to foster the reinvention of child welfare in our own communities. Following the Touchstones meant moving Indigenous-operated child welfare toward a holistic approach and away from the rescue and police approach of the mainstream. Also, we found that it was vital that people thought of this as a social movement and guiding philosophy. The Touchstones are most valuable when applied to all aspects of the field (education, administration, services, etc.) versus being implemented as an event or restricting the approach only within services to Indigenous peoples. Following the principles of the Touchstones, our advocacy efforts focused on greater resources for tribal services, greater autonomy supporting self-determination, and holding others accountable for discriminatory practices. These moves have taken us closer to decolonizing ourselves and our own services.

Although implementation of the Touchstones has been slower than we all would have hoped, we have been uplifted by the robustness of the Touchstones principles and reconciliation process. We expected more from our respective federal governments in moving to implement the Touchstones, but the slow movement means we have had to pursue other means to address past wrongs and strengthen the Touchstones as a social movement, such as the courts, international mechanisms, human rights mechanisms, and public awareness campaigns. In Canada, in many ways we were ahead of our time and now – with the TRC report and the pending Tribunal decision – we have a new window of opportunity to compel non-Indigenous child welfare to implement the many solutions that could substantially improve the well-being of Indigenous children in care. In the United States, progress is slower, as Native American and Alaskan Native Tribes continue the important but more difficult task of broadening the important public dialogue on racism and discrimination toward African-American and Hispanic communities to include the Native American story. However, the recent process to develop regulations, based on community consultations, for the Indian Child Welfare Act for the first time since enacted is a promising sign, despite the backlash from mainstream adoption agencies.

## Around the next river bend

Thanks to the TRC, reconciliation is beginning to catch a strong current in Canada but we need to work strenuously to avoid the public seeing colonization as a tragic black mark on Canada's history versus a contemporary challenge that will require the engagement of every Canadian to put right. As relevant as the Touchstones were in 2005, they are even more relevant today given the building reconciliation movement. Canadian child welfare must embed them quickly while the public spotlight remains because once it dissipates, and it will, it will be much more difficult to move the mainstream child welfare mountain.

In the United States, a backlash against the Indian Child Welfare Act has emerged that has both complicated and fragmented reconciliation and decolonization efforts. The backlash is centered in a very narrow part of the child welfare field, private adoption. Mainstream child welfare has rallied to the cause of tribes and tribal children. The coalition, relationships, and commitments forged in 2005 are holding firm and that is a good sign for the future of the Touchstones. It is difficult, however, to focus on reinventing tribal services when one part of the field is attacking the sovereignty of tribes to operate child welfare programs just to meet their own ends, access to our children for adoption.

Additionally, more Indigenous leadership in both countries (elected, grassroots, organizational, and youth) is coming around to the idea that children's matters are important on the larger public scale. Child welfare issues are becoming more a part of the public vocabulary but, unfortunately, structural interventions are still lacking as are the skills to create change, particularly in a social movement context.

Moving forward, we know that more can be done with the Touchstones. This document was written ten years ago, but the process guided by the principles contained in the document, are just as relevant today as they were in 2006. Upon reflection, what has stalled the implementation of the Touchstones has more to do with capacity and awareness than flaws in the ideas. More effective communication about the issues is needed both to the mainstream public in Canada and the United States. Data collection and analysis in both countries on the issues around Indigenous child welfare are very sparse.

To their credit, advocates and communities have done what they can with the funds and resources available to them, and they are doing the best that they can. We know the major factors driving the over-representation and we know what will work – we just need to do it.

Regardless of what the mainstream does or does not do, we have the power to change ourselves to make sure the failure of child welfare of the past is not repeated in our own services as we grow them. The Touchstones still provide a valid path forward and inform the continuing efforts after ten years. The value of the collective wisdom of a group of committed individuals coming together in healing and acknowledgment of past wrongs continues to resonate, affirming their continuing validity and relevance.

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## Reflections on reconciliation

Dr. Marie Wilson

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From 2009-2015, it has been my greatest honour to serve as a Commissioner of the historic Truth and Reconciliation Commission of Canada. The TRC's huge job has had three key parts: to research, document and record the facts and impacts of over a hundred years of forced residential schooling for Indigenous children; to preserve all that information, and use it to educate the people of Canada about what we have learned; and to 'inspire reconciliation', so that the individuals affected, and our country as a whole, could recover from the past and live in respectful relationships with each other going forward.

When we first began our work, many of the former residential school students, also known as survivors, asked us about the meaning of reconciliation, and whether it could ever be possible given all the injustice and injury the schools had caused so many thousands of individuals, families, communities and Indigenous nations.

We Commissioners agreed early on that reconciliation was about respect, and about establishing or restoring respectful relations. For me, built into that idea of respect, is that reconciliation is also about creating peace...peace in the heart, the home, the community, and in society as a whole. Hearing Canada say it was sorry for the harms caused by the residential schools is not going to be enough to get us to the place of respectful, peaceful relations. So reconciliation also has to mean change...things need to change for the better, especially for the Indigenous peoples of the country.

My understanding of Reconciliation has continued to evolve as I listened to survivors share the stories of their difficult and sometimes devastating childhoods in the residential schools; as I heard statements of remorse and regret from other Canadians; and as I heard voices of resilience, wisdom, and great hope from all sides:

I think reconciliation is about *who we are*...We are beginning to face up to the truth of who we have been and what we have done as a country. We cannot undo that, but we can never again deny it either. Because of our actions as a country, thousands of Indigenous children grew up in faraway residential schools, afraid, lonely, ashamed, and angry. They have told us that they learned to hate themselves and didn't know how to love anyone else either. They grew up not knowing who they were or where they fit in. Reconciliation, then, is about honestly owning up to who we have been.

I think reconciliation is also about *where we are*...We are living in a time and place of slowly but surely healing. So many survivors spoke to us about their 'healing journey,' and about the very important role that elders and others have played in helping them heal as they reclaim language, cultural and spiritual identity and a sense of belonging. One of them said, *"Once I got my culture back I felt proud again. I felt like I was somebody."* Individuals aren't the only ones trying to heal. Families are doing that healing work. Some churches are doing that work. A growing number of departments of education, professional associations, municipalities, other faith communities and charitable organizations, and individual Canadians are doing that work. Most recently, and potentially most significantly, our newly elected federal government has also committed to doing that work. But beyond the political promises, our country still has a lot of practical work to do to rebuild trust, and to forge new relationships.

Finally, I think reconciliation is about *what we are*...We are a country at a cross-roads. Thanks to the expanding national dialogue that the Truth and Reconciliation Commission has helped to make possible, there is much greater public awareness of what happened and what now needs to be done. We are a country faced with the historic opportunity to begin anew; to begin living up to both our legal obligations and our stated national values in dealing with the Indigenous peoples of this country. As one survivor said about reconciliation, *"We do not want a white man's system to trump our indigenous systems and beliefs and cultural practices. We need to look at common spaces, ethical spaces, to look at the parallels between the two, and to find the best practices between the two... to move ahead"*.

Canada's residential school image seems so very different from the picture we paint of ourselves in the world today; about who we say we are and what we stand for as a country....as Canada. We want to believe that we are so different and so much better now, and that all of this is long behind us in the past.

Yet as we contemplate the need for ongoing reconciliation within our country today, here are some things to consider, with rigorous honesty, as we start to change and act. Are Indigenous representatives in the room where policy decisions are made about their children's welfare, and their children's essential need to know who they are and where they come from? Are Indigenous peoples in the rooms where decisions are made about the level of funding for their children's education, which has for so many years been less than for other children in Canada? Are Indigenous peoples in the rooms where curriculum is developed to reflect a more complete history of Canada, to make Indigenous children feel proud of themselves, and to make *all* children feel proud of the rich and shared Indigenous heritage of our country? Are we teaching the honest history of Canada's relations with Indigenous peoples in our professional schools, colleges and universities? Are we preparing our social workers, our lawyers, our doctors, our judges, our teachers and all our public servants with a truthful context for understanding what experiences have affected many of the Indigenous populations they serve? Are we reflecting the three founding peoples of Canada when we design our national symbols, when we name our major roadways and public buildings and spaces, when we sing our national anthem, when we greet each other on traditional Indigenous homelands, when we commemorate our national moments of celebration, remembrance and loss? Are we using the UN Declaration on the Rights of Indigenous Peoples (UNDRIP) as a framework for reconciliation?

All of these questions, and others, underlie the 94 Calls to Action of the Truth and Reconciliation Commission, released in June 2015. For reconciliation is about all of these things. It is about ongoing healing from devastating personal and collective losses. It is also about building new friendships and new

frameworks for social justice within this country, with an essential role for *all* Canadians; losses and healing; promises and public engagement.

I believe reconciliation means that things can, do, and will get better, but it will take time and we all need to play our part. On an individual level, we are beginning to change how we see, talk to, and talk about each other. On a societal and public policy level, as we change some of *what we do*, we must also change a lot of *how we do it*. Reconciliation means new thinking about who decides; about imagining and convening ethical spaces; about consciously deciding who is present in the decisions rooms of our governments, our policy shops, our social services, our schools, and about who controls the resources that such decisions rely upon.

For reconciliation to take root, spread, and grow, we must not allow ourselves or anyone else to get tired of the subject and the dialogue, for we still have so much to learn *about*, and *from* each other. Above all else, in the recent shadow of more than a century of national negligence under the residential school saga, we all need to keep our hearts and our eyes on the next seven generations of children. They are counting on us, and as our future leaders, we will *all* be counting on them.

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## WARRIORS

Hannah Battiste, Canada

Poet, Nova Scotia

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You have walked for years  
Proud of your choices  
Proud of your language  
Proud of the God you worship

You took a group of people  
Not just any people  
First Nations people  
And you broke them down  
Sent One here and Twenty Two there

You didn't take the time to understand  
You took away their identity  
You took away everything  
And buried it in the ground

You watched them suffer  
To this day they suffer  
And all you do is laugh

You punished the child out of them  
You punished the language out of them  
You killed the person inside of them

You made something sacred to them vanish  
Vanish like the happiness  
Vanish like the families  
Vanish like the love  
They had in their hearts

They call First Nations warriors  
Because we are strong



We are infinity  
 We are special  
 Some of us are still angry  
 Some have found forgiveness  
 Some have found faith  
 And some still hurt

We all know the stories that lay  
 Beneath their eyes  
 We feel the hurt  
 That you have caused

We do not understand  
 We do not forget  
 And it still hurts

But we have each other  
 Side by side  
 United as a team  
 of WARRIORS

## Why I became a writer

Growing up, most of my life, I didn't have a father or many friends. I was bullied badly, and I had many mental health issues by the time I was seven years old. I lost a lot of people in my life. I gained new friends, and lost friends. My new friends betrayed me and family. I lost what seemed to feel like everything. When I was nine, my father died. My father didn't take care of himself, and he also abused drugs. After my father died, my family was falling, but we were still standing tall. At the age of 12, my brother committed suicide.

My family suffered a great loss; they broke, and it is still taking them too long to cope. I was going through a lot, and I was suffering every single day. During the suffering, I was being bullied, I did not have any friends and I was in a deep depression. Everything started building up, so on October 21st, 2012, I committed suicide and survived. For two years, I quit school and stayed in my room because of how ashamed I was. I didn't let anybody see me. I would wait until my family was asleep and then I would sneak out of my room to eat. It was a difficult time. One day I was sitting around, and I wrote a story. And then a story turned in to a poem, and a poem turned into more and more poems.

I didn't have any idea that I was smart, beautiful, talented, and IMPORTANT. Life became so meaningful to me, and I shared my stories. My stories became inspirations. My poetry was being published, I was being asked to do performances. I am now a public speaker, poet and student. Sometimes I lose my ways. Sometimes I still need to get help. But I am not afraid to seek help. When I



know my mental health is getting in the way, I run and find help. It takes time for me to get what I need, but struggling only makes us stronger. I struggled so much in my life, and it hurts to think about the things that I've been through.

The bad times are going to make good times. The experience is unreal, and I try not to think about it, but that's how I make myself—through my writings, through my mental health, through my experiences and my life lessons. Writing saved my life and I am completely grateful.

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# Finding their way home: The reunification of First Nations adoptees

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## Abstract

*Entire generations of First Nations people have been separated from their birth families and tribes by historical acts of relocation, boarding schools, and the adoption era. Reunification is an essential component to rebuilding the First Nations population. It is echoed across tribes captured by the phrase, "generation after generation we are coming home" (White Hawk, 2014). The purpose of this study was to investigate personal and social identity indicators that contribute to a satisfactory reunification for 95 First Nations adult adoptees who were separated from their birth families during childhood by foster-care and/or adoption. Retrospective survey data originated from the Experiences of Adopted and Fostered Individuals Project. The overall model of satisfactory reunification was statistically significant, and explained 16.6% of the total variance. The study's findings revealed two social identity variables were statistically significant in relation to the reunification experience – high social connection to tribe (positive relationship) and reunification with the birthmother (negative relationship). First Nations adoptees have not only a biological/birth family to return to, but also a tribe, and ancestral land. Components of social identity are particularly important for the reunification process of First Nations adoptees. Reconnection with extended family and social connection to tribe play a critical role in bettering the reunification experience from the adoptee's perspective.*

## Introduction

Prior to the United States' (U.S.) Indian Child Welfare Act (ICWA) of 1978, thousands of First Nations children were removed from their families and placed into non-First Nations foster and adoptive homes (Crofoot & Harris, 2012; Palmiste, 2011). U.S. data suggests 25-35% of First Nations children were placed in foster or adoptive homes at that time (Jacobs, 2013). Although these statistics exist, little is known about First Nations people who have chosen to reconnect with their birth families. First Nations children who were removed from their families during the 1960s-1980s and placed in non-native homes have grown into adults (ages 40s to 60s) with this traumatic experience fused into their memories. They are the focus of this study.

Although much research exists on search and reunion of adoptees with birth families (Howe &

Feast, 2001; Petta & Steed, 2005), few studies focus on First Nations adoptee reunification. “Reunion” refers to the initial contact between an adoptee and birth family (Child Welfare Information Gateway, 2011b), whereas “reunification” is a process where separated individuals reconnect and rejoin their birth family. Reunification encompasses experiences towards reconnecting (e.g., reclaiming one’s place in the circle, ceremony, tribal enrollment) and satisfactory perceptions. Reunification goes beyond meeting with birth family to assuming one’s role within birth family, returning home to one’s ancestral land, and being acknowledged as a First Nations family member. This study addresses the literature gap by investigating satisfactory reunification among First Nations adoptees. Historically, First Nations adoption research has focused on pre-adolescence and relied on parent or professional report with few studies integrating adoptees’ voices (Carriere, 2005; Peterson, 2002). This study explores contributions of personal and social identity to an adoptee’s reunification using their voice.

## Reunification

Most frequently, research has approached reunification as a permanency path exit from the child welfare system. However, recent literature has re-conceptualized reunification as a process which includes efforts and plans toward the return of children to their birth families (Child Welfare Information Gateway, 2011a). The former approach fails to capture the full picture of reunification, as some children exit child welfare via adoption only to reunify in adulthood. The exploration of reunification as a process is essential as scholars move to identify components constituting a satisfactory reunification process. Previous literature has not captured the complexities of reunification in that it only examined whether reunification was achieved, failing to explore contributing factors of a satisfactory reunification experience.

The study’s contributions are multiple. First, it conceptualizes reunification as a process and explores components contributing to the achievement of a satisfactory reunification. Second, it explores the contributing factors from the perceptions of the individuals who experienced it. Third, it expands on previous atheoretical reunification literature through the integration of identity theory. Doing so places the removed child within their social context indicative of the First Nations cultural collectivistic underpinnings.

## Guiding theoretical framework

Since the core of the reunification process is returning children to their birth families, issues of identity arise; thus, this study was grounded in identity theory. According to identity theory, significant events that trigger self-reflection (such as reunification) are critical times when the concept of identity is challenged (Pratt, 2003). Reunification is a time when an adoptee attributes changes in one’s sense of self to newfound membership within the birth family. The adoptee’s thoughts and feelings about the birth family affect the way the adoptee views oneself.

Theory suggests that identity is about sense making, and although identity is self-referential (i.e., how adoptees refer to themselves), an individual’s identity is composed of personal (i.e., who am I?) and social components (i.e., who am I in relation to others?) of the self (Pratt, 2003). The personal component is inherently retrospective. That retrospection includes how they were treated as a child in their adoptive and/or foster homes. Experiencing abuse while a child may create a feeling that they may not be welcomed home to tribe because they feel no longer worthy. Multiple experiences of varied types of abuse,

poly-victimization, then might color their First Nations identity as a result.

Adoptees may hold multiple identities throughout their lifetime. The more salient a particular identity is, the more likely it will be exhibited across situations (Serpe & Stryker, 2011). Adoptees who label themselves as First Nations consistently across contexts appear to have greater ethnic identity salience. An assumption of identity theory is that identity is socially constructed (Pratt, 2003). The social component of identity is composed of shared similarities with certain members of social categories (i.e., “we”). First Nations adoptive identity cannot be established in its own right; it needs to be recognized by family. An adoptee cannot be an adoptee without family; and an adoptee cannot be First Nations without tribal community. During the reunification process, the more socially connected to tribe, the more the adoptee sees themselves as tribe. In First Nations communities, family and tribe are not separate, but are regarded as one (Red Horse et al., 2000).

In dominant white culture, birth parents are central. However, for First Nations people the collective whole is emphasized over individual relationships. The reunification process moves beyond a parent-child dyad because the process is often described as an experience of being “called” or welcomed home by tribe (White Hawk, 2014). Reunification is a social process, which encompasses reconnection to immediate family, extended family, and tribe. Achieving a satisfactory reunification is affected by the person with whom the adoptee reunifies and how socially connected they are with their tribe. The reunification experience is composed of social interactions (e.g., acceptance, rejection, disappointment). Thus, it is critical to identify the conditions under which satisfactory reunification exists in order to inform reunification practices.

## Literature review

The distinction between searching for birth family, reunion with birth family, and reunifying with birth family is not clear in the literature (Child Welfare Information Gateway, 2011b). While some researchers focus on search and/or contact with birth family (Farr, Grant-Marsney & Grotevant, 2014; Müller & Perry, 2001a; 2001b), others focus on reunion (Gladstone & Westhues, 1998; March, 1995). Adoption searching is an adoptee’s attempt to obtain information and/or locate birth family. Reunion is initial contact between an adoptee and birth family (e.g., letters, phone calls, actual meeting) (Child Welfare Information Gateway, 2011b). Although reunion and reunification represent distinct experiences, this study draws upon reunion research as the nearest body of literature.

Within that literature, many adoptees have reported having “no regrets” about being reunited with their birthmothers (Sachdev, 1992). However, such literature has relied on reunions with dominant culture birthmothers who voluntarily consented to the adoption, many of whom expressed that adoption was in the best interest of the child (March, 1997). First Nations birthmothers differ greatly from dominant culture birthmothers, as they experienced the systematic removal of their children and/or were coerced into adoption. Furthermore, First Nations adoptees differ from other transracial adoptees based on their unique historical and political context. Acts of First Nations adoption occurred within their own homeland under the pressing force of colonialism (Harness, 2006).

Few studies illuminate the complexity of reunion for First Nations adoptees (Becker-Green, 2009; Carriere, 2005). Such studies reveal the search for birth parents is motivated by a desire to know more about their First Nations heritage (Harness, 2006; Hussong, 1978; Peterson, 2002). Overall, studies

suggest First Nations adoptees have been satisfied with reunion experiences, although they describe having been nervous and excited. Some First Nations adoptees felt their birthmothers were happy about the reunion despite it eliciting feelings of guilt (Hussong, 1978), while others described feeling accepted or rejected by the birth family (Harness, 2006). Reconnecting with family provided many with a sense of belonging but reunion is not always a positive experience for adoptees, as some learn dysfunctional aspects of their birth family, which can be painful (Carriere, 2007).

Research to-date has provided an interesting glimpse into satisfactory reunions for adoptees, but left much to be explored about First Nations adoptees as a unique population of focus. Studies of reunion have focused on the adoptee-birthmother relationship (March, 1997) and appear to have neglected the importance of the extended family, which is core to First Nations culture. As more adoptees search for their birth families, additional research is needed to understand the motivating factors of reunions and how, in turn, reunions affect adoptive identity. Motivating factors might include the search for their First Nations identity, the desire to have their identity mirrored back to them, the need to be informed about their genetic inheritance of particular diseases, the need to know one's origin to "feel complete", or the enactment of the principle of the "right to know."

## Methods

### Sampling procedures

The study data originated from the Experiences of Adopted and Fostered Individuals Project (N = 336) by First Nations Repatriation Institute (FNRI). Adoptees Have Answers collaborated in data collection. The University of Minnesota Institutional Review Board approved of all study procedures. Target respondents were adults who experienced adoption and/or foster-care during childhood. Respondents were contacted through two community agency subscription lists explaining the purpose of the survey, inviting their participation, and providing the hyperlink. Respondents were allowed to purposefully pass along surveys because this is a hard-to-reach and understudied population. The survey was retrospective and was made available online and in paper-pencil version. The survey was advertised on the FNRI website, Facebook Adoptee Page, National Indian Child Welfare Association (NICWA) Facebook page, and the Facebook pages associated with two tribes. Fliers were placed in 600 conference packets at the annual NICWA conference in 2013. Informed consent was obtained prior to survey completion and respondents were told the survey would take 45-75 minutes.

### Sample description

A subsample of the original data set was obtained. Respondents who had not reunified with their birth families, as well as those who did not identify as First Nations were excluded resulting in a final sample of 95 respondents. The term First Nations is used throughout this study to refer to the indigenous people of North America, as this term is increasingly recognized in the literature, although the U.S. Census does not yet utilize it. And, although other descriptive labels are used (e.g., American Indian, Native American), no label is universally accepted. The majority (61.1%) experienced foster-care and adoption. Half (50.5%) were adopted before the age of one. The mean age of respondents was 50.41 years old (SD = 9.10) and 80% were female. It is significant to note that the predominance of females in the study is consistent with previous research (Müller, Gibbs, & Ariely, 2004; Müller & Perry, 2001a). Half of

the respondents (50.5%) were married or cohabitating. Personal annual incomes from all sources ranged from less than \$10,000 to \$55,000 or more (median fell within the \$35,000-54,999 category). Slightly more than 10% (10.5%) met the U.S. criteria for living in poverty. The range of the respondents' highest completed education ranged from less than high school to more than a bachelor's degree, with 45.3% of respondents holding a college degree.

## Measures

### *Satisfactory reunification*

Reunification, the dependent variable, was operationalized as the reuniting of an adopted and/or fostered person with birth family. The measure was a three-item index ( $\alpha = .670$ ) developed from the following items, "I felt rejected by my birth relatives during the reunification process," "I was disappointed by what I learned about my birth family," and "I have trouble feeling like part of my birth family." Items were scored on a five-point scale (1 = strongly disagree, 5 = strongly agree). All items were reverse coded and summed ( $M = 10.74$ ,  $SD = 3.34$ , range = 3 to 15).

### *Different family race*

Respondents answered two questions about the race of their adoptive/foster families. First, they were asked, "What were the races of the foster family that you lived with for the longest time?" Second, "What were the races of people in your adoptive family?" Item response options were as follows: (Different from my own, I am not sure, Some overlap in races, but not a complete match, The same as my own). Items were dichotomized to represent whether the respondent had adoptive and/or foster parents of a different race (0 = Not different than my own, 1 = Different than my own). They were considered to have adoptive/foster parents of a different race if they answered "different from my own" to either or both questions. The majority (52.6%) had adoptive/foster parents of a different race.

### *Poly-victimization*

Based on high rates of First Nations child maltreatment and victimization, poly-victimization was included. Poly-victimization represents an accumulation of multiple abuse types. Of central concern was whether abuse occurred within the interpersonal relationship with the adoptive/foster caregiver. Definitions of physical, sexual, and emotional abuse were drawn from the National Child Abuse and Neglect Data System (Department of Health and Human Services, 2012). First, respondents were asked, "Did you experience abuse in any foster home?" For each type of abuse (physical, emotional, sexual, spiritual), response options were: none, single incident, several times, long-term. Next, respondents were asked about their experience of abuse in their adoptive home. It was asked and computed in the same way as foster care abuse. The dichotomized variables were then summed representing the total experience of victimization ( $M = 2.49$ ,  $SD = 1.60$ , range = 0 to 4) (Finkelhor, Ormrod, & Turner, 2007).

### *High social connection to tribe*

The response to a single item was used as an indicator of the adoptee's level of social connection to tribe: "How socially connected do you feel you are with your tribe?" The item was scored on a five point



scale where higher scores represent higher social connection (1 = Not Connected, 5 = Very Connected). The item was dichotomized to create a dummy variable representing whether or not respondents had a high social connection to tribe. If the respondent reported a high connection to tribe (scores of 4 or 5), then the dummy variable was 1; with any report other than 4 or 5, the dummy variable was coded as 0. One-fourth of respondents (24.2%) had a high social connection to tribe.

### *Identity salience*

Respondents responded to two questions regarding their ethnic identity. First, respondents were asked, “Are you an American Indian/Native American?” Item response options were as follows (I suspect so, Not sure, Yes). A dichotomous variable was developed where respondents answering “yes” were coded as 1 meaning they considered themselves First Nations; all other responses were coded as 0. For the second question, the question was coded in the same manner. The identity salience variable was derived from a comparison of these two items. Respondents were considered to have a salient identity if they were coded as a “1” for both questions. If they had a “0” for either question, they were coded as a “0” for identity salience. The majority of respondents (75.8%) had a salient identity. Over half (56.5%) of the respondents who were unclear about their identity, indicated they were Caucasian in the second question.

### *Reunification with birthmother*

Respondents were asked if they reunified with their birthmother using this question: “With whom have you reunited? Someone in your immediate birth family (parent or sibling); someone in your extended birth family (cousin, grandparent, aunt, uncle, etc.)?” The item was coded as 0 = Reunified with someone other than birthmother and 1 = Reunified with birthmother. Less than half (45.3%) reunified with their birthmother.

## Data analysis

Analyses were performed using IBM SPSS Statistics Version 22. Multiple OLS regression was the appropriate analysis procedure. The plan for statistical power was .80 and our sample size of 95 was large enough to detect a medium size effect ( $p = .05$ ) (Cohen, 1992). Independent variables selected for entry into the regression equation were those that were statistically related to the dependent variable within the bivariate correlation analysis and were not highly correlated with a number of other independent variables in the correlation matrix.

## Results

Demographic characteristics of the sample are depicted in Table 1. Bivariate correlations among variables considered in the model are depicted in Table 2. These bivariate correlations provide an initial indication of the relationships between variables, but do not control for the effect of other variables. Those participants who were older and who were more socially connected with tribe experienced a more satisfactory reunification while those reunifying with their birth mother experienced less satisfaction. More identity salience was felt when participants were unmarried, had less than a college degree, were the same race as their adoptive/foster family, and who were more connected with tribe.

Results of the regression model are depicted in Table 3. The overall model was statistically

significant, explaining 16.6% of the total variance of a satisfactory reunification (adjusted  $R^2 = .166$ ,  $F(3,91) = 7.257$ ,  $p < .01$ ); that level of explanation of variance is high for social science research. The two social identity variables explained about the same amount of variance in satisfaction received through reunification, but their effects were opposite. When participants reunified with their birthmothers, they experienced less satisfaction with their reunification. When they had a high social connection with tribe, they experienced a more satisfactory reunification. These results suggest that adoptees that reunify with other family members than the birthmother have a more satisfactory reunification experience. Age was significantly associated with a satisfactory reunification; older participants experienced a more satisfactory reunification.

**Table 1**  
*Sample Demographic Characteristics (n = 95)*

	<i>Percent (%)</i>	<i>Mean</i>	<i>SD</i>
Age in years (25-68)		50.41	9.10
<b>Gender</b>			
Male	20.00		
Female	80.00		
<b>Education</b>			
College Degree	45.30		
<b>Income</b>			
Poverty	10.50		
<b>Marital Status</b>			
Married/Cohabiting	50.50		

**Table 2**  
*Correlation Matrix for Variables Considered in the Regression Model (n = 95)*

	1	2	3	4	5	6	7	8	9	10	11
1. Satisfactory reunification	-										
2. Age	0.268 **	-									
3. Gender	-0.010	-0.081	-								
4. Married/Cohabiting	-0.172	0.099	0.084	-							
5. College degree	0.130	0.019	0.032	0.096	-						
6. Poverty	0.004	-0.099	0.086	#####	-0.105	-					
7. Different race than adoptive/foster family	0.181	0.228 *	-0.053	#####	-0.154	0.051	-				
8. Poly-victimization	-0.081	-0.024	0.007	0.030	-0.096	0.152	-0.023	-			
9. Reunification with birth mother	-0.308 **	-0.210 *	0.137	0.054	0.065	0.102	-0.069	-0.043	-		
10. Social connection to tribe	0.223 *	0.185	-0.067	#####	0.092	-0.021	0.131	0.096	-0.227 *	-	
11. Identity salience	0.118	0.036	-0.037	##### **	-0.227 *	0.034	0.448 **	-0.102	-0.029	0.271 **	-

Note. \*Significant at the  $p < .05$  level. \*\*Significant at the  $p < .01$  level



Table 3

*Multiple Regression Model Predicting a Satisfactory Reunification (n = 95)*

	<i>B</i>	<i>SEB</i>	$\beta$	
Age	0.070	1.898	0.190	*
Reunification with birth mother	-1.519	0.650	-0.228	*
High social connection to tribe	1.855	0.744	0.239	*
$R^2$		0.193		
Adjusted $R^2$		0.166		
<i>F</i>		7.257	**	

Note. \* Significant at the  $p < .05$  level. \*\* Significant at the  $p < .001$  level.

## Discussion

This study offers a number of key contributions. First, this study expanded previous reunion research by investigating components of a satisfactory reunification. Although recent literature recognizes that reunification is a process, this study explored the contribution of personal and social identity to a satisfactory reunification experience. Second, this study offered a deeper look into the factors contributing to a satisfactory reunification experience for First Nations adoptees who were separated from their birth families during childhood by foster-care and/or adoption. Third, this study added to the First Nations adoptee-centered research studies by integrating the voices of adoptees rather than relying on parent or professional report.

Social identity is particularly important for First Nations people. This study's findings revealed two social identity variables were significantly related to the reunification experience – high social connection to tribe and reunification with the birthmother. As an adoptee reunifies with their birth family, they begin to adopt certain values and beliefs of the birth family. They come to define themselves in relation to their birth family (extended kin) and in doing so, they develop social identity, which is part of their individual self-concept, but defined by birth family beliefs (Pratt, 2003). Adoptees search for their birth family because they are looking to fulfill the social dimension of their identity – to find a parent, and possibly even enroll in their parent's tribe. Enrollment is an outcome of the social dimension of individual identity.

Adoptees with high social connection to their tribe experienced a greater satisfactory reunification compared to adoptees with low social connection to tribe. These findings suggest the importance of extended family and tribal relationships beyond the birthparent. Just as the individual cannot be separated from the collective (Red Horse et al., 2000), reunification cannot be separated from extended family and tribe. Within First Nations collectivist culture, social identity and an adoptee's broader social relationships are more central to the reunification experience than personal identity components.

The reunification process encompasses more than merely the adoptee-birthmother relationship.

Although reunification with the birthmother may be of primary focus for adoptees initially, there are broader social relationships that influence reunification. An adoptee's initial search is usually focused on the birthmother (Müller & Perry, 2001b), but later they may seek their birth fathers, siblings, or other birth relatives (Child Welfare Information Gateway, 2011b). In First Nations culture, these relationships may be of equal or even greater importance than reunifying with the birthmother. As March (1997) states, "to focus only on adoptee-birthmother contact is an injustice too often evident in the current adoption literature" (p. 104).

In considering why First Nations adoptees that reunify with their birthmothers might have a less satisfactory reunification experience than those that reunify with someone else in their family, extended family or tribe, any number of considerations may offer explanation to such a finding. Often adoptees have hopes and dreams attached to the image of their birthmothers. As such, adoptees may also attach their own hopes and dreams to the possibility of having a relationship with their birthmother – the expectations of which realistically may not be met.

It could also be related to the residual effects of adoption exhibited by birthmothers throughout the years and even decades following the adoption. Birthmothers can display continued anxiety about their children's fate for years (Weinreb & Murphy, 1988 as cited in March, 1997), and such anxiety may only be exacerbated by the circumstances surrounding First Nations adoption. If anxiety is found in birthmothers who report voluntarily consenting to their child's adoption, might anxiety be even worse in First Nations birthmothers who experienced the coercion or forced removal of a child? This anxiety is echoed across First Nations communities through the use of the phrase "stolen children" which is used to refer to First Nations children removed during the adoption era.

Furthermore, although contact between an adoptee and dominant culture birthmother may alleviate anxiety on behalf of the birthmother by affirming that adoption was in the best interests of the child (Silverman et al., 1988), the reunification of an First Nations adoptee may serve as a trauma-reminder, triggering unresolved grief and pain for the First Nations birthmother. In the reunification process, the return of a First Nations adoptee mirrors back the pain of the child's removal, which may elicit feelings of guilt, shame, and/or disappointment on behalf of birthmothers (White Hawk, 2014). It could be that reunification surfaces old hurt in the birthmother, but when they reunify with others, the experience is more positive for any number of reasons, such as: (1) the tribe is seen as family within First Nations culture, (2) the "coming home" movement being organized within First Nations communities and its recognition of what was done to their people, (3) those family members are better positioned to welcome the adoptee (e.g., the adoptee does not serve as a personal trauma reminder).

Although this research illuminated the perspective of the adoptee, it leaves many questions unanswered regarding birth parents and other family members who are also involved in the reunification experience. Limited literature, to our knowledge, has explored the experiences of First Nations birthmothers and their perceptions of forced removal and reunification. It is critical that research begins to focus on First Nations birthmothers, particularly studies that can inform therapists. First Nations birthmothers who lost their children by forced removal are stuck; they may love their children, but may be unable to accept them because of the traumatic experience of loss. It is essential that therapists understand how to help First Nations birthmothers prepare for reunification. The perspective of First Nations birthmothers is needed, as their voice is underrepresented in the literature. In the context,

studies focusing on experiences of reunification at the individual, family, and tribal level are needed in order to better understand the greater systemic components to the reunification process. Although efforts within First Nations tribal communities have already begun to participate in the reunification process (e.g., welcoming home songs and ceremonies, formal tribal enrollment, etc.), little research has been done to document such experiences. This begs the question, what contributes to satisfactory reunification experiences at the tribal level? How can tribes position themselves in practices that offer support to the reunification process? Just as birthmothers would benefit from preparation for reunification, so too would tribes. A wealth of knowledge could be rendered from the tribes, such as the White Earth Tribe of Ojibwe in Minnesota and the Rosebud Sioux Tribe in South Dakota, who are already leading the movement toward reunification and repatriation, to serve as an example for other tribes.

## Conclusions

First Nations adoptees are searching for their families to find themselves. Birth parents may still be wondering what happened to those children (e.g., ambiguous loss). Residual effects of the adoption era continue to manifest in the lives of birth families and adopted individuals. Future qualitative research is needed with this population that can give us an in-depth experience with the key constructs, such as high social connection to tribe and reunification with the birthmother, which were proposed throughout this study.

Social identity plays an important role in the reunification process in First Nations communities where individuals are not seen as separate from the collective (Red Horse et al., 2000). Extended family member involvement and strong connection to tribe shape reunification from the adoptee's perspective. Therapists working with First Nations adoptees and their families are uniquely positioned to support reconnection across multiple relationships. Therapists need to know the importance of social identity for First Nations adoptees; this will shape how they help people navigate the reunification process. For instance, supporting the adoptee's claims of First Nations identity, participating in song, ceremony, dance, drumming, and other community events.

The tribes need to know how critical their role is in facilitating the reunification process (e.g., honoring and accepting adoptees into the circle through the adoptee song and ceremony). Work needs to be done to prepare family members to receive First Nations adoptees, such as extended family members who may be better positioned to receive the adoptee (e.g., in comparison to those for whom the mere face of the adoptee is a trauma reminder of loss).

Although this study offered strength by focusing specifically on First Nations adoptees, it is not without limitations. Caution must be exercised when drawing conclusions from the findings. Given this is one of the few studies to attempt to sample this population; no claims to generalizability can be made. Findings may be specific to this particular sample and may not represent the experiences of the broader First Nations adoptees. In future studies, more targeted sampling would be helpful, as well as the inclusion of adoptees that attempted but were unable to achieve reunification.

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## An Interdisciplinary Journal

*Honouring the Voices, Perspectives and Knowledges of First Peoples through Research, Critical Analyses, Stories, Standpoints and Media Reviews*

# Psychometrics in Parenting Capacity Assessments: A problem for Aboriginal parents

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## Abstract

*Parenting Capacity Assessments (PCA) are used by child protection workers to assist in determining the ability of a parent to care for their children. They may be used at various stages of the case management process but these assessments serve as powerful tools for decision making by these workers. They can also be introduced in court as part of expert testimony. Most PCAs utilize psychometric assessment measures to elicit data in respect to personality, parenting knowledge, as well as mental health and addiction issues. The authors argue that the norming of these measures has insufficient inclusion of Aboriginal peoples to be used for assessments with this population. They further argue that different approaches need to be developed as current approaches, including assessment measures, are based upon the constructs of the dominant culture, which is individualistic as opposed to the Aboriginal collectivistic approaches to parenting.*

**Key Words:** *Parenting Capacity Assessments; Indigenous Parenting; Child Protection Assessments; Assessment of Aboriginal parents; Aboriginal parenting, First Nations parenting*

## Introduction

Parents involved with the child protection system may be asked to complete a Parenting Capacity Assessment (PCA), to assist child protection workers and courts with case decisions. These assessments carry substantial weight in child protection courts across Canada (Choate & Hudson, 2014; Lennings, 2002). PCAs have three core questions:

- 1) Can this parent be 'good enough' for this child based upon the needs of the child?
- 2) If not, what can be done to enhance the skills of the parent to become good enough? And,
- 3) If that cannot be done, can this parent be involved in the life of this child? (Choate & Engstrom, 2014).



A few structured models exist for PCAs (Budd, Clark & Connell, 2011; Choate, 2009; Pezzot-Pearce & Pearce, 2004; Budd, 2005, 2001; Steinhauer 1993/4; 1991). They suggest a number of steps that would be typically taken which can be summarized as:

- Obtain a good referral that clearly outlines the questions to be answered;
- Review the background data, including material from child welfare that outlines the involvement with the family;
- Conduct clinical interviews that review the personal and family history in detail;
- Complete psychometric testing;
- Observe the parent with the child;
- Interview the child as appropriate;
- Conduct collateral interviews; and
- Prepare a written report with conclusions and recommendations.

This approach is widely used in developed countries including Canada. The models have been constructed using Euro-North America understandings of parenting focusing on the nuclear family. The typical PCA does not consider the larger family system as a parenting system. Muir and Bohr (2014) show that extended family has a central place within traditional Aboriginal parenting, as does the community.

Stairs and Bernhard (2002) note, “Euro-North American views of child development have far too long been privileged over Aboriginal visions and values” (p.310). The assessment literature has limited data on Aboriginal parenting, although there is parenting education and support literature which offers insight into elements of traditional Aboriginal parenting (Parenting Path, 2012; Fearn, 2006; Fox, n.d.; Kawkeka, 2004; NICWA, 2001; Bruyere, 1983). However, PCAs should reflect the cultural reality of the family being assessed (Choate, 2013).

The existing approach to PCAs has not been validated within minority populations. This approach has received criticism for this in the United States (Lee, Gopalan & Harrington, 2014), as well as Australia with respect to the Aboriginal population (Drew, Adams & Walker, 2010). There has also been some criticism in Canada (Mushquash & Bova, 2007). Little attention has been paid to the validity of the present PCA practices with the Aboriginal peoples of Canada. There is a strong argument to be made that the present approach, which is not culturally sensitive, repeats the power dynamics that have been part of the history of Aboriginal peoples interacting with the dominant culture and its regulatory institutions (Denison, Varcoe & Browne, 2013).

The use of psychometrics is an integral part of PCAs (Budd, Clark & Connell, 2011; Pezzor-Pearce & Pearce, 2004). Typically, a parent will complete a personality measure and others that are focused on parenting. They may also be asked to complete questionnaires related to specific issues such as addictions. The test battery might include the Minnesota Multiphasic Personality Inventory, version 2 (MMPI-2) (Butcher, Graham, Ben-Porath, Tellegen & Dahlstrom, 2001), the Personality Assessment Inventory (PAI) (Morey, 1991), Child Abuse Potential Inventory (CAPI) (Milner, 1986), Adult-Adolescent Parenting Inventory (AAPI) (Bavolek & Keene, 2001) Parenting Stress Index (PSI), v. 4 (Abidin, 2012).



While there may be other instruments used, these are the most common (Budd, Clark & Connell, 2011; Pezzot-Pearce & Pearce, 2004).

Developing assessment measures applicable across cultures is challenging. De Klerk (2008) identifies a multitude of issues that must be addressed including construct, method and item biases. For example, if a test is to be valid across cultures, it must be developed in a way that what it purports to measure in a population is actually measured. Thus, the items would also need to be presented in a way that is linguistically and contextually meaningful to the person being assessed.

A Canadian study by Catternich, Gibson and Cave (2001) looked at the assessment of mental capacity in Canadian Aboriginal seniors. Their review aids the present work with their conclusion that assessment overall, including psychometrics, needs to reflect the linguistic conventions as well as the social context of the traditional Aboriginal cultures. They add that there needs to be sensitivity to the dynamics that influence social interaction with Aboriginal peoples (p. 1477).

The goal of this review is to consider whether there has been sufficient inclusion of Aboriginal peoples to conclude that the use of common assessment measures should be used in PCAs with these parents.

## Method

It is important to consider the impact of the inclusion or absence of Aboriginal peoples in test creation and test validation. Item bias can exist if the items are not relevant and meaningful to the population being assessed (de Klerk, 2008). A review was conducted of the test manuals for the MMPI-2 (Butcher et al., 2001), PAI (Morey, 1996,1991), CAPI (Milner, 1986), AAPI (Bavolek & Keene, 2001) and PSI-4 (Abidin, 2001). Each was considered for the degree of Aboriginal population inclusion in the norming. A literature search, using Academic Search Complete, EBSCO and PsychInfo, was also conducted looking for studies identifying norming efforts that specifically targeted Aboriginal populations.

## Results

The literature review identified a number of efforts to provide cross-cultural validity to various measures, particularly the MMPI-2, PSI, PAI and CAPI. The literature review did not identify studies that focused on extending the norming of these measures to Aboriginal peoples, particularly in Canada.

Some efforts were made to examine the specific utility of the MMPI with a few American Aboriginal groups (Robin, Greene, Albaugh, Caldwell & Goldmann 2003; Greene, Robin, Albaugh, Caldwell & Goldman, 2003).

Throughout this section we examine which populations were included in the norming. This identified a number of instances where Aboriginal populations were marginally included or not at all. We show the demographic breakdown identified by the test developers so the reader understands the populations that were included.

The Personality Assessment Inventory (PAI) and the Minnesota Multiphasic Personality Inventory (MMPI-2) are commonly used personality tests. They are both widely accepted by the courts

(Mullen & Edens, 2008).

## PAI

Morey (1991) reports that the sampling for the construction of the PAI was based upon a United States census-matched standardized sample subset of 1000 people from an original sample of 1462 people from 12 American states. The subsample was selected on the basis of gender, race and age from the 1995 census (Morey, 1991, p.47). It consisted of 41.1% Caucasian males, 5.4% Black males, 1.5% other males, 44% Caucasian females, 6.3% Black females, and 1.7% other females.

There were two other samples reported, clinical and college students. The clinical sample consisted of 1265 people from 69 sites. It consisted of 78.8% Caucasian, 12.6% Black and 8.6% other, although no specific breakdown is given of other. The college sample consisted of 1051 students. The samples were drawn from seven universities across the US; 92.5% Caucasian, 2.8% Black and 4.7% other, again with no breakdown of the latter.

The developers of the PAI do acknowledge that psychometrics often bias on variables of gender, culture or other demographics. They took steps to address some of these issues, although there is no indication that Aboriginal peoples were part of that effort

## MMPI-2

The manual for the MMPI-2 (Butcher et al., 2001) offers more specific information on the inclusion of Native Americans (the term used in the manual). There appears to have been a targeted sample from a federal reservation in the Tacoma, Washington area. The overall sample consisted of 1138 males (0.5% Asian; 11.1% Black; 3.1 % Hispanic; 3.3% Native Americans; 82% Caucasian) and 1462 females (0.9% Asian; 12.9% Black; 2.6% Hispanic; 2.7% Native American; 81% Caucasian).

The MMPI manual states:

Although the proportions are quite comparable for blacks and whites, Hispanics and Asian-American subgroups are underrepresented in the normative sample. Native Americans are somewhat overrepresented in the normative sample (Butcher et al., 2001, p.3).

As noted above, a few studies have been done in an attempt to determine the applicability of the MMPI-2 to Aboriginal populations. Robin et al., (2003) and Greene et al., (2003) demonstrated that some efforts could be made to find applicability, although they went to extensive efforts to build relationships with the test subjects. They found this was essential to assist their norming efforts. It also illustrates the steps that need to be taken in working cross culturally. They demonstrated sensitivity to the economic and social hardship, trauma and violence that this population has endured (Robin et al., 2003, p. 356). While they tended towards supporting the use of the MMPI-2, their results still raised caution about the context of interpretation stating, "...the heterogeneity of American Indian tribal groups suggests caution in generalizing results from this community to other tribal groups" (Robin et al., 2003, p.357). Such efforts support the conclusion of de Klerk (2008) that successful inclusion of subpopulations in a norming sample are hard to achieve.

A more recent review of the MMPI-2 by Hill, Pace and Robbins (2010) saw this instrument as having contextual concerns. Their qualitative study looked at how question items were understood. It

built on earlier work by Pace et al. (2006) that concluded that the MMPI-2 “is reductive in so far as it screens out behaviors and perspectives its questions cannot absorb” (p.330). The MMPI-2 was thought, from this research, to assume norms of behaviors that may not be meaningful within the traditions and historical experiences of the American Indian peoples (p.330).

Hill et al., (2010) concluded from their research:

From an Indigenous perspective, the MMPI-2 explicitly represents Western power and domination as an instrument that denies Indigenous peoples the right to psychological self-determination. Based upon the results of the current study, it is not difficult to conclude that the MMPI-2 is not an instrument that legitimates or even acknowledges Indigenous knowledges, worldviews, and experiences, but rather an instrument that legitimates and privileges hegemonic Western standards, norms, values, epistemology, and ontology (p. 24).

### Child Abuse Potential Inventory (CAPI)

The CAPI was validated in three studies. The data indicates that Aboriginal Americans are only marginally represented in the norming populations.

The first study was composed of 38 participants from social services departments in Northern Carolina (Milner, 1986). It was a homogeneous sample matched for comparable variables of location of residence, gender, age, ethnic background, education, marital status, number of children, and gender of children.

A second validity study reported in the manual (Milner 1986) involved 130 people. This sample was drawn from Northern Carolina (social service population) and Tulsa, Oklahoma (At-Risk Parent-Child Program). The sample was matched on variables of location of residence, gender, age, ethnic background, education, marital status, number of children, and gender of children. The sample was 83% Caucasian.

Milner (1986) reports a third sample, which started with 219 people from At-Risk Parent-Child Program, Juvenile Court in Tulsa, Oklahoma and the department of social services in North Carolina. There were 97 people excluded. This left 122 along with 110 matched controls. The sample population was 67% Caucasian, 23% Black and 10% consisting of a mix of Hispanic, Aboriginal American and other.

### Adult Adolescent Parenting Inventory (AAPI)

Bavolek and Keene (2001) report a sample drawn from 53 agencies in 23 states. Racial data is not provided. The sample consisted of 713 adult parents without parent training; 198 adolescents without formal training; and 87 adolescent mothers. The sample was drawn from a variety of agencies and included child welfare and related agencies. They report additional discriminating validity for black high school students and Mexican-Americans. There is a Spanish language version to be used by people who read or speak Spanish only, or for people who comprehend Spanish better than English. Other research has raised questions about the use of the AAPI with child protection populations in general (Lawson, Alamedqa-Lawson & Byrnes, 2015; Conners, Whitseide-Mansell, Deere, Ledet & Edwards, 2006).

## Parenting Stress Index (PSI) – 4th Edition

Abidin (2012) reports that the goal was to match the overall proportion of the United States population for education and ethnicity from 17 states. There were 1056 people in the sample that included 534 mothers (Caucasian 66%; African American 14%; Hispanic 14%; other 5%) and 522 fathers (Caucasian 68%; African American 12%; Hispanic 16%; and other 4%). There was an additional sample of 233 Hispanic parents and a subset of gay/lesbian parents from the standardized sample (N=27).

In the PSI-4 manual, and its predecessor for the 3rd edition, there is a section that speaks to the PSI being multicultural. The PSI has been studied in many cultures. This includes Chinese, European, Portuguese, French Canadian, Finnish, and Dutch (Abidin, 2012). The PSI has been published with norms and detailed psychometric data by publishers in seven countries. They have found the statistics to be comparable to what is listed in the PSI-3 and PSI-4 manuals. The PSI-3 is available in 28 languages and the PSI-3-Short Form is available in 12 languages. They assert:

... the PSI is a robust measure that maintains its validity with diverse non-English speaking cultures. Its ability to effectively survive translation and retain its usefulness with non-English-speaking populations suggests that it is likely to maintain its validity with a variety of U.S. populations (Abidin, 2012, pp. 5-6).

Abidin, Austin and Flens (2013) report that no specific effort has been made to stratify the PSI based upon subsets of populations. These authors note that efforts to create such stratification are complex. Such work might have to look at gender, race, social positioning and geography, for example. The subdivisions, they feel, could be almost endless.

They state that the significant large amount of cross-cultural research that has been done on the PSI would support the notion that the parenting constructs that underpin the tool are robust. Fathers have not been strongly studied suggesting a possible gender weakness (Abidin, Austin & Flens, 2013, p.355). They also report on various studies that have tried to expand the base of the PSI studied populations, including parents with disabled children, behavioral problems, for example. Thus, we see efforts to broaden the cultural base of the PSI, although it appears that Aboriginal peoples have not been included in those efforts.

## Discussion

For each psychometric test used in assessment, it is important to look at the demographic composition of each norming group and validation group. This allows the assessor to establish utility of a particular psychometric for a given population.

The results of this review indicate that the Aboriginal population within the norming groups of these assessment measures is small. There is little data reported on the nature of the Aboriginal grouping other than the MMPI-2 which indicates a sampling with an Aboriginal population in the Tacoma, Washington area, although details are not offered as to which specific population was included. Other Aboriginal inclusion in test development is either not reported or done so in a manner that offers little data about the nature of the population.

Mushquash and Bova (2007) note that researchers have ensured reliability and validity within the dominant populations while the instruments get used with cultural groups for which there is not proper

norming or psychometric research. To change this, researchers need to develop constructs and norming representative of Aboriginal populations. Our review of the manuals, and the very small literature base ascertaining validity of tests within Aboriginal populations, indicates that these assessment measures do not have sufficient presence of Aboriginal peoples. We are not confident that the norms are representative of them. Musquash and Bova (2007) note that Canada's Aboriginal peoples are far from homogeneous. They indicate, First Nations, Metis and Inuit peoples are living on over 2200 reserves, in 596 bands and a large number living off reserve in Canada. The tests do not seem reflective of this population complexity. Butchers, Derksen, Sloor and Sirigatti (2003) have shown that cross-cultural norming is possible but it does not appear to have been done with the various Aboriginal peoples of Canada. The issues can include determining what is normative to a culture, specific meanings of constructs and language, and determining how the original tests constructs can be used within the intended culture. Butcher (2004) indicates that previously developed, validated test items, provide a baseline to assess the factors that can be measured by the particular psychometric. He goes on to note that there is a need for culturally based research to ensure validity within the culture. The PAI test developers examined previously developed test items with other cultures. This revealed some constructs that were not appropriate cross culturally. The cross culture variability was thought to change the intended use of the test questions. The existing test questions served as a baseline, but pointed out that the items needed to be examined to ensure validity within different cultures (Morey, 1996).

Pace et al. (2006) make the cogent observation that the MMPI-2 "does not offer a bird's eye view of the personality landscape, but rather it provides a presupposed form upon which personality may be displayed" (p. 329). We suggest that this is true of all the measures considered here. A determination is developed about the standard against which all who are tested will be measured. The results of an assessment measure compare the norming data with specific results for the client.

There are reasons to be quite cautious in the use of assessment measures with Aboriginal peoples. The lack of substantial Aboriginal presence in the norming population is one concern. Another is a lack of clarity as to whether constructs measured are relevant to this population.

We are also struck by the reality that none of the measures considered here included any Canadian sampling, with the exception of a project with French Canadian parents for the PSI French Canadian version (Abidin, Austin & Flens, 2013). Thus, the versions available on the market in Canada will be drawn from a non-Canadian, mainly American population.

Drew, Adams and Walker (2010) remind us that assessment is a socially and culturally mediated practice. The parenting tests reviewed in this work are developed using constructs of parenting as defined by the dominant culture, although Abidin et al., (2013) suggest that the PSI has been found valid across several cultures. However, Ambert (1994) describes crucial underpinnings to research in this field. She indicates that Western paradigms are being used to construct definitions of parenting creating an ethnocentric view. Muir and Bohr (2014) have made a strong argument that there are traditional Aboriginal child-rearing practices, which vary from the paradigms used to construct both individual and familial social meaning, and behavioral practices measured in the parenting assessment tools. The existing psychometrics to assess parenting were not built utilizing traditional Aboriginal approaches to parenting. Muir and Bohr (2014) illustrate that traditional child rearing practices are still in use in contemporary Aboriginal parenting. They show that traditional Aboriginal values are represented in the

culture. Examples include placing value on the autonomy of the child, the role of extended family, different forms of attachment, different parenting roles for males and females, different views of developmental progress and discipline and the impact of spirituality and language.

If PCAs are going to become more culturally relevant, then not only will the psychometrics used need to be culturally normed, but so too will the foundational definitions of parenting—which is the focus of the PCA. Indeed, if the construct of parenting in a PCA is based upon the dominant cultural definition and the psychometrics are developed using the dominant cultural definitions, then the Aboriginal parent will be disadvantaged in both ways.

The psychometrics that are specific to parenting are rooted in Western definitions of family and family functioning. They are not built upon Aboriginal understandings. Thus, the cultural context of the questions is based upon structural beliefs that may be in contrast to Aboriginal beliefs (Stairs & Bernhard, 2002). Elliott and Smith (2014) have pointed out that there is concern by Aboriginal professionals, leaders and parents that many of the assessment tools being used with children are not culturally appropriate. We suggest the same argument can be made for adult assessment tools.

The Federal Court, in *Ewert v. Canada* (2015), has recently considered actuarial risk assessment tools used in criminal matters. Relying upon the testimony of Dr. Stephen Hart of Simon Fraser University, the court noted that actuarial tests are likely to be affected by cross-cultural variance because of the cultural differences between Aboriginal and non-Aboriginal Canadians (Paragraph 27). The Court accepted the conclusion that the tests were not “sufficiently predictably reliable for Aboriginals because of the cultural variance or bias of the tests” (paragraph 40). Referring to the Criminal Code of Canada, the Court concluded that the assessment tools were not being responsive to the special needs of Aboriginal people, and the use of these tests violated the charter rights of the plaintiff in this case. We believe that the reasoning of the Court in *Ewert* (2015) is applicable to the psychometrics used in PCAs.

Others have argued that foundational constructs that inform PCAs are not supported within the Aboriginal cultures of Canada. For example, Neckoway, Brownlee and Castellan (2007) indicate that attachment theory, which is widely discussed in the PCA literature, is not interpreted in a way that is consistent with the family and cultural structure of Aboriginal peoples. This further undermines the present PCA constructs with this population.

Milner (1986) indicates that social service populations may be different than the majority population. We suggest that, an Aboriginal child protection population may be even more so given the presence of both cultural and child protection issues. We think that the issues of inter-generational trauma and cultural genocide identified by the Truth and Reconciliation Commission (2015) further reinforces the uniqueness of the Aboriginal population. Such factors require consideration in the development, norming and application of assessment measures to be used with Aboriginal clients.

Culturally, Indigenous Aboriginal peoples have a more collective view of parenting and family. We argue the current approach should be changed. The nuclear family system that underpins the assessment framework is not presently adapted to the broader worldview of Aboriginal collectivistic parenting and family perspectives. The Child and Youth Advocate of Alberta, in a recent investigative review, challenged the belief that Aboriginal parents can be effectively assessed using constructs developed within the dominant culture (OCYA, 2014).



Meaningful PCAs of Aboriginals requires the development of a PCA model rooted in Aboriginal culture. Such an approach might include tools such as the Medicine Wheel, for example (Twigg & Hengen, 2009); however, research is needed in this area to accomplish a valid, revised approach. Given the over-representation of Aboriginal children in Canada's child protection system (Sinha, Trocme, Fallon and Maclaurin, 2013), there is an urgent need for a revised method.

If dominant cultural definitions of parenting are to be used, then parents from Aboriginal communities and families are at a disadvantage even before the assessment begins. Understanding the context of parenting, historically and culturally, is essential to approaching PCAs with Aboriginal parents (Muir & Bohr, 2014). Van de Sande and Menzies (2003) offer one of the few publications that has documented that there are identifiable differences between Aboriginal parenting and mainstream Canadian society. The ways Aboriginal families are defined and how they approach parenting are different and must be understood (BigFoot & Funderburk, 2011).

Not all Aboriginal parents will reflect a connection to traditional ways of parenting. Those who have been raised away from their culture may find a PCA approach rooted in Aboriginal cultural parenting approaches unfamiliar. Those parents may be more comfortable with the current approach, although that has not been researched. The parent who exhibits a strong cultural connection will find present approaches to PCAs less reflective of who they are and the culture to which they belong.

In this article, we have raised a number of concerns that should act as a call to action by child protection authorities and assessors to develop different, culturally appropriate methods to assess Aboriginal parents. Such efforts would be part of reforming the relationship between child protection and the Aboriginal peoples of Canada.

## Limitations

This work extends the limited literature on PCAs within the Aboriginal community but raises a number of questions. It raises concerns about both the psychometric norming and the definitional foundation of parenting that are presently used to assess Aboriginal parents. However, there is much research to be done and this paper outlines problems. Further work is needed to extend these concerns towards solutions. This work also suggests that the structure of PCAs might warrant a careful examination beyond psychometrics, to determine the applicability to Aboriginal peoples. It is one thing to point out the problem, it is quite another to build a different approach. Future work will need to address this considering the ways in which PCAs might be constructed in a culturally meaningful manner to assist child protection and the courts in cases where such support is needed.

This research did not review the less commonly used tools. Assessors should approach all PCA psychometrics with caution determining whether or not there is a sufficient Aboriginal inclusion in the norming to suggest validity with their client.

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**An Interdisciplinary Journal** *Honouring the Voices, Perspectives and Knowledges of First Peoples through Research, Critical Analyses, Stories, Standpoints and Media Reviews*

## **The elusive promise of reconciliation in British Columbia child welfare: Aboriginal perspectives and wisdom from within the BC Ministry of Children and Family Development**

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### **Abstract**

*This article considers the unique challenge for Aboriginal professionals working in a government child welfare system responsible for the oppression of Aboriginal children, families and communities. A non-Aboriginal organizational insider researcher uses an Indigenous/ethnographic approach to explore these issues with Aboriginal professionals within the British Columbia Ministry of Children and Family Development (MCFD). This study involves a dual focus that examines the history, identity, values, motivations, and practice approaches of Aboriginal professionals as well as how organizational structural and environment variables support or impede their efforts toward critically needed improvements to child welfare services for Aboriginal children, youth, families and communities. Analysis of these two areas results in significant findings for the organization and its perceived inability to achieve progress with transforming service delivery for Aboriginal peoples.*

*The findings contribute to better understanding of factors that impede Aboriginal professionals from achieving improved practice and outcomes. Organizational variables, such as low Aboriginal practice support, racism, cultural incompetence, hierarchical structure and decision making, risk-averse practice norms, poorly implemented or rhetorical change initiatives, and institutional physical environments impede the ability of Aboriginal professionals. However, significant mitigating factors were found to help, such as meaningful organizational support at the worksite level provided through dedicated culturally competent Aboriginal management and practice teams.*

### **Key terms**

*Aboriginal:* A collective term for Inuit, First Nation, and Métis peoples.

*First Nation:* Describes persons that self-identify as First Nation regardless of Indian Status. The term is also used to describe First Nation governments (collectively) and organizations serving First Nation

peoples.

*Indigenous:* Persons who self-identify as Indigenous. Term often used in an international context.

## Introduction: Aboriginal professionals' struggles to implement Indigenous practice approaches within the mainstream organizational environment of the British Columbia Ministry of Children and Family Development (MCFD)

The Elders took me out and taught me how to crawl around underneath the trees so I could see the tea. I couldn't see it. "Where is it?" You know what? Unless you are lying on the ground looking, you can't see the tea. The Elder introduced me to the tea and then I could see it and it was everywhere. It's the same with the Ministry—unless you get down on your knees, and you're down here [in the communities] working and experiencing, how do you know what it is? You can't see it. (MCFD Aboriginal Reconnection Worker)

Government child welfare involvement with Aboriginal communities in Canada has had significant and tragic consequences. These impacts are felt every day by Aboriginal peoples across this country. Extensive documentation and literature address the systemic abuse and oppression that has resulted in intergenerational trauma, the ongoing overrepresentation of Aboriginal children and families within child welfare systems, alongside the underrepresentation of prevention and support services that may help to address and ameliorate these ongoing impacts (Turpel-Lafond, 2015; Walmsley, 2005; Hughes, 2006; Hudson, 1997; Armitage, 1993; Johnston, 1983). Government child welfare agencies across Canada struggle to find adequate policy, practice, and resources to better serve Aboriginal people. An ongoing strategy has been to pursue the inclusion of Aboriginal social workers.

The Ministry of Children and Family Development (MCFD) provides child protection, foster care, adoption, mental health, youth justice, and disability services to children and their families in British Columbia. Due to the long history of oppressive and inappropriate system interventions in Aboriginal communities, Aboriginal children remain eight times as likely as non-Aboriginal children to live in foster care. In British Columbia, 56% of children in the care of MCFD (during the time of the study) were Aboriginal (Government of British Columbia, 2010). This number has been increasing, rather than decreasing, over the past 15 years.

This article presents a summary and discussion of knowledge gained through in-depth ethnographic research that involved hearing from Aboriginal professionals within MCFD (Rousseau, 2014). It reveals their identities, values, motivations, practices and attempts to contribute to better outcomes for First Nations and Aboriginal children, families and communities served by MCFD. It reveals their experiences of not being included in relevant administrative, policy and practice changes they hope will ultimately transform children's services for First Nations and Aboriginal children, families and communities.

Despite ongoing commitments by MCFD to transform services, there appears to have been very little progress towards shifting control of services to Aboriginal groups and communities, let alone significant internal policy and practice changes to improve services the Ministry provides to Aboriginal children, families and communities (British Columbia Representative for Children and Youth, 2013). The 2013 report, *When Talk Trumped Service*, analyzed MCFD Aboriginal governance initiatives that occurred from 2008 to 2013. The BC Representative for Children and Youth (RCYBC) concluded the MCFD approach during that period had been “rife with perverse performance measures, the absence of any real incentives for change and no end-state goals on how services to Aboriginal children and youth will be improved” (p. 4). More recently the BC Representative, responding to the release of the Truth and Reconciliation Commission report, noted “true reconciliation must begin with families, but it also must depend on governments and communities to support the waves of children affected by intergenerational trauma” and the “the scope and scale of response required is not present on the ground and will not be until significant collaborative work is done” (Turpel Lafond, 2015, para. 5/8). The research presented in this paper supports these assertions that MCFD has yet to provide any realistic initiatives that could result in necessary transformation to children’s services for First Nations and Aboriginal children, families and communities in British Columbia.

This research describes MCFD Aboriginal professionals’ inability to implement Indigenous practice and policy approaches due to low organizational support, and therefore may provide some insight into the ongoing failed attempts by the BC MCFD to achieve necessary change. These insights may assist BC MCFD to identify and utilize the unique and invaluable internal resources of Aboriginal professionals to guide more effective efforts to transform children’s services for Aboriginal peoples.

It is important to acknowledge that First Nations and Aboriginal peoples have altered the policy environment in response to the inability of mainstream child welfare systems to provide culturally relevant and transformative practices for Aboriginal peoples. Many First Nations and other Aboriginal communities in Canada are now delegated to deliver child welfare services through the Aboriginal Affairs and Northern Development Canada (AANDC) First Nations Child and Family Services (FNCFS) Program. However, the Assembly of First Nations, First Nations Child and Family Caring Society and other First Nations and Aboriginal groups point out the many inadequacies in the FNCFS program, including reliance on mainstream provincial legislation, policy, standards and grossly inadequate funding structures. These organizations continue to advocate for autonomous First Nations and Aboriginal child welfare structures that reflect relevant community/cultural practice, policies, standards and equitable funding.

While the obvious goal for First Nations and other Aboriginal peoples is to achieve fair and equitable autonomy over children’s services, the current situation where many Aboriginal children are being served within provincial child welfare systems necessitates an immediate focus and priority on improving those services alongside that goal. Listening to the voices of Aboriginal peoples, and in particular Aboriginal professionals, is an obvious first step to improving services within provincial child welfare systems like MCFD.

## Researcher standpoint

The research involves an in-depth ethnographic and Indigenous methodology undertaken by a



non-Aboriginal insider researcher and social work professional who gained insight and grounding within MCFD and its Aboriginal approach through seven years as a manager and director for MCFD Aboriginal Services in Victoria, BC. A shared Indigenous perspective that envisions First Nations and other Aboriginal communities caring for their own children, combined with positioning within the organization, allowed the researcher to gain credibility and trust with Aboriginal professionals to engage through in-depth conversations about their perspectives of how the Ministry supports their vision of systemic organizational change necessary to transform Aboriginal services. The research was motivated by over twenty years working alongside and witnessing the unique motivation of Aboriginal colleagues who choose to work for government children service organizations as a means to transform them within their communities.

## Relevant literature

The motivations, practice and tensions of Aboriginal child and family practitioners form some of the starting points for inquiry in this research. The proliferation of Aboriginal voices in children's services has meant that growing focus on Indigenous practice and service approaches is relevant to the provision of services for Aboriginal children, families and communities. Better services will be informed by hearing the voices and perspectives of Aboriginal people who know best how to care for their children. The research also seeks to understand how a provincial child welfare system can begin to strengthen existing services, with the ultimate goal of seeing services being delivered through autonomous First Nations and other Aboriginal community structures.

## Motivation, practice approach, and tensions of Aboriginal professionals in a historically oppressive system

There have been several studies that examine the strong values-based motivations, attempts to reconcile cultural knowledge and practice within dominant mainstream organizations, and resulting dual accountabilities of Aboriginal professionals within government children service organizations (Reid, 2005; Walmsley, 2005; Bennett and Zubrzycki, 2003). Each study used qualitative approaches to hear the voices of Aboriginal professionals, and all shared key findings that participants pursued their positions in an attempt to change what they perceived as the system's inability to effectively serve their communities. Similar to all three of the studies was the finding that participants felt mainstream social work organizational settings, and their pursuant mandates and policies, constrained them from responding to community needs through a strong focus on extended family and community engagement, in culturally consistent ways. Resulting from this, some participants expressed feelings that their communities were wary and suspicious of them because of the social work profession's complicity in historic and ongoing oppressive practices toward Aboriginal communities.

These three studies support the concept and premise within this study that Aboriginal professionals have a unique values-based commitment for improving the way in which BC children's services provides services for Aboriginal children and families that are consistent with community values and approaches. They also point to the difficulty inherent in what seem to be competing roles for Aboriginal professionals in their communities and children service organizations, and the tensions that are created when they are unable to reconcile differences and achieve a vision of improved children's services in their communities.



## Indigenous practice approaches

Largely as a result of increasing numbers of Aboriginal people becoming directly involved in delivering services through First Nations delegated and community agencies, models for services designed specifically in response to the unique experience and needs of First Nations and other Aboriginal individuals and communities have emerged. One such model described by Morrissette, McKenzie, and Morrissette (1993), and since widely adapted, is based on four key practice principles: (1) a focus on an Indigenous worldview; (2) developing consciousness within Aboriginal clients about the intergenerational impacts of colonization; (3) utilizing cultural knowledge and traditions to help individuals explore their identity and reconnect to community and collective consciousness; and (4) empowering Aboriginal clients. Work with each Aboriginal person varies depending on their individual orientation and connection to the specific worldview and orientation of their community.

Similarly, Weaver and White (1997) assert that historical trauma and grief experienced by Aboriginal people, which are the root of current social issues, are viewed as a starting point for working with individuals and families. An understanding of the devastating effects of colonization, whereby Aboriginal peoples lost control of their lives through the removal of land, livelihood, traditional lifestyle, and the forced removal of their children and loss of opportunity to parent, provides a narrative in practice to assist impacted Aboriginal people to better contextualize their experiences in terms of trauma, loss and grief (Gray, Yellow Bird & Coates, 2008).

Essentially, the vital yet basic common values held by Aboriginal peoples are the cornerstone of the development of services to address social and health issues. Weaver and White (1997) echo the work of Morrissette et al. (1993) by outlining the differences between mainstream family values that focus on the nuclear family versus a collective Aboriginal orientation to the extended family and community. Hart (2008) says that, in the collectivist worldview, “the welfare of the individual is intricately bound to the well-being of the community and its relationship with the more than human world” (p. 133). Recovering and implementing traditional cultural approaches to child, family and community well-being are key features in Indigenous practice approaches (Gray, Yellow Bird & Coates, 2008). Indigenous ways of helping may include the use of medicines, ceremonies and spiritual interventions aimed at “restoring or maintaining a balanced life” (Weaver, 2008). Ultimately the importance of the community is expressed through all Indigenous practice. Weaver also asserts that Indigenous practice models should arise “directly from an Indigenous context” and be “developed by Indigenous social workers for Indigenous social work practice in a specific local context” and therefore reach beyond culturally competent social work practice (2008, p. 78).

## Touchstones of Hope—reconciliation to improve Aboriginal services

Touchstones of Hope was developed by First Nations and Aboriginal peoples to provide a reconciliatory framework to engage mainstream child welfare system participants in an effort to reconceptualize how services are designed, implemented and delivered (Blackstock, Cross, Brown, George, & Formsma, 2006). Within a reconciliatory framework, relationships and partnerships between Aboriginal communities and mainstream child welfare organizations can be developed to move the agenda forward for appropriate planning and development of Aboriginal child and family services (Blackstock et al., 2006). Basic principles for reconciliation involve acknowledging past mistakes through

open communication, and establishing non-discriminatory practices within the child welfare system by affirming Indigenous families and communities as the best caregivers for Indigenous children and youth. Principles of reconciliation are intended to lead to improved systems of care for First Nations and Aboriginal children through strengthening child welfare professionals' capacity to respond to the needs of Aboriginal children and families and ensure that past mistakes are not repeated.

## A combined ethnographic/Indigenous research methodology

The research was conducted through ethnographic methods framed in a persistent and ongoing effort to decolonize knowledge and research from dominant and Eurocentric influences that have pervaded Aboriginal peoples and cultures. Ethnography is best described as an insider's attempt to understand why group members believe, feel or do what they do (Fetterman, 2010). Quite importantly, it is not an attempt to capture an objective reality but rather "compels the recognition and acceptance of multiple realities" (p. 21). Indigenous approaches to knowledge, practice development and research re-centre Aboriginal beliefs, values, and approaches in relation to the concepts that are of critical interest (Bennett & Blackstock, 2002; Smith, 2012; Wilson, 2001).

Bennett and Blackstock (2002) assert that Aboriginal knowledge and approaches assured that children were best cared for prior to colonization. Specific values, beliefs, and cultural practices varied in relation to different Aboriginal peoples and communities; however, consistent concepts within Aboriginal worldviews saw children as "important and respected members of an independent community and ecosystem" (p. 1). Holism, the foundation within all Aboriginal community approaches, is often viewed as essentially antithetical to the individual rights approach found within Canadian child welfare legislation and practice. Moving an Aboriginal child welfare agenda forward involves building on "the cultural strengths of communal rights, interdependence and knowledge which are often diametrically opposed to the legal requirements to operate within the realm of euro-western provincial values, laws regulations and standards" (p. 1).

An Aboriginal research committee, composed of three Aboriginal child welfare professionals, provided invaluable feedback and direction, sharing their understanding of Indigenous worldviews and encouraging the researcher to engage in self-awareness and reflexivity required to complete the research project.

## Research design, participants, gathering and analyzing the data

The qualitative ethnographic research project included intensive researcher grounding in the organization; examination of organizational documents; discussions with organizational leaders, including one focus group with nine Aboriginal professionals; and in-depth interviews with 22 Aboriginal participants. The overarching research question was:

What are the identities, motivations, and approaches of Aboriginal professionals and how does MCFD support or impede Aboriginal employees to actively represent the interests of Aboriginal youth, families, and communities through the provision of effective and culturally relevant services?

Judgmental sampling techniques that seek to locate the most appropriate members of a

subculture or unit of focus for the study were used to recruit participants (Fetterman, 2010). The interviews occurred in 2010 and were conducted in person at 18 different MCFD worksites across the province (each interview averaged two to three hours in duration). Of the 26 Aboriginal employees who participated, 19 were female and seven male. Fourteen identified as belonging to a First Nation and the other 12 identified as other Aboriginal peoples. Twenty-one participants were currently employed by MCFD while five had recently left their employment with the Ministry. Only four participants worked with individuals in their home community or territory. Four of the five participants who recently left their employment had worked in their home community or territory.

Interviews were conversational and, while open-ended questions sometimes guided participant responses, initial discussion provided a natural opening and opportunity for participants to talk openly and at length about their experience as an Aboriginal employee within MCFD. Kovach (2010) describes using a conversational method in Indigenous research interviewing designed to encourage participants to share their meanings in an unfiltered way.

A qualitative approach to synthesizing data into smaller units of meaning, then identifying similarities and differences between them prior to transforming them into patterns and themes, was used to analyze the data (Unrau & Coleman, 1997). Themes were analyzed for both similarity and diversity of thought and experience. A conscious effort to go beyond dominant and researcher assumptions in an effort to create alternative explanations and challenge dominant discourses was made (Ristock and Pennell, 1996). The results reflect deep, rich descriptions of particular themes that emerged through this process.

## Discussion of research findings

Extensive research findings are presented through visual maps (at the end of each section) that present and illustrate major thematic areas that flowed from the research. This overview of the extensive thematic results is not exhaustive or fully representative of the in-depth sharing of participants but a condensation for the purposes of discussing the failure of MCFD to make space within the organization for the values, beliefs, practices and contributions of its Aboriginal professionals. The stories and experiences of the Aboriginal participants are honest and impactful.

### Identity, value and beliefs, motivation and practice approach

Participants described both strengths and challenges of growing up in communities where the impacts of colonization have resulted in widespread poverty and socioeconomic challenges. Participants reported feelings of community belonging as critically important. They exist parallel, and at times in sharp contrast, to the knowledge and experience of extensive family and community dissolution and intrusive involvement of government systems.

Some participants described being raised in traditional and connected ways to their communities while others describe their families burying their Aboriginal heritage in an attempt to assimilate into dominant culture. Others describe various experiences that fall in between. One participant who disconnected from her culture as a youth compared her experience to that of the challenge of Aboriginal children in care to find connection with families, culture and communities:

I absorbed something negative about being Aboriginal. I know what it did to me and I know how much my life has been changed by reconciling that within myself, and I think of the children in care and so many don't know their identity, their cultural identity isn't nurtured.

Another participant revealed feeling deep responsibility to her community after coming to terms with her Aboriginal identity. Becoming involved in traditional ways through ceremony and practices within her community was an important part of her journey to becoming a social worker. She described how, at her graduation, respected community members gave her a name that represented her significance and responsibility within the community. The deeply personal nature of this responsibility is something she carries throughout her career.

Another participant, whose mother was raised in an abusive non-Aboriginal foster home as a result of the sixties scoop, said she became a social worker to address the history in her family and to develop a practice “to sort of make amends...I wanted to ensure that the children that I worked with didn't end up losing their culture, their identity, like my mom, and therefore myself and my siblings”. Several other participants described being young single parents experiencing government intervention as a daily part of their existence—much like the parents they now work with—and believed they can help make a difference in how those services are provided and experienced.

## Values and beliefs

Participants described their values and beliefs as being deeply influenced by personal identification with the social-historical context of colonization. Having personally experienced or witnessed the impacts of child welfare systems, participants valued structural explanations of colonial impacts and resist attempts to isolate and pathologize individual behaviours. One participant said, “the social-historical context is really important ... I wouldn't be able to move forward without that context being acknowledged.”

Indigenous holistic perspectives and worldviews that include understanding the interconnected clan and family systems as the focal point for community healing were widely promoted by participants. Collective well-being was viewed as being attained through partnership within the community to explore and reassert cultural teachings and family values. As one participant expressed:

I'm learning from my people, what their tradition is, and sometimes they share with me that little bit of scared knowledge that we have ... children who do not have these connections end up dividing their own culture.

Other values expressed by participants included deep respect for community protocols and approaching communities and families from a non-expert orientation of not “knowing all the answers”. Sharing power with individuals was believed to assist in gaining acceptance in and learning about the community. The importance of building trust and respect in relationships was described by several participants as having the ability to acknowledge the impact the system has had on Aboriginal peoples. As one participant put it: “I'm always mindful of how I present to people in a really respectful way ... and keeping an openness, like a curiosity. I'm just mindful of the power.”

Other values shared by participants included modeling for, rather than directing, others. This approach involves more process and complexity, as one participant shared: “it is harder to do our job that

way than to just bark orders and tell people how to run their life”. Use of authority was seen as the ability of participants to remove barriers for clients rather than to use authority to compel them to change their behaviors. A participant said, “[I would] use my authority to get into jails so I could talk to the dad ... or get [a client] into a welfare line quicker”. Participants commonly talked about the need to demystify the system for Aboriginal clients and provide advocacy and support rather than to exert authority or power.

## Motivation

The impacts of colonization on individual participants appeared to shape and inform an Indigenous values and beliefs-based orientation that motivated Aboriginal participants to seek change in the Ministry. Their values and belief-based approaches clearly emerged from lived collective experiences, their desire to express and engage an Indigenous worldview, and a deep internal passion to change and improve services for Aboriginal people. This is well illustrated by a participant who said:

We’re here because we want to help our kids. We want to empower our people. We take the hits of the oppressors because we want to do good work and we want to promote families. We are resilient, so we’ll do it. This is my purpose. This is what’s laid out for me.

Some participants anticipated challenges and deficits within MCFD, given their experiences of the system growing up in and around First Nations and Aboriginal communities. Participants revealed remarkably similar perspectives of working in the highly complex, emotionally challenging and contentious environment of a government child welfare system that is seen to be complicit in the oppression of Aboriginal people. Their shared motivation was to seek child welfare system change and transformation through the increased design and delivery of services by Aboriginal people committed to empowering and strengthening Aboriginal families and communities to keep children out of care and to reconnect children who are in care. As one participant said, there is a critical “importance of having Aboriginal people working within to make those shifts”, and another who added that there needs to be “overall recognition for the need for services to be delivered by Aboriginal people to Aboriginal people”. Shared perspective and openness was described by one participant as essential as she saw non-Aboriginal counterparts as often reluctant and even fearful to work openly with Aboriginal children and families.

## Practice

Flowing from strong collective values, beliefs and motivations, participants’ identified striking similarities within their practice approaches. A congruent vision of necessary systemic and practice approaches to providing effective services for Aboriginal children and families was shared by participants. Practice goals were repeatedly identified throughout participant descriptions as: first, keeping children out of government care; and, second, reconnecting system-impacted children and families to their cultural teachings and communities.

Participants described an expectation that practice should occur within the context of Aboriginal communities where children and families reside or come from. Given the historical impact the Ministry has had for Aboriginal people, participants believed community focus should be coupled with the strong need to build relationships, trust and respect; they saw renegotiating and strengthening Ministry-worker relationships within communities as a critical starting point for practice. A commitment to this means having a presence in the community through direct participation in the community. As one participant

explained, when social workers are invited to participate in the community,

the government has to understand that that's okay....what I find is [Aboriginal workers] go without being paid. They just go. They show up for their kids at the pow wows. They show up at the namings and the events, whether they get paid or not.

Many participants said MCFD needs to legitimize informal relationship building in Aboriginal communities because it provides the groundwork for gaining trust needed to work effectively. Following protocols, engaging informally within the community, and using collaborative and non-authoritative approaches to decision making were described as essential. As one participant stated:

Really the core of it is our system stepping back and letting the community fill that void. Child protection was imposed into a society that already had those laws in place and we saw the results of that—it's really about us stepping back and our community leaders taking over some of those roles.

Another participant explained:

There are going to be some key people in each community that can help you navigate some of it. There are going to be some families that are not going to be healthy and even though you engage with them they might not come up with the best plans. Yes, so you need to have all those pieces and after you work in a community for a good amount of time then you're able to know what that is, you are able to challenge a little...You need those key people who know the families.

Strength-based holistic practices, that more effectively respond to intergenerational trauma, and that emphasize an Indigenous worldview through cultural knowledge and teachings, were described as difficult to engage within the Ministry. A participant who was a long time MCFD employee said:

Because we are spiritual people, the approach is different. We need to put the belief, the culture or the teachings, the ethics, the family values back into how we work with our families and for me it is very important that we, as one of the Chief's said, "we lead from behind, we walk, we model, we teach", and that is a big responsibility.

A repeated theme in participant interviews was viewing each community as a unique entity with different belief systems, social structures, and cultural teachings where community engagement needs to occur through appropriate and respectful adherence to community protocols. Participants also stressed the importance of sharing information and decision making with involved Aboriginal individuals and communities, resisting an expert orientation, acknowledging system impacts, and being comfortable with not always having the answers.

Prevention and support were promoted by most participants. Child protection workers tended to focus their practice on support services following critical intervention—placing more emphasis on strengthening families so children can potentially remain in or near their communities. Many described ongoing tension with mainstream colleagues whom they perceived as having a strong child-safety stance while failing to spend time identifying and supporting strengths in Aboriginal families and communities. One participant described this dilemma in the Ministry:

I think a big piece of working with Aboriginal people is looking at a strength-based perspective



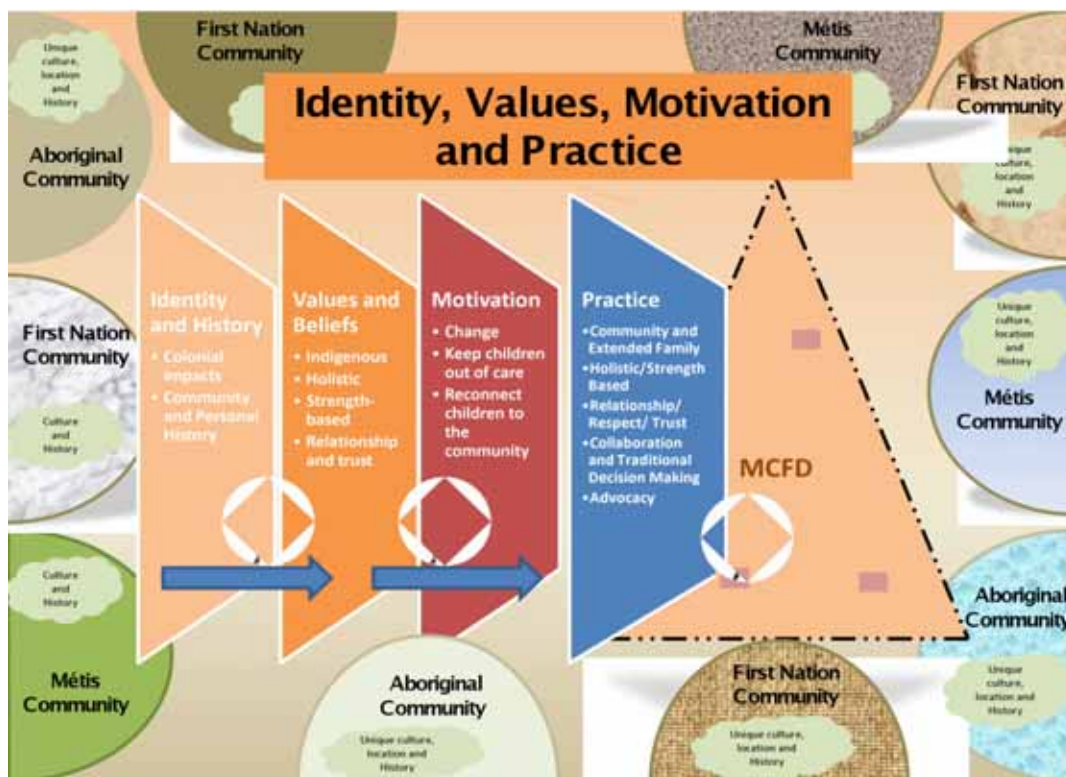
... but a lot of the time we are practicing in fear, a trembling system—if something happens to the child—so sometimes that affects how we practice.

Another participant spoke about how her cultural orientation conflicts with the organization and delivery of services within the Ministry, thereby impacting her ability to practice. She contrasted a highly rigid, task-oriented environment to a worldview that focuses on process, patience and presence. One participant talked about “trying to jam as much as you can into a day” which prevents her from being “on the same page as that person you are walking into the room to talk to”. Another said she gets “really stressed out sometimes, mainly because I don’t have the time the community wants me to have”.

Participants also spoke of empowering Aboriginal communities to find appropriate solutions for their children and families who are experiencing the effects of intergenerational trauma. These practice approaches include looking to extended family and community for support and caregiving, and as partners in the child welfare decision-making process. These approaches were described by many participants as standing in sharp contrast to that of the existing mainstream organization.

The visual map below illustrates prevailing themes that emerged in the study regarding how MCFD Aboriginal professionals’ described their identity, values, motivations and practice approaches.

Figure 1: The identity, values, motivation and practice of Aboriginal professionals





## Disempowering organizational environment

Many descriptions of Ministry work settings by participants include examples of discriminatory treatment of themselves and Aboriginal children and families. One participant described the “blatant use of racist or discriminatory terminology around clients”. One example given was, “they are playing the residential school card now because I said I’m applying for permanent custody”. Another participant described hearing co-workers in the halls outside her office, as she said, “speaking with such disrespect for respected members in our community. It just tears you apart ... I would just slam my door or I would just leave”. Another said, “Some of the situations that I’ve come up against that really used to hurt me and make me angry are workers mocking Aboriginal clients”. And yet another participant said, “it is disheartening to me to hear ... when they are putting down Aboriginal communities and families for whatever reason and they don’t believe that some of the things from the past [colonization practices] have affected where they are today”.

These expressions of racism were viewed by some participants as a reflection of wider mainstream societal attitudes. A research participant who worked as a manager said she saw limited support for the Ministry’s “Aboriginal agenda” and that she witnessed many conscious or unconscious attempts to sabotage organizational goals to improve services:

Really the root of all that misunderstanding is racism, is prejudice ... that affects our system and affects our organization. ... I don’t think the values were there. It was very clear, I think to everyone, myself and other managers ... the only reason we were doing it in this region, because provincial office was forcing it ... none of us saw any commitment to it.

When asked why she thinks there is reluctance within MCFD to openly address racism, one participant explained:

Because this is an organization of social workers. Social workers don’t have biases, they can’t be racist because they are social workers ... so you can’t acknowledge that that exists ... what’s worse than calling a white, middle class person a racist?

Participants saw many of their non-Aboriginal colleagues as dismissive of both historical perspectives on oppressive practices with Aboriginal people and the significantly increased challenges Aboriginal people face due to the impacts on their families and communities. Mainstream attitudes and assumptions, and a distinct lack of Aboriginal cultural competence amongst many professionals, were seen to guide Ministry practice values, norms and approaches in ways that lead to intolerance and resistance to change. Prevalent Ministry practice was described by participants as characterized by the exertion of power and a low-risk approach that often results in child removal. As one participant described:

You have too many people delegated to remove children that don’t have the experience. Their mentorship is coming from people that practice from an adversarial place ... they are not being challenged ... they are not being asked to do anything differently.

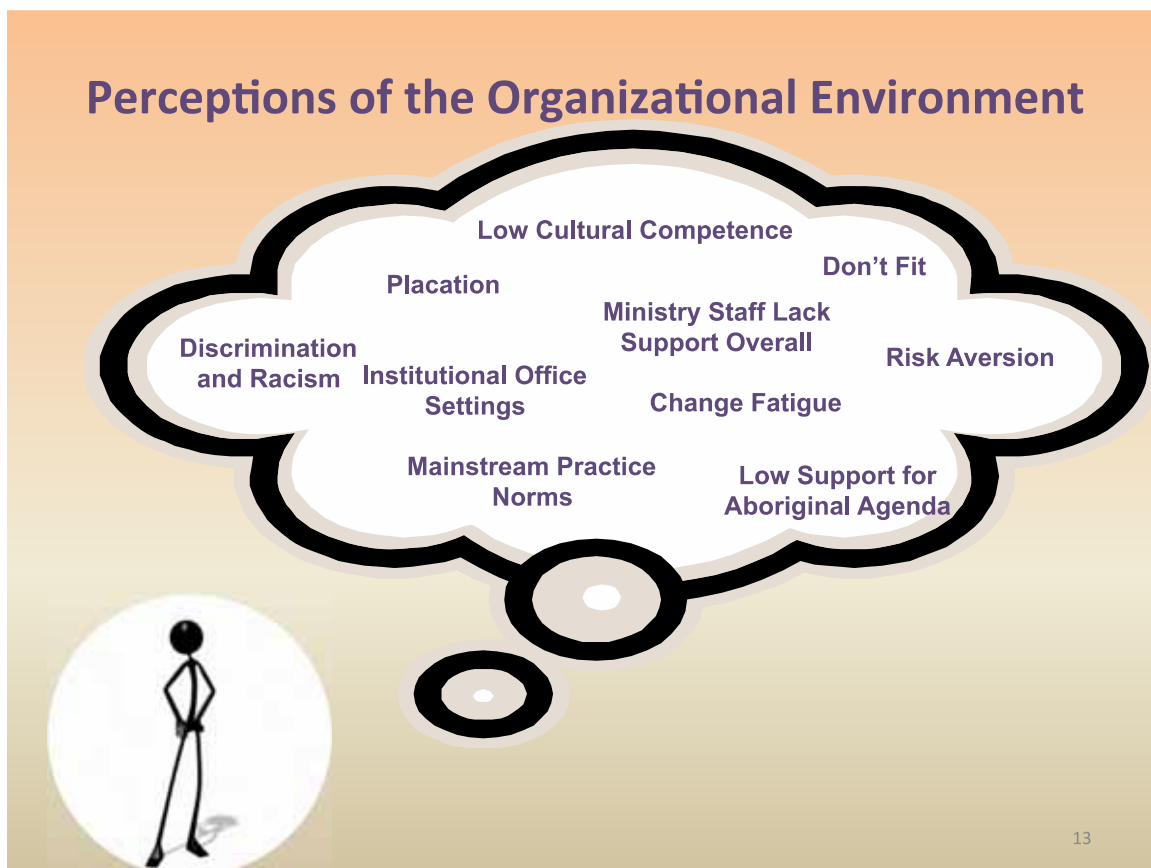
Participants pointed out that some non-Aboriginal colleagues might have low empathy and display low-risk behaviour due to both a lack of cultural competence and a lack of overall support within the Ministry for frontline work, which can result in compassion fatigue or burnout. Change fatigue, described as change initiatives being implemented at the frontline without clear organizational direction and support,

was also viewed as contributing to an overall feeling of powerlessness and apathy at the frontline. This translates into an environment where Aboriginal practitioners have to constantly rationalize and justify, or even conceal, their practice approaches to colleagues and team leaders. As a result, participants described feeling powerless to make change within the organization.

The physical environment was described by participants as institutional and cold and also contributing to a poor fit for Aboriginal staff and service recipients. When all of these variables come together in terms of the impact on Aboriginal professionals, the situation is best described as an unsupportive and depersonalized environment where highly motivated and value-driven individuals are challenging a bureaucratic, rigid practice environment to become more collaborative and community based.

The following conceptual map visually illustrates the prevailing themes that resulted from participant descriptions of organizational support for their practice within the MCFD organizational environment.

**Figure 2 Perceptions of the organizational environment**



## Organizational commitment to change is conceptual and politically driven

While there appears to be strong conceptual support from Ministry regional and provincial leaders with respect to the Aboriginal agenda, many participants felt there is a disconnect with the operational/frontline structure. One participant described how “management had this great dream of change and it really sounded positive, but that didn’t trickle down to the frontline”. Another frontline participant said mainstream frontline staff “do not respect management”. This is a critical contradiction for effective Aboriginal service delivery.

An important component of this observation is there does not appear to be effective and committed management support for improved Aboriginal service delivery. Slow organizational system response (because of the reactive and fear-based nature of the organization) may also be due to what participants describe as reactivity to public opinion, oversight bodies, and subsequent political intervention.

Many participants viewed the hierarchy of the organization as rigid and creating a huge disconnection between leadership, management and the service delivery frontline. Participants offered several causes for this disconnect. They saw the limiting of communication through prescribed narrow and formal channels as decreasing the amount of information available both to the frontline and to the decision makers at the top of the organization. They characterized the hierarchy as being personality driven, based on longstanding relationships, like-mindedness, regional bias and narrow communication where there is a superficial appearance of conformity to the top which ultimately creates a buffer for the deputy minister who is purposely shielded from the reality of what is happening at the frontline. First Nations and other Aboriginal individuals placed into key leadership positions were seen as unable to make substantial changes within the impenetrable hierarchy.

Relentless ongoing strategic planning was viewed largely as rhetorical without enough sustained effort or sufficient resources being directed to actual implementation. Participants described the organization as experiencing ongoing implementation of new practice initiatives with inadequate resources: “it seems like every year it always switches ... we got this new thing ... you get all excited then – well, we won’t put any money in it”.

According to participants, a highly bureaucratized workplace, driven by mainstream policy, within a constrained union environment where staff have limited decision-making autonomy, translates to a structure that is unsupportive to Aboriginal employee attempts to shift practice that requires more time invested in the community and with families.

A focus on the importance of team leaders was also noted by participants. There was a perception among participants that team leaders are promoted for conforming to mainstream values that emphasize complying with and completing administrative requirements. Another prevalent theme was how high caseloads translate in to critically high work demands that de-prioritize collaborative time spent with children, families and in communities.

Aboriginal participant perspectives on the effectiveness of the Ministry organizational structure for supporting Aboriginal employees and effective Aboriginal children services are presented visually in the conceptual map below.

Figure 3 Rhetoric or reality: Organizational structure and support for Aboriginal agenda

## Rhetoric or Reality: Organizational Structure and Support for the Aboriginal Agenda



### Discussion of Aboriginal practice approach within MCFD

MCFD has been noted in the past several years to continue to drift in terms of setting observable goals and direction for improving services for Aboriginal children, families and communities. This research provides valuable information regarding the identity, values, motivation and practice approaches of Aboriginal employees and the potential they have to help transform practice within MCFD. The findings develop an understanding of the unique orientation and circumstances that bring Aboriginal employees to work for MCFD and their subsequent interface within the organizational environment, culture and structure. Participants described systemic racism, organizational change fatigue, low levels of support regarding their own motivations and the Aboriginal agenda, a lack of cultural competence, mainstream practice and policy norms and extreme risk aversion (opting for child removal).

While they come from highly diverse and varied backgrounds, participants share a remarkably collective, value-based orientation and motivation to work in MCFD. More simply, they want to improve services for Aboriginal children and families. Unfortunately, they indicated that services provided to Aboriginal people by MCFD are culturally unresponsive, inadequate and need to change. Based on participant responses, a focus on rhetorical, and poorly planned and implemented, initiatives appears to characterize an organization that is hierarchical, under-resourced, and lacking in effective communication. Fear of political fallout from oversight bodies and public opinion results in a low risk

approach that results in reactive practice, policy and organizational practices—a situation likely responsible for the ongoing over-representation of Aboriginal children in care.

The study participants are highly motivated and intrinsically driven to seek better outcomes for Aboriginal children, families and communities. They share a collective belief and orientation regarding re-energizing community values and restoring capacity within Aboriginal communities. Their ultimate goal is to support the community to regain responsibility for Aboriginal children—ending the need for government system intervention. A critically important finding in this study is that Aboriginal professionals require more support, mostly by having obstacles within the organization removed, to work to their full potential in MCFD. They can then direct passionate, insider value-based knowledge, skills and experience to full potential to improve services within the organization for Aboriginal children, youth, families and their communities.

Given the limited internal capacity and low cultural competency described within the organization, a more realistic approach for improving services may be to pursue some promising approaches described by participants. Focusing on a specialized stream of practice within the ministry, where the capacity of culturally competent Aboriginal and non-Aboriginal professionals is tapped into, appears to make considerably more sense than another rhetorical attempt to Indigenize the organization. The impact of effective team leaders and specialized management streams where dedicated resources exist to create equitable policy and practice approaches may lead to both better utilization of highly committed and knowledgeable Aboriginal professionals (and their non-Aboriginal allies). These teams may provide better services for Aboriginal children, families and communities until autonomous community control of Aboriginal children services becomes a reality.

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## An Interdisciplinary Journal

*Honouring the Voices, Perspectives and Knowledges of First Peoples through Research, Critical Analyses, Stories, Standpoints and Media Reviews*

# Promising healing practices for interventions addressing intergenerational trauma among Aboriginal youth: A scoping review

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## Abstract

*There is growing recognition in Canada around the role of intergenerational trauma in shaping physical and mental health inequities among Aboriginal youth. We examined recommendations on best practices for addressing intergenerational trauma in interventions for Aboriginal youth. Academic-community partnerships were formed to guide this scoping literature review. Peer-reviewed academic literature and "grey" sources were searched. Of 3,135 citations uncovered from databases, 16 documents met inclusion criteria. The search gathered articles and reports published in English from 2001-2011, documenting interventions for Indigenous youth (ages 12-29 years) in Canada, the United States, New Zealand and Australia. The literature was sorted and mapped, and stakeholder input was sought through consultation with community organizations in the Calgary, Canada area. Recommendations in the literature include the need to: integrate Aboriginal worldviews into interventions; strengthen cultural identity as a healing tool and a tool against stigma; build autonomous and self-determining Aboriginal healing organizations; and, integrate interventions into mainstream health services, with education of mainstream professionals about intergenerational trauma and issues in Aboriginal health and well-being. We identified a paucity of reports on interventions and a need to improve evaluation techniques useful to all stakeholders (including organizations, funders, and program participants). Most interventions targeted individual-level factors (e.g., coping skills), rather than systemic factors (e.g., stressors in the social environment). By addressing upstream drivers of Aboriginal health, interventions that incorporate an understanding of intergenerational trauma are more likely to be effective in fostering resilience, in promoting healing,*

<sup>1</sup> While recognizing the move towards the preferential use of the term "Indigenous", we have used "Aboriginal" in this paper because it remains, at this time, the most commonly accepted umbrella term for the Indigenous peoples of Canada.

*and in primary prevention. Minimal published research on evidence-based practices exists, though we noted some promising practices.*

*Keywords: Aboriginal, Indigenous, youth, intergenerational trauma, historical trauma, interventions, best practices, health*

## Introduction

For Indigenous communities around the world, colonialism has created negative health outcomes that resonate across generations (Sotero, 2006). In Canada, the Indian Residential School policy stands out as particularly harmful. With it, children of First Nations, Métis and Inuit descent were forcefully taken from their families at a young age and sent to boarding schools for the purposes of cultural and linguistic assimilation (AHF 2006a-c). As documented in the final report released by the Truth and Reconciliation Commission of Canada (2015), the cultural and linguistic loss accompanied widespread physical, sexual and psychological abuse of students (Smith et al., 2005). Many residential school survivors have displayed a host of mental and physical health issues (Quinn, 2007; Bombay et al., 2014). A phenomenon called “intergenerational trauma” (also known as historical trauma transmission, collective trauma, transgenerational grief, and historic grief) has occurred among families of survivors, including among those who did not themselves attend the schools (Quinn, 2007; Brave Heart & DeBruyn, 1998). Intergenerational trauma is defined by Evans-Campbell (2008, p. 320):

A collective complex trauma inflicted on a group of people who share a specific group identity or affiliation.... It is the legacy of numerous traumatic events a community experiences over generations and encompasses the psychological and social responses to such events.

Evidence links many negative health outcomes to intergenerational trauma. One systematic review of research in Canada highlighted the link between colonization, cultural discontinuity, and mental health and violence (Kirmayer et al., 2000). The association between intergenerational trauma and substance abuse has been found in relatives of trauma survivors who develop symptoms of post-traumatic stress disorder (PTSD) (Brave Heart, 2003). Other studies have identified connections between intergenerational trauma and homelessness among Aboriginal men (Menzies, 2006), as well as youth suicide (Strickland, et al., 2006). Hepatitis C and HIV/AIDS in youth have also been linked to historical trauma and prior experiences of sexual abuse (Pearce et al., 2008; Craib et al., 2009). Such research highlights a need to explicitly address intergenerational trauma at individual and population levels, for the development of effective interventions and prevention efforts (Roy, 2014a).

Discussions about Aboriginal youth are often framed in terms of disproportionately negative indicators of health status and well-being. One study found significantly lower measures for the United Nations Human Development Index, mortality rate, educational attainment and household income in Aboriginal youth relative to other Canadians of the same age (15-29 years) (Guimond & Cooke, 2008). Aboriginal youth suicide rates are much higher than national averages (Chouinard et al., 2010); relative to non-Aboriginal youth, First Nations youth commit suicide about six times as often, and Inuit youth about eleven times as often (Health Canada, 2011). HIV and diabetes mellitus rates are also significantly higher (Health Canada, 2009). Public attitudes towards Aboriginal youth are often constructed on prevailing stereotypes and colonial attitudes, which remove youth from the broader historical context of colonial practices and subjugation that have contributed to these contemporary negative health outcomes (Hodge et al., 2009).

Other intersecting factors contributing to health issues are complex, raising questions when designing interventions: Is it best to address the source or outcome of trauma? How can interventions halt the negative consequences of intergenerational trauma? What is the role of older generations in youth interventions? Can interventions to address cultural loss and alienation be integrated into mainstream interventions tested among non-Aboriginal populations? To address these, we sought information on successful interventions by undertaking a scoping literature review to identify meaningful practices for addressing intergenerational trauma with Aboriginal youth. The seminal work of the Aboriginal Healing Foundation (AHF) guided the analysis (AHF, 2006a-c). Our objectives were to identify: 1) how intergenerational trauma among Aboriginal youth has been addressed in interventions, and corresponding promising and/or best practices; 2) whether and how interventions reflect components of the AHF healing framework; and 3) what specific health or social outcomes were addressed, and the means of evaluation. This paper begins with an overview of the AHF framework and guiding definitions, followed by presentation of the methods and the results, and a discussion of future directions.

### *A framework linking trauma and healing*

Founded in 1998 and in operation until 2014, the Aboriginal Healing Foundation (AHF) aimed to address healing among individuals, families and communities affected by the residential school system and its intergenerational legacy. Until 2006, it worked with multiple stakeholders from across Canada, creating evidence-based background materials and frameworks. It funded a large number of healing projects, and in 2006 released a three-volume final report on funded work (AHF, 2006a-c). The term 'healing' is defined in AHF reports according to a Royal Commission on Aboriginal Peoples framework (2006c, p. 7):

Healing, in Aboriginal terms refers to personal and societal recovery from the lasting effects of oppression and systemic racism experienced over generations. Many Aboriginal people are suffering not simply from specific diseases and social problems, but also from a depression of spirit resulting from 200 or more years of damage to their cultures, languages, identities and self-respect.

The AHF report notes difficulties with the concept of 'best practices' around Aboriginal healing, as 'best practice' is primarily a Western concept emphasizing replicability and an empirical evidence base. Instead, the AHF uses 'promising healing practices,' defined as (2006c, p. 7): "Models, approaches, techniques and initiatives that are based on Aboriginal experiences; that feel right to Survivors and their families; and that result in positive changes in people's lives." While embracing AHF's use of the term 'promising practice', the terms 'best practice' and 'evidence-based practice' are also used in this paper, in reflection of their common usage in the broader body of published intervention and evaluation literature.

Conceptual models for intergenerational trauma seek to explain the pathways by which trauma is transferred across generations. The AHF recommends the integration of such a model into the rationale, design and implementation of interventions. Intergenerational trauma theory offers context for the AHF framework (Sotero, 2006; Brave Heart, 2003; Wesley-Esquimaux & Smolewski, 2004; Whitbeck et al., 2004). According to the theory, trauma begins with collective subjugation, loss, abuse or other forms of population-level oppression and is not limited to those who directly experience it. Instead, cumulative effects of trauma are passed down along generations and result in maladaptive coping (e.g., substance

abuse, violence, suicide), often amplified when youth are traumatized by their caregivers. Contemporary structural and systemic inequities, such as personal-level and institutional-level racism, are further sources of oppression and cultural alienation, aggravating intergenerational trauma by reinforcing ancestral stories of oppression.

The AHF framework identifies three necessary elements for healing interventions (2006c, p. 15): integration of an Aboriginal worldview throughout the planning, design and implementation of an intervention; a culturally safe healing environment; and healers who are competent to heal. The AHF cites values of “wholeness, balance, harmony, relationship, connection to the land and environment, and a view of healing as a process and lifelong journey” (ibid) as consistent with Aboriginal worldviews, and thus integral to effective healing programs. Cultural and personal safety refers to environments in which participants can feel physically and emotionally welcomed. Finally, the capacity of a program to heal rests in the ability of healers to establish cultural and personal safety.

The AHF (2006c) identifies three complementary intervention pillars; a holistic program incorporates all three for best results. The first pillar is “reclaiming history”, or “legacy education”, which seeks to raise awareness of residential school (or other traumatic) experiences and consequences. In so doing, it builds an understanding of shared experiences; allows responses to trauma to be seen as a result of institutional forces; and allows children to better understand the situation of their parents. By facilitating understanding, this pillar can motivate survivors and youth to pursue healing (AHF, 2006c). The second pillar is “cultural interventions”, drawing on cultural teachings including healing ceremonies, pow-wows, language programs, and traditional journeys that reinforce a positive sense of identity (AHF, 2006c). The third pillar is “therapeutic healing”, which can include traditional therapies, Western-based therapies, or other non-Aboriginal therapies, alone or in combination with each other. Western approaches generally favour medical models of disease that look at individual-level pathology and act to alleviate suffering. Rooted in Aboriginal worldviews, traditional Aboriginal therapies are generally more holistic and keep the individual integrated within a collective. Combined therapies attempt to integrate two or more approaches by embedding traditional components into mainstream or alternative medical therapies, or by using Western or other non-Aboriginal models within a traditional Aboriginal setting (AHF, 2006c).

The AHF stresses that evaluations of the effectiveness of interventions should be of value to all stakeholders including researchers, organizations, governments, families, and program participants (2006b). AHF-identified questions of value to decision-makers include: “What were the best or promising practices and greatest challenges? What lessons have been learned? What can be done to better manage program enhancement? Did we address the need? [And], is the healing process sustainable?” (2006b, p. 8).

Although guided principally by the AHF framework for healing, the approach in this article is also consistent with the Touchstones of Hope framework. Notably, there is support of the phases of reconciliation through respectful relationships in the design, implementation, and monitoring of youth-centered healing programs, and in learning from restorative efforts to heal from harm (Blackstock et al., 2006, p. 8-9). As reflected in the results and conclusions, findings of this review also highlight the Touchstones of Hope through evidence around the promotion of self-determination and the role of non-Aboriginal professionals in decision-making that affects youth (Ibid, p. 10).

## Methods

A scoping review is a systematic method for reviewing literature, to summarize and examine its current state and to identify gaps (Brien, et al., 2010; Kania et al., 2013). We drew on the methodological framework of Arksey and O'Malley (2005) to: identify the research question and relevant studies for analysis; chart data; collate, summarize and report results; and, consult stakeholders. The following question guided our research: *What recommendations exist for promising and/or best healing practices for interventions that address intergenerational trauma among Aboriginal youth in Canada?*

The inclusion criteria sought documents describing interventions for Aboriginal youth ages 12-29 years in Canada, the United States, Australia or New Zealand. These four countries have similar colonial histories, and international collaborations in research and advocacy concerning Aboriginal populations (INIHKD, 2010). Sources also addressed intergenerational trauma in a broad sense; for example, addressing ongoing abuse or oppression while linking to colonialism. We included documents published in English from 2001 to 2011 from peer-reviewed and grey literatures. We excluded literature documenting interventions with youth as part of a mixed-age population; interventions for youth of multiple ethnic groups; and interventions targeting non-Aboriginal youth who may be experiencing intergenerational trauma.

We searched the following academic databases: MEDLINE/PubMED, EMBASE, PsycINFO, SocINDEX, Sociological Abstracts, CINAHL, CBCA, Social Work Abstracts, Canadian Periodical Index, Social Services Abstracts, Family and Society Studies Worldwide and Family Studies Abstracts. We also searched the Canadian Health Research Collection and Canadian Research Index for “grey” literature, which refers to publications (from government sources, academic institutions, businesses, non-profit agencies and other organizations) which are not produced by a commercial publisher (Public Health Action Support Team, 2011). We scanned references of selected papers in order to identify additional relevant interventions meeting inclusion criteria, and conducted internet searches on youth programs mentioned in Volume III of the AHF report *Promising Healing Practices*. An initial title-abstract screen of all identified citations helped exclude unrelated documents, with those potentially eligible for inclusion going on to full-paper screening.

We sorted and mapped the selected interventions according to the sex of participants, intervention location, health issue addressed, type of intervention in terms of AHF pillars framework, adherence to the three elements in the AHF framework for healing, evaluation techniques, and proposed recommendations. We then conducted stakeholder consultation by presenting results at a community gathering in December 2011 in Calgary, Alberta. The gathering was attended by approximately 70 community members and representatives from 60 area agencies, many serving Aboriginal youth. Following presentation of results, attendees broke into small groups for roundtable discussions around three questions:

- 1) Of the recommendations that were discussed today, do you have similar practices in your agency's programs?
- 2) How do you know what you do is effective in addressing intergenerational trauma?
- 3) What would your agency need to better implement and evaluate youth programming?

Discussions were audio-recorded and transcribed, while notes were taken throughout. Common ideas and emerging themes were coded.

## Results

The database search yielded 3,135 unique articles (see Table 1), while the title and abstract screen determined 129 relevant and 153 possibly relevant. Seven additional papers were identified from screening reference lists of selected articles and the AHF report. After applying the inclusion criteria, 16 documents remained for the final review (identified in the References list with asterisks). Table 2 summarizes included documents.

**Table 1: Search terms and database hits**

1) Outline of search terms and search strategy	
<i>Population:</i> Indigenous, Aboriginal (First Nations, Métis, Inuit, Indian)	
<i>Ages:</i> youth 12-29 years	
<i>Geographic locations:</i> Canada, US, Australia, New Zealand	
<i>Issues and outcomes:</i> Trauma, abuse, sexual abuse, historical trauma, collective trauma, PTSD, residential schools, reserves, oppression, torture, colonization, exclusion, assimilation, degradation, intergenerational trauma, denigration, subjugate, racism, racist, cultural loss, cultural deprivation, Indian Act, settlement, cultural genocide, marginalization, gangs, addictions, alcoholism, drug use, smoking, glue sniffing, gambling, mental health, depression, prostitution, suicide, homelessness, incarceration, diabetes, cardiovascular disease, risky behaviours, tuberculosis, pneumonia, unemployment, education, socioeconomic factors, income, poverty, resilience, violence, criminal behaviour, HIV/AIDS, disparities, identity loss, teen pregnancy	
<i>Language:</i> English	
<i>Years of publication:</i> 2001-2011	
2) Number of hits per database searched	
Database	# of hits (citations)
MEDLINE (OVID)	659
EMBASSE	294
PubMed (2009-2011)	90
PsycINFO	654
Sociological Abstracts	590
CINAHL	248
CBCA	276
Social Work Abstracts	14
Canadian Periodical Index	159
Social Services Abstracts	176



Family and Society Studies Worldwide	222
SocINDEX	378
Canadian Health Research Collection	79
Total found: 3,839	
Duplicates removed: 704	
Final citation list for screening: 3,135	

Table 2: Summary of characteristics of 16 papers reviewed

<i>Paper</i>	<i>Sex of participants</i>	<i>Location of intervention (rural vs. urban)</i>	<i>Issue(s) addressed</i>	<i>Intervention type(s), using AHF categories</i>	<i>IGT theory used?</i>	<i>AHF framework elements present</i>
<b>Aguilera &amp; Plascencia, 2005</b>	Not specified	Urban	HIV/AIDS, substance abuse	Cultural intervention + traditional therapeutic	Yes	All 3 elements
<b>Aho &amp; Liu, 2010</b>	Not Specified	Rural	Suicide	Reclaiming history (Legacy education)	Yes	1 element: Aboriginal worldviews
<b>Dell et al., 2011</b>	Not Specified	Rural	Substance abuse (inhalants)	Traditional therapeutic	No	All 3 elements
<b>Gilder et al., 2011</b>	13 males, 23 females	Rural	Substance abuse (alcohol)	Western therapeutic	No	1 element: safe environment
<b>Goodkind, Lanoue &amp; Milford, 2010</b>	7 males, 16 females	Rural	PTSD/ trauma response	Combined therapeutic	Yes	1 element: safe environment
<b>Higgins, 2005</b>	Not specified	Urban/Rural	Youth at risk	Combined therapeutic	Yes	All 3 elements
<b>Holland, Gorey &amp; Lindsay, 2004</b>	Not specified	Rural	Sexual abuse	Western therapeutic	No	1 element: safe environment
<b>Lafrenière et al., 2005</b>	Not specified	Urban	Offender rehabilitation	Other	Yes	All 3 elements
<b>Lowe, 2006</b>	Not Specified	Rural	Substance abuse	Combined therapeutic	Yes	2 elements: safe environment + Aboriginal worldviews
<b>Marlatt et al., 2003</b>	Not Specified	Urban	Substance abuse (alcohol)	Combined therapeutic	No	2 elements: safe environment + Aboriginal worldviews
<b>Palmer, 2006</b>	Not Specified	Rural	Substance abuse	Cultural intervention	No	All 3 elements
<b>Shantz, 2010</b>	Not Specified	Rural	Diet	Cultural intervention	Yes	All 3 elements
<b>Skye, 2002</b>	Not Specified	Rural	Substance abuse	Cultural intervention	Yes	All 3 elements
<b>Tsey et al., 2010</b>	Not Specified	Rural	Suicide	Combined therapeutic	Yes	1 element: Aboriginal



						worldviews
<b>Veroff, 2002</b>	Not Specified	Urban	General well-being	Other	No	1 element: safe environment
<b>Wexler, 2006</b>	Not Specified	Rural	Suicide	Western therapeutic	Yes	1 element: safe environment
<b>SUMMARY NOTES</b>	Only 2 papers specified sex of participants (both were mixed-sex interventions)	4 Urban, 11 Rural, 1 Both	7 papers on substance abuse, 3 on suicide, 1 each for other issues	1 Legacy Education, 4 Cultural interventions, 2 traditional therapeutic, 3 Western therapeutic, 5 Combined therapeutic, 0 Alternative therapeutic, 2 Other	10 of 16 papers directly address IGT theory	7 interventions have all 3 elements, of which 5 also address IGT theory

### Intervention types

One intervention was aimed at reclaiming history, four were cultural interventions, two contained traditional therapeutic interventions, three were Western therapeutic interventions, five were combined therapeutic interventions, and two were labelled “Other” due to not fitting into AHF categories. One cultural intervention was also categorized as a traditional therapeutic intervention because of a mixture of components. Cultural interventions generally involved traditional excursions, community or large-scale gatherings, or programs immersing youth in traditional diets or special ceremonies. A cultural intervention from Ontario encouraged youth to learn how to prepare foods traditionally and distribute food in their community (Shantz, 2010). Another intervention in Western Australia focused on the intergenerational exchange of cultural traditions and positive coping skills, instead of focusing on the negative transfer of trauma (Palmer et al., 2006).

Most therapeutic interventions combined traditional and Western approaches. One sought to address alcohol use, modifying a program used in schools specifically for Cherokee youth. This was done by changing the existing 10-step program into a talking-circle and weaving into sessions the concept of self-reliance, which is important to the Cherokee community (Lowe, 2006). Another combined therapeutic intervention modified the Cognitive Behavioural Intervention for Trauma in Schools model (Jaycox, 2004) for use in an American Indian community, by reframing sessions around topics of historical injustice, traditional history, and coping through community. Though rooted in Western healing, the authors aimed to address PTSD from an American Indian perspective (Goodkind et al., 2010). One intervention undertaken with Inuit youth took the form of an art project, in which participants were encouraged to explore their identity (Veroff, 2002). Yet another intervention, this time aimed at young offenders, used alternative means of retribution to discourage risky behaviour (Lafreniere et al., 2005).

### Addressing issues of health and well-being

Nearly half the documents (7 of 16) addressed alcohol or substance abuse. Other issues addressed included suicide, PTSD, depression, sexual abuse, HIV/AIDS, diet and diabetes, offender rehabilitation,

and general well-being.

### *Urban or rural location*

Of the 16 interventions reviewed, four took place in urban areas, working with youth not immersed within a larger Aboriginal community. Eleven described rural interventions, referring to areas within which a distinct Aboriginal community resided, or a town or village with a small population but a significant number of Aboriginal families (AHF, 2006c). One intervention, which featured an annual camp and used traditional activities to build resiliency, involved Aboriginal youth from both urban and rural settings (Skye, 2002).

### *Use of AHF framework*

Determining coherence with the AHF framework first involved identifying whether intergenerational trauma theory articulated the rationale for intervention design, and, secondly, if the intervention incorporated any of the three necessary AHF elements (i.e., guided by Aboriginal worldview; cultural safety; skilled healers). Ten of the 16 (63%) directly addressed intergenerational trauma theory, for instance articulating how intergenerational trauma affects health outcomes, how trauma is transmitted across generations, or how it may come about. Although the other six papers did not directly address intergenerational trauma theory, they had some element addressing cultural deprivation, historical circumstances, colonization, or oppression. Most included only one of the three necessary elements for healing interventions listed by the AHF.

### *Evaluation techniques reported in papers*

The literature documented varied evaluation techniques for assessing intervention effectiveness. Some papers reported the use of formal standardized measurement instruments, while others reported no evaluation mechanism. Only two offered detailed program evaluations, featuring quantitative scales (e.g., for depressive symptoms, PTSD, stress and coping) and follow-up assessments for long-term impact (Lowe, 2006; Goodkind, 2010). These detailed evaluations were conducted on combined therapeutic interventions that showed positive results immediately after the intervention, namely reduced stress and trauma; however, these reductions were not maintained after extended follow-up. In both cases, this reversal was attributed to interventions not altering the traumatic and/or stressful environments in which youth participants lived. Of papers reporting Western therapeutic interventions, two used quantitative assessments: one reported on the collective responses of Elders (Gilder et al., 2010); the other used “client complexity measures” that assessed changes in factors such as mental health or propensity for conflict (Holland et al., 2004). The final paper concerning a Western therapeutic intervention used specific interview questions to describe intervention outcomes (Wexler, 2006). For the two traditional therapeutic interventions, one used self-reported data on substance use and on perception of change in various psychosocial indicators, to quantitatively describe success (Aguilera & Plasencia, 2005), and the other used qualitative stories to support conclusions (Dell, et al., 2011). Only one paper (Aho & Liu, 2010) documented an intervention that could be categorized as “reclaiming history”; it lacked an evaluation.

### Proposed recommendations

Table 3 summarizes the main recommendations drawn from the literature. Only two papers (Marlatt, et al., 2003; Higgins, 2005) offered no recommendations.

**Table 3: Summary of recommendations made in papers**

<i>Recommendation</i>	<i># of papers (of 16)</i>	<i>Papers</i>
Integrate Aboriginal worldviews or views on healing	5	Dell et al., 2011; Lowe, 2006; Palmer, 2006; Tsey et al., 2010; Wexler, 2006
Strengthen cultural identity as a healing tool	5	Aguilera, 2005; Lowe, 2006; Tsey et al. 2010; Skye, 2002; Wexler, 2006
Build self-determining or politically active Aboriginal organizations	5	Goodkind et al., 2010; Lowe, 2006; Palmer, 2006; Shantz, 2010; Tsey et al., 2010
Integrate interventions into mainstream health services, acquaint mainstream professionals with Aboriginal views of healing	5	Aho & Lui, 2010; Dell et al., 2011; Holland et al., 2004; Lafrenière et al., 2005; Palmer, 2006
Reframe negative manifestation of trauma as a challenge to overcome (i.e., take a positive, strengths-based approach)	2	Aho & Lui, 2010; Tsey et al., 2010
Use Aboriginal-specific health determinants	1	Dell et al., 2011
Normalize holistic therapy as part of interventions	1	Dell et al., 2011
Make Western healing approaches culturally relevant	2	Aguilera, 2005; Skye, 2002
Build positive relationships with intervention participants, and, once trust is established, used critical discussion for participants to reflect on their own progress	1	Veroff, 2002
Reframe oppression and colonization as ongoing structural factors that are grounded in history	1	Tsey et al., 2010
Encourage youth to take leadership roles	1	Skye, 2002
Use digital technology	1	Palmer, 2006
Allow information to flow between families, youth and project planners	1	Skye, 2002

Many papers recommended approaches grounded in Aboriginal worldviews; empowering the cultural identity of youth; promoting autonomy of Aboriginal organizations; supporting political

advocacy; and integrating effective interventions into existing health services. These are consistent with the AHF's recommendations. Calls to integrate Aboriginal traditions and worldviews into interventions emphasized concepts of holism and interconnectedness to community and family. Recommendations concerning cultural identity of youth were based on the argument that a strong sense of identity can be a positive way to reduce stigma around some issues, as well as serve as a tool for building self-reliance and encouraging political and community engagement (Wexler, 2006).

Papers also advocated for increased autonomy of Aboriginal organizations and youth groups, and the capacity for these groups to be politically active. Two articles (Shantz, 2010; Goodkind, et al. 2010) identified the need for youth groups to be agents of political advocacy, as a means to build resiliency and empower youth to combat ongoing oppression. The literature also emphasized self-determination for Aboriginal groups, in order for them to avoid being constrained by organizational structures with which they are uncomfortable, and to be fully in charge of their own programs, rather than being directed by other agencies or governments. Additional recommendations addressed the need for Aboriginal interventions to better tie into existing services. Mainstream health agencies and workers were called to learn more about Aboriginal worldviews and determinants of health, and apply this knowledge for the creation of culturally competent and culturally safe care. Broadly, the literature recommended that health departments work with Aboriginal healers and with each other, to yield interventions culturally rooted in Aboriginal ideas of healing. Recommendations specifically geared towards addressing intergenerational trauma were few, but included the need to ground discussions of oppression and discrimination in a historical context, and to explain how ongoing oppressive forces link with disparities along health outcomes and the social determinants of health.

### *Stakeholder consultation*

According to stakeholder consultation participants at the community gathering, there is a move to integrate Aboriginal worldviews into programming at various agencies in the Calgary area. Stakeholder consultation participants articulated general consensus on the need for holistic interventions. Various agencies reported offering cultural programming, and explicitly connected the integration of culture to the goal of building a strong sense of identity in youth. In concordance with the AHF's element around the requirement for skilled healers, various agencies reported efforts to ensure staff competency around Aboriginal youth well-being. Participants also indicated that Aboriginal staff may provide more comfortable healing environments. Finally, participants reflected that more could be done by their agencies to explicitly address intergenerational trauma as an issue.

Some participants disclosed that programs do not always assess for intergenerational trauma, although health and well-being issues related to intergenerational trauma are often addressed. Some agencies described using questionnaires to assess the effectiveness of programs. Pre- and post-intervention assessments were occasionally used, some with standardized instruments; in other cases, more informal surveys were employed. Other reported indicators for program success included oral feedback (e.g., direct interviews, informal discussions). Some participants argued that subjective, verbal assessment from a youth participant may be the best marker of impact, reflecting that verbal feedback is in line with oral traditions among Aboriginal cultures. Levels of attendance and participation were also deemed by some participants to be key indicators of program success.

Participants expressed considerable frustration around funding barriers during stakeholder discussions, including: limited access to funding opportunities; a lack of continued funding for successful programs; inconsistent funding impacting sustainability and continuity of programs; funding allocation criteria not reflective of individual and community needs; and lack of accurate understanding among funders around key issues to address. Some argued that, relative to mainstream programming, Aboriginal youth programming requires more financial resources to properly execute and evaluate, due to the enhanced complexity of the issues at hand. Participants felt that greater collaboration between stakeholders could facilitate sharing of ideas and promising practices, yielding new funding avenues, while collaboration with researchers and/or universities could improve evaluation capacity.

Participants identified involvement of families in youth programming as helpful for parental buy-in and quality-improvement feedback. Participants considered increased access to skilled Aboriginal staff for programs and services critical for intervention effectiveness, as they felt that healers who were Aboriginal themselves could provide a more comfortable setting by more readily empathizing with youth experiences. Finally, participants desired better education and training among staff at agencies about the concept of intergenerational trauma.

## Discussion

The development of best or promising practices for interventions to address intergenerational trauma among Aboriginal youth appears to be in its infancy. More comprehensive, evidence-based interventions are required. Among interventions captured in this review, most were not formally evaluated, adding reporting and evaluation challenges to the task of identifying promising healing practices. This gap may prove a barrier to overcoming key concerns identified by stakeholders around generating funding support for innovative programming, as standards among policy makers and funders may be more demanding than that outlined by the AHF. None of the interventions encapsulated all three pillars recommended by the AHF. It may not always be practical for a single program to contain all three; accordingly, a multipronged approach is warranted, involving coordination and collaboration across organizations and sectors. Further research could examine whether interventions can be successful without all three pillars. It is important to note that the success of interventions is highly influenced by the environment in which youth find themselves; if the environments are highly traumatic and not supportive of healing, skills developed during an intervention are less likely to be maintained. This is a basic tenet of health promotion (WHO, 1986), and was reflected in two interventions (Lowe, 2006; Goodkind, et al., 2010). Thus, interventions are required that target changes within the community as a whole, and support youth to become agents of change within their environments.

The sole legacy education intervention identified was part of a new youth suicide prevention strategy among Maori communities in New Zealand. The intervention sought to situate high levels of suicide within a colonial and historical context to reframe existing strategies that target individual pathology (Aho & Liu, 2010). Legacy education, focused on increasing awareness of colonialism and its ongoing impacts, may be vital for youth. Despite not directly experiencing historical events such as residential schools, youth are nonetheless deeply affected by the intergenerational impacts on their families and communities (Wesley-Esquimaux & Smolewski, 2004), and often feel personally responsible for their suffering. Cultural interventions such as the Midwinter Harvest Food Program (Shantz, 2010) and the Yiriman Project (Palmer et al., 2006) sought to train youth in traditional skills, while fostering personal connection with culture. Combined therapeutic interventions were the most

common types identified, though both Western and traditional therapeutic practices were also promising.

One challenge in evaluation for effectiveness may be in balancing Western techniques and Aboriginal worldviews in seeking indicators of success appropriate for communities (Robinson & Tyler, 2006). The conceptualization of 'best practice' put forth by the National Aboriginal Health Organization (NAHO) (Mable & Marriott, 2001) would suggest that this challenge is not an excuse for avoiding the search for excellence; Aboriginal youth equally deserve effective, evidence-based interventions, if not more so when viewed through an equity lens. As concepts such as resilience, engagement with cultural identity, cognitive reframing of challenges, and internalized trauma become articulated, ways to measure them need development. The sources in the review that included some form of evaluation did little to address the question of balance between Western and Aboriginal views on evaluation. They generally chose either Western or Aboriginal-centric methods, rather than finding a hybrid that addressed advantages and disadvantages of each through an approach of "two-eyed seeing" (Martin, 2012). Evidence on efficacy and effectiveness should be gathered, so that funds are not used on less successful programs, resulting in opportunity costs; that is, the use of funds on ineffective programs.

Funding agencies often expect quantitative approaches to evaluation in order to assess effectiveness of outcomes. However, oral or narrative methods may be more culturally appropriate, pointing to the importance of qualitative methods such as interviews, oral accounts and narratives. Qualitative methods allow a high degree of insight into mechanisms through which interventions function. Meanwhile, well-constructed quantitative instruments – properly validated for the context or population at hand – typically allow more generalizable assessment of group-level outcomes. The outcomes of successful healing may include issues deemed important by communities. Mixed-methods and multiple-methods research involves combining qualitative and quantitative methods (Sandelowski, 2000; Morse & Niehaus, 2009). In one scoping review concerning evaluation of health promotion interventions, authors found that evaluations using both quantitative and qualitative methods better capture the complex processes at play in interventions (Kania et al., 2013). Thus, a mixed- or multiple-methods approach to evaluation, done in a way that engages Aboriginal worldviews and reflects community perspectives and priorities, may resolve the evaluation dilemma (Roy, 2014b).

While colonization and oppression were addressed in most documents, not many interventions incorporated intergenerational trauma theory. The same conclusion emerged at the stakeholder consultation gathering, regarding descriptions offered by participants of their own agencies' programs. The lack of concrete incorporation of intergenerational trauma theory into intervention design may yield programs that miss the broader, upstream context linking Aboriginal youth well-being to past atrocities. Further research is warranted on how to practically apply existing frameworks for healing to intervention design. Sotero (2006) explains that for public health to effectively address intergenerational trauma, it is important for practitioners to understand the place of the individual in Aboriginal perspectives. This means situating the individual in relation to community, the land, the family and history. Therefore, simply adding in some cultural elements to a pre-existing program can be ineffective – even tokenistic – without broader engagement with Aboriginal worldviews. The need for personally and culturally safe environments was reflected with 14 of 16 documents referencing efforts to make participants feel comfortable and safe. Cultural safety in health settings is defined by NAHO (2008) as an environment where professionals "can communicate competently with a patient in that patient's social, political, linguistic, economic, and spiritual realm" (p. 7). Other definitions suggest it involves reflection on the part



of health professionals on questions of power and privilege, ensuring that clients can feel empowered in interactions with health professionals (ANAC, 2009). NAHO indicates that the setting in which healing takes place must not diminish a person's confidence or alienate them from cultural affiliations or identity (NAHO, 2008). Some of the interventions reviewed took place in community centres, or in parks or outdoor settings; these may be inherently less threatening for participants. None of the interventions reviewed took place in a hospital or clinical setting; this may indicate that hospitals or clinical settings are not seen as ideal locations for healing from intergenerational trauma; or, alternatively, that the clinical health sector is not directly working to address intergenerational trauma among patients. Some of the interventions reviewed took place in schools; schools may or may not be a 'safe' environment for Aboriginal youth – a question that was not deeply examined in the papers. As hospitals, clinics and schools are often practical locations for public health interventions (due to ready access to target populations), there is a need to consider how cultural and personal safety can be increased in these locations.

The final element in the AHF framework, the capacity of healers, was not explicitly addressed in many of the documents. The importance of having committed and well-trained practitioners, staff, and volunteers, is vital to best practice (Mable & Marriott, 2001). Aboriginal nurses have been identified as holding a unique position in healing intergenerational trauma (Lowe, 2002; Struthers & Lowe, 2003). However, before identifying one profession or group to shoulder the task of healing, it is important to assess their capacity and to foster capacity-building across all sectors, while also supporting the healers' own level of healing from past trauma.

As discussed above, a recommendation emerging from the review was to better tie interventions into existing mainstream health systems, and to assist mainstream practitioners to become versed in Aboriginal ways of healing. This seems contradictory to another recommendation that emerged, concerning the need for self-determination and autonomy in organizations governed by Aboriginal peoples. While the latter is undoubtedly important, limiting healing work to exclusively Aboriginal organizations may reduce the range and accessibility of interventions available, and place an undue service burden on organizations that may already be struggling to meet their service mandates. For instance, a study of services for urban Aboriginal peoples facing homelessness found few Aboriginal-specific services, despite disproportionate representation among the homeless population (Thurston et al., 2013). Integration of Aboriginal-specific services with, or drawing support from, existing mainstream services carries potential benefits, including support in rural areas; access to existing health infrastructure; improved accessibility to specialists; greater funding opportunities; and improved capacity for evaluation (DeGagne, 2007). Partnership and community engagement may be mediating forces in allowing effective Aboriginal-specific programming to be offered within mainstream services, in a manner that accounts for the concurrent need for independence and self-determination. Carefully crafted terms of partnership may facilitate finding the right balance in this regard. Growing interest in collaborative research and practice exists in public health; while it is often challenging to execute, the benefits occur at many levels and accrue over time (Israel et al., 1998; Roy et al., 2014). Meaningful engagement of Aboriginal communities in research should not be neglected, and should be of value to all parties involved in the research (Dunne, 2000). The community and service-provider consultation for this scoping review facilitated networking between community groups and academic researchers, nurturing the possibility for fruitful and equitable relationships to further research and practice with Aboriginal youth (Crooks, et al.,

2009).

A lack of attention to gender in trauma and healing was clear. Many documents did not differentiate intervention participants by sex, and none discussed the needs of males, females, transgender, or gay and lesbian or two-spirited people. The experience of intergenerational trauma and potential for ongoing abuse may differ according to gender, as may health-based manifestations of trauma; thus, this gap is notable. The role of setting was also ignored, specifically around designing interventions for urban or rural populations. The importance of the above was illustrated in a study of differences in suicidal thoughts and attempted suicide among American Indian youth. This study found lower rates of psychosocial problems related to suicide ideation among urban youth, even though rates of attempt in both rural and urban populations were similar (Freedenthal & Stiffman, 2004). Finally, few interventions attempted to influence policy or address ongoing structural factors that cause systemic oppression and allow intergenerational trauma to persist.

## Conclusion

According to the Canadian Senate Standing Committee on Aboriginal Peoples, the framing of issues facing Aboriginal youth must “move beyond the near exclusive focus on problems and begin to explore a more constructive approach, one emphasizing the contribution Aboriginal youth now make, and can continue to make, to Canada's future” (p. 4) (Chalifoux, 2003). In Canada, the residential school experience and other ongoing legacies of colonization continue to negatively impact Aboriginal youth. Interventions capable of effectively addressing intergenerational trauma are crucial to preserving and improving the health and well-being of Aboriginal youth, families and communities. As discussed here, a paucity of published research on best practices exists, in addition to significant oversights. Nevertheless, a number of promising practices are developing, and require rigorous and meaningful evaluation for support. Further research and action, across sectors in health, social services, and academia, are necessary to address the gaps identified in this review and improve capacity to address this critical issue.

## List of abbreviations

AHF = Aboriginal Healing Foundation; HIV/AIDS = Human Immunodeficiency Virus / Acquired Immuno-Deficiency Syndrome; NAHO = National Aboriginal Health Organization; PTSD = Post-Traumatic Stress Disorder

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[Note: The 16 papers included in the scoping review are marked with an asterisk]

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**An Interdisciplinary Journal** *Honouring the Voices, Perspectives and Knowledges of First Peoples through Research, Critical Analyses, Stories, Standpoints and Media Reviews*

## Community-based participatory research with Aboriginal children and their communities: Research principles, practice and the social determinants of health

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### Abstract

*Conventional health and social science research has contributed to advances in public well-being over the past century. Despite these advances, a significant gap exists in the health of Aboriginal children as compared to non-Aboriginal children in Canada. This has occurred, in part, as a result of the failure of conventional research to acknowledge the worldview of First Nations, Inuit, and Métis peoples, to fully take into account their experience of the social determinants of health (SDOH) and to address the intergenerational impact of colonization. In this article we review and discuss the social determinants of health (SDOH) with a specific focus on Aboriginal children and youth. Motivated by our experience in carrying out community based participatory research (CBPR) with children and families from First Nations and Métis communities in Alberta, Canada we review how use of CBPR approach to research with Aboriginal children and communities can serve to enhance research results, resulting in greater relevance to community identified questions. We will address these issues in the context not only of good research practice but as an aspect of "wise practices" (Wesley-Esquimaux & Calliou, 2010) occurring within an "ethical space of engagement" (Ermine, 2007). We conclude that CBPR allows for meaningful and equitable research partnerships to occur in an ethical space without reinforcing colonial processes of knowledge construction and translation while marginalizing Indigenous knowledge.*

**Key Words:** *Aboriginal children, health, CBPR, SDOH, research approaches, ethical space*

### Introduction

Aboriginal peoples are diverse in cultures, perspectives, and languages; however, all agree that the health of their children is essential to their futures. Elders' teachings express the belief that Aboriginal children need to be welcomed and supported by family and community while engaged in healthy learning

and spiritual practices. Children are understood to develop through relational and experiential learning within frames of identity, kinship, relationship with all beings, language, and culture—a process referred to by Mi'kmaw scholar Marie Battiste, as “nourishing the learning spirit” (2010, p.14). Knowledge is authenticated through observation, respect for the knowledge holder, and accounts of learning through personal experience. Throughout life, one's own experience adds to this body of shared empirical, experiential and revealed knowledge (Castellano, 2000). Decisions are made while keeping in mind the needs of future generations who are also connected with past and present, ancestors and descendants. From this view, well-being takes place through a holistic approach to individual, family, community, and environmental health. Sources of illness and appropriate interventions are understood not only physically but in the context of relationships of spirit (Malloch, 1989). Knowledge of health, medicines and healing processes are available through use of proper protocol, actions and thought.

## The health of Aboriginal children in Canada

Canada's Aboriginal population is made up of First Nations, Métis, non-Status and Inuit peoples. Personal, community, and cultural identities are important to the well-being of Aboriginal peoples. The effect of colonization, including particular efforts aimed at children and families, resulted in devastating effects on community well-being. Loss of land and mobility, legal definitions of membership, legal restriction and differential rights for particular Aboriginal peoples intersect to compound this ongoing process. These limitations are enshrined in Canadian law, principally the *Indian Act* (Imai, 2002) and reinforce legal, economic, and sociocultural factors that produce and reinforce health inequity (Adelson, 2005; Bombay, Matheson & Anisman, 2010; Smylie & Adomako, 2009).

Aboriginal children lag behind their non-Aboriginal counterparts on almost every standard measure of health (Smylie & Adomako, 2009). There are numerous areas for improvement in Canada's performance on Aboriginal child health and wellness, including addressing the social determinants of health (SDOH) which are especially relevant to the experience of Aboriginal children and their families. As Reading and Wien (2009) note, “Aboriginal children, youth and adults are distinctly, as well as differentially, influenced by a broad range of social determinants ... includ[ing] circumstances and environments as well as structures, systems and institutions that influence the development and maintenance of health” (p.1). For example, one in four Aboriginal children in Canada live in poverty, with historical and systemic roots manifest in children's health, as compared to one in nine for the overall population (Greenwood, 2009; Greenwood & de Leeuw, 2012).

That Indigenous health inequities world-wide rise from the interaction of the SDOH with “culturally and historically specific factors particular to the peoples affected” (King, Smith & Gracey, 2009, p. 76) is generally agreed upon. In Canada, these factors not only influence health status, per se, they are implicated in historical and ongoing colonial processes, inherently undermining the health of Aboriginal children and communities (Adelson, 2005; King et al., 2009; Reading & Wein, 2009; Smylie & Adomako, 2009). Aboriginal health researchers agree that the colonization process and its continuing impact is the most influential determinant of health for First Nations, Inuit and Métis peoples (Greenwood, 2009; King, Sanguins, McGregor & Leblanc, 2007; King et al. 2009; Macaulay & Saylor, 2009; Reading & Wein, 2009; Smylie & Adomako, 2009). For instance, almost every one of the SDOH is influenced by residential school attendance by self or family members (Reading, J. & Elias, 1999); children experience the ongoing cumulative effects (Blackstock, 2007; Bombay, Matheson & Anisman, 2009). In

Canada, access to equitable health services along with discriminatory processes experienced by Aboriginal children and youth in schools and communities has a significant effect on their prospects for adult well-being (McQuaid, Bombay, McInnis, Matheson & Anisman, 2014).

Aboriginal peoples in Canada have shown significant resilience in light of these dynamics. They have faced historical and current challenges to health sustaining relationships with relatives, lands, economic systems, rights, and sovereignty. However, traditional ways of spiritual expression, healing, ecological knowledge and relationship to the land, and methods of collective governance have faced opposition from Western society and governments. The overall health impact of colonial assumptions, legal processes and regulatory practice and the resulting decrease in both individual and collective autonomy on Indigenous peoples cannot be understated.

Western health and social research was, and is, a part of this process. Understanding how and why these disparities are created and maintained is an important first step in developing and implementing appropriate interventions and policy to improve the health and well-being of children, families and communities. Researchers have not focused, to any great degree, on cultural strengths or on the SDOH and their cumulative effects as experienced by Aboriginal communities, but rather on identifying and reducing specific disease and social factors. Disparity in the health status of First Nations, Inuit, and Métis children in Canada and Indigenous peoples worldwide can, in part, be understood as a result of the failure of conventional research to address both Indigenous worldviews and the ongoing impact of the SDOH (King et al., 2009).

## Challenges to current approaches to research with Aboriginal children and communities

Aboriginal peoples in Canada tend to rely on models of well-being that view health as not just related to the health of the individual but of the entire community. Saylor and Blackstock (2005) explain that:

Aboriginal peoples believe that health goes beyond the physical body to the spirit, emotions, and the mind. It goes beyond the individual to encompass the relations one has with family, the community, the world, the spirit and the land. It exists in the past and future as much as it does in the present, so decisions regarding health must be reflective and prognostic at the same time (p.523).

Maintenance of cultural knowledge promotes growth and well-being and increases health equity. For Aboriginal children, “the importance of culture is that it contains many teachings that children need at an early age to establish the foundation for both emotional and holistic health” (L. Brown, personal communication, Oct. 4, 2012).

Western definitions of health and Western models of research, service delivery, and health promotion are frequently ineffective in communities that rely on holistic understandings, serving to destabilize rather than enhance cultural foundations, contributing to the undermining of the health of Aboriginal children (King et al., 2009; Reading & Wein, 2009; Smylie & Adomako, 2009). Further, Aboriginal beliefs regarding ethical behaviour and good ways of learning may not always be compatible with evidence-based research or best practices based in Western traditions (Castellano, 2004; Battiste, 2010;

Fletcher et al., 2011; Wesley-Esquimaux & Calliou, 2010).

Additional ongoing research is needed to address Aboriginal child health considering the significant gaps in needs, prevention, service delivery and under-representation in research data reflecting community-identified research questions (King et al., 2009; Smylie & Adomako, 2009). As well, academic research is often carried out in a manner that fails to maximize value to the community (Schnarch, 2004). As a result, reliance on the principles of ownership, control, access and possession (OCAP) (First Nations Centre, 2007) was adopted as a research guideline by Aboriginal organizations and by the Tri-Council of Canada (2014). The principles recommend addressing these issues with communities and research ethics boards prior to the start of research and note that omission may create risk to participants and their communities (Canadian Institutes of Health Research et al., 2014; Schnarch, 2004; Travers, Guta, McDonald and Meagher, 2007). From Indigenous community frameworks, risk applies not only to individuals but also to communities (Baydala et al., 2011; Fletcher et al., 2011). For example, “participants may be placed at risk when research design and data collection procedures, including informed consent, are inappropriate for the specific research context” (Tilley & Gormley, 2007, p. 273). This process may, as a result, stigmatize entire communities.

Given concerns regarding past inaccurate and harmful misrepresentation, misuse of research, and failure to produce tangible benefits, “research is not a word that is taken lightly by Aboriginal peoples” (Pidgeon & Hardy Cox, 2002, p. 96). Aboriginal communities have reported feeling both over-researched and, also, under-represented in research that responds to community-identified needs (Castellano, 2004; Schnarch, 2004). This research history perpetuates the historical failure of Western institutions to keep their word in signed agreements including treaty, medical, and human rights (Ruttan, 2004), and failure to produce tangible benefits to communities is raised frequently (Castellano, 2004). Some communities have expressed the sentiment that they have been researched ‘to death’ (Castellano, 2004; Pigeon & Cox 2002). In response, Ermine, Sinclair & Jeffery (2004) call for a “decolonization agenda that has as a principal goal, the amelioration of disease and the recovery of health and wellness for Indigenous populations” (p.9). We suggest that a community-based participatory research (CBPR) approach is a good place to start.

## Community-based participatory research: What is it?

CBPR is a philosophical approach to research which looks beyond questions of individual health care and health risk to those of community health and well-being. CBPR is defined as a collaborative approach to research that equitably involves all partners in the research process and recognizes the unique strengths that each brings. Beginning with a research project of importance to the community, CBPR aims to integrate knowledge generation and action in order to advance community health and eliminate inequity. The key to CBPR success in Aboriginal communities is the participation of community representatives in all stages of the research, including identification of the research question, research design, advice on appropriate community protocol, data interpretation, and the application and dissemination of findings (Israel, Eng, Schulz, & Parker, 2005). CBPR is especially useful in research with “marginalized communities that experience a disproportionate burden of environmental, health, and other problems and that typically have not been included in deciding what types of research and interventions are most appropriate for and likely to be most effective in their communities” (Israel et al., 2005, p.1469).



By maintaining a focus on research that addresses community concerns, and while developing ownership and pride in the project, CBPR enhances community capacity while engaging in research aimed at reducing health disparities (Cochran, Marshall, & Garcia-Downing, 2008; Baydala, A., Plasco, Hampton, Bourassa & McKay-McNabb, 2006). To build the integrity and trust needed, CBPR relies on a set of guiding principles to guide research relationships, ethics, and decision-making. Developed by Israel and her colleagues, these principles are particularly applicable to the context of Aboriginal communities (Israel, Schulz, Parker, Becker, 1998; LaVeaux & Christopher, 2009). They include:

- 1) Acknowledgement of 'community' as a unit of identity.
- 2) Building on strengths and resources within the community.
- 3) Collaborative, equitable partnership in all phases of research, involving an empowering and power-sharing process that attends to social inequalities.
- 4) Co-learning and capacity building among all partners.
- 5) A balance between knowledge generation and intervention for the mutual benefit of all partners.
- 6) Emphasis on the local relevance of public health problems and on ecological perspectives that attend to the multiple determinants of health.
- 7) Systems development using a critical and iterative process.
- 8) Dissemination of results to all partners and involving them in the wider dissemination of results.
- 9) Understanding of the need for long-term processes and a commitment to sustainability (Israel et al., 1998, p.178-180).

Often associated with qualitative research and public health questions, CBPR can and is being used in a variety of research studies. For example, environmental health studies measuring the effects of contaminants on children benefitted from this approach (Israel et al., 2005; Kwiatkowski, 2011). Other examples include research on substance abuse prevention for First Nations children and youth (Baydala, et al., 2014; Baydala et al., 2009), diabetes prevention with First Nations school children (Macaulay et al. 1999), health and genetics research (Boyer, Mohatt, Pasker, Drew, & McGlone, 2007) along with food security and diet studies (Wesche, Schuster & Tobin, 2011).

There are challenges common to the use of CBPR, including the additional time typically required and the need to build both community capacity, as well as, researcher capacity in the skills required to work with Aboriginal communities. One of the major benefits of CBPR is that community involvement contributes to a more thorough understanding of data and design of culturally relevant interventions (Leung, Yen & Minkler, 2003; Williams, Bray, Shapiro-Mendoza, Reisz & Parenteau, 2009; Wallerstein et al., 2008). CBPR enhances an ethical and valid approach to the conduct of research with and by Aboriginal communities and their children (Wallerstein & Duran, 2006). We believe that CBPR research increases the probability that research takes place in an ethical space

## Carrying out research in an ethical space

To address some of the historical and ethical challenges inherent in this research context, Ermine,



Sinclair and Jeffery (2004) recommend the use of a less objectifying research paradigm developed as “a result of the decolonization agenda” (p. 9). It has “as a principal goal, the amelioration of disease and the recovery of health and wellness for Indigenous populations” (p.9). If future health research partnerships are to produce results based in the principles of justice and beneficence for Aboriginal communities and children, the dialogue and practices that establish these relationships must take place in the space between Western and Indigenous knowledge systems (Ermine, 2007, Ermine et al., 2004). Working with philosopher Roger Poole’s original concept, Ermine (2007) advances the concept of ethical space by using “an analogy of a space between . . . Indigenous and Western thought worlds” (p. 194) where the “encounter and interaction of two entities with different intentions” may take place (Ermine, Sinclair & Jeffrey, 2004, p.19). This found space, located between Indigenous and Western knowledge systems, presents itself as one with the potential for exploration of interests through engaged dialogue. This dialogue has the potential to lead to ethical and collaborative research practice and enhanced research outcomes, importantly ensuring that the “ethics of the research process not only comply with academic standards but with the ethical values of the community where the research will be conducted” (Fletcher et al., 2010, p. 324).

CBPR is intended, similarly to the OCAP principles, to situate research with Indigenous peoples within this ethical space. In our experience, community research team members from the Alexis Nakota Sioux Nation located in central Alberta (Baydala, 2014), stressed that the principles of CBPR come close to their own value systems and the teachings of the Elders. They indicated that CBPR research took place at a more meaningful level than earlier research projects carried out in their community; one with greater spiritual significance, creating more useful outcomes (S. Letendre, personal communication, 12/8/2014). Similarly, they noted that a CBPR approach was particularly effective because it mirrors kinship relations. The acquisition of knowledge through equitable research partnerships, which value the varied skills that each team member brings to the work, is a critical dynamic. This process can be as critical to community health and empowerment as the health knowledge produced (Cochran et al., 2008).

Working from this perspective, researchers may begin to develop relationships by stepping into this ethical space. This action allows community members to initiate active involvement to meet them there and begin the trust building essential to successful CBPR. All team members benefit from the capacity building inherent in this approach. Humility is required; in order to succeed, academic researchers must be as willing to learn as to teach, to listen as to speak, and to share, rather than control, power and decision making. Drawing from Aboriginal knowledge systems rather than solely from Western knowledge systems is also mandatory. Given the history and perception of research outlined above, if academic researchers cannot engage in legitimate partnerships within this space, they may be told not enter this place of research at all.

## CBPR and the social determinants of health

The SDOH are described as the interacting social and economic factors (education, income, housing, employment etc.) that affect people’s health and the experience of well-being or lack of wellness (Mikkonen & Raphael, 2010). According to King et al. (2009), “Indigenous health inequalities arise from general socioeconomic factors [i.e. the social determinants] in combination with culturally and historically specific factors particular to the peoples affected” (p. 76). This interaction contributes to inequities in life experience and reinforces inequitable and unethical institutional structures along with

attitudes about moral responsibility for health (blame or credit) that serve as justification for the status quo. These factors not only influence health status, per se, but are also implicated in both past and ongoing colonial dynamics, inherently undermining the health of Aboriginal children (Smylie & Adomako, 2009; Greenwood & de Leeuw, 2012; King et al., 2009, Reading & Wein, 2009).

Willows, Hanley and Delormier (2012) recommend situating research and intervention with Aboriginal children “within the context of a history of colonization and inequities in the social determinants of health” (p.1). To explore these impacts several models were developed which expand on the SDOH model to take into account the particular circumstances of Aboriginal peoples in Canada. For instance, Smylie and Adomako (2009), stress the importance of employment, income, education, food security, and housing, as well as, kinship and support networks, communication technology, and language skills. Experiences of racism, language loss, reduction in connection with the land and environment, spiritual, emotional and mental dispiritedness and undermining of identity are added to the SDOH by King et al. (2009). Macaulay and Saylor (2009) refer to the impact of categories of loss, including land, language, rights, and traditions while also experiencing racism and discrimination.

Aboriginal scholars agree that the colonization process and its continuing impact is, in fact, the most influential determinant of health for First Nations, Inuit and Métis peoples in Canada (Greenwood, 2009; King et al., 2009; Saylor & Blackstock, 2005; Smylie & Adomako, 2009). According to Reading & Wein (1999), almost every one of the SDOH is influenced by residential school attendance of self or family members. This experience can have an intergenerational effect that, rather than being diluted by time, is exacerbated through ongoing systemic and interpersonal aggressions at collective and individual levels (Bombay, 2009). In Canada, health inequalities continue to have significant effects on growth, development and the adult prospects for well-being of Aboriginal children, often expressed as statistics without analysis of social, economic and historical factors (King et al., 2007).

## Discussion

Economic, social, and political factors entailed in the SDOH have significantly affected the health of Aboriginal children in Canada. Failure to address the SDOH results in interacting cumulative effects that increase health inequities and restricts efforts to work in an ethical space. Finding ways to address the SDOH to enhance health promoting strengths, particularly cultural strengths, known for their importance to child development is essential (L. Brown, personal communication, Oct. 4, 2012; Greenwood, 2009). Early childhood, a critical developmental period, is marked by particular vulnerability to the impacts of the SDOH for Aboriginal children (Greenwood, 2005). Child welfare involvement in Aboriginal families is, also, influenced by the cumulative effects of the SDOH as a result of the historical context (Blackstock, 2007; Greenwood, 2005; de Leeuw, Greenwood & Cameron, 2010; Greenwood & de Leeuw, 2012; Saylor & Blackstock, 2005; Smylie & Adomako, 2009). For example, the inequity found in the interaction of poverty, social exclusion, access to health service and housing, along with limits to education and child welfare funding have roots in colonial and assimilationist processes (Blackstock, 2007; Trocme, Knoke, & Blackstock, 2005; Bombay, 2009). The resultant disparities have substantial effects on growth, development, and prospects for well-being (Greenwood, 2005; Smylie & Wein, 2009).

Traditional health and social research are implicated in both past and present colonial practices. Finding solutions to address systemic factors which perpetuate health inequity for Aboriginal children

and communities is not simply a matter of doing more research. Effective research approaches are needed to conduct research that is significant, empowering and ensures that results drive policy and practice. CBPR research begins with the development of meaningful relationships between researcher/s and community/ies providing a base for making sure sound, ethical research is carried out. Wesley-Esquimaux and Calliou (2010) describe a “wise practices” approach to research with Aboriginal peoples. Based originally on a UNESCO concept and consistent with CBPR principles, wise practices are understood as highly contextual and build on and enhance community strengths, culture and efficacy (Wesley-Esquimaux & Snowball, 2010). The basic skills required for success in carrying out CBPR include: deep listening, establishing authentic and meaningful relationships, showing respect for each team member’s gifts/skills, revising taken-for-granted language and terminology, displaying belief in the process, and a willingness to make changes or respond to change as needed or as informed by the community.

Conventional approaches are often taken as a given, failing to take full advantage of the knowledge, insight and expertise that Aboriginal community members could contribute to framing and answering important research questions. Inequities in the health status of First Nations, Inuit and Métis children can, in part, be understood as a result of the failure of conventional health research to address the worldview of Aboriginal peoples and their experience of the SDOH. Understanding how and why these disparities are created and maintained in specific populations and communities is an important first step towards ethical research interaction aimed at developing and implementing appropriate interventions, practices and policies. Comprehending how the SDOH interact in a cumulative manner, adding not only to the health burden for an individual child but for entire communities of people in a cyclical process that increases over time is necessary.

Programs that address the SDOH and asset enhancing strategies for improving the well-being of marginalized groups are vastly underfunded, potentially undermining researcher’s intent and results. CBPR principles and practices, along with the ethics of Indigenous research and the skills needed to work with communities must be taught to students prior to beginning research. The use of collaborative research methods is not just legitimate but preferred in this context. The implications of ethical guidelines in research with Aboriginal and Indigenous peoples as discussed in OCAP and the Tri-Council policy must be understood. Commitment to incorporating these guidelines in an ethical space of dialogue and co-learning is required by researchers, academic institutions, research ethics boards, and funding agencies (Baydala, 2011). Research must meet ethical standards, respect contextual community-based processes, and ensure results appropriate to community use. Institutional change is needed to support the education needed to use CBPR appropriately, to open up research practice models, and prepare university ethics boards for assessing ethics in this research context. Funding bodies must also reflect the greater time and costs involved in CBPR research. In addition, change is needed in the institutionalized culture of how status is achieved and rewarded in order to validate CBPR and take into account the additional time required.

## Conclusion and recommendations

Recently, Nigel Fisher, President and CEO of UNICEF Canada, reported that “the health conditions of Canada’s Aboriginal children are not what we would expect in one of the most affluent

countries in the world” (as cited in Greenwood, 2009, p. 2). Given this discrepancy, we hold that CBPR is an important approach to research which enhances our ability to address these issues. CBPR is centered in ethical and collaborative research partnerships that require that team members, both academic and community-based, engage in trust, co-learning and capacity building and avoid replicating colonial dynamics that have contributed to a guarded response to research and researchers. In seeking an ethical space to communicate and work together, CBPR allows for the bridging of community concerns regarding trust, while addressing self-identified community needs, protocol and methods.

We endorse the Canadian Paediatric Society’s position statement supporting CBPR as the first option for all research involving Aboriginal children and youth, especially research that encompasses the SDOH (Baydala & Starkes, 2014). Researchers must make certain that everyone involved whether as co-researchers, Elders and/or research participants are fully aware of their options for meaningful collaboration. To carry this out, research engagement and practice needs to take place within a dialogical and relational space where actions reflect regard for respective knowledge systems, experience, and principles of self-determination, protocol, and decision-making. Working together in this ethical space requires that researchers fully comprehend the historical, social, and culturally embedded factors that influence appraisal of child and community health and relevant ways to address them. Avoiding risk in research with all children must bear especial weight, given their vulnerability. In Aboriginal community’s research involving children needs to be based in context, in strengths and community assets and importantly in relationship. Given high needs, social and health research should not reify approaches that perpetuate inequities, however unintentional (Baydala, 2011). CBPR should be considered by all researchers working with Aboriginal children, families and communities as a means to meet these requirements.

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## An Interdisciplinary Journal

*Honouring the Voices, Perspectives and Knowledges of First Peoples through Research, Critical Analyses, Stories, Standpoints and Media Reviews*

# Cultural considerations in play therapy with Aboriginal children in Canada

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## Abstract

*Aboriginal youth in Canada need mental health services that address culture as an integral component of treatment. Suffering and oppression caused by colonialism have led to collective distress among Aboriginal peoples and continue to impede the health and wellness of children. Counsellors have an ethical responsibility to recognize culture as an important construct that may influence a client's healing and treatment preferences. Play therapy is a promising therapeutic approach that allows counsellors to utilize developmentally appropriate theoretical orientations and methods in treatment; however, current literature fails to provide adequate direction and guidelines for culturally competent practice. Counsellors can assume an active role in ensuring that all components of counselling are conducted in a culturally sensitive manner. More research is needed in this area, but this article explores cultural considerations that could be relevant to a child and family accessing play therapy services.*

**Key words:** *Aboriginal peoples, play therapy, multicultural counselling*

According to Statistics Canada (2013), Aboriginal peoples 14 years of age and under represent 28% of the total Aboriginal population and 7% of the national population of children. Aboriginal peoples in Canada have endured many challenges associated with colonization and forced assimilation, which has resulted in devastating consequences for many (Kirmayer, Tait, & Simpson, 2009). Moreover, the effects of group trauma experienced among many Aboriginal peoples continue to influence the well-being of contemporary Aboriginal populations—including children. Therapeutic treatment for current problems related to a child's well-being should be approached from a historical perspective to support change in a meaningful and culturally sensitive fashion. Because a significant proportion of Canada's Aboriginal population is young, it is imperative that practical, developmentally suitable mental health services are accessible for this demographic. Play therapy is one approach for working with children; however, to work effectively with Aboriginal peoples, counsellors must possess the awareness, skill, and knowledge to implement effective services with culturally diverse clients. In this paper, I explore the intersection between culture-infused counselling practice and play therapy. To engage in an ethical counselling practice, culture-infused play therapy with Aboriginal children should consider traditional arts, culturally

relevant materials and symbols, the involvement and participation of family and community members, and spirituality in treatment planning.

## Culture-infused counselling with Aboriginal peoples

### Culture and competence

Aboriginal peoples in Canada require counselling services in which the importance of culture in healing is acknowledged and valued. Culture is a vital construct for understanding all people and is a “more idiosyncratic concept than ethnicity, with each individual selecting, consciously or unconsciously, the components of their experience, history, context, and relational affiliation that define who they see themselves to be” (Arthur & Collins, 2010, p. 15). Thus, culture can be conceptualized as part of an individual’s unique identity, comprising ideological, personal, cultural, contextual, and universal factors (Collins & Arthur, 2010a). A critical component of the discourse surrounding multicultural counselling is cultural competence (Collins & Arthur, 2010b; Brown, 2009; Sue, Zane, Hall, & Berger, 2009). The construct of cultural competence is a point of contention among scholars and varies in definition (Sue et al., 2009). There is much debate between what is known as the etic perspective—one that defines culture broadly and focuses on similarities between cultural groups that can be generalized across populations—and what is called the emic perspective—one which insists that specific or essential cultural knowledge is required by counsellors working with particular populations (Arthur & Collins, 2010).

In this paper, I refer to multicultural counselling as culture-infused counselling, a definition that suggests that cultural awareness and sensitivity are infused in all aspects of counselling and provides balance between the etic and emic perspectives (Arthur & Collins, 2010). Developing the cultural competence needed for best practice requires counsellors to advance their awareness, knowledge, and skills, and various approaches to building cultural competence serve as a foundation to effective and ethical practice. Nonetheless, Brown (2009) has claimed that the concept of cultural competence is problematic in delivering effective counselling services. Counsellors are often poorly equipped with conventional paradigms of cultural competence, which emphasize specific knowledge of cultural groups and further delineate the differences between counsellors and clients (Brown, 2009). For example, Sue, Arredondo, and McDavis (1992) describe a conceptual framework that emphasizes cultural knowledge as a core domain in building competency. Collins and Arthur (2010b) offer a comprehensive framework to remedy this problem, which includes developing attitudes, knowledge, and skills across the three domains of (a) cultural self-awareness, (b) awareness of the cultural identities of clients or understanding the worldview of clients, and (c) culturally sensitive working alliances. For the purpose of this paper, cultural competence refers to the integration of the cultural knowledge, attitudes and beliefs, and skills needed to understand a client’s worldview, to collaborate on goals within the context of a culturally sensitive working alliance, and to promote a social justice agenda (Collins & Arthur, 2010b). This framework acknowledges the significance of clients’ individual identity while offering a clear and concrete set of tools with which to navigate culture-infused practice.

### Ethics of culture-infused counselling

Cultural considerations are not only necessary for constructive therapy; they are also an ethical responsibility for counsellors. Unfortunately, counsellors can neglect culture in therapy because ethical

principles and guidelines are often inadequate in supporting actual practice (Pettifor, 2010). For example, ethical codes often lack specificity, clarity, and precise language in defining ethical principles (Pettifor, 2010). In addition, ethical codes may reflect the values of the dominant culture and a hidden moral framework (Pettifor, 2010). Gil (2006) suggested that a downfall of counsellors who strive to be culturally competent is their inability to take action and utilize skills and knowledge effectively in practice. Regardless, a failure to adjust therapeutic practice to be more inclusive of diversity is irresponsible (Gil, 2006). It is the obligation of counsellors to engage in practices that minimize discrimination and help create a more just society (Arthur & Collins, 2010). Although ethical guidelines may not provide definitive tools needed for culture-infused counselling, counsellors can nonetheless assume a leadership role in which respect and caring are used to acknowledge the diversity of all people in therapy (Pettifor, 2010). Although assuming this role is a significant undertaking that pushes counsellors toward the exploration of both self and others, engagement in this process is necessary to ensure best practice.

## Colonization of Aboriginal peoples in Canada

### *Impact on wellness*

The importance of culture in a Canadian counselling context is particularly crucial for Aboriginal peoples. Collectively, Aboriginal peoples in Canada have endured oppression, discrimination, loss of human rights, displacement, and disconnection from traditional ways of life (Kirmayer, Tait, & Simpson, 2009). The cumulative effects of colonialism have resulted in economic, social, and political inequalities that continue to influence the well-being of Aboriginal peoples. These effects are exhibited in physical, emotional, and mental health challenges experienced by many Aboriginal peoples (Reading & Wien, 2013). The residential school system is one historical example of a colonialist structure that has impeded the health of Aboriginal peoples (Kaspar, 2014). Aboriginal individuals who attended residential schools have exhibited diminished health status when compared to those who did not attend (Kaspar, 2014). Moreover, many Aboriginal peoples are still grappling with the effects of the residential school system, and many of these effects have affected multiple generations (Bombay, Matheson, & Anisman, 2014). For example, the loss of parenting skills by residential-school survivors has created a disconnection between many Aboriginal children and their families (Niezen, 2009). Unfortunately, present-day child welfare systems may also contribute and perpetuate problems related to the care of Aboriginal children (Blackstock, 2008). Overall, the residential school system was a source of distress that perpetuated a cycle of undue hardship for all Aboriginal peoples—a cycle that may continue through the contemporary welfare system.

### *Historical trauma*

To understand the complexity and depth of current suffering experienced by many Aboriginal peoples, the historical context from which trauma originated must be acknowledged. The legacy of suffering imparted on Aboriginal peoples through forced assimilation via residential schools is now well documented and can be conceptualized as historical trauma (Brave Heart, 1998; Evans-Campbell, 2008; Gone, 2013). Many individuals were deeply afflicted by various forms of maltreatment in the form of physical and sexual abuse (McCormick, 2009). According to Evans-Campbell (2008), there are three characteristics of historical trauma that differentiate it from other psychological concerns. Specifically,

historical trauma is (1) generated by widespread events occurring across a population that (2) cause significant collective distress, and that (3) are executed by out-of-group members with intentionally destructive aims. Additionally, historical trauma is transmitted across generations and affects contemporary group members (Bombay et al., 2014). An understanding of the residual effects of experiences of colonialism and their impact on wellness is imperative to understanding the well-being of Aboriginal children.

### *Effects on children*

Enduring consequences of oppression and colonialism have multigenerational effects on Aboriginal peoples, including a psychological impact on Aboriginal children and families. The contemporary effects of colonialism are exemplified in Aboriginal peoples' experiences with stress (Bombay et al., 2014). A familial history of residential-school attendance may increase the frequency with which an individual experiences stress as well as their susceptibility to the negative effects of stress (Bombay et al., 2014). Research findings also suggest that parents who have experienced trauma report social-emotional difficulties in their children (Briggs et al., 2014). In addition, high incidence rates of suicide in Aboriginal populations—particularly in youth—can be at least partially linked to the effects of colonization (Kirmayer, Brass, Holton, Paul, Simpson, & Tait, 2007). Children's experiences within the mainstream education system may also reflect possible colonialist perspectives in school curricula that fail to meet their needs (Ball, 2004). Other factors affecting maternal and child health supporting the well-being of Aboriginal mothers and children have been identified by frontline workers (Health Council of Canada, 2011). These include emotional, financial, and spiritual poverty; overcrowding; a lack of appropriate housing; domestic violence; a lack of self-esteem; and addiction. Clearly, there are a multitude of issues affecting the health and well-being of Aboriginal children.

### *Therapeutic treatment*

Culture-infused counselling should involve an acknowledgment of traditional methods of healing as valuable therapeutic frameworks, and counsellors should strive to integrate these methodologies when they are preferred by clients in order to prevent the continued oppression of Aboriginal peoples. Graham (2013) claimed that the notion of client preference is central to empowering Aboriginal peoples and that counsellors should refrain from making assumptions about the best course of treatment. To prevent assumptions and errors, counsellors should acknowledge the unique cultural constitutions of clients (Collins & Arthur, 2010a). Furthermore, counsellors should ask clients about their preferences and integrate their wishes as much as possible in order to engage in best practice (Canadian Psychological Association, 2000). Some Aboriginal clients may prefer Indigenous approaches to healing (Comas-Díaz, 2011; Hartmann & Gone, 2012; McCabe, 2007), while others may not. Making adjustments to Western approaches to treatment may also provide clients with preferable service delivery options (Kirmayer, Brass, & Valaskakis, 2009). Although child clients may not possess the verbal capacity to communicate their preferences with clarity, it is critical that counsellors honour the preferences of both the child and the family in the therapeutic process to empower Aboriginal clients.

## **Play therapy with Aboriginal children**

To meet the therapeutic needs of Aboriginal children, counselling needs to be both culture-



infused and developmentally appropriate. In addition to providing therapeutic services that validate culture as a critical factor in the healing process, counsellors must balance this with the need to utilize therapeutic orientations that are suited to the unique developmental capacities of a child. A developmental perspective offers a framework for understanding children's behaviours as part of a developmental sequence, which provides information regarding their abilities (DeHart, Sroufe, & Cooper, 2004). In turn, applying a developmental lens when working with children provides counsellors with rich information in guiding case conceptualization and therapeutic decision making suitable to a child's developmental stage (Shokouhi, Limberg, & Armstrong, 2014). Counsellors can interpret children's verbal and nonverbal behaviours and use developmental cues as indicators in determining developmentally appropriate interventions (Shokouhi et al., 2014). Landreth (2012) suggested counsellors must relinquish their need for reality and verbal expression. Instead, counsellors should consider children's phenomenological worlds and rely on alternative forms of expression when suitable. This assertion suggests that counsellors must be willing to work within the parameters of a child's current capabilities.

One counselling approach that provides children with an appropriate developmental framework for therapeutic growth can occur through play. Play is a medium that allows children to engage with their environments, to create new experiences, and to become active agents in their development (DeHart et al., 2004). For example, Landreth (2012) asserted "[that] in play, children discharge energy, prepare for life's duties, achieve difficult goals and relieve frustrations" (p. 9). Play serves a variety of functions that help children utilize personal resources and reveal their individuality (Landreth, 2012). In addition, the safety of play allows children to practice and make sense of their social exchanges and interpersonal experiences and helps strengthen bonds between children and their peers, siblings, and caregivers (VanFleet, Sywulak, & Sniscak, 2010). In turn, children are able to develop strong connections and attachments that foster independence while being able to return to a safe relationship when needed (VanFleet et al., 2010).

Mental health providers are employing the therapeutic powers of play in their work with children more frequently (VanFleet et al., 2010). Children are motivated by play because it is part of their biopsychosocial composition (VanFleet et al., 2010). For children, play is a natural form of communication and one that easily lends itself to therapeutic interventions by skilled practitioners (Landreth, 2012; VanFleet et al., 2010). Play serves as a medium to address psychosocial concerns in a form that frees children of the common restrictions of everyday life, while enabling safe and creative problem solving without real-life consequences (VanFleet et al., 2010). In addition, children may not possess the cognitive, verbal, or emotional capacities to process and express their feelings through talk. Play enables children to transform their concrete thinking into meaningful forms of self-expression in the present, in a way that does not rely on the abstract nature of verbal communication (Landreth, 2012).

Although there are many different frameworks of play therapy, with distinct philosophical and methodological underpinnings (VanFleet et al., 2010), the Association for Play Therapy (n.d.) defines it as "the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development" (para. 1). Meta-analytic reviews of play therapy suggest that it is a viable form of treatment for child clients with a range of presenting concerns (Bratton, Ray, Rhine, & Jones, 2005; Lin & Bratton, 2015). Research findings suggest that play therapy is effective

regardless of differences between theoretical models, although the greatest effect sizes have been noted in studies that utilized humanistic approaches (Bratton et al., 2005). It appears that parents can also fulfill a critical role in achieving positive outcomes (Bratton et al., 2005). Bratton et al. (2005) noted that filial play therapy performed by parents produced enhanced treatment effects when compared to treatment provided by professionals. Schaefer (2010) also claimed that play therapy is an effective form of treatment for children as young as three years of age. In sum, despite differences between various theoretical orientations, it appears that play therapy is a treatment suitable to meet the diverse therapeutic needs of children across stages of development.

## Culture and play therapy

Literature regarding multicultural counselling in the context of play therapy is increasingly focusing on the importance of cultural competence (Gil & Drewes, 2006; Penn & Post, 2012; Yousef & Ener, 2014). Specifically, researchers have emphasized the importance of graduate training courses (Yousef & Ener, 2014) and advanced education courses in multicultural play therapy (Penn & Post, 2012). Penn and Post (2012) suggested that enhanced multicultural training increased counsellors' awareness of White privilege, systemic discrimination, and the racial issues experienced by clients. In addition to developing competence through educational means, Ceballos, Parikh, and Post (2012) reported that play therapists' social justice attitudes were positively correlated with quality multicultural supervision and the number of multicultural continued education credits. These findings are promising in that mental health professionals recognize that multicultural counselling demands an appreciation for the systemic influences that impede a client's well-being. In turn, conceptualizing issues from a systemic perspective allows counsellors to recognize which concerns could be effectively addressed through advocacy. An increased understanding of the value of culture-infused counselling allows counsellors to provide more ethical and relevant therapy to clients.

Although play therapy is an efficacious and developmentally appropriate form of treatment for children with a range of presenting concerns, limited literature and research exists to address how counsellors can ensure that client preferences and cultural considerations are applied to work with Aboriginal children. This is problematic given that mental health and overall well-being is important to healthy functioning for Aboriginal children. As previously mentioned, Aboriginal peoples have been subjected to decades of oppression, racism, and discrimination, which have produced sustained and deep-rooted problems influencing their wellness. Therefore, it is imperative that mental health services afford Aboriginal children the right to access developmentally suitable interventions that are also culture-infused. While some attempts have been made to draw attention to cultural competencies and multicultural practice in play therapy (Gil, 2006), more research and thoughtful considerations by clinical practitioners are needed. In order to engage in ethical practice, counsellors must develop the competencies necessary to provide culture-infused play therapy both to progress psychological practice and to increase successful counselling outcomes with Aboriginal clients.

In the literature available, a few perspectives have been applied to enhancing and understanding work with Aboriginal children. For example, Glover (2006) suggested that an understanding of traditional Aboriginal values, such as generosity and harmony, are helpful in developing competence; however, Collins and Arthur (2010a) cautioned pursuing cultural awareness when acquiring knowledge about another culture. Although it is a responsibility of counsellors to gain culture-specific knowledge to best

help their clients, the authors suggested conceptualizing cultural knowledge in the form of a hypothesis—counsellors should apply cultural understandings as a starting point from which they learn about the clients' individual experiences. These recommendations help counsellors avoid making false assumptions in the form of overgeneralizations or stereotypes. Alternatively, other researchers have investigated which play theories (e.g., ecosystemic and filial play therapy models) are most effective with Aboriginal clients (Boyer, 2011; Boyer, 2010; Glover & Landreth, 2000). Apart from examining broad cultural influences and identifying factors that may be relevant for Aboriginal peoples, more direction is needed for counsellors using play therapy with Aboriginal children.

## Considerations for play therapy with Aboriginal children

### Creative arts

Counsellors using play therapy with Aboriginal children should consider the value of traditional arts as a healing modality. Given that Aboriginal peoples have collectively experienced cultural disconnection historically, traditional arts may provide child clients with the opportunity to use cultural reclamation as a source of healing in the context of play. Creative art activities include writing and storytelling, music, visual arts, movement, dance, and drama (Archibald & Dewar, 2010). Both Western and traditional arts are perceived to have healing benefits and to allow for a deepening and enhancing of the healing process (Archibald & Dewar, 2010). Creative processes may also serve as a protective factor against poor health (Muirhead & de Leeuw, 2012). In a study by Archibald and Dewar (2010), participants of healing programs in Canada identified increased self-esteem, stronger relationships, enhanced confidence, and diminished tension and stress as benefits of utilizing creative processes in therapy. For a child who has had experiences with jewellery making, fabric decoration, beading, and other needle arts, providing craft materials such as fabric, beads, yarn, and other objects may be particularly helpful (Malchiodi, 2008). The benefits to health and wellness associated with creative pursuits are evidence that the arts hold potential for those working with Aboriginal clients.

Music is a type of traditional creative therapy that could be especially helpful. Research participants in a study by Archibald and Dewar (2010) described drum making and drumming as having particular significance for boys and young men. From an Aboriginal perspective, the usefulness of drumming lies in the vibrations produced by the drum, which allows people to feel emotions more readily. Moreover, music has had an important role in Aboriginal healing ceremonies, and drumming connects individuals to the spirit and teachings that are linked to the construction and use of the drum. From a Western perspective, Hilliard (2008) suggested that drumming is a technique that is well received by both children and adolescents and that rhythmic improvisation can be used to facilitate the identification and expression of emotions. It appears that drumming is a powerful therapeutic tool from both Aboriginal and Western perspectives and should be considered a useful treatment modality.

### Cultural symbols and materials

Counsellors should adequately prepare play therapy rooms with toys, symbols, and other play therapy materials that are representative of Aboriginal children's lives and that provide the tools needed to represent and process their experiences. Counsellors could also explore the ways in which nature could be incorporated into play therapy. McCormick (2009) postulated that nature might be a vital component

of healing for Aboriginal peoples because individuals understand themselves to be part of nature and hold a spiritual connection to it. A history of displacement and dispossession of land has contributed to social suffering that has disrupted an intimate relationship with the environment based in tradition (Kirmayer, Brass, & Valaskakis 2009). McCormick asserted that traditional land-based activities might assist Aboriginal clients in feeling more centered and connected to something outside of themselves.

Similarly, Janelle, Laliberté, and Ottawa (2009) reported positive results in enhancing cultural pride and prosocial behaviours using traditional land-based activities, such as hunting, trapping, and game preparation, with Aboriginal youth. These findings suggest that traditional land-based healing activities have potential for not only adults but younger generations as well. It is not surprising that a strong relationship exists between Aboriginal peoples and nature, given that hunting peoples have unique bonds with animals and the environment (Samson, 2009). For some Aboriginal clients, bringing natural materials into the therapy session could be useful in providing a connection with nature. Because a traditional relationship with nature involves a strong tie to wildlife, it is imperative that these elements be represented in a play therapy room. For example, in the Yukon, animals such as caribou, moose, bison, rabbit, and fish are pertinent to northern living (Greer & Strand, 2012). Toy representations of animals should be accessible to children for the purpose of accurately representing their lived experiences. Counsellors should investigate the particular wildlife in their geographical areas that could be relevant to clients in order to ensure appropriate representation in the playroom. Aboriginal peoples' cultural disconnection from the environment suggests that natural materials and land-based experiences that facilitate an exploration between self and culture could hold therapeutic potential.

Counsellors should develop a strong knowledge of symbols pertinent to Aboriginal culture, considering that play therapy approaches often support therapeutic healing through metaphor. For example, when counsellors utilize nonintrusive responding approaches, children may become immersed in the symbolic nature of play and choose objects, activities, and scenarios with no conscious awareness of how these symbols relate to the presenting concerns (Yasenik & Gardner, 2012). Children may use these materials because they provide psychological distance from issues (Yasenik & Gardner, 2012). Counsellors need to select objects that allow Aboriginal clients to represent themselves on an unconscious level. As Ray et al. (2013) asserted, objects and toys must also be diverse because children frequently play with toys from categories such as family/nurturing, expressive, pretend/fantasy, and scary/aggressive. Counsellors must develop the cultural knowledge needed to engage in contemplation and exploration in the treatment-planning stage and must learn more about which objects may need to be included to allow children to represent their experiences. Specific adjustments in objects and materials may be required to ensure that Aboriginal clients can fully express themselves.

Symbolism is a central component of many traditional healing practices that counsellors should be aware of. The medicine wheel is a distinguishable visual representation of many Aboriginal worldviews associate with wellness (McCormick, 2009) and balance (Blue, Darou, & Ruano, 2010). It is composed of four dimensions: mental, physical, emotional, and spiritual (McCormick, 2009). Counsellors incorporating play therapy should acknowledge a holistic approach to healing that might differ from Western theory, as this may be an important consideration in treatment planning. Ceremonies also involve the use of symbolism and may be cultural practices that hold relevance for Aboriginal clients seeking play therapy treatment. Some examples of ceremonies and traditional practices that have been

acknowledged as useful treatment modalities for intrapersonal and interpersonal concerns include, name giving, drumming, singing, and storytelling (Blue et al., 2010). Garrett et al. (2011) suggested that various aspects of the sweat-lodge ceremony involve symbolism. For example, the lodge represents the womb of life, and the stones used in the ceremony are conceptualized as the earth's unwavering healing power. McCabe (2007) also noted the importance of using ceremonies and rituals that utilize symbols and medicine as a method of providing clients with hope, comfort, focus, and a sense of grounding. It is the responsibility of counsellors to demonstrate attentiveness to and respect for various symbols and their use in traditional healing practices and to appreciate that symbolism could be relevant to understanding important aspects of the lives and experiences of children and families.

## Involvement of family and community members in treatment

The value of interconnectedness is emphasized throughout literature related to Aboriginal health (Blue et al., 2010; Kirmayer, Tait, & Simpson, 2009). Counsellors should consider the value of interconnectedness for Aboriginal peoples and be receptive and flexible to the direct and indirect involvement of family and community members, through their active participation in therapy or by inviting recommendations and feedback. Aboriginal clients may hold the belief that a network of relationships to animals, the natural world, spirits, ancestors, extended family, and other people living off the land contributes to a person's identity (Kirmayer, Tait, & Simpson, 2009). The value of involving family or community members in treatment is twofold: it acknowledges the importance of caregiver relationships and family systems, and it demonstrates respect for traditional knowledge and expertise. The success of incorporating family members has been demonstrated in filial (Boyer, 2011; Glover & Landreth, 2000) as well as ecosystemic (Boyer, 2010) play therapy outcomes with Aboriginal clients. These models of therapy incorporate caregivers into the therapeutic process in a way that recognizes that relationships with others are vital to promoting sustained change for children and provide caregivers with helpful relational tools and strategies. In a study examining child rearing from the perspective of members of the Lil'wat Nation, Gerlach (2008) postulated that the family system is a critical social construct that provides valuable support in child rearing as well as decision making when it comes to issues concerning children. These findings affirm that healing is done with the assistance of others (McCormick, 2009) and is indicative of the importance of community for Aboriginal peoples.

Community and family members may serve as integral figures in the therapeutic process. If a member of a client's family or community is not directly included in treatment, counsellors can use a collaborative approach to gain insight from knowledgeable Aboriginal individuals. In traditional therapeutic approaches, relatives and community members are often requested to be involved in client treatments (McCormick, 2009). In addition, counsellors may find the knowledge of community experts, such as elders, to be helpful for clients. Elders often assume multiple roles, including acting as guiding agents toward self-actualization and discovery (Blue et al., 2010) and acting as intercessors for spirit ancestors who share gifts, such as medical knowledge (Adelson, 2009). Given Aboriginal peoples' rich knowledge of well-being, it is imperative that counsellors utilize traditional knowledge to prevent colonial imperialism (Comas-Diaz, 2011).

## Spirituality and traditional healing

For some Aboriginal peoples, spirituality is closely linked to general wellness and therapeutic



healing efforts. Although spirituality may not be overtly salient for a child accessing play therapy, collaborative efforts with relatives and elders may require counsellors to accommodate Aboriginal worldviews that emphasize the importance of spirituality in treatment. Spirituality is inextricably linked to Aboriginal worldviews as well as other considerations for a child in play therapy. Understanding the value of the spiritual dimension in health is central to many efforts to heal holistically and to regain balance (Hunter, Logan, Goulet, & Barton, 2006). Moreover, given that Aboriginal peoples are turning more frequently to traditional ways of healing (McCabe, 2007) and that many individuals from non-dominant cultures distrust conventional methods of healing (Comas-Díaz, 2011), it is essential that counsellors welcome new ideas about how to engage in ethical play therapy practices that empower children and families to seek preferable treatment methods.

Spirituality is part of culture and is emphasized in many traditions, pursuits, and ceremonies. Undoubtedly, then, spirituality can be conceptualized as a thread that is woven into all aspects of Aboriginal healing. According to Adelson (2009), spirituality is perceived as fundamental to and inseparable from healing; clients may believe that they need spirituality in order to heal or that the notion of healing involves the fulfillment of spiritual beliefs and practices. It appears that for some spirituality is intrinsic to cultural reclamation, and a reconnection to traditions that have been relinquished can be therapeutic (Comas-Díaz, 2011). In a study examining how Aboriginal peoples used healing traditions to address health concerns, Hunter et al. (2006) reported that participants described regaining culture as an integral component of healing, which involved learning about ceremonies and using ceremonies to become part of Aboriginal culture. The outcome of connecting to these traditions offered a sense of balance, peace, and comfort for participants and reestablished a relationship to the Creator. The link between spirituality, healing, and cultural connection could therefore be beneficial for Aboriginal clients.

## Recommendations for future practice

Play therapy with Aboriginal children is an important subject of discussion given that Aboriginal peoples are faced with barriers and challenges to experiencing wellness in their lives. More research is needed to understand how counsellors can infuse culture in play therapy with Aboriginal children. The ideas outlined in this article are a starting point for counsellors to consider in therapeutic treatment planning. However, the importance of cultural competence must be underscored in the pursuit of culture-infused play therapy practice with Aboriginal children. Developing this competence requires an introspective exploration by counsellors in understanding their own cultural identities, acquiring awareness of their clients' cultures, and forming culturally sensitive working alliances (Arthur & Collins, 2010). Counsellors must ensure they develop cultural competencies, through ongoing training, education, and collaboration with professionals and knowledgeable group members, in order to integrate cultural knowledge and traditional healing methodologies into their practice with respect and thoughtfulness. Furthermore, counsellors must avoid haphazardly applying cultural knowledge or making assumptions about the salience of culture with regard to presenting issues. To prevent the latter from occurring, it is recommended that counsellors conceptualize the client's case and treatment plan from the perspective that we each hold a unique cultural identity and acknowledge both emic and etic perspectives of culture-infused therapy. Collins and Arthur (2010b) suggested "[that] what is important to competence is an appreciation of the broad brushstrokes that may enhance our understanding of particular groups combined with the unique colourful, idiosyncratic experiences and self-definition of individual clients" (p.



55). When culture is acknowledged as a powerful force in each of our lives, counsellors can consistently consider its value not only for Aboriginal clients but for every client they engage.

## Conclusion

Cultural factors should be an important consideration in the therapeutic process. As awareness and understanding of multicultural counselling increases, counsellors must assume the responsibility in developing the competence needed to work proficiently with diverse clients. However, the most efficacious approach to multicultural counselling is one that positions culture as an integral part of all counselling relationships—not just with clients who are visibly different from the counsellor. In this light, culture-infused counselling allows counsellors to conceptualize presenting problems and treatment based on a client's distinct cultural identity (Collins & Arthur, 2010a). The necessity of culture-infused counselling is particularly relevant to Aboriginal peoples given their collective loss of culture through colonialist imperatives such as residential schools. Moreover, the provision of culture-infused counselling is needed not only for Aboriginal adults but for children as well. Play therapy is a useful treatment option for work with children, but current literature on how to apply cultural competence in a play-therapy context needs to explore further and consider both emic and etic perspectives of culture. Some cultural considerations that may be salient for children in play therapy include the incorporation of traditional arts, the use of relevant materials and symbols, the value of interconnection through participation and collaboration with family or community members, and the role of spirituality. Although these suggestions are simply a starting point in establishing more specific ways to approach culture-infused counselling with Aboriginal children, counsellors can reflect on each of these considerations at the onset of treatment. It is through the process of a thoughtful exploration of clients' distinct cultural identities in relation to their presenting concerns that counsellors can expand the possibilities and avenues for change.

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## An Interdisciplinary Journal

*Honouring the Voices, Perspectives and Knowledges of First Peoples through Research, Critical Analyses, Stories, Standpoints and Media Reviews*

# Counselling within Inuit systems in Canada's North

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## Abstract

*This article builds upon limited resources available to support counsellors working with the Inuit population in Nunavut, Canada. The author discusses the history of Inuit culture with a focus on the intergenerational trauma that stemmed from colonialism, forced assimilation, and the Canadian government's sovereignty efforts. This article addresses the loss of cultural identity that resulted among Inuit people due to these events. An analysis of current statistics and drawing on literature that discusses differences between Northern and Southern Canada reveals the stark prevalence of psychosocial issues such as drug and alcohol abuse and family violence. The modernization of society has contributed to the gap between traditional and modern Inuit culture. This population is in a state of cultural transition and therefore requires culturally sensitive and knowledgeable counsellors. It is the position of the author that by using a family systems therapy approach, the interventions would more closely align with Inuit values and therefore be the best choice when counselling Inuit clients.*

## Introduction

The territory of Nunavut is a unique part of Canada due to its remote location, its high percentage of Inuit people (81% of 37, 000 people) (Nunavut Bureau of Statistics, 2014), and its distinction from many other parts of Canada. Nunavut – like many First Nations communities, reserves, and towns – is home to a difficult history of colonialism, residential school systems, and sovereignty efforts which disregarded the culture of First Nations and Inuit people. Even decades after the last residential school closed its doors, it is in Canada's North where the intergenerational effects of residential schools are most acutely felt (Davison, 2014). The sudden and drastic changes to the Inuit way of life have had lasting impacts on Inuit culture to this day. With the rapid modernization of society, many Inuit people are left trying to connect with the way their ancestors were raised. The ever-increasing presence of non-Inuit service providers, government personnel, and health care workers further distance Inuit individuals from their traditions. The need for mental health support in Nunavut is great. Individuals struggling with past



trauma, substance abuse, identity crises, and family issues, are looking for counsellors that understand their needs and culture. Therapists who wish to provide culturally sensitive therapy to the Inuit population in Canada's North should have an understanding of the traditionally collectivist Inuit social structure, the history of colonialism, and the resulting psychosocial issues. Drawing on family systems therapy which encompasses familial, cultural, and historical dimensions, combined with Inuit societal values is a very beneficial approach. Despite a host of psychosocial issues, housing shortages, food insecurity, and an education system that doesn't measure up to national standards (Healey, 2010); the territory is made up of people with incredible strength and resiliency.

## Gaining background knowledge of Inuit culture

Counsellors working in Canada's North should educate themselves on the history of Inuit culture in order to understand the social and environmental factors affecting their clients. Inuit societal values or Inuit Qaujimajatuqangit translates into, "the Inuit way of doing things: the past, present and future knowledge, experience and values of Inuit Society" (IQ Task Force, 2002, p. 4). Knowledge of these values would assist counsellors by providing them with a better understanding of Inuit clients, thus strengthening their cultural sensitivity. As part of the commitment in the Nunavut Land Claims Agreement, the Government of Nunavut created an all-encompassing mission statement of these principles in order to incorporate both traditional and contemporary values of Inuit people (Arnakak, 2002). Today, Inuit Qaujimajatuqangit has been adapted for practical use in government, public sector, and private organizations. It is guided by several principles which involve acquiring skills and knowledge that encourage one to provide for their community, as well as environmental stewardship which is viewed holistically as including people and wildlife (Arnakak, 2002). All of these guiding principles overlap, revealing the foundation of this society which values the interconnected nature of all involved. These principles provide evidence that Inuit society was built upon community values, shared responsibility, and using consensus for problem solving (Tagalik, 2012). Today they are accepted and integrated within Inuit society.

Colonialism has caused psychosocial issues that are antithetical to mental and holistic health. Survivors of this era experienced isolation, separation from family, loss of identity and loss of their language and culture (Carriere & Richardson, 2013). Young children were often forcibly removed from their homes and communities to attend residential schools which were federally-supported and church-operated (Davison, 2014). Many children were inadequately fed and all lacked the care and nurturing of parents, grandparents, and supportive communities (Harper, 2008). Those who survived residential school returned to families they no longer knew, to cultures and traditions with which they had lost touch (Davison, 2014), and were left to start families of their own. Children who grew up in the residential school system did not have consistent parent role models. As a result, when they later became parents, many re-enacted the same abusive practices. Research by Davison (2014), Dell et al. (2011), Kral (2014), and Sider (2014) suggested that the residential school experience has significantly contributed to drug and alcohol abuse, violence, and sexual abuse issues, compared to non-First Nations and non-Inuit Canadians. It has been found that adults who were reared in dysfunctional settings as children are more prone to psychological distress as adults (Mackrill, Elklit, & Lindgaard, 2012). Thus, the cascading effects of the residential school experience are still felt today; children of survivors that were raised in dysfunctional families are often at risk of repeating the same abusive practices with their own children.

The forced assimilation of Inuit people into Western society caused a significant loss of cultural values and identity within the Inuit population. Elders were no longer valued for their knowledge, thus halting the transmission of traditional practices. This loss has inflicted pain on Inuit society that is only now being understood in Nunavut and across Canada.

Inuit people in Nunavut have faced an immense amount of change in their history; although restoring their culture to pre-colonialism state is likely not realistic, counsellors working in Canada's North can offer appropriate support throughout this cultural transition. Making sure that Inuit people have mental health support that acknowledges their collective experiences and incorporates the historical, cultural and societal contexts of their culture is critical. One way to gain knowledge of these contexts is by learning about traditional counselling practices.

## Drawing from traditional Inuit counselling practices

Few written accounts of traditional Inuit counselling practices exist; however, a book entitled *Ilagiinniq: Interviews on Inuit family values* from the Qikitani Region includes interviews with elders from the territory who wished to pass on their knowledge. From these stories, one can see how traditional counselling was conducted in Inuit culture (Niutaq Cultural Institute, 2011).

As Inuit people traditionally lived in small, tight-knit communities, when one person was having personal or familial problems, the whole community was affected (Niutaq Cultural Institute, 2011). It was in the best interests of the entire community to help people with their struggles. An elder discussed that if someone was struggling, they were expected to handle their problems on their own; however, if people in the community started to notice these problems, attention would be brought to the elders. Certain elders would be designated to counsel others, and those chosen for this position were thought of as specialists in human behaviour and good advisers. The process of traditional counselling would commence with the elders discussing what they should do until they reached consensus. Then the person causing disturbances would be brought to either one-on-one counselling with an elder or to a group of elders, sometimes using a false pretense to draw the individual in. The elders would reprimand the individual until he or she took responsibility for their actions and confessed wrongdoing. At times, counselling would involve physically holding the person's face up if they felt ashamed and tried to look at the floor. Those being counselled would often be brought to tears as it was seen as important to let out all emotions. If counselling did not work the first time, the individual would be counselled repeatedly. Elders were responsible for teaching the community to live a good life together as those who tried to survive alone would only end up injured or dead. Group consensus with the whole community was sometimes used in counselling practice where the community would surround the individual while the elders talked to them. This method was also thought to prevent gossiping (Niutaq Cultural Institute, 2011).

As explained in this account of traditional counselling practices, one can see that individualistic counselling was not as preferred. It was the understanding that the actions of one individual could affect the entire community; therefore, everyone was responsible for helping the individual heal. Family systems therapy utilizes aspects of this traditional approach such as reaching consensus and soliciting support from family members who could assist with the process of healing. However, aside from counsellors in Nunavut equipping themselves with knowledge of Inuit history, the mental health workforce first needs to be expanded.

## Unique psychosocial issues among Inuit in Nunavut

It is common to see devastating statistics in the media which reveal problems in Northern Canada. The limited resources are not for lack of need, as the statistics set the territory of Nunavut apart compared to the rest of Canada. The issues discussed in the following section are not unique to Nunavut or Inuit people. Rather, the statistics show a striking prevalence of these issues within a very small population.

According to 2011 census data, the highest rates of police-reported family violence were found in the territories. The rate of family violence per 100,000 people was 3,294 in Nunavut compared to an average of 279 for the whole of Canada (Nunavut Bureau of Statistics, 2013). This rate does not account for the numerous cases of family violence that go unreported. Perhaps the most tragic statistic in Nunavut is the high rates of attempted and completed suicide in the territory. Suicide in Nunavut occurs at a rate of about 110 deaths per 100 000 people, which is about 10 times the rate in the rest of Canada (11 per 100 000) (Eggertson, 2013). Researchers from McGill University found high rates of childhood sexual and physical abuse, depression, as well as alcohol and marijuana abuse in the histories of 120 people who took their own lives between 2003 and 2006 (Chachamovich & Tomlinson, 2013). Rates of suicide attempts and suicidal ideation (thoughts of dying by suicide) are also very high in Nunavut (Chachamovich & Tomlinson, 2013). Victims of childhood abuse attempt or complete suicide significantly more often than those who were not maltreated in childhood (Chachamovich & Tomlinson, 2013). By identifying the reasons behind suicidal behaviours one can better understand the realities individuals in Nunavut face and the need for appropriate assistance.

From their extensive study of determinants of suicide in Nunavut, Chachamovich and Tomlinson (2013) concluded:

the rapid increase in suicidal behaviour in recent decades, especially among young people, is probably the result of a change in the intensity of social determinants – among them is the intergenerational transmission of historical trauma and its results [which may include] increased rates of emotional, physical, and sexual abuse, violence and substance abuse, etc. (p 51).

This research suggests a correlation between high rates of suicide and the prevalence of psychosocial issues in the territory. The following section will discuss several independent, yet often interrelated, psychosocial issues including historical trauma, substance abuse, and family violence.

### Historical trauma

Historical trauma can be defined as multigenerational trauma experienced by a specific cultural group. It manifests in a range of dysfunctional behaviours that then inform the learning environment of subsequent generations (Pihama et al., 2014). Historical trauma is particularly destructive as it effects those who were directly and indirectly involved in the event(s). Some people who suffered during those years have since healed, but many others are passing historical trauma on to their children (Hicks, 2009). Survivors are now adults with their own children. The current generation of young people is now being raised by those whose parents had been students in the schools. The ripple effect of damaging parenting practices and traumatization are being passed down through the years (Davison, 2014).

Children who are raised in dysfunctional homes are at risk of psychological distress as adults. Some of the factors which constitute a dysfunctional home are: the presence of mental illness, the presence of substance abuse, witnessing or being the victim of violence and the absence of one or both caregivers (Mackrill et al., 2012). Adult children from dysfunctional families often develop coping strategies which helped them survive their tumultuous upbringing, but manifest as unhealthy patterns in adulthood. Thus, a common avenue for intergenerational transmission of historical trauma is family dysfunction, which impacts the social and emotional well-being of children through high rates of adverse childhood experiences (Hicks, 2009). The experience of being removed from the family home as a child to attend a residential school that imposed strict rules, a new language and in some instances physical, sexual, and emotional abuse has caused immense trauma among survivors. Those who survived their experience often turned to alcohol and drugs to cope with their pain (Kral, 2013).

### *Substance abuse*

High rates of alcohol and drug abuse persist in the territory despite the complete prohibition of alcohol in some Nunavut communities. Various complexities related to alcohol abuse exist which add to the importance of counsellors gaining an understanding of the factors that influence problem drinking (a spectrum of alcohol use that may result in numerous health, legal and social problems). According to Kral (2013), alcohol appears to be more of a problem for the middle-aged, residential school generation. Among Inuit, alcohol-related suicide, family violence, and disruption to family are frequent (Seale, Schellenberger, & Spence, 2006). Heavy drinking (five drinks or more on a single occasion) is common in parts of Nunavut with close to 9 out of 10 consumers having drunk heavily at least once in the past year (Nunavik Inuit Health Survey, 2004). Alcohol use is also linked to homicide, family violence, and numerous health problems (Seale et al., 2006).

The most prevalent drug in Nunavut is marijuana (Kral, 2013). However, solvent abuse is becoming more common, especially among Inuit youth. Solvent abuse among First Nations and Inuit youth has been linked to high rates of poverty, boredom, loss of self-respect, unemployment, family breakdown, as well as poor social and economic structures (Dell et al., 2011).

Magnifying substance abuse problems further is the lack of in-territory addictions treatment facilities. With limited addictions resources, interventions are almost always made by police and hospital staff. Once the individual is assessed as no longer a danger to themselves or others, they are discharged and generally return back to their home. Further, those who are sent out of territory for addictions treatment return to their community with limited after-care resources (Healy, 2010). Counsellors working in Canada's North should be prepared to assist Inuit clients with complex substance abuse issues with little in-territory assistance. Alcohol is often used as a coping strategy for adults brought up in dysfunctional families. The risk for further dysfunction increases in these families as the problematic use of alcohol is greatly associated with the presence of violence among couples in Nunavut today (Burkhardt, 2004).

### *Family violence*

It is not uncommon for Inuit children to witness violence between parents, most commonly, the father abusing the mother (Kral, 2013). A report titled, *Qanuippitali Inuit Health Survey: 2007–2008*,

revealed 31% of respondents had been victims of severe physical abuse during childhood (Eggertson, 2013). Taking out pain and suffering on those closest to the traumatized individual through physical, emotional and sexual abuse is a common dysfunctional coping pattern. The most notable and negative effect of colonial history among Inuit appears to have been on family relations, providing yet another example of cultural discontinuity (Kral, 2013). Individuals reared in an environment where physical, sexual, and emotional abuse was common, may be predisposed to using violence also. Individuals living in the territories are at far greater risk of being a victim of violence than anywhere else in the country (Davison, 2014).

The Qanuippitali Inuit health survey indicated a staggering 41% of Inuit in Nunavut suffered severe sexual abuse as children (Eggertson, 2013). Individuals who experience these and other types of maltreatment in childhood are more prone to psychological distress as adults. Child abuse and sexual traumatization have long-lasting effects on mental health, such as a wide variety of cognitive and emotional disturbances, later problems with drug and alcohol abuse, risky sexual behavior, a tendency to become overweight, and higher risk for criminality both in childhood and in adulthood (Jacobi, Dettmeyer, Banaschak, Brosig, & Herrmann, 2010). Coping with psychological distress is made more difficult for individuals in Nunavut who are also navigating major cultural changes in their society.

## Modernization of society

Although numerous factors have impacted changes in Inuit society, this article has discussed colonialism and residential schools as the catalysts for a process of change that has continued on. After the residential schools closed, individuals moved home, and settlements began growing into communities. The territorial government was shifting, police presence was larger and health care centers with Western medicine practices were being opened. Schools with non-Inuit teachers were opening and people from Southern Canada were moving to the Northwest Territories (present-day Nunavut) to work. Today, many high-level government jobs are filled with non-Inuit employees. Therefore, government priorities may move further away from traditional values as Inuit priorities may not align with the Western wage-based economy. In a study by Brown, Fraelich, and Ahnungoonhs (2013), researchers surveyed social workers in a First Nations community regarding job satisfaction. Results concluded that among First Nations social workers living and working in their home community, job satisfaction came primarily from serving their community. Participants did not report money as a benefit to working in their own community, nor did they describe moving up in their job. Instead of personal autonomy, participants referenced their appreciation of teamwork and collective efforts of staff as well as the agency as a whole (Brown, Fraelich, and Ahnungoonhs, 2013).

Today, there is less reliance on knowledge from Elders, thus less transmission of traditional cultural identity. There are lower levels of Inuit language acquisition among youth, causing language barriers between youth and elders, which is one aspect that contributes to a change in cultural identity (Tagalik, 2012). School systems are attempting to encourage more youth to acquire traditional knowledge. For example, elders will be incorporated more prominently into Nunavut schools for teacher and student support. At times, positions may include supportive counselling services in conjunction with the School Community Counsellor and Guidance Counsellor (Laugrand & Oosten, 2011).

Cultural identity is a central part of healing, recovery, and empowerment. The Inuit cultural



identity is a holistic entity that takes into account social, historical, and communal experiences. At all levels of service in Nunavut, support is needed that addresses the shame that some people carry regarding the residential school experience and other experiences of trauma and the need for comfortable places for working through stress and vicarious traumatization (Poole, Chansonneuve, & Hache, 2013). Using a family systems approach to counselling would solicit the support of family and community members, therefore building upon aspects of Inuit societal values.

## Using a family systems approach

In learning about Inuit culture, one can see that collectivistic tendencies and a focus on the community differentiate Inuit culture from Western cultural values. Western individualism creates barriers to holistic health for indigenous people (Carriere & Richardson, 2013). Working with Inuit clients in the context of their family, community, and the interconnected reality of their culture may help counsellors working in Canada's north ensure cultural sensitivity. Counsellors who use a systems approach while incorporating values from Inuit Qaujimaqatigangit may be more effective because historically, counselling focused on the individual in the context of their systems. Family systems and social approaches that build upon interpersonal supports and kin and familial relationship networks would support two of the Inuit societal values of Pijitsirniq: Serving and providing for family and/or community and Piliriqatigiinni/ Ikajuqtiigiinni: Working together for a common cause (Arnakak, 2012). The importance of building upon the foundation of Inuit culture has become obvious as past events of imposing Western ideas has resulted in cultural loss. Therapy with a focus on the relationships between people, and practices that promote healing, positive change, and new ways of being have been key in family therapy (Richardson, 2012).

Shifting focus from an intra-psychic to a family and community systems theory approach (more aligned with systemic ideas of family therapy, social psychology, feminism, activism, and social justice work) relates to the ethics of working respectfully with First Nations communities (Carriere & Richardson, 2013). A family systems approach would be an appropriate intervention for counsellors to use in situations where family members are available and willing to engage in therapy, to contribute to problem resolution and to disengage from the family processes that maintain the identified clients' presenting problems (Carr 2014).

Family systems interventions aim to reduce distress while concurrently increasing support systems (Carr, 2014). This is done through engaging the client's family members through participation in either family or couple counselling. In the initial phase the focus is on increasing the ratio of positive to negative interactions, decreasing demoralization and generating hope by discovering areas for possible change. The second stage focuses on helping clients jointly reflect on positive and negative recurrent patterns of interaction, destructive belief systems and underlying relationship themes. Finally, the third phase of treatment would involve avoiding the reoccurrence of destructive behaviours, primarily, helping clients develop plans if they begin to fall back into problematic patterns. Throughout all phases of therapy, the therapist would encourage clients to practice positive communication skills with each other in between sessions (Carr, 2014). Using an approach such as this would focus less on the individual and more on the context of their situation. The individual would be supported throughout the counselling process and afterwards by their family members.



Family systems therapy can appropriately address many of the prevalent psychosocial issues that many Inuit people face. This type of approach can assist individuals suffering from post-traumatic stress disorder (PTSD); such as survivors of the residential school system in Nunavut. Research by Pukay-Martin et al. (2015) found that PTSD symptomatology negatively affects partners and relationships. Additionally, certain partner behaviors have been shown to negatively affect individuals' PTSD symptoms and treatment. For example, the partner of the individual with PTSD may facilitate avoidance of stressful events, thereby reducing the client's engagement in potentially pleasurable experiences. Therefore, enlisting the partner and family of the client suffering from PTSD would help support trauma recovery in a way that is consistent with therapy. Research by Carr (2014) suggested that engaging the client's family system and community can be effective when treating those who have issues with alcohol and drugs. A family systems approach may help sober family members improve communication, reduce the risk of being physically abused, and encourage sobriety and treatment-seeking in people with alcohol and drug problems (Carr, 2014). In situations involving intimate partner violence, systems therapies have been found to be more effective than one-on-one counselling (Carr, 2014).

The main philosophy behind systems theory, which views the individual within the context of their relationships, aligns with Inuit culture. Allowing and encouraging Inuit clients to engage with their families and communities when coping with difficulties would reconnect these clients with their cultural values. Inuit Qaujimagatunqangit reflects traditional values which encourage actions which serve one's family and community. Therefore, using a counselling approach which moves away from an individualistic perspective and towards a collectivistic mindset would be more culturally sensitive.

When counselling Inuit clients in Canada's North, counsellors must consider their own cultural biases.. Cultural sensitivity in counselling includes five key components: the analysis of personal, professional, and health system cultures and their impact on the patient or community; diversity, recognition, and legitimacy of difference; consideration of historical, social, economic, and political influences on health and healthcare experiences of individuals and communities; recognition of power differentials between the patient and the counsellor; and the involvement of the client (Oelke, Thurston, & Arthur, 2013). Counsellors should focus on relationships and social justice with a critical analysis of historical, political and social knowledge of individuals and their culture (Oelke et al., 2013).

An integrated family systems approach could strengthen the existing services and build capacity for individual communities to address and guide their unique needs for mental health and wellness (Healy, 2010). A holistic approach would assist counsellors in the provision of treatment that is culturally sensitive, respectful of northern ways of knowing and understanding health, and inform solutions for focused after care plans (Healy, 2010). Additionally, building interpersonal supports within existing kin and family relationship networks that are long term, self-sustaining and self-directed (Tagalik, 2011) would benefit Nunavut long-term. The residential school events endured by Inuit people has caused lasting damage to their traditional ways of being. In order to best support Inuit individuals to heal, the counselling practices used should be built from the foundation of this culture. Counsellors should use a practice which involves negotiating an understanding of the client's self in community - with therapy grounded in that negotiation - while validating the selves of the clients and respecting the uniqueness of each individual (Robertson, Holleran, & Samuels, 2015). Facilitating cultural viability and identity in Inuit

clients can provide a basis for all other types of health as it cultivates the collective social supports for the individual, and grounds their sense of belonging (Tagalik, 2011). Some First Nations communities in Canada have adopted systemic approaches to community counselling and are seeing success, Nunavut could benefit from similar methods.

## Current program development in First Nations communities

It has been demonstrated that using a family systems approach to counselling would align with fundamental Inuit cultural values and be most beneficial; other First Nations regions of Canada have programs which lend evidence to this proposal. Systems approaches are currently being used with First Nations populations in programming, employment centers and community development projects. Robertson et al. (2015) supported the idea of integrating systemic counselling when working with First Nations clients. They stated that “using a community [systems] approach would allow clients to situate themselves in a collective framework with respect to family, community, and their Nation” (p.132). These researchers also emphasized the importance of the counsellor embodying the cultural values, not only discussing them. In order for the counsellor to become identified as part of the community, “counsellor visibility in both formal and informal settings should be maintained on an ongoing basis (e.g. traditional feasts)” (Robertson et al., 2015, p.132). This way, the counsellor becomes identified as part of the community that these individuals are a part of. This example illustrates a clear contrast with Western counselling practice, which often recommends limited self-disclosure and non-acknowledgement of clients outside of the counselling room.

An example of a family systems model being used currently is within the Centre for Northern Families in Yellowknife. The staff of this facility developed a family support model of practice that trains families to provide peer support within the community (Robertson et al., 2015). First Nations, Métis and Inuit elders described this model as a traditional approach they have always understood. In the model, individual family members, including children, identify goals and strategies that are subsequently negotiated within the family and community context. Using a community development approach and allowing clients to situate themselves in a collective framework with respect to family, community, and their nation provides an opportunity to reconnect with lost cultural identity (Robertson et al., 2015).

Another example is the work done in British Columbia by the Northwest Inter-Nation Family and Community Services (NIFCS) agency. This agency works with First Nations youth who are in the foster care system. Each First Nations youth in care has a cultural plan of care which ensures the individual remains connected with their community and cultural identity (Bennett, 2015). This agency recognizes that in First Nations cultures, children grow up in their community, receive cultural and spiritual guidance from their Elders, and have opportunities to participate in ceremonial events. To reflect those values, this agency began celebrating major milestones in their client's lives through cultural ceremonies. One event was described where a female youth was leaving the foster care system after 11 years in care. The ceremony was attended by biological and foster family, elders, community members, friends, agency staff and other professionals. By celebrating this youth's accomplishments and transition into adulthood, she was able to draw on cultural strength and resiliency (Bennett, 2015). This ceremony highlighted supports and resources that were available to this young person as she moved into independence. Follow up support was provided by NIFCS staff to ensure she has the support she needed (Bennett, 2015).

Development of future programs such as those run at the Centre for Northern Families and the NIFCS would benefit the territory of Nunavut as a whole. Integrating traditional knowledge from elders and pre-existing values would assist counsellors in being culturally sensitive. Offering counselling practices which are aligned with Inuit cultural values will assist individuals in supporting themselves, their family, and their community.

## Conclusion

Counsellors working in Canada's North would be best prepared to effectively assist Inuit clients after understanding the difficult history within the territory. Colonialism and residential school experiences are responsible for numerous psychosocial issues within this population today. By looking at traditional methods of counselling and identifying Inuit foundational values, counsellors would begin to understand this collectivist culture which prioritizes family systems and community before the self. Counselling support should be aligned with that foundation to best support the needs of this population.

After the damaging effects of the residential school system on Inuit culture and the cultural transition that was sparked, the chance to revert to traditional practices may be out of reach. Due to the increasing population of non-Inuit people moving to Nunavut and the limited mental health services, a great need for culturally sensitive counselling exists. Family systems therapy can address many of the psychosocial issues faced by Inuit people as the theory aligns with traditional values and solicits the support of community and family members. This approach allows for a more holistic perspective and enables counsellors to integrate a social justice lens into their practice.

It is the position of this author that using a family systems approach in counselling and community programming such as those being used in other First Nations populations would benefit the territory of Nunavut immensely. Linking family systems therapy with Inuit culture provides a culturally sensitive approach for counsellors working in Canada's North that would enable them to better assist their clients. In order to help Inuit people heal, counsellors, health practitioners, and even government personnel should align with the foundation of Inuit culture to give the opportunity for Inuit cultural identity to be reclaimed.

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## An Interdisciplinary Journal

*Honouring the Voices, Perspectives and Knowledges of First Peoples through Research, Critical Analyses, Stories, Standpoints and Media Reviews*

## Using a community of practice model to create change for Northern homeless women

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### Abstract

*This is a story about three virtual and face-to-face communities which met in the capitals of Canada's three Northern territorial cities over a two-year period to discuss and act on culturally safe and gender-specific services for Northern women (and their children) experiencing homelessness, mental health and substance use concerns. It is a story of how researchers and community-based advocates can work across distance and culture, using co-learning in virtual communities as a core strategy to create relational system change. The three communities of practice were linked through a pan-territorial action research project entitled *Repairing the Holes in the Net*, in which all participants: learned together, mapped available services, discussed the findings from interviews with northern women about their trajectories of homelessness, analyzed relevant policy, planned local service enhancements, and generally took inspiration from each other.*

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## Introduction

Repairing the Holes in the Net was a 2-year project aimed to inform the development of culturally safe and gender-specific services for northern women (and their children) experiencing homelessness, mental health and substance use concerns.<sup>34</sup> It became a story of how researchers and community-based advocates can work across distance and culture, using co-learning in virtual communities as a core strategy to create “relational system change” (Markoff, Finkelstein, Kammerer, Kreiner, & Prost, 2005).

The project was led by researchers and community advocates working with northern and Aboriginal women who were homeless or at risk of homelessness in the following organizations: The British Columbia Centre of Excellence for Women’s Health, the Four Worlds Centre for Development Learning, the Yukon Status of Women Council, the Council of Yukon First Nations, the YWCA Yellowknife, the Centre for Northern Families, the YWCA Agvvik and the Qullit Nunavut Status of Women Council.

## Our co-learning approach

Repairing the Holes in the Net chose a community of practice (CoP) approach as its key methodology for creating a shared reflective practice space that could stimulate a shift in the system or “net” of services aimed at addressing the needs of homeless women in the North. The primary purpose of a CoP is to deepen knowledge and expertise (Wenger, McDermott, & Snyder, 2002). Individuals participate in a CoP to share skills and information with others and, in turn, to learn from the experience and knowledge of their colleagues.

The project invited participation from government departments and service agencies from such diverse sectors as addictions, mental health, primary health care, justice, housing, police, income support, child protection, shelters and women’s advocacy. In the course of meetings held approximately monthly over two years, participants in each of the three northern territories<sup>5</sup>:

- Learned from each other as they shared the challenges and successes of the work being done by their own agencies and programs;
- Considered the relevance of conceptual models from the literature as well as practical examples of service delivery approaches that have demonstrated promise elsewhere;
- Reflected deeply on the implications for their own individual and collective practice of the data collected from the interviews and focus groups with service users and service providers carried

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<sup>3</sup> This applied health services study was funded by the Canadian Institutes for Health Research (CIHR), in partnership with the Mental Health Commission of Canada (MHCC), through the Partnerships for Health System Improvement (PHSI) Program.

<sup>4</sup> An overwhelming majority of homeless women in the North are Aboriginal, as identified by earlier research by the Repairing the Holes in the Net team, captured in the You Just Blink and It Can Happen: A Study of Women’s Homelessness North of 60 report.

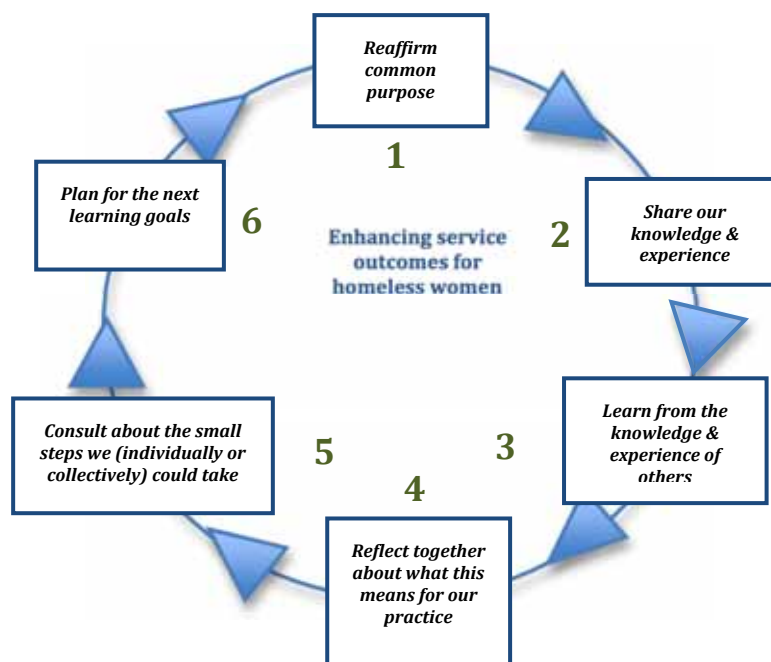
<sup>5</sup> Canada’s three Northern territories are Yukon, Northwest Territories and Nunavut. The community of practice meetings were held in the capital cities of these territories (Whitehorse, Yellowknife and Iqaluit).

out as part of the Repairing the Holes in the Net project;

- Designed and implemented a service innovation initiative that they could take on to test what they learned about pathways for achieving better outcomes for homeless women with mental health/addiction issues; and
- Continuously set new learning and practice goals, while retaining a clear focus on practice improvement.

These steps were incorporated into this simple graphic that served as a model for structuring the community of practice process in each of the three northern territories (See Figure 1).

**Figure 1 – The CoP process**



## Deepening understanding of foundational practices

The Repairing the Holes in the Net territorial CoPs began their work by sharing and discussing what is known about promising practice from the literature, and from the comparable work by others in different locations. Academic literature, grey literature and web-based searches were conducted to identify approaches, programs and policies addressing mental health concerns, homelessness, addictions and the experience of violence for women in general and in the northern context. Key components of programs and approaches were extracted and synthesized into preliminary report documents, circulated to members of the CoPs, and discussed and analyzed throughout the CoP process. Northern service providers and decision makers engaged in discussions of the relevance of these guiding approaches, and how these might be effective in specific, northern cultural contexts. Three critical themes emerged from

this early collaborative study, and they became lenses through which later work on systems change was viewed:

1) *The gendered nature of the experience of northern homeless women with mental health and addiction issues*

Service systems are often blind to the gendered nature of the experience of mental illness and substance use problems, and do not incorporate gender-informed responses (Greaves & Poole, 2007). The communities discussed how trauma arising from interpersonal violence such as childhood abuse, intimate partner violence and sexual abuse is generally greater for women than for men, and how women exposed to violence develop post-traumatic stress disorder approximately twice as frequently as men (Ad Hoc Working Group on Women, 2009). Women are also more likely to be disadvantaged relative to many of the social determinants that contribute to mental ill health (e.g. poverty, social marginalization, lack of agency) (Benoit & Shumka, 2009; Spitzer, 2005). Gender affects the response to women with mental health concerns. There are discernible differences in the diagnoses and treatments offered to women as compared with men, for example, women are more often prescribed psychotropic medications such as benzodiazepines (Currie, 2003; Salmon, 2006). We also found and examined program examples where homeless women were being offered holistic, gender- and trauma-informed support (Paradis, Bardy, Cummings Diaz, Athumani, & Pereira, 2012).

2) *The importance of incorporating First Nations and Inuit cultural perspectives and approaches to understanding mental health concerns and supporting women who struggle to remain housed and living well*

The community participants shared and discussed key features of Aboriginal perspectives on colonization, reconciliation, wellness and approaches to healing. A key theme in these discussions was that mental health or wellness cannot be separated from a holistic understanding of the interrelationship between all the dimensions (mental, emotional, physical and spiritual) of an individual's life (Vicary & Bishop, 2005). The health of individuals, of families and communities are interconnected, and it is impossible to conceive of healthy individuals apart from healthy communities and vice versa (Royal Commission on Aboriginal Peoples, 1996). Mental health issues in Aboriginal communities cannot be separated from the colonial history of those communities (Maar et al., 2009). The many faces of mental ill health, such as substance abuse, violence, psychiatric disorders and suicide, are not separate problems, but rather manifestations of the same underlying social context (Lavalley & Poole, 2010). Cultural safety and responsiveness to the identity and wellness of Aboriginal women need to characterize the response to women's homelessness, mental illness and substance use problems (Acoose, Blunderfield, Dell, & Desjarlais, 2009; Ball, 2008; Brascoupé & Waters, 2009).

3) *The role of trauma as an underlying factor in the mental health and addictions concerns of northern women*

The participants spent considerable time learning about the effects of trauma, trauma-informed approaches and healing. Northern women face overwhelming life circumstances such as interpersonal violence; poverty, hunger and cold; the legacy of adverse early childhood experiences; unresolved grief;

persistent exposure to discrimination and racism from many segments of the dominant society; and lack of access to real education and employment opportunities (Bopp et al., 2007). Most women are also impacted by the legacy of intergenerational trauma that derives from the historical experience of Aboriginal peoples of missionization, residential schooling, the discriminatory and punitive policies and practices of federal and territorial governments and economic exploitation (Aguiar & Halseth, 2015; Royal Commission on Aboriginal Peoples, 1996). Trauma-informed approaches to service delivery that do not require disclosure of trauma or pathologize people's experiences are increasingly being applied (Jean Tweed Centre, March 2013; Poole, Urquhart, Jasiura, Smylie, & Schmidt, May 2013). Trauma-informed approaches focus on creating safe, welcoming services that do not retraumatize (Greaves & Poole, 2012; Prescott, Soares, Konnath, & Bassuk, 2008).

These three themes, and the way in which they are braided together, were visited and revisited by the communities of practice. The community of practice (CoP) model supported a range of other collective activities underlying system change including: mapping/appreciating existing services and policy strategies; reviewing and synthesizing the perspectives of homeless women and service providers (derived from interviews) about trajectories of service access and ideas for service improvement; and identifying and piloting some initial actions designed to address the need for improvement in the response to northern homeless women. The overall learning focus, the relationship building and the strengthening of knowledge about these three key approaches—trauma informed, gender informed and culturally relevant and safe—which can be integrated to serve as a foundation for service system design, were highly valued by participants.

## The key elements of communities of practice as locations for stimulating systems change

Most of those participating in the CoPs had experience with cross-departmental committees or working groups as strategies for attempting to address challenges that overlap typical government jurisdictions. These types of bodies tend to be formal groups with a delegated authority and clear mandates related to developing policies or plans. CoPs differ from such planning committees in several important ways. Denscombe (2008) clearly describes this difference:

Compared with formal groups created within organizations whose structure, tasks, and identity are established through functional lines and status hierarchies, communities of practice hinge on the fact that they can, and do, transcend boundaries of departments, organizations, locations and seniority. It is crucial to the whole idea of communities of practice that they come into existence through the need to collaborate with those who face similar problems or issues for which new knowledge is required (p. 276).

### *CoPs pay attention to relationships*

The word “community” in community of practice is deliberate. The CoP process is designed to foster relationships characterized by openness, trust, respect and authenticity. CoPs are deliberately non-hierarchical and work conscientiously to become safe spaces for all members to share their experiences, concerns and ideas in an atmosphere of mutual support. It is recognized that change comes from paying attention to how we relate to each in a system of services as much as it does from what we do.

### *A key dynamic of CoPs is learning*

The stimulus for learning can be both reflection on practice (i.e., things that the members have tried or are trying to do to achieve their goals) as well as effective practice and concepts from the literature or from resource people. Listening to the voices of those with lived experience of the focus issue can also be a vital avenue for learning.

### *CoPs are geared to stimulating change*

Effective CoPs use a highly dynamic iterative process that creates a collaborative platform for reflecting on past actions, learning, considering options for change, and trying out innovations.

## **The outcome of facilitating relational system change**

In creating voluntary, relational, learning communities in Whitehorse, Yellowknife and Iqaluit with facilitation by invited southern researchers, it was possible to honour experiential wisdom, practice wisdom, policy wisdom, research evidence and traditional Indigenous ways of knowing. In this way the CoP model had the potential to redress exploitative research processes, and bridge north/south isolation. Participants identified how the CoPs encouraged them to keep going, in the face of so little progress on the determinants of homelessness such as poverty, access to trauma-informed mental health and addiction services, societal indifference or animosity, racism and punitive social policy. The CoP became a space to share struggles, but also to feel hope that collaboration could bring some positive changes.

The CoP helped participants experience being part of a larger, supportive net of service providers and to reflect on ways that this culture of openness could penetrate their own agencies more deeply. Part of this evolving culture was the development among CoP participants of a common, respectful and inclusive language to share experiences, insights and suggestions for moving forward. In some cases, partnerships emerged, based on the need by shelter and other voluntary sector services to work with governmental child protection and income support services to make a difference in outcomes for homeless and at-risk women with mental health challenges.

During the CoP meetings, trauma-informed practice was identified as a critical construct in service provision to vulnerable women experiencing homelessness and this focus sparked dialogue in the communities. As a component of trauma-informed practice, participants identified the importance of creating more inclusive, non-judgmental, and welcoming spaces and interactions with individuals seeking services. CoP members described that they are now much more aware about the impact of the way that they interact, not only with clients, but also with their co-workers and colleagues in other agencies. A shared commitment to incorporating the principles and strategies central to culturally safe and trauma-informed practice was made in each territory.

All in all, using a communities of practice model, the *Repairing the Holes in the Net* project was able to enact key touchstone principles of holism, structural intervention and non-discrimination (Blackstock, Cross, George, Brown, & Formsma, 2006). The CoP approach fostered dialogue between the community, researchers and agencies (community-based and government) and celebrated these dialogues as locations from which hope for change emerge. It is hoped that CoP participants, and an ever widening circle of research, practice, and policy collaborators, will continue to be empowered to influence systems

that can offer a net of support to northern Aboriginal women who face homelessness and other health and social concerns.

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