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MOVING SYSTEMS TO CULTURAL SAFETY

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Editorial

Moving and enhancing system change

All Indigenous peoples across the globe have experienced multiple historical colonial aggression and assaults. In Canada and the USA for example, education was used as a tool of oppression for Indigenous peoples through residential school. Child welfare, health and health care, and forced land relocation are also sites of intensive and invasive harms.

Health services continue to be a site of systemic and personal oppression for Indigenous peoples across Canada and the world (Reading 2013). For many years, Indigenous peoples have faced discrimination and racism when accessing biomedical health care. Implementation of colonization in Canada, Australia, New Zealand, and elsewhere, have been well documented to adversely influence aspects of health in many Indigenous communities worldwide and linked to high rates of mental health, education, and employment challenges (see Loppie & Wein, 2009; Mowbray, 2007; Paradies, Harris, & Anderson, 2008); these traumas are rooted attempts in cultural extermination and deep-set pains in regard to identity and well-being (Stout & Downey, 2006; Thurston & Mashford-Pringle, 2015).

In Canada, the Indian Act (1876) outlawed Indigenous healing practices and traditional healers, traditional healing ceremonies, such as sweat lodge, smudging, potlatch, and more, and the use of traditional medicines. These systemic legislative changes to Indigenous peoples' lives effectively made illegal the practice of traditional health and wellness for Indigenous peoples and replaced them with ineffective and underused biomedical mental health service (Loppie & Wein, 2009). Currently, healing and health promotion for Indigenous peoples who are surviving colonial traumas can begin through the reconnection and the relationship with current Indigenous traditional knowledge as well as through reducing experiences of personal and systemic racism and oppression within biomedical health care (Richmond, Ross, & Bernier, 2007).

Research by Stewart (2016; 2017) and others (Allan & Smylie, 2015; Smylie & Anderson, 2006) has shown a generally poor Indigenous experience of health and mental health services, despite efforts

to enhance cultural competency and culturally based service by Indigenous organizations and some biomedical community health centres and hospitals.

There has been an evolution of cultural care in Canada and worldwide. Despite well-meaning efforts to create cultural awareness and sensitivity, initially in the 1980s, among health care providers, little has been done to improve the health care system until Maori nurses in New Zealand introduced "cultural safety". Papps and Ramsden (1996) described cultural safety as having knowledge about the context and culture of people who are culturally different from the self in a way that acknowledges and addresses social and political power inequities toward a goal of self-determination for the patient and decolonization for the health care provider.

Cultural safety is defined by Papps and Ramsden (1996) as high-quality health care for individuals of diverse ethnicities in that it addresses value and identity difference, uses empathic listening and speaking, and holds health care providers to self-reflection in this process, and has an overarching goal of empowerment, advocacy, and collaboration.

Researchers and practitioners in health have suggested that employing a Western paradigm of both health and education with Indigenous peoples is a form of continued colonial oppression…and this continues to perpetuate intergenerational trauma (see Gone, 2004; Smylie, 2001; Stewart 2008). Cultural safety as both a framework and practice offer both health researchers and practitioners an alternative to colluding with a current colonial biomedical western system. As with any new framework, prescribed goals and processes will be required to measure and consider its success.

However, it is urgent that these new program and evaluations, like the practice of cultural safety itself, be based in Indigenous cultural values and knowledges and not biomedical western edicts, as all these have successfully proven is that all western biomedical programs and interventions have not worked with Indigenous peoples everywhere in the world. This issue shares articles about programs and research that strive towards this type of resistance to collusion and an adherence to practice grounded in Indigenous knowledges and cultural safety.

Miigwetch/Thank you,

Dr. Suzanne Stewart & Dr. Angela Mashford-Pringle,

Co-Editors

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Community-Specific Risk and Protective Factors for Risky Alcohol Consumption in American Indian Women of Reproductive Potential: Informing Interventions

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Community-Specific Risk and Protective Factors for Risky Alcohol Consumption in American Indian Women of Reproductive Potential: Informing Interventions

Abstract

Objective: To explore the effect of community-specific risk and protective factors on risky alcohol consumption and vulnerability to having an alcohol-exposed pregnancy in women within a Southern California American Indian community. Methods: A sample of 343 American Indian women of childbearing age was enrolled in a study of risky drinking. All participants completed a questionnaire including alcohol consumption, other health behaviors, the T-ACE risky alcohol consumption screen and the PHQ-9 to measure depression and functionality. A subset of 80 women additionally answered focus group-derived questions about why they choose or do not choose to drink. Results: Risk and protective factors varied among sample subgroups. Broadly, factors affecting risk and protection included: depression, perception of other women's drinking, children/family, perception of risk to the unborn child, and feeling pressured to drink. Women's drinking was highly influenced by female friends and relatives. Women were most likely to drink with a girlfriend. Nearly 40% of all participants asked felt pressured to drink. Depression was associated with riskier alcohol consumption, less effective contraception, and testing positive for risky drinking using the T-ACE screen. Depressed women were more likely to binge drink because of stress, trauma, and "to escape my problems", and more likely to have been exposed to trauma including sexual assault. Conclusions: Interventions should incorporate community-specific factors. In the present sample, two separate strategies are indicated by the data: an information campaign to increase women's awareness of true social norms and the risks of prenatal alcohol-exposure; and screening for and treating depression.

Keywords

Alcohol, women, AIAN, prevention research, fetal alcohol spectrum disorders

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Introduction

Alcohol exposed pregnancies result in a range of persistent cognitive, behavioral and adaptive function deficits termed Fetal Alcohol Spectrum Disorders (FASD) (Jones & Smith, 1973; Riley et al., 2011; Secretary of Health and Human Services, 2000; Streissguth, 2007). Interventions to prevent risky alcohol consumption and FASD may be more effective when specifically targeted (Caldwell, 2005; Fisher et al., 2007; Griner & Smith, 2006; Kreuter et al., 2000; Montag et al., 2012; Skinner et al., 1999). For this reason, a good understanding of both risk and protective factors for risky alcohol consumption among women of reproductive potential is of high importance.

In the general population, the strongest known risk factor for an alcohol-exposed pregnancy (AEP) is drinking prior to pregnancy (Ethen et al., 2009; Palma et al., 2007). Other risk factors often cited but not always significantly associated include higher maternal age, gravidity and parity; being unmarried or unemployed; heavy alcohol consumption by spouse or partner; psychological stress; being less religious or spiritual; smoking; and illegal drug use (Bakhireva et al., 2011; Cannon et al., 2015; Flynn & Chermack, 2008; Green PP, 2016; McLeod, 1993; Naimi et al., 2003; Palma, et al., 2007; Tsai et al., 2009; Waterson et al., 1990). Depression has also been associated with problem alcohol consumption in women (Helzer & Pryzbeck, 1988; Kessler et al., 1997; KUO et al., 2006; Parker et al., 2010; Slade et al., 2013; Tsai, et al., 2009).

In addition, cultural norms influence the consumption of alcohol leading to varying vulnerabilities to an AEP (Balachova et al., 2012; Green PP, 2016; Nilsen et al., 2008; O'Keeffe et al., 2015; Roozen et al., 2016). Variations in these norms are of high relevance in the various distinct American Indian/Alaskan Native (AIAN) populations across the U.S. (Beals et al., 2003; May & Gossage, 2001; O'Connell et al., 2005; Spicer et al., 2003; Yuan et al., 2010). However, risk factors for an AEP have not been well characterized for these communities. Similar to the general population, depression in AIAN communities may play a role (Beals et al., 2005; Dillard et al., 2012; Duran et al., 2004; Gone & Trimble, 2012); and among several AIAN population samples, problem drinking and depression have been linked (Dillard, et al., 2012; Kunitz, 2006; Montag et al., 2015; O'Connell et al., 2006). As in other communities, healthcare provider advice may be largely ignored (O'Connor & Whaley, 2006a) and women may not understand the extent to which they are at risk (Kaskutas, 2000), nor appreciate the true amount of alcohol they consume (Branco & Kaskutas, 2001).

In addition to risk factors shared by the general population, there may be other risk and resiliency factors specific to AIAN communities (Allen et al., 2006; Hawkins et al., 2004; Whitbeck et al., 2004). Historical loss, trauma, and discrimination resonate throughout AIAN life today, and mistrust of research and externally imposed interventions may be important factors (Caldwell, 2005; Davis, 2002; Szlemko et al., 2006; Whitbeck, et al., 2004). Conversely, enculturation may be a source of resilience (Gray et al., 2010; Torres Stone et al., 2006; Whitbeck, et al., 2004), and family and community may exert protective influences for an AEP (LaFromboise et al., 2006).

In this manuscript we describe the risk and protective factors in a specific AIAN community for risky drinking and an AEP using data from a study of AIAN women of reproductive age. This community-based study can inform prevention strategies specifically targeted to the risk and protective factors for that community. Given the known variability in AIAN communities' characteristics, an intervention's potential to succeed may depend upon the degree to which it is grounded in community-specific factors.

Methods

Ethics

This study was approved by University of California at San Diego (UCSD), San Diego State University (SDSU), and Southern California Tribal Health Clinic (SCTHC) Institutional Review Boards. A Certificate of Confidentiality (CoC), obtained from the National Institutes of Health (NIH), further protected the confidentiality of participants' data. All participants provided informed consent through a process where the consent form was read aloud and all staff members completed human subjects' protections training.

Sample Source

American Indian Alaska Native (AIAN) women from 18 to 45 years of age, of childbearing potential, were recruited from one of three AIAN health clinics located in Southern California between April 2011 and April 2014.

Recruitment and Study Protocol

Potential participants were approached by project staff, local AIAN community members, in waiting areas of health clinics and screened for eligibility. Interested and eligible participants were brought to a private room where they were taken through the consenting procedure, assigned a unique identifier, and completed a self-administered paper and pencil survey. The majority of women who completed the paper-based survey then completed a web-based survey, while a randomly selected subset was instead asked to complete an additional paper-based survey. Participants had the opportunity to be referred for professional substance problem use treatment following completion of each survey. Participants were provided incentives in the form of a $10 gift card and a choice of a project fan or t-shirt emblazoned with the project logo at baseline.

Data Collection

Data was collected by project staff members who were trusted local AIAN community members.

Entire sample

 Paper and pencil questionnaire. The self-administered, paper-based questionnaire included questions regarding current relationship situation (an eight response option question reduced to "cohabitating" or not), employment, religiosity, gravidity, parity, birth control use and frequency of correct usage, current use of prescription and non-prescription medications, smoking, illegal drug use, awareness of FASD, and alcohol consumption including number of standard drinks consumed per week and per occasion, and number of binge episodes in the past two weeks (binge defined in this setting as consuming ≥ 3 standard drinks/occasion). They were asked to complete a T-ACE and a PHQ-9 questionnaire.

Sample subgroups

 Web-based questionnaire. Participants selected for the web-based survey self-reported additional information by computer regarding alcohol consumption over the past two weeks, pregnancy status, family history of alcohol problems, the age they began drinking alcohol, and contraceptive use. Illustrations of various alcoholic beverage containers were used to prompt recall.

 Paper and pencil questionnaire. These questions were the result of feedback from the community obtained through a focus group and interview process described in detail elsewhere (Montag et al., 2017). Topics included whether and, if yes, when women felt pressured to drink; why they drank when they binge drank and why they chose not to when they did not drink; who they drank with when they were binge drinking and questions about this person's drinking; and whether they had experienced trauma or abuse. At each point of contact, participants were offered referrals for professional treatment.

Measures

 The nine item Patient Health Questionnaire (PHQ-9) measured depression and functionality. In a variety of studies it has been found to have a sensitivity of 73% and specificity of 94% for major depression (Kroenke & Spitzer, 2002; Kroenke et al., 2001; Spitzer et al., 1999). In 2016, the PHQ-9 was adopted as a HEDIS (Healthcare Effectiveness Data and Information Set) measure of depression and incorporated into the majority of healthcare plans in the US. Despite extensive validation among other groups and use within AIAN communities, the PHQ-9 has not been specifically validated among AIAN women of childbearing age. However, using NHANES data, the PHQ-9 was found to be invariant across race/ethnicity and education level groups (Patel, 2017). Depression variables derived from this measure included "depression" (depressed or not depressed), and "functionality" (impaired or not impaired) and were calculated as follows: Depression: a participant scoring >5 was identified as "depressed"; Functionality: a participant scoring 2 or 3 was identified as having their "functionality impaired".

T-ACE (Tolerance, Annoyed, Cut down, Eye-opener) is a validated screening instrument of four questions structured to identify risky drinking (Sokol et al., 1989) shown to be valid in an AIAN population (Gale et al., 1998). The T-ACE questions and scoring were as follows: How many drinks does it take to make you feel tipsy/high? ($\leq$2 = 0 points, >2 = 2 points); Have people annoyed you by criticizing your drinking? (No = 0 points, Yes = 1 point); Have you felt you ought to cut down on your drinking? (No = 0 points, Yes = 1 point); Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover? (No = 0 points, Yes = 1 point). A score of $\geq$2 was considered positive for risky drinking ("T-ACE positive" variable). Sensitivity of the instrument has been estimated at 80-90% and specificity at 40-70% (Chang, 2001; Chang et al., 1998; Chiodo et al., 2010; Russell et al., 1994; Russell et al., 1996).

Contraceptive effectiveness defined as by WHO (see http://www.fphandbook.org/). *Using Birth Control Correctly* was defined as responding that birth control was used correctly every time or most of the time, as opposed to some of the time or none of the time.

The "Vulnerability to Alcohol-Exposed Pregnancy" variable was defined in four categories: "not at risk", "at risk", "not at high risk", and "at high risk". Being "at risk" for an AEP was defined as 1) currently using alcohol and 2) using a less than highly effective contraceptive method. The NIAAA defines "risky drinking" for women as more than 3 drinks at one time or more than 7 drinks per week (NIAAA, 2011). For the purposes of this study, we defined "binge" or "risky" drinking as 3 or more standard drinks per occasion and/or 8 or more drinks per week as this level of consumption has been predictive of risk of adverse pregnancy outcomes in other studies (May et al., 2013; May et al., 2007; May et al., 2008; May et al., 2004; May & Phillip Gossage, 2011). Being "at high risk" for an AEP was defined as "at risk" coupled with either consuming $\geq$3 drinks per occasion or consuming $\geq$8 drinks per week. The categories of vulnerability to AEP were not mutually exclusive, i.e., all "at high risk" women were also included in the "at risk" category.

"Regret" was measured by asking "Imagine you drank alcohol while you were pregnant and your child was born with fetal alcohol syndrome. How much would you regret drinking during your pregnancy?"

Statistical Analyses

Comparison of continuous, dichotomous, or categorical variables in tables of demographics, alcohol consumption, birth control use, knowledge questions (Appendix C), and depression were conducted using t-tests (continuous), χ2 (dichotomous), Fisher's exact test (dichotomous with small cell sizes), ANOVA, or nonparametric analyses (for data not normally distributed and not log-transformed). Normality in continuous variables was investigated by looking at skewness and kurtosis. ANOVA was used to examine associations among population characteristics. Regression was used to test for predictors of depression / impaired functionality and for vulnerability to AEP. First, each predictor was

tested to determine whether there were significant independent associations with that factor and depression/ functionality/ vulnerability to AEP. Then multiple logistic regression analysis was used to examine all variables previously found to be significant. All two-way interactions among significant variables were tested. Statistical significance was defined as 2-sided, p-value of <0.05. Statistical analyses were carried out using SPSS (PASW 18, SPSS Inc., Chicago, IL).

Results

Total Sample

A total of 343 women were recruited into the study, 33 of whom were pregnant. All women were included in analysis and tables indicate number responding to each question. Half of participants reported not currently consuming alcohol. As shown in Table 1 (see Appendix A), those reporting that they currently consumed alcohol were more likely to be employed, to have had more pregnancies, to use effective birth control and use it correctly, to smoke tobacco and to take illegal drugs. Drinkers and non-drinkers did not differ in the proportion who wanted more children, who were religious, or who were cohabitating. Furthermore, they did not differ in proportion identified as depressed or functionally impaired, or in FASD awareness.

Participants who did drink tended to drink in a heavy episodic pattern (binge drinking). Of 113 women responding to T-ACE questions, 73.5% (a quarter of the total sample) were T-ACE positive, identified as a risky drinker. A quarter of participants used no form of contraception (including abstinence) and less than a quarter used highly effective birth control. Applying the definitions specified in the methods section, we found 42.3% of participants to be "at risk" of having an alcohol-exposed pregnancy and more than a third, 35.2%, "at high risk" of AEP.

The level of awareness of FASD (nearly ¾ of participants had heard of FAS or FASD) and familiarity with community members affected by prenatal alcohol exposure (more than a third of participants knew someone affected) did not different across the study subgroups (Tables 1 and 2, see Appendix B).

The level of knowledge regarding the risks of alcohol to pregnancies was relatively high. Risky drinkers were slightly less likely to answer questions correctly (Table 3). The level of knowledge regarding the risks of alcohol to women and prevalence of local alcohol consumption was relatively low and not different across the study subgroups.

Table 3.
Knowledge Questions (percent answering correctly)

Type Questions	Comparator Group	n	Selected Subgroup	n	p-value
	Not current drinker		Current drinker		
Relating to Pregnancy	95.9	62	92.0	58	.040
Relating to Women's Health	34.4	61	31.0	58	.542
Total	84.6	62	80.9	58	.043
	Not risky drinker		Risky drinker		
Relating to Pregnancy	95.8	69	91.5	51	.025
Relating to Women's Health	36.0	68	28.4	51	.175
Total	84.8	69	80.0	51	.009
	Not depressed		Depressed		
Relating to Pregnancy	94.7	78	92.8	40	.339
Relating to Women's Health	33.3	78	30.8	39	.668
Total	83.5	78	81.3	40	.263

More than a third of our sample (115 women) was identified as depressed. The proportion of participants categorized as depressed did not differ among current drinkers and abstainers. Nearly 14% of these women reported that their functionality was impaired. Women identified as depressed were more likely to consume alcohol in a risky fashion and to perceive a higher social norm regarding how many drinks are consumed by women of childbearing age in their community than women not identified as depressed (Table 2). In addition, they were less likely to use birth control (trend) and less likely to use it effectively; more likely to take prescription and illegal drugs; and more likely to test positive for risky drinking using the T-ACE screen. In this study, depression was associated with risk factors for having an alcohol-exposed pregnancy.

Subset Sample

Among the 80 women in our subset sample, 39% reported feeling pressured to drink. The times women reported feeling most pressured to drink were "Girl's Night Out" (22.4% of total and 56.7% of those feeling pressured), "Holidays/occasions" (22.4%), and "when I'm at the casino" (7.9%).

When binge drinking, women were by far most likely to drink with a girlfriend, followed by partner/spouse, sister, and cousin (Table 4). This is true among the sample of all women responding to the question "On occasions when you drink 3 or more drinks in one sitting, who are you most often drinking with?" (n=69) and among the more limited sample of current drinkers responding (n=51). The

proportion choosing to binge drink with a girlfriend increased as the level of risk for an alcohol-exposed pregnancy increased. More risky drinkers and women at high risk for an AEP responded that they drank with a girlfriend than those not identified as risky drinkers or at high risk for AEP. While depressed participants reported binge drinking with a girlfriend more than with anyone else, they were statistically less likely to drink with a girlfriend than non-depressed participants (p=.038).

Table 4.
The Person Participants Reported Drinking with when Binge Drinking. (Percent among indicated sub-sample of 69 persons responding.)

Person drinking with	Total Sample N=69	Current drinkers n=51	Risky drinkers n=39	At high risk for AEP N=29	Depressed N=22
Partner/spouse	30.4	31.4	33.3	27.6	22.7
Mom	13	13.7	10.3	10.3	4.5
Dad	8.7	7.8	7.7	6.9	4.5
Sister	25.1	27.5	30.8	24.1	18.2
Brother	8.7	7.8	10.3	6.9	9.1
Myself; I drink alone	17.4	21.6	25.6	20.7	22.7
Grandparent	2.9	2	2.6	3.4	0
Cousin	24.6	27.5	25.6	37.9*	31.8
Uncle	4.3	2	2.6	3.4	4.5
Aunt	7.2	2	2.6	3.4	13.6
Friend (girlfriend)	58	66.7	71.8*	79.3*	40.9*
Coworker	11.6	11.8	15.4	13.8	4.5
Other	7.2	7.8	10.3	6.9	0

The most common reasons, in order, that non-drinkers cited for not drinking were children, health, and family. Other reasons included "don't like alcohol", "I'm a recovering alcoholic", and "lost loved ones to alcohol related incidents". Current drinkers, when choosing not to drink, reported doing so because of children, having to drive or having to work or go to school. Risky drinkers cited "no money" significantly more often than non-risky drinkers. Women at high risk for an AEP were significantly more likely to credit having to work or drive. Women identified as depressed were significantly more likely to say they choose not drink because they "don't like alcohol".

The top reasons cited for why participants binge drink were "to relax", "to help me enjoy time with friends or partner", "because of stress", and "to get buzzed". Subgroups differed slightly with risky drinkers significantly more likely to drink to relax (p<0.001) or escape their problems (p=0.007) than non-risky drinkers. Depressed women were more likely than non-depressed women to drink to escape

their problems (p=0.010), or because of stress (p=0.004) or trauma (p=0.013). They were more likely to have been exposed to sexual assault (p=0.032).

Depressed women were slightly less likely (p=.024) than non-depressed women to regret drinking during pregnancy when imagining that they had given birth to a child with FASD, and slightly less likely (p=.008) to worry about their baby being harmed if they were to consume alcohol while pregnant (data not shown).

Of the 80 women in the paper-and-pencil subgroup sample, 17 declined to answer the abuse/trauma questions. Among the participants responding, 44.4% had been exposed to physical abuse, 50.8% to emotional abuse, and 61.9% to verbal abuse. Thirty-seven percent (36.5%) had been exposed to trauma and 36.5% had witnessed a traumatic event. Of the entire responding sample, 27% had been exposed to sexual assault. This did not differ by current drinker status, which was true for all abuse/trauma questions, but women identified as depressed were significantly more likely to have experienced sexual assault.

Regression analysis reveals that approximately 40% of variation in the amount alcohol women consumed per week could be explained by their perception of risk to a potential pregnancy, their perception of the drinking patterns of other women, how much their drinking partner drinks, whether they smoke, and whether they feel pressured to drink or not.

Limitations

Data in this study were self-reported and may have been biased by social acceptability. In view of this possibility, we strove to ensure and convey confidentiality by a variety of means including a Certificate of Confidentiality from the NIH. Approval and support was obtained from the Tribal IRB. Preparation of materials (detailed elsewhere, Montag, et al., 2017), recruitment, and interactions with participants were carried out by trusted community members trained as research staff. Participants were self-selected volunteers and may not represent all women of child-bearing age within the community. However, recruitment occurred at locations throughout the community to allow equal access for all. Validity may have been threatened by our use of 2-week increments when assessing alcohol consumption. A longer period of time may have provided more precise data.

Discussion

High risk drinking is increasing among women in the US including AIAN women (Grant et al., 2017). To maximize the benefit of interventions to reduce risky drinking and prevent FASD, it may be prudent to target efforts to address specific risk and protective factors among differing subgroups.

In the present study, the relevance of specific risk and protective factors varied depending upon alcohol consumption and depression status. Some factors found to affect drinking in general population

samples did not do so in the present sample including age, employment, religiosity, and being married or cohabitating. Other factors identified elsewhere as important were also found to be important in our study such as depression, smoking, and trauma. The strength of our finding that women's drinking is influenced by female friends and family members is interesting. As Table 4 shows, the influence of female friends grows with increased risk of harmful alcohol consumption. We did not specify "cousin" as male or female but, consistent with our other findings, many women verbally reported drinking with female cousins.

How do women make choices regarding alcohol consumption? As in previous literature, healthcare provider advice was not cited as a reason to abstain in the present study and appears to be largely ignored (O'Connor & Whaley, 2006b). Decision making strategies of drinkers and non-drinkers may differ. Reasons cited by non-drinkers for not drinking tended to reflect a more well thought-out or long-term strategy than those cited by current drinkers.

Among study participants, 115 women (34.2%) were identified as depressed (36.7% non-drinkers, 31.4% current drinkers, NS). This rate is high; comparable studies using the same depression instrument found a national prevalence of 14% (Farr et al., 2010) and an Alaska Native sample prevalence of 20% (Dillard, et al., 2012). Depression is an independent risk factor for risky drinking and was found to be meaningful in this study. The good news is that there are effective treatments for moderate and severe depression, and that depressed women may be identified using brief, culturally acceptable, inexpensive screening. Present results are being used to inform community response.

Implications for Prevention

- Differences in risk and protective factors exist among communities and community subgroups necessitating modification and targeting of interventions to maximize impact
- Two strategies are recommended for the present community based on study results:
  1a) Community wide ("girl power") intervention campaign, geared to all women, seeking to shift cultural norms by empowering women to protect friends/female relatives. This would include broad information dissemination regarding the reality of lower community alcohol consumption and risks of drinking to women and pregnancies (FASD), as well as encouraging friend-networks focused on support. Self-assessment of drinking may be encouraged by the campaign and required at each clinic interaction;
  2a) Screening for depression to help identify women at increased risk for AEP; and 2b) treating depression to prevent alcohol-exposed pregnancies.

Conclusion

Risk and protective factors varied among community subgroups. In our sample, girlfriends and female relatives played an important role in influencing the level of risk associated with alcohol consumption. Their impact could be harmful or protective. Perception of community drinking norms was skewed in that participants at greater risk believed the amount of drinking by their peers to be greater. Protective factors, beyond the perception of a lower social norm of drinking, included knowledge of the risks of alcohol consumption, drinking with people who consume less alcohol, and certain decision-making strategies. Consistent with previous literature, children were the top factor inducing AIAN women to stop or reduce drinking (Bezdek et al., 2004).

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Appendix A

Table 1.
Characterization of Sample by Alcohol Consumption Status

Variable	Not Current Drinker	n	Current Drinker	n	P value
Age (years)	28.0 ± 0.62	161	28.9 ± 0.57	179	.282
Has had a child	67.7	161	64.0	178	.479
Pregnancies (number)	2.44 ± 0.20	154	1.86 ± 0.15	176	.018
Children (number)	1.63 ± 0.14	161	1.44 ± 0.11	178	.269
Wants more children	59.5	148	59.8	174	.955
Employed	35.0	160	50.3	173	.005
Religious	84.8	151	87.3	166	.507
Cohabitating	43.8	160	42.4	177	.799
Birth Control Effectiveness		145		161	<.001
High	9.0		17.4		
Medium High	22.1		35.4		
Medium Low	25.5		20.5		
Low	0		1.2		
No birth control	43.4		25.4		
Using Birth Control Correctly	72.2	133	83.9	155	.016
Smoker	26.3	160	38.2	178	.019
Taking illegal drugs	8.1	161	15.1	172	.046
Taking prescription drugs	41.3	160	35.2	175	.273
Depression medication	9.2	131	6.5	123	.432
Depressed	36.7	158	31.4	175	.310
Functionality impaired	7.5	134	5.2	154	.428
Heard of FASD/FAS	75.8	153	72.1	172	.446
Know someone affected by FASD/FAS	36.4	154	35.7	154	.906
Alcohol consumption variables					
Total Sample					
Age at first drink	15.4 ± 0.3	143	15.0 ± 0.3	178	.423
Perception of Other Women's Drinking					
Drinks per week	7.13 ± 0.81	139	9.03 ± 0.72	165	.080
Drinks per occasion	3.23 ± 0.31	140	4.43 ± 0.28	168	.004
Depressed Subset					
Age at first drink	15.6 ± 0.6	55	13.9 ± 0.4	55	.023
Perception of Other Women's Drinking					
Drinks per week	7.38 ± 1.26	49	13.4 ± 1.9	47	.008
Drinks per occasion	2.87 ± 0.34	50	4.98 ± 0.53	51	.001

Appendix B

Table 2.
Characterization of Sample by Depression Status

Variable	Not Depressed	n	Depressed	n	P value
Age (years)	28.2 ± 0.5	221	29.1 ± 0.8	115	.332
Has had a child	63.2	220	73.0	115	.070
Pregnancies (number)	2.08 ± 0.15	213	2.28 ± 0.21	114	.436
Children (number)	1.45 ± 0.10	220	1.74 ± 0.15	115	.111
Wants more children	58.6	210	62.2	111	.642
Employed	45.4	218	38.4	112	.223
Religious	87.3	205	84.4	109	.475
Cohabitating	46.6	219	36.8	114	.089
Birth Control Effectiveness		201		104	.038
High	14.9		11.5		
Medium High	29.4		28.8		
Medium Low	24.9		16.3		
Low	0		1.9		
No birth control	30.9		41.4		
Using Birth Control Correctly	83.2	196	67.8	90	.003
Smoker	29.4	221	37.7	114	.123
Taking illegal drugs	8.2	219	18.0	111	.015
Taking prescription drugs	31.4	220	53.6	112	<.001
Depression medication	4.8	165	14.9	87	.006
Functionality impaired	1.2	169	13.9	115	<.001
Heard of FASD/FAS	75.7	210	70.8	113	.337
Know someone affected by FASD/FAS	36.1	202	35.6	104	.923
Alcohol consumption variables					
Total Sample					
Drinks per week	2.88 ± 0.35	203	6.10 ± 1.18	108	.001
Drinks per occasion	2.31 ± 0.27	206	2.29 ± 0.37	110	.972
Binge episodes / 2 weeks	0.95 ± 0.12	202	2.04 ± 0.45	108	.004
Age at first drink	15.5 ± 0.3	204	14.7 ± 0.4	110	.069
Perception of Other Women's Drinking					
Drinks per week	7.04 ± 0.58	203	10.2 ± 1.1	98	.006
Drinks per occasion	3.78 ± 0.29	203	3.89 ± 0.33	103	.805
Current Drinkers					
Drinks per week	5.15 ± 0.53	114	12.4 ± 2.1	53	<.001
Drinks per occasion	4.06 ± 0.40	117	4.67 ± 0.60	54	.400
Binge episodes / 2 weeks	1.64 ± 0.19	117	4.15 ± 0.83	53	<.001
Age at first drink	15.6 ± 0.3	119	13.9 ± 0.4	55	.002
Perception of Other Women's Drinking					
Drinks per week	7.07 ± 0.61	115	13.4 ± 1.9	47	<.001
Drinks per occasion	4.07 ± 0.33	114	4.98 ± 0.53	51	.137

Appendix C.

Knowledge Questions

Knowledge Questions (Percent Answering Correctly)
Questions Relating to Pregnancy
When a woman drinks alcohol when she is pregnant, the alcohol enters the baby's bloodstream. (T)
Just having a FEW drinks (1-3) during pregnancy is safe for the baby. (F)
Babies of women who drink alcohol during pregnancy are at risk for developing physical, mental and behavioral problems. (T)
Drinking alcohol is OK during the last 3 months of pregnancy. (F)
If a woman is already pregnant but does not know it yet and she is drinking alcohol, she can have a child with an Alcohol Related Birth Defect. (T)
During pregnancy, it is OK to drink during the morning. (F)
If you are breastfeeding and you drink alcohol, the alcohol can be passed to the baby through the milk. (T)
It is OK to drink wine during pregnancy. (F)
If you are nauseous or feel sick to your stomach during pregnancy, you should drink a beer. (F)
Questions Relating to Women's Health
Women are at a greater risk for developing alcohol-related problems than men. (T)
Most women aged 18-44 who are members of Southwestern Tribes currently drink alcohol. (F)

Evaluation of the Indigenous Relationship and Cultural Safety Courses among a sample of Indigenous Services Canada nurses

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Evaluation of the Indigenous Relationship and Cultural Safety Courses among a sample of Indigenous Services Canada nurses

Abstract

In 2015, Cancer Care Ontario (CCO) launched the Indigenous Relationship and Cultural Safety (IRCS) courses, which support the importance for healthcare professionals to understand and apply First Nations, Inuit, and Métis (FNIM) cultural safety to provide effective person-centred care. The courses address a key recommendation from the Truth and Reconciliation Commission of Canada report, to provide skills-based training in cultural competency, conflict resolution, human rights and anti-racism. The objective of the evaluation was to validate the tool, with a sample of nurses, to assess: if the delivery mechanism is appropriate and feasible; if participants acquire an increased knowledge of the courses' contents; and if positive change in how healthcare practice is delivered is perceived to have resulted. The IRCS courses have been mandated for Indigenous Services Canada (ISC) nurses who service mostly on reserve communities. The evaluation consisted of an anonymous and voluntary survey and a focus group that were conducted at a regional meeting. The responses from the surveys were gathered in an excel spreadsheet for analyses and the focus group data were analyzed for key themes. All the nurses in attendance completed the survey (n=22) and a portion participated in the focus group (n=8). Our evaluation demonstrated that free, online, module formatted courses were appropriate and relevant for ISC nurses (81%); the courses increased the knowledge about FNIM people (72%); and the nurses have/will apply what they learned in their practice (82%). There has been an increasing movement for regions and organizations in Canada to complete cultural competency training. Our evaluation demonstrated that the IRCS courses were successful at meeting learning objectives.

Keywords

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Introduction

First Nations, Inuit and Métis (FNIM) people bear a disproportionately high cancer burden and face a number of health disparities, barriers and gaps to health services (Cancer Care Ontario, 2015). One barrier for FNIM people receiving adequate healthcare is the experience of culturally insensitive healthcare including racism and discrimination. Indigenous people may experience racism in the healthcare system so extensive that prior consideration is given or there is avoidance of accessing the healthcare system altogether (Allan & Smylie, 2015).

Conversely, people who experience culturally safe healthcare are more likely to: access care earlier, feel more comfort and control while receiving care, share details about their health concerns and preferences, and return for follow up visits and follow treatment plans recommended by healthcare providers (National Collaborating Centre for Aboriginal Health, 2014). People also feel more in control of their health when engaging with a healthcare provider that empowers them to make shared decisions about their care (Jull et al., 2015). In short, cultural safety is a critical component for improving patient experiences and outcomes.

Another barrier for FNIM people receiving culturally appropriate healthcare are the Canadian federal government policies that are in place, specifically policies related to how healthcare is delivered in First Nations communities. Healthcare is provincially legislated and the Canadian provinces receive federal transfer payments under the Canada Health Act to address healthcare related items such as insurance, billing payments, and healthcare professionals (Canada Health Act, 1985). Given that the Indian Act is also currently in place, registered First Nation people are the legal responsibility of the federal government and as such, the delivery of healthcare is the federal responsibility (Indian Act, 1985). The Indian Act and the policy on how healthcare is delivered is based on assimilation and does not allow those under the Act to determine how services should be delivered in their own communities. This in turn, forces Indigenous communities to navigate both a western healthcare system often foreign to them and a traditional system where health is addressed in a holistic way (Mashford-Pringle, 2011). Many Canadians are only starting to understand the complexities of the discriminatory policies for FNIM people and the impacts these policies have had and continue to have on their health and well-being. An impact can be made on how policies and services are developed and implemented at institutions, by creating an understanding of cultural safety through educational opportunities (Brascoupé & Waters, 2009).

In 2015, Cancer Care Ontario (CCO) launched the Indigenous Relationship and Cultural Safety (IRCS) courses. With the release of the Truth and Reconciliation Commission (TRC) of Canada report, the courses address a key recommendation, to provide skills-based training in cultural competency, conflict resolution, human rights, and anti-racism (Truth and Reconciliation Commission of Canada, 2015). The Joint Ontario Indigenous Cancer Committee (JOICC), which is an advisory group to the Indigenous Cancer Control Unit at CCO and consists of First Nations, Inuit, Métis and urban Indigenous

organizations, played an integral role in the creation of the IRCS courses. JOICC was the group to first suggest that CCO update the once paper-based cultural competency training modules and move the content to an online format to increase audience access and allow for increased interactivity. The members advised on specific content in their area of expertise and helped to inform the different topics that should be included in the courses.

The 13 IRCS courses are free of charge and although the original target audience were healthcare providers, the courses are open to anyone. The IRCS courses are stand alone modules, do not need to be completed in any particular order and take approximately one and a half hours to complete the interactivity guides, course content, quiz questions and the feedback survey. The courses cover a variety of topics including:

1. First Nations, Inuit and Métis Culture, Colonization and the Determinants of Health
2. Aboriginal History and Political Governance
3. The Need for Cultural Competence in Healthcare
4. Current Array of Aboriginal Health Services
5. CCO - Aboriginal Cancer Strategies and Ontario Renal Network
6. Indigenous Knowledge and Traditional Health
7. Aboriginal Community Health Services
8. The Health Landscape of First Nations, Inuit and Métis People
9. Cancer and Renal Issues and Challenges
10. Truth and Reconciliation Commission of Canada (TRC) and the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)
11. Health Literacy - Indigenous Perspectives on Health and Well-Being
12. Chronic Disease Prevention for First Nations, Inuit and Métis People
13. Pediatric Oncology

After review of the online enrollment data (2015-2018), the majority of those who are enrolled or have completed one or more courses identify themselves as registered nurses, followed by the categories of 'other health professionals', 'students' and 'medical doctors' (to name a few). Given that the majority of those on the eLearning site who are enrolled are nurses and the original target audience were healthcare providers, it is valuable to understand the perspective from nurses to determine if the content of the IRCS courses is beneficial to them. This current work is the first phase of a large scale evaluation of the IRCS courses, which will validate the IRCS courses as a tool to determine if change is created in healthcare providers' perceptions of how culturally appropriate care is delivered.

In this first phase of the evaluation of the IRCS courses, we wanted to validate the tool with a group of nurses that work primarily with FNIM people and that have completed the IRCS courses as their cultural competency training. Given that the Indigenous Services Canada (ISC) First Nations and Inuit Health Branch (FNIHB) Ontario region has nurses in the Sioux Lookout Zone area that only

provide healthcare to First Nations communities in Northwestern Ontario, this was an ideal group to evaluate. Furthermore, in the fall of 2017, through a phased approach, FNIHB made the IRCS courses mandatory for their nurses over the course of a year. Through a collaborative effort, we were able to gain insight on the IRCS courses from the perspective of the FNIHB nurses.

Methods

There were two parts to this phase of evaluating the IRCS courses, the first of which was a survey. The objective of the survey was to gather contextual and demographic information of the nurses and high-level feedback on their experience and perception of the IRCS courses as a training method for cultural competency. The second part of the data collection was through focus groups, with an objective to further understand how the IRCS courses impact the nurses' understanding of cultural competency and how the tool/training will be applied to their practice.

Participants

Both the survey and the focus groups included the involvement of the FNIHB Sioux Lookout Zone nurses however, participation was voluntary. Given the vast geographic distances it would take to interview each of the nurses individually, we leveraged a workshop held by FNIHB that brought all of the Sioux Lookout Zone Nurses in Charge together. Nurses in Charge (referred to as 'nurses' from hereon in) are defined by the Government of Canada as those who have the same responsibilities as community health nurses, in addition to other roles such as, supervising station nurses and support staff, providing support to community health representatives and liaising with local band administration and community organizations (Government of Canada, 2018). By using this meeting to conduct the research, it allowed us to engage with all of the nurses for a survey and those who wanted to participate in a focus group were able to do so as well.

Survey

The survey tool was designed through a collaborative process, leveraging knowledge from the various partners. There were 26 questions in total which covered topics including: demographics, professional experience, community characteristics where they work, previous and current knowledge of FNIM people, and characteristics of the IRCS courses. The possible responses were all multiple choices and included yes/no, content specific, and Likert scale answers.

The survey was conducted with the nurses who agreed to participate in the research project. We offered no compensation. A consent agreement was first distributed for the nurses to sign and then those who completed the agreement were given the anonymous paper survey. The results of the survey were then gathered and coded in an excel spreadsheet for analysis. Frequency distributions showed the percentage of observations for each question in the survey.

Focus Groups

The focus group supplemented the information gathered from the survey and allowed for greater exploration of the high-level feedback that was provided in part one of the research. The focus group was conducted in a one-hour session with the nurses who chose to participate. The nurses who participated in the focus group had already participated in the survey. No demographic or identifying information was collected in the focus groups. During the focus group, two external staff captured the focus group discussion with written notes; the discussion was not recorded. Each note taker independently analyzed the data for key themes and categorized the content based on the most relevant theme.

Relationship

Ethical approval was obtained from the University of Toronto Research Ethics Board. Engagement with the Sioux Lookout Zone nurses was done through collaborative efforts led by CCO and ISC FNIHB Ontario Region.

Results

Survey Results

A total of 22 nurses from ISC FNIHB Ontario Region participated in the survey (see Table 1). The majority of the participants worked as a nurse for 15+ years (73%) and are registered nurses (77%). Over half of the nurses have worked with FNIM people for over 10+ years (59%) and currently, almost half (45%) of nurses serve large First Nations communities (population size 1,000 – 4,999 people).

Table 1.
Demographics of the ISC FNIHB Ontario Region Sioux Lookout Zone Nurses in Charge

Characteristic	Sample size	
	n	*%*
Age range		
<35	2	9%
35-44	4	18%
45-54	9	41%
55-64	5	23%
65+	2	9%
Number of years worked as a nurse		
5-9 years	4	18%
10-14 years	2	9%
15-19 years	7	32%
20+ years	9	41%
Type of nursing degree		
Registered Nurse	17	77%

Nurse Practitioner	4	18%
No Response	1	5%
Number of years as a nurse working with FNIM people?		
0-4 years	3	14%
5-9 years	6	27%
10-14 years	9	41%
15-19 years	2	9%
20+ years	2	9%

The majority of the nurses (86%) mentioned that the IRCS courses met their expectations. While almost all of the nurses had knowledge of FNIM people before taking the IRCS courses (96%), 95% of the nurses found the course content relevant to their career or practice and the majority of the nurses (72%) found that the program content enhanced their knowledge of FNIM people (see Figure 1). Most of the nurses (82%) said they will/have applied the learning in their practice (see Figure 2), however, a small percentage (14%) felt as though the IRCS courses did not add value. Seventy-three percent of the respondents felt that the courses will also help the nurses better understand and work with First Nations patients. All of the nurses (100%) agreed that the IRCS courses would be of benefit to new nurses and 91% of the nurses felt that others, beyond nurses, should take the IRCS courses. While 81% of the nurses found the online learning system to be a good way to deliver the information (see Figure 3), half of the nurses (50%) thought that the online only was the best method for delivering the content and 45% of the nurses thought that the content should be delivered through a combination of online and in-person facilitation. Key findings of the survey related to the evaluation are displayed as a visual depiction of the results.
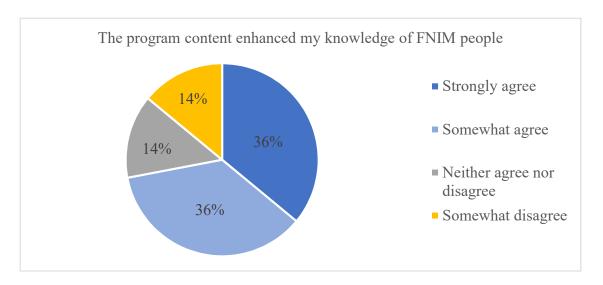

Figure 1. *Likert question from the survey 'this program content enhanced my knowledge of FNIM people'*
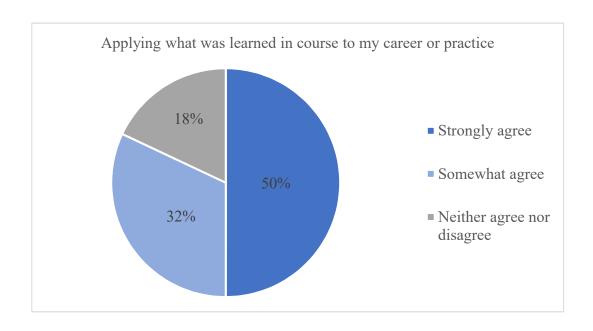
Figure 2. *Likert question from the survey 'I have/will apply what I learned in this course to my career or practice'*
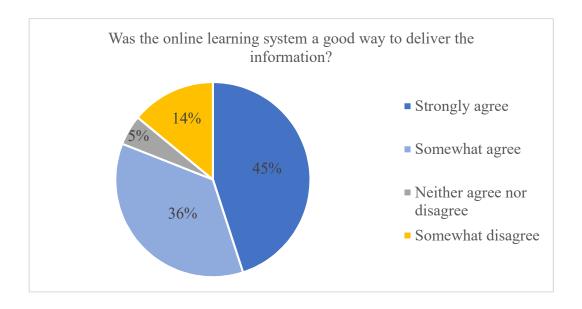

Figure 3. *Likert question from the survey 'Do you think the online learning system was a good way to deliver the information?'*

Focus Group Results

There were a total of eight nurses who participated in the focus group discussion and although the nurses who participated in the focus group also completed the survey portion of the evaluation, demographic information was not collected during the focus groups.

Over the course of an hour, several key themes emerged from the focus group, including: reinforced knowledge, initial resistance, time for completion of the courses, course content and eLearning system specifics, delivery method, and value in the eLearning tool. Each of the key themes had no less than three discussion points, and some themes had an upwards of 10 discussion points. Overall, the discussion was positive towards the IRCS courses as a tool for providing knowledge on Indigenous history, culture and the health landscape to improve health outcomes and person-centred care. Many of the nurses expressed how the IRCS courses reinforced their knowledge of FNIM people.

> *We work in holistic care, looking at the individual, the family, the whole community,*
> *so it is good to take courses that focus on the same issues and reinforce things that we*
> *have learned on the job.*

The majority of the nurses felt that the content in the IRCS courses were beneficial and enhanced their knowledge of FNIM people. Many of the nurses also felt that the information was clearly delivered and relevant, however some felt that certain parts of the content in the courses were not relevant to their work, such as courses related to the cancer strategy, and courses with cancer screening information.

> *The cancer strategy, cancer screening modules and all the numbers [statistics]*
> *are tedious and feel more like work. They feel disconnected from the rest of the*
> *modules.*

There was lots of discussion around the delivery method of the cultural competency courses; some nurses liked that the courses were online and self-paced, whereas others thought it would be helpful to first take the courses online and then have an in-person facilitated session. Some participants thought that regardless of the delivery method, it was difficult to find time to take the courses and learn about cultural safety, especially when working full time and having clinic hours. Nonetheless, all of the participants agreed that it would be beneficial for new nurses first starting their career or for nurses who are working with FNIM people for the first time, to take the courses early on.

> *Having it [IRCS courses] self-paced was helpful, better to have it online and*
> *completed at your own time; good for the work environment of nurses.*

Some of the nurses shared that they initially felt that they did not need to take the courses because either they were Indigenous or they have worked with FNIM people for many years; however,

after completing the courses, those participants agreed that they had learned a lot of things related to cultural safety that they did not already know.

> If I'm First Nations why do I need to take these courses? But I took them anyways
> because they can be applied to other cultures. In the end I learned a lot of things
> that I didn't know about my own culture.

There was also consensus that the nurses found value in the learning tool. Many felt that the IRCS courses provided them with knowledge and information that will help to empower them when working with First Nations communities specifically. Some thought that the IRCS courses were a good starting point, but that more needs to be done to ensure that life long learning in cultural humility is embedded into core competencies of the profession.

> All healthcare providers that work in the communities should have basic
> knowledge, and the IRCS courses give you this basic knowledge.

> The IRCS courses don't provide all of the answers, but it's a start. It takes years
> to be able to gain cultural competency.

Limitations

The participants in this study were Nurses in Charge who are employed ISC and predominately work with First Nations communities. Given that their primary population is related to the content of the IRCS courses, there is already a certain level of knowledge that the nurses would have compared to the average Canadian, therefore the impact of the courses may not be as great compared to a healthcare worker that does not primarily work with First Nations or Indigenous peoples.

Although the survey and focus group occurred at a Nurse in Charge workshop meeting in Sioux Lookout, with all of the Sioux Lookout Zone nurses in attendance, the sample size was too small to make any inferences. It would not have been possible to conduct power calculations before conducting the study, as we surveyed the maximum amount of Nurses in Charge and could not have sampled more people. There was also less of a spread in the data for the survey responses, due to sample size and the Likert scale questions containing five possible options for response from "strongly agree" to "strongly disagree".

Discussion

Since the Truth and Reconciliation Commission of Canada released the final report in 2015, cultural competency training has been a large area of focus for many non-Indigenous organizations, institutions, and Canadians (O'Sullivan, 2013). Medical schools and hospitals in Canada are working

towards implementing the TRC Calls to Action that are relevant to their institutions and professions, recognizing that Canada's healthcare leaders have a role to play in addressing the widespread racism that exists in the healthcare system and contributes to health gaps we continue to see (HealthcareCAN, 2018).

Canadian nursing schools are also embedding cultural competency training into their curriculum from an early onset, recognizing that nurses play a critical role in providing healthcare in northern Canada regions for First Nations and Inuit communities. Nurses are often the main primary care providers in geographically remote communities and thus it is important that cultural competency is a main part of their training and that more Indigenous nurses are recruited into nursing programs (Aboriginal Nurses Association of Canada, 2009).

Cultural competency training is one element in addressing the TRC Calls to Action to provide skills-based training in cultural competency, conflict resolution, human rights, and anti-racism, however it is not the only solution in improving racism in healthcare. Another TRC Call to Action is:

"23. We call upon all levels of government to:

i. Increase the number of Aboriginal professionals working in the health-care field.

ii. Ensure the retention of Aboriginal health-care providers in Aboriginal communities.

iii. Provide cultural competency training for all healthcare professionals. (TRC, 2015,p.322-323)

It is crucial that medical, nursing and other healthcare professions also put efforts into the recruitment and retention of Indigenous healthcare professionals. Research has demonstrated that nursing schools are more likely to recruit and retain Indigenous nurses when there is a positive environment that has cultural safety in the curriculum and an institution that supports cultural identity for Indigenous students (Thurston & Mashford-Pringle, 2015). Therefore, it is important that institutions and non-Indigenous organizations recognize the importance of a two-fold approach to address racism in the healthcare system that includes Indigenous cultural competency training to create an environment that supports diversity and inclusion of Indigenous healthcare professionals.

Conclusion

More research in the field of evaluation will help to understand the impact of the IRCS courses with other healthcare professions, such as physicians and specialists, who may not have received cultural competency training as part of their undergraduate medical education. It will also be important to

evaluate the impact of the IRCS courses with medical and nursing students who are receiving this cultural competency training as part of their curriculum.

The evaluation of the IRCS courses as a cultural competency training tool demonstrated that free, online, module formatted courses were appropriate and relevant for ISC nurses, that the courses increased their knowledge about FNIM people, and the nurses have/will apply what they learned in their practice. There has been an increasing movement for regions and organizations in Canada to complete cultural competency training. Our evaluation demonstrated that free, online, module formatted courses were successful at meeting learning objectives.

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I'taamohkanoohsin (everyone comes together): (Re)connecting Indigenous people experiencing homelessness and substance misuse to Blackfoot ways of knowing

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I'taamohkanoohsin (everyone comes together): (Re)connecting Indigenous people experiencing homelessness and substance misuse to Blackfoot ways of knowing

Abstract

Substance misuse and homelessness are closely related outcomes for many Indigenous Canadians who live with extensive intergenerational trauma caused by residential school and the 60s Scoop. In recent years, the rise of opioid addiction along with related overdoses and mortalities in many parts of Canada has led to what is being called an opioid crisis. (Re)connection to Indigenous ways of knowing and practices are frequently seen as a path to healing. To address substance misuse and homelessness within a Canadian city, a grassroots program was developed for a largely Blackfoot population. The program increased access to traditional cultural resources and activities in a visible, downtown location. Two-Eyed Seeing informed the development and evaluation of the program. Results indicated that attendance connected people with their spirits, inspiring strength and hope for the future, and ameliorated spiritual homelessness. The program formed a safe space where relationships were strengthened, people felt respected, and meaningful activity away from substances was available.

Keywords

Homelessness, substance misuse, Indigenous peoples, healing, cultural connection, spirit

Acknowledgements

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Introduction

The experience of homelessness and substance misuse among Indigenous people in Canada is the result of a legacy of colonialism that has separated peoples from their lands, ceremonies, and spirits. Racist and genocidal policies, the Indian Residential School system, and the institutionalized practice of removing Indigenous children from their families wrought historical and ongoing intergenerational traumas (Daschuk, 2014). The government's prohibitions against practicing ceremonies, speaking original languages, and confining peoples to tiny reserves effectively removed the very things that kept Indigenous people strong and healthy (Linklater, 2014).

Access to cultural resources facilitates healing within Indigenous communities (Dell et al., 2011; Gone, 2011). Traditional approaches to wellness ease distress because they address aspects that Western methods typically do not: spirituality, cultural reclamation, cultural continuity, and communal bonds (i.e. Goudreau, Weber-Pillwax, Cote-Meek, Madill, & Wilson, 2008; Lincoln, 2010; Linklater, 2014). These approaches include participation in ceremony, drumming, singing, dancing, storytelling, traditional arts, and traditional food gathering. Therapeutic activity that is based partly or wholly on traditional Indigenous knowledge, values, and activities can help with the reduction or cessation of substance misuse (Dell & Hopkins, 2011; McCormick, 2000; Rowan et al., 2014).

Alcohol was the most common substance of addiction in southern Alberta but prescription medication and crystal meth use are present (Belanger & Lindstrom, 2016) and likely growing. Canada has seen a dramatic rise in fentanyl-related deaths (Fischer, Vojtila, & Rehm, 2018; Tyndall, 2018). Mortality incidents rose in Alberta from 116 in 2014 to 673 in 2018 (Government of Alberta, 2019), an increase that became part of an "opioid crisis" (Fischer et al., 2018; Government of Alberta, 2017). Rates of fatal fentanyl overdose are three times higher in First Nations populations than in non-First Nations groups (Government of Alberta, 2017a). Prevention and harm reduction approaches are effective at reducing mortality rates but need more extensive implementation to make a difference (Fischer et al., 2018). Publicly funded treatment programs are difficult to access with waiting lists up to eight weeks long.

Homelessness and substance misuse are interrelated; each reduces access to health care (Belanger & Lindstrom, 2016; Christensen, 2013; Fazel, Geddes, & Kushel, 2014; Grinman et al., 2010; Palepu et al., 2013; Thurston, Milaney, Turner, & Coupal, 2013). Indigenous people are eight times more likely to be homeless than non-Indigenous people (Belanger, Awosaga, & Weasel Head, 2013). They experience additional barriers to seeking help and accessing treatment services that include racism, inadequate childcare or transportation, and a lack of culturally appropriate models and social supports (Thurston et al., 2013; Venner, Greenfield, Vicuna, Munoz, Bhatt, & O'Keefe, 2012). Indigenous youth who are homeless or victimized also experience difficulties accessing addictions treatment (Phillips et al., 2014). Indigenous people who are homeless and misusing substances are routinely confronted with

social exclusion and the risk of violence. Their social position in an urban centre makes it more difficult to access Elders, ceremony, and traditional activities (Wilson & Peters, 2005).

Non-Indigenous definitions of homelessness limit the experience to inadequate physical housing whereas Indigenous homelessness is conceptualized more broadly to include historical dispossession from lands and isolation from relations (Thistle, 2017). Indigenous "home" identifies a sense of belonging, safety, and proximity to family (Belanger & Weasel Head, 2013). The Aboriginal Standing Committee on Housing and Homelessness stated,

> *"Indigenous homelessness… is more fully described and understood through a composite lens of Indigenous worldviews. These include: individuals, families and communities isolated from their relationships to land, water, place, family, kin, each other, animals, cultures, languages and identities. Importantly, Indigenous people experiencing these kinds of homelessness cannot culturally, spiritually, emotionally or physically reconnect with their Indigeneity or lost relationships" (as cited by Thistle, 2017, p. 6).*

Existing housing services are less effective, primarily because the issue is not viewed from an Indigenous perspective (Thistle, 2017). Homelessness can be directly linked to colonial policies of the Indian Act, intergenerational trauma of residential school, and the removal of children from traditional family systems by child welfare agencies (Menzies, 2009).

Spiritual homelessness is a form of Indigenous homelessness resulting from displacement from traditional lands and kinship networks (Memmott & Chambers, 2007; Memmott, Long, Chambers, & Spring, 2004). It contributes to an acute, pervasive sense of loneliness and loss of identity, family, community, and trust (Belanger & Lindstrom, 2016; Christensen, 2013). Spiritual homelessness diminishes one's ability to thrive within their environment.

This paper describes the development, implementation, and evaluation of a program that provides a more holistic and culturally-based approach to healing. The program and research represents a journey of co-learning between each of us and the program attendees. Sharing leadership (Goulet & Goulet, 2014), we combined our knowledges of Niitsitapi' cultural beliefs and practices, addictions recovery, research, and life on the street to implement an innovative approach to support those who are homeless and misusing substances.

I'taamohkanoohsin[1]

Situated on traditional Blackfoot territory in southwestern Alberta, Canada, Lethbridge is a growing city of over 90,000, 5.8% of which are Aboriginal (Statistics Canada, 2018). The two closest First Nations are the Kainai (Blood) Nation adjacent to Lethbridge and the Piikani (Peigan) Nation west

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[1] Pronounced ee-TAH-moe-ga-NOGH-sin

of the city. Their respective populations are over 12,800 (Blood Tribe, n.d.) and 3600 members (Piikani Nation, n.d.). Reserve-urban migration in the region translates into a regularly shifting population (Belanger & Weasel Head, 2013). Blackfoot people use the word, *Niitsitapi*[2] to refer to themselves, which translates into "the real people." The region is also home to a smaller but diverse group of people representing other First Nation, Métis, and Inuit communities.

I'taamohkanoohsin targets an extremely marginalized and vulnerable population, primarily Indigenous people who are homeless, and nearly all of whom engage in substance misuse. In addition to intergenerational trauma, this group experiences high rates of concurrent physical, mental, and developmental conditions. "Tipi in the Park" or the "Tipi Program," as it was known in the beginning was developed to increase access to Blackfoot cultural activities in an open, welcoming environment. Every second Friday, we set up a tipi in a downtown park that is a main hub for people living on the street. For three to four hours, we shared hot drinks, snacks, and served a simple lunch to anyone walking by. Blackfoot activities – typically drumming, singing, storytelling, hand games[3] or face painting[4] – were offered. The program was later renamed, I'taamohkanoohsin, which means "everyone comes together." This name signified the spirit of the program along with the power of collaboration and resource sharing to create a social space where everyone, even the most marginalized, is welcome, valued, and respected.

The Story of How We Came Together

The authors come from different organizations and backgrounds, but each of us desired to improve the lives of the homeless population. Chelsey works for the Aids Outreach Community Harm Reduction Education Support Society (ARCHES), an organization that provides support and harm reduction services for people who engage in substance misuse. Les is the Community Diversity Liaison Officer for the Lethbridge Police Service (LPS) and conducts community outreach activities. Mark was a former client of ARCHES' Housing-First Team and volunteers with numerous community organizations. Roger is a local Elder and a Blackfoot societal grandfather. Melissa is an undergraduate student in Public Health who will soon begin graduate studies. Janice is a faculty member at the University of Lethbridge. Melissa, Mark, and Roger are Niitsitapi. Les is Cree but was raised in a Euro-Canadian settler family. Chelsey and Janice are Euro-Canadian settlers. The diversity of those involved led organically to a Two-Eyed Seeing practice in the program's development and implementation.

Each of us along with other community organizations contributed something different to I'taamohkanoohsin. Chelsey identified a distinct lack of accessible and culturally relevant services for Indigenous people. She consulted with clientele, Elders, and Blackfoot mental health workers, and then surveyed youth and adults to assess their interests in cultural activities. Chelsey presented her data to the

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[2] Pronounced nit-SI-tah-pee
[3] Hand games are a traditional Blackfoot game played in teams.
[4] Face painting is a Blackfoot blessing using bison fat and ochre.

Lethbridge Indigenous Sharing Network interagency meeting. There she met Les, who sought to improve relations between the police and the homeless population, and proactively address the root causes of substance misuse and other community issues. As the two brainstormed ideas, Les offered the use of the LPS tipi to create a place for programming. This innovation circumvented the need for an indoor space and increased visibility and accessibility by positioning the program in a central park. Les coordinated the setup, obtained necessary permits, arranged coffee and snack donations from McDonald's, and provided supplies to build a fire inside the tipi.

Roger joined the collaboration when Les asked him to become the Elder for the program. Chelsey invited Mark who had strong relationships with the target population and could organize cultural activities. Melissa volunteered to reconnect with, and support, family and friends who were experiencing homelessness. Janice joined to build community relationships and was later asked to document the program. Other non-profit and health-related organizations saw the benefit of the program for their own clientele, and contributed by providing meal preparation, transportation, and active participation. Activities were based upon ongoing feedback from the program attendees.

I'taamohkanoohsin was initiated by the desire to support people to begin their healing process and it grew into a multi-organizational collaboration. The first event was held on January 21, 2017, two weeks after Chelsey and Les first met, demonstrating how the joint effort of community organizations and volunteers can enable the rapid mobilization of resources. Supporting I'taamohkaanohsin furthered the organizational mandates of contributing agencies. During the first year, ARCHES expanded I'taamohkanoohsin to offer several activities at other locations: beading, talking circles, a mini pow wow, and traditional teachings. Out-of-city excursions occurred to visit sacred sites, harvest tipi poles and pegs, and to go fishing. The most visible and well attended activity remained the tipi program.

Methodology

A general inductive approach to impact and process evaluation was used to assess the program after its first year (Thomas, 2006). The assessment goals were to: a) determine impact on participants, b) gather program feedback to expand future activities, and c) to investigate successes and challenges to implementation. This evaluation focuses only on one part of I'taamohkanoohsin, that is, the "tipi program." Ideally, research with Indigenous people is decolonizing and participatory (Bartlett, Iwasaki, Gottlieb, Hall, & Mannell, 2007; Smith, 1999), but the extreme disempowerment of the target population limited expectations for a participatory process. Instead, we prioritized relational accountability with the participants (Wilson, 2008). Our team met in August 2017 to finalize the methodology and construct two brief semi-structured interview guides, one for program participants and one for key informants. Key informants included program facilitators and people within the community who interacted regularly with program participants. The University of Lethbridge Office of Research Ethics granted ethical approval.

Data Generation and Analysis

Data generation occurred over two events in September 2017. We co-facilitated interviews with two or three participants at a time within the tipi. Interviews lasted four to 15 minutes. Of the twenty-four adult participants interviewed, twenty were Indigenous, four were Caucasian, and eight were women. Five participants were currently housed but may have misused substances frequently. Participants received a five-dollar McDonald's gift card for each interview. Six key informants were individually interviewed in winter 2018 regarding their observations of the program. Their data is used to supplement results from participant interviews. Key informants did not receive any compensation.

Analysis was guided by a Two-Eyed Seeing framework that views knowledge production as a journey of co-learning through the interweaving of two worldviews (Bartlett, Marshall, & Marshall, 2012). Janice first analyzed the data using thematic content analysis (Braun & Clarke, 2006) undergirded by narrative inquiry's "ontology of experience" (Clandinin & Rosiek, 2007, p. 39). Melissa then followed with a deeper interpretation that contextualized and interwove responses within Blackfoot knowledge, relationships, and histories.

Results

The results identified a web of connections between what drew people to the program and why they returned. Essentially, I'taahmohkanoohsin gave people *Something to Look Forward To*. Starting with seemingly simple things like *Food and Drinks*, people had the opportunity to *Build and Renew Relationships* and connect with *Niitsitapi' Ways of Knowing*. Activities under all three themes triggered *Memories of Better Times*. These experiences would *Bring Spirit Home*, enhancing participants' strength and hope, however brief, until the next event. Figure 1 illustrates the connections between these themes.
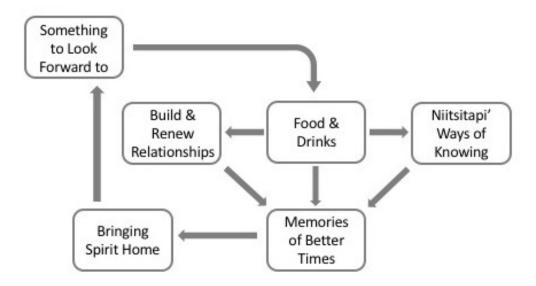

Figure 1. *Process of coming together.*

Something to Look Forward to

People living on the street experience extreme social marginalization and risk of violence. I'taahmohkanoohsin counters marginalization, even if only for a short period. It offers a non-judgemental and inclusive environment that counters the dehumanizing tropes of "drunk" or "junkie." Paul[5] (40s) had dropped in to investigate the activities for the first time and explained how important seemingly small things are for people on the street: "Our people need something... to make their day, because their day is empty. Something that… will help them, you know? Something to look forward to." The program provides that something to anticipate: "I find it fun… [and] interesting. I like coming here" (Laura, 50s).

Food and Drinks

Several things drew people into the activities. Participants mentioned drumming or seeing the tipi, but they most consistently identified *Food and Drinks* as a benefit of or draw to the program. "Food" was the most common response to what participants liked and what kept them returning; but it was entwined with relationships: "I like their mint tea, and they always have good food, and I like the people" (Evelynn, 50s). Sharing food and drinks are a small way to show care and respect for people. More than just physical nourishment, food demonstrates to participants that they have value: "You can actually come here and get a cuppa coffee and you don't have to beg for it…. You can... get a cookie. I don't have to pick it up out of the garbage" (Alex, 30s). Food brought people to the tipi to talk and laugh. Brian said, "This is good. Coffee, and donuts and that, that's a beginning." As with any relationship, whether it is for research or friendship, it most often begins with sharing and talking with one another over coffee or tea. This simple offering opened the door to more meaningful interactions.

Food is an important part of Blackfoot culture that connects people to one another and strengthens relationships. Sharing food is a form of respect and reinforces the value of looking after one another. Hosts always offer food and drinks to visitors and food is often the most important part of community gatherings. Sharing food is one of many daily rituals or protocols that ensures good relations with allies or kin. Providing food also gives energy to our visitors, assists in the continuation of life, and it helps maintain balance on their daily journey.

Connecting and Building Relationships

Sharing food was an entry to *Connecting and Building Relationships*. Participants attributed repeat attendance to the welcoming space and meeting with friends and new people. They enjoyed the relational elements embodied through laughter, sharing, kindness, and conversation. The few hours that the program ran each time provided a reprieve from the struggle and isolation of street life. It was Alex's first time attending the program and this was his impression:

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[5] All names are pseudonyms

This (program)… is one place where you can come and you can find peace….
where you come and… just talk, share your heart, share your spirit, and share your
soul. And you don't have to be afraid, [like when] we walk around the streets.... I'm
not afraid that somebody's going to come up behind me and stab me in the back.
[…] Right now, I get to talk. When I'm out there on the street I can't. (Alex).

Compared to existence on the streets, the space created by the program was a safe one that provided a sense of belonging.

The program aspired to be supportive and respectful. Everyone was welcome, even if they were intoxicated or high. Disruptions were rare. Some stayed away when using: "I didn't bother stopping because I was under the influence. So… I showed more respect than just stopping in… smelling like alcohol and stuff." Cultural protocols requiring people to avoid ceremony when intoxicated are still respected by many.

Relationships between community service workers and people on the street are more easily forged when meeting outside of the formal and intimidating office setting. Some participants became connected to housing services this way. One worker who attended the program was able to de-escalate a situation at the social services office because she recognized that individual from the tipi program. There are indications that the relationship between police services and people living on the street can be improved through program interactions. Les was always present out of uniform, but other officers would visit in uniform. Trixie[6], a woman who took on a leadership role as participant-volunteer, "Did not like police," according to Mark. But after becoming involved in the program, "She had a real, 'Well *not all* police are bad,' ...attitude instead of, 'All police are bad, we don't like the police.'"

Niitsitapi' Ways of Knowing

Coming together to share food and stories enables the transmission of cultural knowledge. Traditionally, Niitsitapi' knowledge and values were passed down to younger generations through storytelling and other oral practices as well as land-based teachings. Given that cultural transmission was disrupted by forced assimilation, the program's goal was to improve access to cultural resources and facilitate cultural (re)connection.

Participants affirmed that I'taamohkanoohsin achieved this goal and described the necessity of restoring *Niitsitapi' Ways of Knowing*: "It is very important, because… we'd like to keep it active for the younger generation, so it can carry on" (Mary, 50s). Older and younger participants expressed similar views even though their experiences diverged. Older participants referred to childhood memories where they were learning Blackfoot ways from their grandparents. Younger participants who grew up within the foster care system indicated little knowledge of their cultural ways,

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[6] Trixie passed on in the fall of 2017. It is for people like her that we do this work.

I was raised in a Christian home... and then in the foster care system…. I never got the opportunity to learn about my culture. I was sort of against it for awhile because of how I was raised. But now... I'm very proud of my culture and who I am... so I would like to learn about my culture a lot more now and take part in ceremonies…. My daughters dance pow-wow… and I'm happy that they dance. It was something that I never did…. Now I'm more open to it because that's who we are and that's who we have been…. It is important… to learn that and to pass it down, and I think it is another way for us to step towards healing. (Jared, 30s)

Attending community events provides opportunities for members to obtain Indigenous knowledge from community leaders and members. Participating in pow-wows helps people feel better about themselves, strengthens or reaffirms Blackfoot identity, and creates a pow-wow "family." This new family offers resources to learn Niitsitapi' ways of knowing through connections to Elders, ceremonies, and land-based teachings which may have not been previously accessible.

(Re)connection to Blackfoot ways of knowing supports people to feel that their lives have value and meaning. It can lift spirits, instill pride, and provide a sense of belonging. Mary explained how, without traditional knowledge, people are denied the life guidance that it provides.

"A lot of the younger ones, they're lost because not a lot of the tradition has gone to them. And they're seeking something. Like a foundation together. And walking this way brings back a lot (of) blessings within themselves…. They want to find it but they don't know how." (Mary)

Without cultural guidance, it can be difficult to decipher the lessons within stories and teachings. Mary was explaining how, by following a traditional path, people will learn to understand the oral teachings they have been unknowingly gifted or blessed upon them from their kin.

Non-Indigenous participants felt it was valuable to learn about other cultures. This sentiment was expressed most strongly by two participants who had Niitsitapi' and Métis grandchildren. For Gail (50s), it was important to learn Blackfoot culture to share it with grandchildren who were not receiving this knowledge from their custodial parent.

Memories of Better Times

Connecting and Building Relationships and *Niitsitapi' Ways of Knowing* elicited pleasant reminders of participants' childhoods. The atmosphere around sharing food and visiting with others at I'taamohkanoohsin invited memories of the grandmothers. Their homes were always open to their kin. A pot of *siksikimi* (tea) was always waiting on the stove, instantly inviting conversations from aunts, uncles, and cousins. Stories were transferred in Blackfoot between the *kaáhs/kaasiiks* (grandparents) and the children. Sitting around the tipi, especially, brought memories to resurface among participants. Mary explained that "[the tipi] brings back lots of history… it's a reminder of who we are." Evelynn shared, "It brings me back to the days [when] we would go to pow-wows and sleep in the tipi."

Opportunities to participate in ceremony and other activities are limited when one is unhoused. Traditional knowledge can be a source of strength and resilience: "I learned a lot from [my grandparents], how to speak my language, how to survive" (Evelyn). Participants suggested the program had a restorative effect that mediated, temporarily, a very difficult reality brought on by colonialism, residential schools, and foster care. The tipi program was a reminder of the imperative to learn Blackfoot knowledge gifted from grandparents and transfer it on to others.

Bringing the Spirit Home

Connecting and Building Relationships, *Passing on Traditional Culture and Knowledge* and *Memories of Better Times* all feed into *Bringing the Spirit Home*. Spiritual identity is strongly valued by Niitsitapi' and creating a relationship with it tends to our spiritual needs. The sharing, laughter, relationships, memories, cultural activities, and storytelling of I'taamohkanoohsin are all medicines that nurture the spirit (Portman & Garrett, 2006). Through these activities, the program brought people's spirits back to them by facilitating reconnection between people's mental-self and the spirit-self. Arnold explained, "Sometimes my spirit gets lost and it (my tradition) helps bring it up." Mary said I'taamohkanoohsin "brought (a connection to) spirituality and… belief…. You get your strength here." Niitsitapi' believe that when you use substances it disconnects your spirit-self from your body resulting in a lost feeling. *Bringing the Spirit Home* to one's body offers strength to support healing and recovery from substance misuse. Smudging and prayer is needed "to give them strength for the day because most of them are lost out there "(Donna, 40s). Given the precariousness of many participants' lives, surviving each day is an ever-present challenge. Connection to spirit gives people hope for a better future and hope gives them something to look forward to when coming back to the program.

More than a symbol or reminder of traditional ways, the tipi transformed the park space and served as a gathering point to draw people in. It was a place to warm up on cold days. The interior had a feeling of sacred space where people's stories where shared and respected. It had a powerful influence upon spirit: "I like the tipi… it makes me feel safe [and] brings out my light. This makes me feel at home" (Arnold). Arnold's experience contrasts profoundly with the dislocation and violence of homelessness. The tipi formed a safe space in the park and embodied the spirit of "everyone comes together."

Discussion

Blackfoot knowledge understands spirit as a separate entity from the body that is connected to all of creation (Little Bear, 2000). Spirit is the foundation for wellness and resilience. Living by daily Blackfoot values empowers the spirit to connect to the land and all that it contains (Bastien, 2004) and maintaining a relationship with one's spirit is vital to feeling at home in the world. Niitsitapi' participants are not so much homeless as they are displaced from their family homes and community because of their problems with substance misuse. They have homes they might return to if they could

resolve the pull of alchohol or drugs. Their displacement from community, kin, and land precipitates the experience of spiritual homelessness.

I'taamohkanoohsin offered individuals a path out of spiritual homelessness with an opportunity to develop pride and confidence in who they are as Niitsitapi'. Attending the tipi program would counteract spiritual homelessness by offering a sense of kinship, belonging, and spiritual connection. The experiences around the tipi were reminders that life can still have bright moments and inspire a sense of hope. Identity, spirituality, and a return to traditional values are all implicated in recovery from addiction (Prussing, 2007; Tempier, A., Dell, Papequash, Duncan, & Tempier, R., 2011). This program can be a catalyst to seeking alternative ways of living by guiding people back to this path, particularly with the support of community members working together to address the negative effects from residential school. It provided the safety and care missing with spiritual homelessness. Welcoming interactions instilled feelings of belonging and demonstrated that participants are worthy of respect from society. Sharing traditional knowledge reaffirmed Niitsitapi' identity and provided guidance. Overall, the tipi program fortified people with hope and brought their spirits home.

The immediate benefits were evident, although successes must be viewed on a smaller scale. Actions like showing up to meet workers or staying temporarily sober are all successes for this population. Furthermore, at least two participants transitioned into recovery and one obtained housing. I'taamohkanoohsin provides a short reprieve from the challenges of daily survival. Coming together around the tipi improved moments and hours within a participant's day and kept them from engaging in substance use for a time. It provided meaningful activity instead of walking the streets to pass time.

Program Challenges

Implementation had its challenges due to participant and organizational factors. Participation depended largely on how people prioritized attendance with their addictions. Acknowledging he would like to learn more about his culture, Sam (40s) indicated he did not have the capacity to explore it: "So much [is] going on in my life, I can't think straight. I keep thinking about my family, my uncles that passed away…. That's too much for the brain to think about it." The trauma and grief many experience can be complex and people must be stable enough to even attend events like I'taamohkanoohsin that might trigger memories or trauma related to their loss. Feeding one's addiction will also take priority over attendance. Jared revealed, "Honestly if there was somebody (who)… got like $30 and (said), 'Let's go get a two-six,' you know, my addiction with alcohol is pretty strong. I'd most likely go and drink."

I'taamohkanoohsin had limited capacity in the first year. Employers were supportive but unable to delegate additional resources. The help needed to set up and take down the tipi was sometimes absent. The low cost of the program was good initially but then began to limit the range of activities possible. Small sources of funding were located for day trips, but other challenges like insured transportation and risk mitigation arose. ARCHES received funding the following year to expand other I'taamohkanoohsin

activities substantially. Workplace changes and community dynamics also decreased the ability for some co-authors to continue collaborating on tipi activities.

Limitations

This research is unable to track the program's long-term benefits and results may only be applicable to the southern Alberta region. However, the lessons learned here may be useful for harnessing the power of community and cultural reclamation to develop similar grassroots activities in other locales. There are small but discernible benefits to participants, yet significantly more action is necessary to lower rates of substance misuse and mortality due to overdoses and violence. Single programs are insufficient without changes to policies, budgets, and institutional structures, the absence of which allow the cycle of poverty, addiction, violence, and marginalization to continue (Oelke, Thurston, & Turner, 2016; Marshall, 2015; Tait, Henry, & Walker, 2013). Future research and development must press for a systemic integrated approach to increase access to long-term, culturally appropriate treatment and post-treatment supports. Creative grassroots solutions may be necessary to work around the failure of governments to implement known solutions (i.e. Blackstock, Brown, & Bennett, 2007), such as poverty reduction and changes to child welfare and health policies, until the time when systemic change occurs.

Conclusion

The people with whom we work are vulnerable, frequently in crisis, and yet are some of the strongest and most accepting people with whom we have had the honour to work. The patterns of their lives are formed around the cycle of their substance misuse and by being unhoused and displaced on their home territory. Blackfoot values and practices can be the starting point to good relations and life balance. Embodying those values connects people to their spirit, which is a source of strength and resilience. The program increased opportunities for cultural connection and supported people in nurturing their spirit-self. Participants (re)connect with kin, community, and self. People from all walks of life were attracted to the tipi, providing opportunities to learn about one another and alleviate fears or stereotypes among people who would otherwise have little interaction. I'taamohkanoohsin created a very visible presence of Niitsitapi' regional identity in the heart of Blackfoot homeland. It made the statement that Blackfoot culture is strong and vibrant.

Overcoming substance misuse is a personal journey that begins when a person decides s/he is ready. Our desire is that the moments of hope gleaned in the program will accumulate into stronger identities and self-worth, greater agency, and the beginning of that journey. The ongoing and increasing numbers of overdoses and mortalities in the Blackfoot community punctuates the urgency of this work. The Tipi Program is currently on hold but ARCHES has expanded other I'taamohkanoohsin activities at its new supervised consumption site. There, daily cultural supports are provided in a ceremonial room including counseling, smudging, beading, and music jam sessions. Some clients have recorded music

mixes in a hip-hop club; and another is developing a Blackfoot language class. These are all individuals who still use substances regularly but are now showing the other gifts they possess.

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Cultural Safety Training for Health Professionals Working with Indigenous Populations in Montreal, Quebec

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Cultural Safety Training for Health Professionals Working with Indigenous Populations in Montreal, Quebec

Abstract

Urban Indigenous populations face some of the most significant barriers to accessing health services out of any population in Canada. The Indigenous community in Montreal developed a cultural safety training program to help decrease some of these barriers. An extensive review of published literature on cultural safety in health care was performed. A training program was developed to: describe the diversity of Indigenous populations in Montreal; explain historic and present-day determinants of health inequities in this population; develop competencies to respect clients' diversity and promote cultural safety in care. A pre-test survey was circulated to participants receiving the training to establish baseline knowledge and attitudes towards Indigenous populations. The program was divided into 3 half-day sessions. After each session, a satisfaction evaluation grid survey was circulated to participants. The Indigenous Cultural Safety Training Program was presented to a total of 45 nurses, social workers, and physicians with frequent interactions with the Indigenous community in Montreal. Having an Elder and community member present appeared to have been successful in increasing participants' level of awareness of the importance of improving the quality of health care services provided. Challenges were identified regarding the transmission of the political aspect of the cultural safety concept, and the importance of decolonizing health care systems. Reflections on how to address these in the future will be discussed. Cultural safety training for health professionals is challenging, yet, a necessity to improve access to care and improve health outcomes in urban Indigenous populations.

Keywords:

Cultural safety, Barriers, Health access

Acknowledgements

Introduction

The term cultural safety can best be described as "an environment that is spiritually, socially, and emotionally safe, as well as physically safe for people; where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience of learning together" (Williams, 1999, p 213). The concept originated in the 1980s in New Zealand as a means to provide more appropriate health services for Maori people (Nursing Council of New Zealand, 2011). It is a combination of cultural awareness (acknowledging the differences between cultures), cultural sensitivity (respect towards other cultures), and cultural competency (effective work with diverse populations through appropriate behaviours, attitudes, and policies (Brascoupé & Waters, 2009; Darroch et al., 2017). The term made its way into Canadian literature in the early 2000s via the National Aboriginal Health Organization and the Aboriginal Nurses Association of Canada (Schill & Caxaj, 2019). In recent years, cultural safety has become prominent in health care education and services in Canada, particularly when working with Indigenous populations.

Like elsewhere around the world, Indigenous peoples in Canada face some of the most severe health inequities in comparison to their non-Indigenous counterparts. In addition, the increasing mobility of Indigenous populations from communities towards urban centres in the hopes of improving their living conditions has contributed to making urban Indigenous populations the fastest growing population in Canada. For example, between 2001 and 2011, the Indigenous population living in Montreal grew by 135% (Aboriginal Affairs and Northern Development Canada, 2014; Government of Canada, 2013). In spite of these populations being in urban centers - where health services are available, and, in principle, "universally accessible" - urban Indigenous people continue to face substantial challenges in terms of access and quality of health and social services in Canada (Allan & Smylie, 2015); a situation that has resulted in the Indigenous population's lack of trust in the health care systems, hence exacerbating the health iniquities they are currently facing (Montreal Urban Aboriginal Health Committee, 2012).

In 2012, the Montreal Urban Aboriginal Health Committee conducted a Needs Assessment through a series of group and individual interviews with 89 urban Indigenous people (First Nations, Métis, and Inuit) and 94 health service providers (Montreal Urban Aboriginal Health Committee, 2012). The results of this needs assessment revealed that a majority of Indigenous respondents rated their health as poor, and more than half of them reported being dissatisfied with the health services available and provided to them in the city. Reported barriers to care included inadequate levels of cultural safety, discrimination, language barriers, limited access to mental health services, lack of provincial medicare (RAMQ) coverage, lack of identification papers, and prohibitive costs associated with care. In addition, lack of access to traditional healing services and the need for a centrally located, culturally safe, holistic health centre were identified. These barriers were also corroborated by many of the health care providers interviewed.

Whether patients are First Nations, Métis, or Inuit, it is evident that current services in Montreal are not culturally safe, and do not answer the needs of the population.

British Columbia, Saskatchewan, Manitoba, and Ontario have developed their own cultural safety training programs for health professionals. In British Columbia, the program, known as San'yas, is an online training program that has gained recognition across Canada. Course materials are interactive and investigate culture, stereotyping, and the health and social impacts of colonization. Both Manitoba, and Ontario have adapted the San'yas program to reflect the realities in their respective provinces (Provincial Health Services Authority in BC, 2018; Southwest Ontario Aboriginal Health Access Centre, 2014; Winnipeg Regional Health Authority, 2017). The Saskatoon Health Region has developed an online toolkit for cultural competency and cultural safety that consists of documents encouraging health professionals to engage in reflection, relationship building, and reconciliation (Saskatoon Health Region, 2016). Finally, the National Indigenous Cultural Safety Learning Series is a partnership between the Provincial Health Services Authority of British Columbia and the Southwest Ontario Aboriginal Health Access Centre that provides monthly webinars of 90 minutes in duration (Indigenous Cultural Safety Collaborative Learning Series, 2019). The goal is to bring together key provincial, federal, and international stakeholders in order to collaborate and provide a shared learning environment for cultural safety.

In New Zealand, cultural safety teaching has been an integral part of nursing education since the 1990s. Cultural safety teachers informed nursing students of the positive impact of attitude changes on the delivery of health services, and, examined the power imbalances often seen in the nurse-patient relationship. The New Zealand Education Department hired a Maori Education Officer to introduce bicultural education into the nursing curriculum. This new curriculum was developed through partnerships between the New Zealand Council of Maori Nurses, the Department of Education, Department of Health, and Maori and *Pakeha* (Maori term for New Zealanders of European descent) nurse educators. This partnership addressed the needs of nursing students and the needs of Maori. Since its inclusion almost 30 years ago, the debate about how cultural safety should be incorporated into nursing education continues; however, it is evident that the facilitated group process is the best model for students to learn, and develop discourse in a supportive environment (Richardson & Carryer, 2005).

In Australia, the National Aboriginal and Torres Strait Islander Health Workers Association (NATSIHWA) launched their cultural safety framework in 2013. This framework focuses on 8 critical domains: country and community; local cultural contextuality; recognizing and valuing the role of Aboriginal and Torres Strait Islander health workers; individual reflection; systemic reflection; equity and sustainability; collaboration and cooperation; and monitoring and evaluation (National Aboriginal and Torres Strait Islander Health Workers Association, 2013).

It is evident that Quebec has much work to do to ensure culturally safe, accessible health services for Indigenous people. In addition to the lack of cultural safety training for health professionals, Indigenous people in Quebec's urban settings lack appropriate centres for health care. In Ontario, for example, 10 Aboriginal Health Access Centres (AHAC) provide culturally safe care to Indigenous communities, as well as comprehensive cultural safety training to their health care professionals (Southwest Ontario Aboriginal Health Access Centre, 2014). The Wabano Centre for Aboriginal Health in Ottawa, Ontario is a successful example, providing a multitude of services to promote the health of all Indigenous People in a culturally safe environment (Wabano Centre for Aboriginal Health, 2017). In Toronto, Ontario, Anishnawbe Health Toronto was created in 1984 and services the community in 3 locations across the Greater Toronto Area. These services include primary care, diabetes prevention, education, and management, family services, mental health and addiction services, and fetal alcohol spectrum disorder services following a traditional model of care that includes Traditional Healers, Elders, and Medicine People (Anishnawbe Health Toronto, 2013).

The structure of the health care system in Quebec presents challenges in terms of implementing cultural safety training and developing a culturally safe, holistic health centre for Indigenous people. Currently, primary care services are housed under one roof in local health service centres, with the emphasis on inclusion and access for all. In reality, this causes disjointed service provision. Some of the issues that exist for the general population include minimal walk-in hours, long wait times, and often minimal staffing to support the needs of the area it serves (Loopie Reading & Wien, 2009). In combination with the aforementioned barriers to access to health services described in the Health Needs Assessment, significant structural and individual problems must be addressed to ensure equitable access to health services in a culturally safe environment.

Additionally, from a medical education standpoint, it is only within the last few years that schools in Canada have begun implementing Indigenous curricula as part of the core training for future physicians. In Quebec, the idea of Indigenous teaching in health education is still in development. Most of the health care workers who are already in practice have had limited exposure to these issues as part of their professional training. Moreover, although there has been an increased focus on Indigenous health in Canadian health education curricula in recent years, it appears that cultural competency has been the area of focus thus far in nursing and medicine programs, which, as explained earlier, falls short of truly bringing equity in care for Indigenous peoples (Verma, 2017).

With the rapid urbanisation of Indigenous populations in the province, health care professionals working in urban centers are sure to see an increasing number of Indigenous patients, whether they practice in Emergency Departments, primary health care clinics, or in hospitals.

It is with this context in mind that the Montreal Urban Aboriginal Health Centre, in conjunction with the Institut National de Santé Publique du Québec, developed and piloted training material aimed at health care professionals already in practice in the city. The main goal of this training was to develop the professionals' knowledge, abilities, and attitudes to better understand and address barriers to care for Indigenous peoples in Montreal.

Methods

This project was a partnership between the Montreal Urban Aboriginal Community Strategy Network's (NETWORK) health working committee and the Institut National de Santé Publique du Québec (INSPQ). The NETWORK is an organisation that was created in 2008 to improve the quality of life of the Aboriginal people in the greater Montreal area through a coordinated and concerted approach. The NETWORK encompasses six working groups: health, arts and culture, social services, youth, employability and education, and communications. The health working committee recently incorporated one of its sub-committees in order to secure funding and grant opportunities to develop a culturally safe holistic health centre for the urban Indigenous population in Montreal – the Montreal Urban Aboriginal Health Centre.

The INSPQ was created in 1998 as the centre for expertise in public health in Quebec. The Indigenous Health team of the INSPQ was created in 2008, with the objective of supporting Indigenous organisations in developing and implementing strategies to improve the health and well-being of the Indigenous populations in the province.

Training material development and piloting

Beginning in the summer of 2016, members from the INSPQ working team conducted an exhaustive review of the published literature, documenting the components and efficiency of already existing cultural safety training programs that were developed elsewhere in Canada and across the globe. From this documentation, a training manual was drafted and validated by members of the NETWORK's health working committee. While many programs developed across Canada were implemented via online training sessions, in discussions with health professionals in Montreal, it was felt that in-person sessions would be more valuable as health professionals are constantly bombarded with required online training sessions. It was thought that to continue with this format would not place sufficient emphasis on the importance of cultural safety training. Additionally, in-person interaction with Elders and Indigenous community members, and hearing their stories first-hand, would provide greater impact and a stronger message to alter subsequent health services.

In the summer of 2017, the team was approached by one of the Integrated Primary Care Centers of Montreal with a request to provide training to some of their interdisciplinary health care teams working with marginalised populations in the city. The group of health care professionals was divided into two subgroups of 20-25 participants each, and each received three sessions of three hours each. Sessions began with a ceremony and opening prayer by an Elder. The goal of the training was to develop participants' ability to:

(1) Recognize the sociocultural and socioeconomic diversity of Indigenous populations in Montreal;
(2) Describe the links between the history of colonisation in Canada and the current health status of the Indigenous population; and
(3) Apply a cultural safety approach when interacting with Indigenous patients, by developing their ability for reflective practice, cultural humility, and respect.

Training facilitators included an Elder, a First Nation's community member, as well as a non-Indigenous public health physician and a medical student with clinical experience in Indigenous populations.

The project submitted did not require REB review because it aimed to assess the performance of a training activity, as part of regular quality assurance and quality improvement activities as stipulated in article 2.5 of the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans*.

Training evaluation

A process evaluation of this pilot training was conducted in order to evaluate the satisfaction of participants with the training, as well as to test the feasibility of incorporating the training program in primary care centres in Montreal. To achieve this, a questionnaire was provided to all participants prior to the first training session; this pre-training needs assessment was meant to develop an appreciation of participants' level of knowledge on issues surrounding Indigenous peoples and cultural safety. In addition, a satisfaction assessment grid was provided after each training session, where participants could rate their experience of the session and provide comments on how it could be improved.

Results

A total of 45 health care professionals (including nurses, social workers, and physicians) were initially enrolled in the nine-hour training. The training sessions were held between December 6, 2017

and March 20, 2018. The questionnaires that were distributed to participants at each session can be found in the appendices.

Table 1 below presents the results of the initial needs assessment. About a third of participants reported having already received some form of Indigenous health training. While participants appeared to already be quite knowledgeable in the realities and challenges faced by Indigenous peoples accessing health services in Montreal, the vast majority of them admitted being unaware of the concept of cultural safety. An average score of five (5) good answers out of 10 questions was achieved on the knowledge scale, with the highest score (9/10) being achieved only by a very small minority of participants. The questions that were most often missed were the ones pertaining to the rapid growth rate and language barriers faced by the Indigenous population in Montreal.

Table 1: *Pre-training needs assessment results*

	Average	**Maximum**
Knowledge of Indigenous Peoples in Canada	5/10	9/10
Beliefs and attitudes with regards to the care of Indigenous Peoples in Montreal.	6/7	7/7

Moreover, the vast majority of participants seemed to demonstrate a positive attitude towards Indigenous patients in general, acknowledging that this population continues to face discrimination within the health system. The overall average on the 'attitudes' scale was of six (6) good answers out of seven (7) questions, with approximately one third (1/3) of participants receiving a perfect (seven (7) out of seven (7)) score.

When asked to define the term "cultural safety", the vast majority of participants came up with a definition that appeared to be closer to that of "cultural competency" than of "cultural safety". Yet, approximately one third of participants (28%) did define cultural safety as a way of providing care that is "adapted to the needs of the patient". Also, a small number of participants admitted that providing a culturally safe environment was difficult in the current health care context, mostly due to structural and organisational constraints, particularly when referring patients to other institutions than their own.

When asked about training expectations, almost half of participants noted that they wanted to "learn more about the culture, values, and beliefs of Indigenous people" (again reflecting more of an interest in cultural competency than cultural safety itself). In addition, a quarter of the participants chose

not to answer this question, which may have indicated a lack of interest in (or a perception of lack of pertinence of) the training itself. Yet, the remaining quarter of participants provided answers that revolved around cultural safety principles, such as "interest in knowing how to remove barriers to adequate interventions", as well as "learning more on the needs and desires of the Indigenous population in terms of health and health care services".

As the sessions went on, participation in the post-training satisfaction evaluation dropped from 98% to 29%, likely indicating a decreased interest in the evaluation over time. On a whole, the evaluation grids received revealed positive reactions to the training program.

Table 2: *Session evaluation*

	Module 1 (N=44)	Module 2 (N=12)	Module 3 (N=13)
	% Satisfied/very satisfied	% Satisfied/very satisfied	% Satisfied/very satisfied
Pertinence of content	91%	83%	54%
Pertinence for practice	73%	67%	54%
Quality of the trainers	89%	75%	92%

The inclusion of an Elder as one of the facilitators appears to have been perceived as a very strong aspect of the training provided, and many participants reported having appreciated the traditional opening ceremony during the first training session. They felt her presence and testimonies made them more aware of Indigenous realities.

"*Re-telling of events from the elder were touching and pertinent*"

"*It made me realise that I have to take into account heritage to better listen to Indigenous People*"

Areas for improvement reported by participants included increased discussion time to ask questions to trainers, as well as to share experiences among participants. On the other hand, many declared that offering the training over 3 sessions was too long and that two sessions would have been sufficient to cover the topics presented. A small minority of participants did express their profound dissatisfaction with the "tone" of the training, as they perceived it to constitute a form of judgement towards "white" people.

"A more neutral tone would have been appreciated as there was some discrimination felt towards health care professionals"

"Events that were described showed judgement towards 'white' people and not all 'white' people have prejudices against Indigenous Peoples"

Discussion

Lessons learned from our pilot training evaluation

The present work was aimed at evaluating the satisfaction and feasibility of providing cultural safety training to health care professionals working in the primary care setting in Montreal. We were able to observe that the majority of participants seemed unaware of the concept of cultural safety prior to receiving the training sessions; hence, many were expecting the training to cover topics that are more related to cultural competency than to cultural safety principles. This raises the issue of the weaknesses in health education in Canada when it comes to training professionals on Indigenous health.

Our evaluation results also raised the questions of what would constitute essential factors to ensure the success of future cultural safety trainings in health care institutions in Quebec. Building on existing guidelines for effective change of practice for health care professionals, our experience seems to reiterate the importance of ensuring that the need for trainings be identified by the health care professionals themselves. Indeed, it was felt that the mandatory status of the training we provided could have explained the attrition challenges we faced.

Additionally, the number of participants in such training sessions should be small enough to allow for better interaction. It appeared that having more than 20 individuals per session made it difficult to engage participants in discussions. Yet, participants seemed to have appreciated the opportunity for interdisciplinary conversations, making the interaction between nurses, social workers, and physicians vital during cultural safety training. A portion of the training should bring together participants from the same profession so that they can more easily share past experiences. In order to achieve discussion and to share experiences, other training programs have incorporated a talking circle model.(Jain, Peters, & Lambright, 2017) This can allow participants to reflect on the mornings content in the presence of an Elder, and perhaps a Traditional Healer as well, to debrief. Additionally, this adds another element of an Indigenous framework to the training program.

Finally, we realised that, for some participants, the content of cultural safety trainings constituted a "tough pill to swallow". Cultural safety training requires covering sensitive topics such as systemic

racism and structural discrimination, as well as concepts of colonialism and assimilation that were likely never addressed as part of core training. Some seemed to have felt that these discussions constituted an unwelcome critique of their performance as health care workers. We have to admit we were initially surprised with the strength of dissatisfaction being expressed. Upon further reflection, however, it came to light that this sense of discomfort was in fact a necessary first step towards evoking change within the health care system. Disclosing the sensitive and difficult nature of the material prior to the start of training would allow for individuals to be more prepared. The presence of an Elder should also help in creating a dialogue and debriefing participants.

The inclusion of an Elder and Indigenous community members in the facilitation of the training is of utmost importance. The direct interaction with members of the community lowers the resistance towards learning about Indigenous health, knowledge, and cultural safety (Ranzijn, McConnochie, Day, Nolan, & Wharton, 2008). Furthermore, recent studies have shown that this interaction leads to an increased interest in continuing to engage with the Indigenous community via volunteering and employment (Roche, 2014; Roche, Jones, Hinman, & Seoldo, 2007).

It is difficult to compare this cultural safety training program to other existing models as few publications exist. San'yas, however, was recently evaluated in the EQUIP Study (Equity Oriented Primary Health) (Masinde, 2017). This study combined staff education with strategies for encouraging the provision of equity-oriented care for marginalized populations in a community. Eighty staff members took the San'yas Indigenous Cultural Safety online training, many of whom were already knowledgeable about cultural safety and anti-discriminatory care. It was noted that the training encouraged staff to challenge institutional discrimination as determinants of poor health and wellness. They also noted an importance on improving patient-physician relationships, as well as the relationships within the community. Participants mentioned that many aspects were difficult to integrate at the clinic level due to structural challenges in the design and flow of a clinic. In addition, tension developed when participants tried to prioritize varying aspects of care that strayed away from a biomedically-influenced health care delivery system. The EQUIP study provided strong evidence for participant self-reflection. Participants were able to evaluate how they presented themselves, how they were perceived by patients, and how this could result in barriers to care.

From this evaluation of the San'yas Indigenous Cultural Safety online training, there are many similarities to our pilot project in Montreal. Participants found it difficult to prioritize other aspects of care and to acknowledge the difference in the patient-physician relationship when working with Indigenous patients. Additionally, there was limited awareness of cultural safety prior to commencing this training. With the advent of cultural safety training built into educational programs, future health professionals

should be cognisant of the key points of cultural safety and will be better suited to incorporate these into their practice.

Finally, this pilot training stresses the importance of early cultural safety education. Not only is it important that training be incorporated into the structural organization of a workplace but must also be integrated into formal professional and medical training. A recent literature review investigated cultural safety education in post-secondary health sciences curricula in Australia, Canada, New Zealand, and the USA (Kurtz et al., 2018). This review found 40 articles published between 1996 and 2016 that investigated cultural safety education in health science education. Thirteen were interdisciplinary in nature, while 11 studies focused on nursing education, and 6 focused on medicine. Other specialties included dentistry, pharmacology, psychology, social work, audiology, and midwifery. Surprisingly, more than half of the curricula examined did not include Indigenous people in the development or delivery of the training. The programs that developed a university-community partnership found it to be highly mutually beneficial. Programs held consultation between faculty, students, Indigenous community practitioners and community representatives, and this was found to successfully meet the learning needs of students, while also being an asset to the community. In Australia, New Zealand, and the USA, students who received cultural safety education prior to practicum experience were also noted to be more aware of health care power imbalances. This, also, increased their confidence and cultural humility in their practice.

Six studies in this review stemmed from Canada (Kurtz et al., 2018). Arnold, Appleby, and Heaton (2008) assessed a cultural immersion weekend with 4th year nursing students and community members. The nursing students gained a better understanding of Indigenous health inequities and the effects of colonialism. Community members met staff and attended career fairs and saw nursing as a viable career choice. Bernhardt et al. (2011) studied a training program in audiology and speech language pathology. This was an 8-month course developed by an advisory group comprised of Indigenous and non-Indigenous community representatives, academics, practitioners, a project coordinator, and student assistants. The curriculum consisted of face-to-face class meetings, student community visits, as well as a website containing articles, announcements, and a discussion forum. Students found they were better prepared to work with the Indigenous community and had a broader understanding of culture after course completion. Carter and Rukholm (2009) studied an interdisciplinary model consisting of nursing, medicine, social work, and health promotion in collaboration with four universities. An Elder directed the curriculum that contained online learning modules. There was increased personal growth and increased awareness of Indigenous health beliefs/attitudes and inter-professionalism. Hudson and Maar (2014) developed a pilot study for medical and nursing students in collaboration with Northern Ontario's Aboriginal political bodies and organizations. Students had mandatory placement in Indigenous communities for 2 weeks and a 2-week on-campus session with online material. It was found that greater in-class preparation was necessary and there was a lack of meaningful discussion online. Jarvis-Selinger et al. (2008) described a social accountability model collaborating with community health administrators, Indigenous community

members, health professionals, policy makers, and Indigenous leaders to provide training to medical, pharmacy, nursing, and social work students. This was a 4-week community immersion program taught by Indigenous university and community instructors. They found that there was a greater need to integrate an Indigenous perspective into health curricula, as well as social accountability. Kline, Godolphin, Chhina, and Towle (2013) developed an interdisciplinary health science approach whereby students participated in a summer camp for Indigenous youth led by Elders, youth workers, and cultural leaders. The students developed self-awareness, cultural humility, and respect for Indigenous people and cultures. This review acknowledged that more cultural safety education is necessary in Canada prior to the immersion of medical and nursing students into the field.

Drawing from the behaviour change literature

As often mentioned in the competency-development literature, the content of such training should address the participants' self-perceived learning needs, but also their initial level of knowledge. Indeed, as observed in our pilot training, when participants present with a wide range of backgrounds and funds of knowledge with regards to Indigenous peoples, it can make achieving common learning objectives difficult. This is why it is important for facilitators to ask participants to complete a pre-training needs evaluation prior to the start of the sessions. This will ensure that trainers can adjust the training content to best fit the needs of each group.

As cultural safety training programs are increasingly being developed and implement, the topic of "white resistance" is emerging. Currently very limited published empirical research exists. Yet, drawing from the behaviour change literature and the challenges to behavioural change in health care institutions, we believe Prochaska's Transtheoretical Model may be useful in adapting training content according to participants' readiness to change (Prochaska & Velicer, 1997). Prochaska's model is used widely in health care as a method for counselling patients on behavioural change. It states that there are 6 stages people move through when they modify a specific behaviour. The precontemplation stage is the initial stage. Individuals at this stage are uninformed and not ready to take action. At the contemplation stage, individuals become aware of problems with a specific behaviour and are intent on making a change. At the preparation stage, an individual has started taking action, or is getting ready to do so in the immediate future. Individuals in the action stage have made specific, measurable changes. At the maintenance stage, individuals are becoming more confident in the changes they have made and less tempted to relapse. The termination stage represents the final stage where individuals are no longer tempted by previous behaviour. This model has been extremely useful in moving patients along the continuum of smoking cessation, for example. This model has also been used and adapted to organisational change in complex institutions (C. Bareil, 2004; C. Bareil & Gagnon, 2004). Based on Western conceptions of behavioural

and organisational change, we believe this is an appropriate model that fits well with the epistemological perspective of the health care providers and service institutions we are attempting to change.

From a cultural safety standpoint, individuals who are in the pre-contemplation stage do not see current practices and systems as creating barriers to care for Indigenous people. These individuals may need to be challenged in their convictions. This can be achieved by reviewing Canadian history of colonisation and colonialist policies through an Indigenous lens that will magnify the consequent health inequities. Participants at this stage, might require a significant amount of "credible evidence" demonstrating the impact of barriers to access to health care on Indigenous people, as well as a number of high quality research findings demonstrating how improved cultural safety can contribute to improving health outcomes in this population.

In contrast, participants who are already aware of the systemic barriers to care that Indigenous people face would be in the contemplation or preparation stage. They may find a review of history and evidence repetitive and may seek real concrete solutions. These participants will benefit from training focusing on developing practical skills and advice on how to become cultural safety champions within their organisations. Furthermore, these individuals are ideally suited to be future cultural safety trainers.

Research on the factors that facilitate health care professionals' change of practice has demonstrated the importance of organisational support in driving and maintaining change. It is essential that health care managers be present during cultural safety trainings. In fact, some even advocate for training health care system managers and decision-makers prior to offering trainings to health care professionals This ensures that the required organisational changes are in place before health care professionals receive training (Satterwhite, Teng, & Fernandopulle, 2007). In the cultural safety context, one of the most vital structural changes to improve health access is hiring Indigenous staff. Working closely with Indigenous community members will also improve health care professionals' understanding of the needs of the community. Finally, integrating cultural safety into institutional performance evaluations is important in order for both institutions and individuals to be held accountable for this collective change of practice.

Conclusion

This published evaluation of a pilot cultural safety training was, to our knowledge, the first of its kind in Montreal's health care system and it was found to be an overall positive experience. Going further, many adjustments can be made to improve the success of future trainings, including shortening its length, as well as ensuring that group size and time management allows for sufficient discussions between participants. Additionally, Indigenizing the training format through more inclusion of an Elder, talking

circles, and the presence of a Traditional Healer could allow for more meaningful discourse and a safer space for both participants and trainers. Success of such trainings also require that facilitators have a good a priori understanding of the baseline knowledge about Indigenous peoples and cultural safety principles, so that groups can be set up to bring together participants with similar learning needs, when it comes to their "readiness" to change practice.

Building on organisational change literature, we can also suggest that health care managers and decision-makers be trained on cultural safety principles before their employees/professionals receive the training, so that institutions' missions and procedures can support professional interventions in providing a health care environment where Indigenous patients can truly feel welcome, respected, and safe at all levels of care. Most importantly, one should not forget that cultural safety training cannot be done without Indigenous facilitators present, so as to be truthful to the basic principle of "never again about us without us".

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Appendix 1: Timeline for the half-day sessions

Module 1: Comprendre l'origine des iniquités vécues par les populations autochtones au Canada

Ce premier module s'échelonnera sur deux demi-journées, soit les 6 et 19 décembre, pour le groupe 1 et les 8 et 20 décembre pour le groupe 2.

Première demi-journée (6 et 8 décembre)

Formateurs : Carrie Martin, Aîné, Faisca Richer

9h-10h.　　　　**Introduction et contexte**

　　　　　　Mot de bienvenu et de reconnaissance du territoire (Aîné)

　　　　　　Objectifs et approches pédagogiques (Faisca)

　　　　　　Testons nos connaissances (Faisca)

10h-10h30　　**Les réalités des populations autochtones au pays**

　　　　　　Portrait démographique et sanitaires des populations autochtones (faisca)
　　　　　　Populations urbaines et mobilité

10h30-1045　　Pause

10h45 – 11h45 Le système colonial et la santé des populations autochtones *(Carrie et Aîné)*
　　　　　　Historique du système colonial au pays
　　　　　　Impact des mesures coloniales sur la santé des populations autochtones
　　　　　　Perceptions autochtones de la santé et zones de malentendus culturels

11h45-12h00　**Sommaire et appréciation des participants**

　　　　　　Prochaine séance

Deuxième demi-journée (19 et 20 décembre)

　　　　　　Formateurs : Sean Yaphe, Faisca Richer

9h-9h30　　　**Retour sur la première séance**

　　　　　　Questions commentaires suggestions
　　　　　　Objectifs et approches pédagogiques

9h30-10h30　**Accès aux services pour les populations autochtones**
　　　　　　Masures coloniales et discrimination systémique
　　　　　　Barrières à l'accès pour les populations autochtones au pays sean

10h30-1045　　Pause

10h45 – 11h45 **La sécurité culturelle dans les soins et services de santé**
Introduction au concept de sécurité culturelle
Les modèles de soins et services prometteurs sean
Changements requis à de multiples niveaux de gouvernance

11h45 – 12h00 **Sommaire et appréciation des participants**

Prochaine séance ; vos histoires de cas SVP

Module 2: Sécurité culturelle et Implications pour la pratique

Ce deuxième module sera donné sous la forme d'un atelier d'échanges d'une demi journée, soit le 17 janvier pour le groupe 1 et le 23 janvier pour le groupe 2.

Formateurs : Faisca Richer, Sean Yaphe

9h-9h30   **Retour sur la dernière séance**

Questions commentaires suggestions

Objectifs et approches pédagogiques

9h30-10h30   **Nos 'angles morts' culturels**

Comprendre les diverses formes de discrimination

L'impact de nos lunettes professionnelles

Le concept de sécurité culturelle dans mon champ pratique;

10h30-10h45 Pause

10h45-11h45 **La sécurité culturelle au quotidien**

Conseils pratiques et application dans mon milieu

La pratique réflective et l'humilité culturelle

11h45 – 12h   **Sommaire et appréciation des participants**

Post- test

Remerciements

Quelques lectures utiles

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Appendix 2 : Pre-test questionnaire

Ce petit questionnaire anonyme nous servira à mieux identifier vos besoins en lien avec cette formation; il vise essentiellement à évaluer votre niveau de connaissances de certains concepts de base, ainsi qu'à vérifier certaines croyances et attitudes en lien avec les soins offerts aux populations autochtones à Montréal.

Une version similaire de ce questionnaire vous sera également remise à la toute fin de la formation, afin de vous permettre de constater si la formation vous aura été utile. N'hésitez surtout pas à nous faire part de vos commentaires et suggestions sur tout aspect de la formation que vous souhaiteriez voir amélioré.

1. Connaissance des peuples autochtones du Canada

	Veuillez indiquer si selon vous ces énoncés sont vrais ou faux.	Vrai	Faux	Ne sait pas
1	La très grande majorité des Autochtones résidant dans une communauté autochtone parlent une langue autochtone comme langue maternelle; ainsi, pour plusieurs d'entre eux, le français (ou l'anglais) constitue une langue seconde.			
2	Montréal est l'une des villes où la croissance de la population autochtone urbaine est la moins forte au pays			
3	Au Canada, les Premières Nations, les Métis et les Inuit sont tous exonérés de la responsabilité de payer des taxes et des impôts			
4	Le Québec est la première province à avoir accordé le droit de vote au Autochtones en 1969			
5	Il a été démontré que les forts taux de tuberculose et d'influenza observés parmi la population inuite sont reliés à des prédispositions génétiques			
6	Les enfants autochtones devaient obligatoirement aller aux pensionnats (écoles résidentielles) de 1920 jusqu'à qu'en 1969, sous peine de privation alimentaires			
7	La proportion de personnes n'ayant consommé aucun alcool dans la dernière année est plus élevée chez les Autochtones urbains que parmi la population générale canadienne			
8	Comme c'est le gouvernement fédéral qui finance les services de santé pour les Autochtones au pays, ceux-ci ne peuvent pas se présenter aux			

		Totalement en désaccord	Plutôt en désaccord	Plutôt en accord	Totalement en accord
	cliniques au Québec sans avoir une référence du centre de santé de leur communauté				
9	Tous les Autochtones qui vivent à Montréal n'ont pas à débourser pour obtenir leurs médicaments				
10	Selon le système de surveillance du VIH du Québec, moins de 1% des personnes séropositives sont d'origine autochtone				

2. Croyances et attitudes en lien avec les soins offerts aux populations autochtones à Montréal

Dans quelle mesure êtes-vous en accord avec les énoncés suivants?	Totalement en désaccord	Plutôt en désaccord	Plutôt en accord	Totalement en accord
1 En tant que professionnel de la santé, j'ai surtout la responsabilité d'offrir des soins qui répondent aux standards de pratique habituels ; il ne me revient pas de vérifier si les patients ont les ressources requises pour adhérer aux conseils que je leur prodigue				
2 Les patients autochtones qui fréquentent les institutions de santé au Québec devraient pouvoir s'exprimer en français				
3 Je suis conscient du fait que ma lunette culturelle de professionnel non-autochtone peut entraver la qualité de ma relation avec mes patients autochtones				
4 Selon moi, les personnes d'origine autochtone devraient pouvoir bénéficier d'un statut et de privilèges uniques en tant que premiers habitants du pays				
5 Je suis très à l'aise que mes patients autochtones utilisent à la fois des traitements conventionnels et la médecine traditionnelle				
6 Les problèmes des Autochtones au Canada est le résultat de leurs difficultés à s'intégrer à la société occidentale				
7 Je pense que les Autochtones au Canada font souvent l'objet de discrimination dans les institutions gouvernementales, incluant dans le système de services de santé				

Avez-vous déjà suivi une formation en lien avec la santé des Autochtones, et si oui, dans quel contexte?

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Que signifie pour vous le concept de sécurité culturelle dans les services de santé? Vous sentez-vous en mesure de l'appliquer dans votre contexte de pratique au quotidien?

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Que souhaiteriez–vous surtout apprendre au cours de cette formation?
Veuillez indiquer tout sujet ou thème que vous aimeriez voir abordés, toute habileté que vous souhaiteriez développer, ou encore toute question précise à laquelle vous aimeriez obtenir des réponses)

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D'autres commentaires et suggestions en lien avec cette formation? N'hésitez pas!

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Merci!

Appendix 3: Session evaluation questionnaire

Formation sur la sécurité culturelle des services de santé à Montréal

Le but de cette grille d'évaluation d'obtenir vos impressions sur l'atelier auquel que vous avez participé aujourd'hui. Celles-ci nous aiderons à améliorer notre formation.

Dans quelle mesure êtes-vous en accord avec les énoncés suivants?	Totalement en désaccord	Plutôt en désaccord	Plutôt en accord	Totalement en accord
En lien avec le contenu				
1 Cette formation m'a permis de revoir certaines de mes connaissances, idées reçues et façon de faire en lien avec les services aux patients autochtones à Montréal				
2 Le matériel remis (incluant les documents de référence à lire) m'ont été utiles				
3 Je sens que je suis maintenant en mesure de mettre en pratique les apprentissages acquis aujourd'hui				
4 Je recommanderais cette formation à mes collègues				
Les formateurs : Faisca Richer				
5 A démontré une bonne connaissance des thèmes discutés				
6 A su encourager la participation aux discussions				
7 A été en mesure de faire des liens utiles entre les connaissances présentées et leur application dans la pratique quotidienne				
Les formateurs : Morning Star				
8 A démontré une bonne connaissance des thèmes discutés				
9 A su encourager la participation aux discussions				
10 A su faire des liens utiles entre les connaissances et la pratique quotidienne				

Quels sont, selon vous, les apprentissages les plus précieux que vous avez acquis aujourd'hui?

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Comment pourrions-nous améliorer cette formation, selon vous?

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D'autres commentaires et suggestions en lien avec cette formation? N'hésitez pas!

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Merci!

A First Nation Framework for Emergency Planning: A Community-Based Response to the Health and Social Effects from a Flood

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A First Nation Framework for Emergency Planning: A Community-Based Response to the Health and Social Effects from a Flood

Abstract

In June 2013, a severe flooding of the Bow and Elbow Rivers affected southern Alberta, a province in Canada. The flood was subsequently described to be the costliest natural disaster in Canadian history. Among the hardest hit communities was the Siksika First Nation, located on the Bow River banks about 100 kilometers east of the city of Calgary. A community-university partnership was formed to qualitatively document the Siksika First Nation community-based response to the health and social impacts to their community resulting from the flood. Our findings informed the development of a culturally appropriate framework for disaster and emergency planning in First Nations communities. The Siksika Nation's work to mitigate the impacts from the flood followed a holistic and socio-ecological approach that took the determinants of Indigenous peoples' health into consideration.

Keywords

Community-based disaster response, emergency planning, First Nation's health, resilience, Canada

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Introduction

In June 2013, a severe flooding of the Bow and Elbow Rivers affected southern Alberta, a province in Canada. In addition to a provincial state of emergency, there were 29 local states of emergency declared across the province. According to the Government of Alberta, the "scale and impacts of the flooding [were] unprecedented in Alberta," causing significant damage to homes and infrastructure in the southern region of the province (Government of Alberta 2013, p. 4). The flood was subsequently described to be the costliest natural disaster in Canadian history, with an estimated $6 billion cost to the province (Government of Alberta 2013; Calgary Herald 2013).

Among the hardest hit communities was the Siksika First Nation, located on the Bow River banks, about 100 kilometers east of the city of Calgary. Unprecedented water levels forced the evacuation of many residents of the Siksika community – approximately 1,000 people over the duration of the flood. The flood destroyed 170 homes, and nearly 780 Siksika residents were displaced and unable to return home. Given the extremely fast rise of the floodwaters, Siksika residents had only thirty minutes warning to gather personal items and evacuate the area. As a result, many items were left behind, inside of homes and vehicles and on the land, and were destroyed by floodwater. These included spiritually significant items that were used in ceremony and had great inherent value to families.

Siksika declared a state of emergency on the evening of June 20, 2013. This was not the first time that the community was impacted by a flood; previous floods occurred in 1995 and 2005. More than 80 families were evacuated from their homes during the 2005 flood (R. Medicine Traveller, personal communication, March 10, 2016). Infrastructure and damage costs from the floods in Siksika were $100 million in 1995, and $4 million in 2005. The total estimated costs of damage to the affected residents from the First Nations of Siksika and Stoney Nakoda in 2013/14 was $345 million (CBC News, 2014), making it by far the worst flood experience.

A community-university partnership was formed to document the Siksika First Nation community-based response to the health and social effects to their community from the flood. Specifically, the study sought to: (1) document Siksika First Nation's response to the health and social impacts resulting from the flood in their community; and (2) develop a culturally appropriate framework for disaster and emergency planning in First Nations communities.

Literature Review

Disaster and Emergency Planning in Indigenous Communities

We searched empirical and non-empirical papers from 1995 to 2016. We reviewed 25 empirical papers and 11 grey literature reports that met our inclusion criteria. Of the papers that were reviewed, 11 examined case studies were from Australia and New Zealand; 4 were from Asia or the Pacific Islands; 6 were from the US; and 2 were from Canada. Several knowledge gaps were identified from our literature review of disaster and emergency response planning in Indigenous communities across the globe. First,

it demonstrated that very little attention has been paid by researchers to disasters or emergencies in First Nations or other Indigenous communities in Canada and globally. Second, existing generic disaster and emergency preparedness and response plans were not meeting the needs of the diverse Indigenous populations globally (Andrulis et al., 2011; Cutter et al., 2008; Thompson et al., 2011). Third, no existing Indigenous frameworks for disaster or emergency response planning were identified. Fourth, there was limited knowledge of what an Indigenous disaster or emergency response plan should include.

While the research literature provided little insight on Indigenous frameworks for disaster or emergency management, some important considerations for implementing disaster or emergency response plans were discussed. Some literature emphasized the importance of Indigenous knowledge (Mercer et al. 2010) and respecting the land, people, and impacts to community. The lack of Indigenous community engagement and attention to cultural safety in the planning and decision-making around disaster and emergency plans were raised as issues (Ellemor, 2005; Howitt et al., 2012). Two papers examined cultural sensitivity training programs for externally-employed emergency responders and service providers; however, evaluations of the training programs were not conducted and no information about their effectiveness in disaster or emergency response efforts in Indigenous communities was available. Another important consideration noted in the literature was that partnerships between Indigenous communities and government agencies needed to recognize Indigenous institutions of governance and their cultural values (Howitt et al., 2012).

A small number of studies have examined the public health impacts of disasters on the health and well-being of Indigenous peoples in Canada. Scharbach (2014) found that residents of Hatchet Lake First Nation in northern Saskatchewan experienced considerable distress during a wildfire evacuation in 2011. Research in Whitefish Lake First Nation in northeastern Alberta also found that residents experienced considerable emotional and mental stress during a wildfire evacuation, also in 2011, and were still experiencing stress three years later (Christianson & McGee, 2015). Preliminary findings from a current CIHR-funded study led by the lead author found that Indigenous youth and their families who lost their homes during the 2016 Horse River wildfire in Fort McMurray were having a difficult time coping after the fire. Insights from disaster response in Indigenous communities can provide valuable lessons to inform and improve future disaster response planning by the federal and provincial governments that reduce negative impacts on Indigenous peoples' health and well-being after a disaster.

The Siksika First Nation

Siksika First Nation is a member of the Blackfoot Confederacy and has the second largest reserve land base in Canada with 186,000 acres located in southern Alberta. At the time of this study, Siksika had a total population of approximately 7,300, with close to half residing off the reserve lands. Siksika is represented by a Chief and twelve Councillors (elected by Nation members for three-year terms), and through the Treaty 7 Management Corporation, which advises and advocates on behalf of the majority of signatory Nations of Treaty 7. Siksika provides and administers a range of health, social,

educational, and recreational services to Nation members through the departments of Siksika Health Services (with an accredited primary care facility); Siksika Family Services; Siksika Board of Education (with three schools providing K-12 education); and other community support services (including recreational services and a Sportsplex). Siksika also administers departments responsible for land management and resource development. A Tribal Manager oversees the operations of all departments and reports to Chief and Council.

Methods

Our study took place between January, 2014, and March, 2016. Documenting the Siksika Nation community-based response to the 2013 flood, through a case study methodology, provided an opportunity to increase knowledge of disaster response and mitigation in First Nations communities and assess how the Nation-led emergency response effectively addressed the flood's health and social impacts on Siksika residents and the community at large (i.e., best practices). From this, we propose guidelines for the development of a holistic population health framework for future culturally safe disaster and emergency response planning in First Nation communities.

A memorandum of understanding/partnership agreement between university researchers and the Siksika Community Wellness Committee (SCWC) to study the response to the health and social effects to the Siksika community was approved in June, 2014 by the SCWC and Chief and Council. The SCWC was created in January, 2014 to oversee the coordination of the Community Wellness Plan, a response to promote health and resilience in the community. The research strongly affirmed OCAP^{TM} principles, in particular by first engaging community leadership in a community-university partnership, ensuring that community members played key roles in the design and implementation of the research, and ensuring that appropriate Nation-specific communication strategies were used so that Chief and Council were informed and gave their approval. The study was also approved by the University of Calgary Research Ethics Board.

For this case study of Siksika First Nation's response to the flood impacts, we gathered information from multiple sources (Creswell, 2007; Yin, 2009).

Key Informant Interviews

We conducted key informant interviews with members of the SCWC, service providers from Siksika First Nation, and representatives from the provincial government departments of Alberta Health, Alberta Health Services, and Alberta Aboriginal Relations. These interviews were completed by the principal investigator between May and July, 2015. Email invitations were sent by the principal investigator to individuals identified as key informants to formally invite them to participate in the study. Each interview began with informing the participant of the study's purpose, the expected contributions of participating in the interview, and the expected outcomes of the study. Verbal and written informed consent was provided and obtained from each participant. With the consent of the key

informants, we were permitted to include direct participant quotes where relevant in our reporting of results of the study.

Attendance at the SCWC Meetings

SCWC committee meetings were held once monthly in Siksika, and the research investigators attended the 11 meetings between December, 2014 and September, 2015. At the meetings, we took notes on department reports and updates on the flood response (e.g., issues or concerns as they arose; decisions that were made regarding allocation of resources; hiring of staff and provision of health and social services; and planning of community initiatives). We also received the minutes of meetings as distributed to committee members.

Site Visits

In the first year following the flood, we visited the reception centre at the Deerfoot Sportsplex, the donation centre organized by the Dancing Deer Disaster Recovery Centre, the temporary housing units set up by the Chief Crowfoot School, the facilities at Siksika Health Services, and the three schools on the reserve and in the nearby town of Strathmore. In the following two years, we continued to make regular visits to Siksika through our attendance at the SCWC meetings, which were held initially at the Administration building and later at Siksika Health Services. We documented our observations during these visits.

Review of Publicly Available and Internal Documents

We reviewed documents publicly available and internal to the SCWC related to the emergency management on Siksika to promote an in-depth understanding of our case study and to ensure analytical rigor (Creswell, 2007; Yin, 2009). Internal documents that we were permitted to review included information such as the number of community evacuees and houses destroyed, the rebuild process, and overview and allocation of funding for specific health and social services and programs provided to evacuees.

Participation in Community Events for Recovery

We attended and participated in Siksika community events for recovery, including the one year anniversary of the flood, a Christmas blessing ceremony for flood evacuees that was held at the end of 2014, two community and family resilience conferences held in March of 2015 and 2016, and the Siksika Health Fair held in April, 2015. At the two resilience conferences, we were given the opportunity to present our research findings and gather feedback.

Data Analysis

All interviews were audio-recorded, and extensive notes were taken to supplement the recorded material. Interviews were transcribed verbatim and the formatted transcripts and notes were imported into the qualitative data analysis software program QSR NVivo (version 10) for analysis. The principal investigator and co-investigator read through a subset of the transcripts to generate a set of preliminary themes. Document reviews and participatory observation notes were compared with the findings from the key informant interviews. A draft community report was prepared by the principal investigator and then shared with members of the SCWC to seek their input and comments on the analysis and findings as reported. Their input was then integrated into the final report.

Findings

Siksika Nation Emergency Management

When key informants were asked to describe the Nation-led response to the 2013 Southern Alberta flood, they described disaster and emergency planning in First Nations communities as contextual, multi-faceted, and situational. They disagreed with the portrayal of disaster and emergency planning as a linear process with discrete phases that showed a progression from response to mitigation and preparedness or, in the case of Alberta's process, from response and stabilization to intermediate and long-term recovery. Key informants described how the socio-political and socio-economic contexts of First Nations communities can change quickly, in a few days or weeks. More importantly, the relationships among individuals, families, and different communities may be positive, negative, in flux, or stuck in one place, so that responses to services provided and decisions taken will not be uniformly positive or negative. Moreover, consideration of the determinants of First Nation peoples' health is essential to emergency planning at each phase. Determinants of Indigenous people's health include gender and sexuality, age, economic and educational opportunity, spirituality, relationship to the land, geography, history, culture, language, knowledge systems, and daily micro-aggressions arising from racism and colonialism. In response to this lack of linearity, the Siksika Nation emergency planning of the flood is grouped under headings that respect the overlap in the phases of response, recovery, mitigation, and preparedness.

Preparation to Response

Siksika exhibited a rapid and strategic community-based response to the flood. As stated previously, this was not the first time there was a flood that forced the evacuation of Siksika residents from their homes. The speed with which the water rose was unprecedented, however, and left little time for planning per se. Siksika was prepared though because of their experiences with previous floods. The Siksika Peacetime Emergency Plan was developed in 2005 by Siksika Health Services in consultation with Siksika Nation Emergency Services and identified the four stages of emergency management from

initial response that involves evacuation and protection of the community, through recovery, mitigation, and preparedness. The Peacetime Emergency Plan included Indigenous knowledge about the history of the river and community capacities in emergency planning. When it became necessary, the Siksika Nation Fire Chief was enabled through the plan, approved by a previous Chief and Council, to make the declaration of a state of emergency and put the emergency plan into action. Key informants described the importance of Siksika having developed their own disaster and emergency plans instead of having externally developed disaster and emergency plans imposed on them.

Table 1. *Some Examples of the Intersection of Determinants of Health in an Indigenous Emergency Response Plan by Phase.*

Community or Individual Determinants of Health	Response	Recovery	Mitigation	Preparedness
Sex and Gender	Domestic and gender-based violence in temporary shelter units and within families	Male and female mental health support groups offered by Siksika Health Services	Male and female mental health support groups continued	Male and female mental health support groups continued
Age	Dancing Deer Disaster Recovery Centre (DDDRC) provided outreach to families, children and youth evacuees	DDDRC partners with the schools in Siksika to delivery mental health support to youth	Lack of funding to continue new service from DDDRC	Family and Community Services and expertise in place
Political Power	New chief and council elected in Nov 2013, slowed the flood response at the onset	Negotiations with the province stalled the rebuild process. Limited communication from provincial ministers and their predisposition to direct decision-making in First Nations	Flood evacuees upset that homes will be rebuilt in new subdivisions and away from their family kin	Blockade of road to construction to express disfavour towards housing plan
Socioeconomic Status	Donations of clothing, bottled water, and food are collected at Sportsplex	DDDRC continue to provide support to families	Families moved into temporary shelters with different family clans. The tight living quarters and increased stress due to the living situation created significant issues for residents	The food bank that was originally set up for flood evacuees has now been established as an ongoing service for residents to access
Degree of social relationships and social capital	Clans like to remain physically close in houses; offer a means of support and strength Family is deeply respected and highly valued	Siksika held two community resilience and wellness conferences in 2014 and 2015 to bring the community together and strengthen community resilience	Traditional parenting program provided to families	Involvement of Spiritual Elders in promoting community resilience

In the response phase, the Siksika Emergency Team was called together and coordinated the evacuation of affected residents, placing them in temporary emergency shelters. The team members were trained and skilled, and no lives were lost nor serious injuries experienced during the evacuation. An emergency reception centre was soon set up at Siksika's Deerfoot Sportsplex. The Siksika Emergency Team then established a call centre and set-up a Facebook page to coordinate relief efforts, donations, and volunteers.

Temporary housing for evacuees were subsequently placed at three sites on the reserve (Deerfoot, Crowfoot, and Poor Eagle Flats); these were referred to as New Temporary Neighbourhoods (NTNs). In addition to providing housing to displaced residents, these temporary shelters distributed donations of food, water, and clothing. Donations came from Calgary as well as closer communities, such as Strathmore.

The Chief and Council established the Siksika Nation Disaster Relief Fund to receive financial donations. The Disaster Relief Fund received $900,000 in donations from private donors, corporations, faith-based organizations (e.g., the Salvation Army), and non-governmental organizations (NGOs) (e.g., the Canadian Red Cross). In addition to the money distributed from the Disaster Relief Fund, the Salvation Army provided $2500 to each evacuee, and Chief and Council allocated $3000 to all 138 heads of households. Siksika Nation flood evacuees also received preloaded debit cards of $1500 from the Alberta government to purchase necessities or household items.

Key informants described the Peacetime Emergency Plan as an asset in Siksika's immediate response to the flood. One key informant said, "Having their own predetermined peacetime response plan enacted by the Nation and not an external plan really helped...it was unbelievable to see how resilient and how effective all community members were at responding to their own needs." Some observers from outside the community had the same opinion:

> Search and rescue had a good plan and pulled it together…Siksika pulled together
> and made it better afterward. You need to be proud of each other and of being
> family. I know the challenges between provincial and federal governments and
> trying to get things done, but you are in good hands with Chief and Council. (MLA,
> speaking at public meeting, June 21, 2014).

Some key informants described delays in the Nation's response to the flood after the immediate emergency. Siksika was in an election year, and a new Chief and Council were elected on November 27, 2013, which was five months post-flood. It took the next six months for new members (a majority) to become orientated to the governance issues. Other delays were reported to result from limited communication from provincial ministers and their predisposition to try and direct the decision-making process in First Nations. One key informant put it this way, "One provincial ministry had provided

direction to the community on what they should and shouldn't be doing. Which was a challenge because the community was doing what they felt was needed and it wasn't helpful. That complicated matters."

Memorandum of Understanding with the Provincial Government

Siksika Nation and the Government of Alberta signed a memorandum of understanding (MOU) for the rebuild of homes on November 6, 2013. Funding from the Alberta government supported the hire of the Siksika Rebuild Team to coordinate, organize, and communicate the rebuilding efforts on the Nation. The team comprised a Project Coordinator, Housing Coordinator, Communications Coordinator, Site Coordinators for the three NTNs, NTN Property Manager, Administrative Assistant, and three Community Representatives. The Siksika Rebuild Team carried out day-to-day functions including assessing interim housing needs, demolition, or new construction and relocation; community consultation; and housing policy development.

The Rebuild Funding Envelope of $49 million from the Alberta Government included coverage for costs of the demolition and future rebuild of 136 homes on the Nation, and the relocation of 307 displaced residents into the shelter housing in NTNs until their permanent housing was available. Rather than being a one-time emergency expenditure, the MOU indicated that an effective flood recovery response must address long-term housing needs, including meaningful opportunities for Siksika Nation members to participate in community and economic development. Additionally, the MOU also set aside $10 million to be used for training Siksika Nation members through a mentoring process to increase employment. This provided an opportunity for Siksika members to gain skills they could use for employment both on and off the reserve, and to increase capacity to support the community. As reported in the Siksika First Nation Annual Community Report (2015), 265 Nation members had been trained in various trades to support the demolitions and housing rebuilds, including security, construction, heavy equipment operation, accounting and early learning childcare.

Federal government participation was conspicuously absent in the MOU. Key informants expressed that future government involvement in emergency and disaster planning requires that both provincial and federal governments sit at the table with Siksika Nation.

Response to Recovery

As the rebuild and repair efforts were well underway, Siksika began to initiate strategies to promote community resilience and healing. A documentary video titled "Siksika Strong" was filmed and released August 19, 2013 (see https://www.youtube.com/watch?v=ITosNIwQB9I). The film became a popular representation of the Nation's healing post-flood as it highlighted the collective efforts and strengths of the community as they responded to the devastation and loss. A newsletter titled "*Aakyistowapsiini*", a Blackfoot word for resilience, was created by the Communications Coordinator of the Siksika Rebuild Team to communicate updates on the rebuild and recovery efforts, and also included information about services and supports offered to evacuees. Perhaps most importantly, Siksika developed and

implemented a Community Wellness Plan specifically to address health and social concerns following the flood.

Recovery to Mitigation: Community Wellness Plan

In December 2013, Siksika received funding from Alberta Health to develop and implement their Community Wellness Plan (D. Turner, personal communication, January 8, 2014). A funding proposal to Alberta Health was initiated by Siksika Health Services and the Tribal Manager. This funding supported a Nation-led initiative to promote health and wellness and strengthen resilience of the community following the flood, but also thinking long-term (preparedness) about future challenges, whether from natural disasters or emergencies.

The overall goals and objectives of the Siksika Community Wellness Plan were to: a) assess the health and social needs of community members; b) develop an interdepartmental, multidisciplinary network of service providers and resources and assist community members with connecting to these supports and services; c) provide flood relief and recovery supports to evacuees; d) counsel community members; and e) promote resiliency.

As one key informant noted, community leaders hoped that one outcome of the Community Wellness Plan would be Nation members with less dependency on external governments that was evident and had developed as a result of colonial policies. An overall spirit of self-determination was being enhanced and enabled by Siksika community members.

The provincial funding for the Community Wellness Plan was broken down into two phases. In phase 1, health and social services were provided for the more immediate needs of flood evacuees living in the three NTNs (Deerfoot, Crowfoot, and Poor Eagle Flats). In phase 2, Alberta Health secured additional funding for the continuation of some health and mental health services as evacuees adjusted to living in the NTNs.

Siksika Nation Administration, responsible for the Nation's service area operations, was tasked with dividing the funding into priority areas, including health, mental health, education, and recreation, and hiring the new staff and service providers needed. The following departments received funding to administer services and programs to flood evacuees, including families and youth: Siksika Health Services; Siksika Parks and Recreation; Siksika Family and Child Services; and Siksika Board of Education.

The SCWC was created in January, 2014, and was responsible for overseeing the coordination of the Community Wellness Plan. It included representatives from Alberta Aboriginal Relations, a community liaison from Alberta Health Services, representatives from Siksika Child and Family Services and Social Work, Siksika Health Services, the Siksika Tribal Manager, Siksika service providers, and the lead investigators on this study. Terms of Reference that outlined roles and

responsibilities of committee members guided the work of the committee. The SCWC was able to identify and respond to emerging issues because of their relationships and knowledge. For example, key informants talked about the rise of family or domestic violence post-flood in Siksika. While there was no systematic collection of data to support claims for an increased rate of violence in the community, concerns about the breakdown of the family and domestic disputes were seen to warrant attention based on the wisdom of service providers and community leaders.

Attention to Children and Youth

Recognizing the needs of children and youth and families required attention in the aftermath of the flood. Siksika Family Services, with support from Siksika Health Services, established the Dancing Deer Disaster Recovery Centre (DDDRC) almost immediately. DDDRC was a one-stop-service for families, including a donation centre (with food, clothing, and furniture), counseling, and recreational activities. DDDRC hired six family support workers and provided outreach services to 357 flood evacuees in the first year of recovery (Key informant). The program manager for DDDRC explained that, "the human aspect of a disaster are usually not considered and people are traumatized by the experience."

Through the DDDRC after-school recreational programs and youth counseling were offered at the three schools on the reserve. Four mental health workers were hired, including three psychologists and one therapist. These mental health workers worked with the schools to provide culturally-based programs to address several issues among the youth, ranging from depression, behavior changes, suicidal thoughts, and grief. As well, three wellness coaches were hired, one for each school. The mental health workers also referred youth to the Siksika Medicine Lodge when appropriate.

DDDRC also partnered with external organizations, such as Save the Children, to secure additional funding for youth activities and programs. DDDRC program ended on March 31, 2016, however, the SCWC raised concerns about the ongoing needs of children and youth in the community during the recovery period. This resulted in the loss of mental health services and supports for children and youth in the community.

Key informants explained that it was important for children and youth to continue to participate in activities and sports that promoted their physical and social development. The Siksika Deerfoot Sportsplex was used as an emergency evacuation shelter for the first four months post-flood, and during that time Siksika Parks and Recreation had to temporarily stop all recreational programs. Once flood evacuees moved out of the Sportsplex and into the NTNs, recreational programs and activities resumed. Siksika Parks and Recreation also hired two recreational program coordinators to provide recreational activities for children and youth living in the NTNs. One key informant described this experience:

> *Once the evacuees moved out of the Sportsplex…we just started running programs*
> *again and ensured that the community had access to the Sportsplex…and we also*

worked with the schools to deliver recreation programs.…The Deerfoot Sportsplex
is where we bring the community back together, and providing sports and
recreation for families and youth is a way of promoting their resilience.

New Model of Service Delivery Envisioned

Interdepartmental collaboration was identified as a key priority by the SCWC. The Community Wellness Plan therefore aimed for a multidisciplinary approach to service delivery that reflected a holistic understanding of health and wellness and acknowledged First Nation cultural protocols and values. Multidisciplinary teams were envisioned that included family support workers, mental health therapists and psychologists, youth social workers, childcare workers, traditional counselors, addiction counselors, and health care personnel including physicians and registered nurses. The Tribal Manager brought together Siksika department managers to talk about an integrated service delivery model. He stated that, "getting rid of our invisible walls" was key to multidisciplinary team care.

One key informant commended Siksika for developing and leading their own plan to promote community health and wellbeing. However, key informants also described the challenges in carrying out the proposed plan. Although the intention was to work in a multidisciplinary approach to service delivery, silos across the different departments (e.g., Siksika Health Services, Family Services, Community Support Services, and Education) were reported to hinder collaboration and integration of services. There was limited or lack of communication about the roles of and actions taken by each department. As one key informant described it, "There is lack of clarity on who is responsible for what." Another key informant reported their own personal challenges in working with other departments and explained a lack of understanding as to what a multidisciplinary team approach entailed.

Pressing Need to Support Mental Wellness

The mental health of flood evacuees and the community as a whole was a key focus of the Community Wellness Plan. Community leaders recognized that this was an opportunity to work on resolution of some of the accumulated trauma experienced by Nation members. The trauma experience of the 2013 flood could not be solely separated out from the experience of residential schools and racism, and micro-aggressions in daily life.

Evacuees spent four months in emergency accommodations, some in the Siksika Deerfoot Sportsplex with cots, some in hotels, and others with families (contributing to strain on other people). They were then moved to the NTNs created with ATCO trailers, which were very small for families of three or more. These NTNs were surrounded by fences and guarded by security staff from outside the Nation. For some the NTNs reflected a re-experience of the colonial past, residential schools,

surveillance by other governments, and disrespect (Calgary Herald, 2013). Some people remained in the NTNs from 10 to 14 months.

A large portion of the funds from the Alberta Health was allocated to support staffing of service providers, that is, hiring of mental health workers, nurses, and psychologists. These service providers provided outreach, care and support to evacuees living in the NTNs.

Additionally, Siksika Nation held two community resilience and wellness conferences, in March of 2014 and 2015. These conferences were intended to "bring the community back together" (Key Informant, Tribal Administration). The two-day conferences provided a space for evacuees and their families to share stories of the flood and to voice their concerns about the Nation's responses and plans. Service providers and community partners were present at these conferences to inform the community of services and/or programs available to them. A focus of these conferences was to connect community members to traditional teachings and values. Topics addressed at the conferences included traditional parenting, grief counseling, and post-disaster recovery and resilience. The conferences ended with a traditional powwow ceremony.

Mitigation and Preparedness

Through the MOU, the Government of Alberta provided $49 million to the Siksika Nation to aid with rebuilding of homes destroyed by the flood (Siksika Nation, 2015). While First Nations housing remains a Government of Canada responsibility, steps taken by the Alberta government to provide aid reflected the extent of flood damage and need for immediate solutions, although the negotiations with the provincial government had delayed the rebuilding. The community was informed about the rebuild process and mitigation efforts to rebuild the homes away from the floodway and contaminated sewage systems. According to the housing policy that emerged from the MOU Housing Agreement between Siksika First Nation and the province, houses were to be rebuilt in new subdivisions with clusters of 10 to 14 homes in each. With these new subdivisions, families who would be receiving the new homes would not be together with their extended families as before. Also in the new housing policy was that multiple families living in a single dwelling was no longer prohibited, which raised concerns about overcrowding.

Siksika members were more than a little uneasy about the decision to move them away from their family clans. In Spring 2015, the Siksika Rebuild Team held consultations, facilitated by the Project Coordinator, with the community to obtain their input on the *on-reserve housing policy* pertaining to the location of the new homes that were damaged in the flood. However, since the Nation appeared to have no leeway to change decisions about building on the flood plain (where some people wanted to return), these were more opportunities to express concerns than to really be consulted.

While several key considerations were taken into account in Siksika Nation's Peacetime Emergency plan, other important issues for mitigation were described to be a challenge. According to

one key informant, "the challenge with mitigation efforts is to address the many layers of impacts from infrastructure, to health, and the social" (Key Informant, Family and Community Services). The challenges to multi-sectoral and multidisciplinary collaboration contributed to some lack of efficiency and effectiveness in mitigation.

While still in the response/recovery phases, interviewees spoke about what needed to happen for future mitigation and preparedness. Past, present, and future experiences were regarded as important in the response; for instance, the legacies of residential schools and intergenerational trauma must be considered. Vulnerabilities were considered from the start. The Siksika First Nation's response to the disaster did not depend on members being characterized as affected/not affected, as it was assumed that everyone in the community was affected in one way or another because of strong family and other social relations; in fact the concept of family could not be interpreted using non-Indigenous standard criteria of biological or legal relationships. Unlike many response plans, Siksika prioritized the children and youth, recognizing they were a vulnerable population.

A First Nations Framework for Responding to Disasters or Emergencies

Aspects of a framework for First Nations disaster and emergency planning arose from this study. In Table 2, we list these aspects along with further descriptions, and we also include some recommendations for moving forward with framework development. A major forest fire in Fort McMurray in northern Alberta in 2016 has further reinforced the urgent need for a holistic population health framework for Indigenous emergency planning. Siksika First Nation sent people to help the Fort McMurray First Nation in their response and recovery efforts. Alberta Health Services also sent its Aboriginal community coordinator, who had served on the SCWC.

Recognition of traditional ways of life and cultural protocols were considered important in recovery and mitigation strategies. One key informant specifically talked about the role of spiritual Elders to "help the Nation heal" from disaster. Cultural protocols and historical sensitivities have shaped current relationships between Siksika First Nation and government agencies. To build relationships and meaningful partnerships for emergency planning, Indigenous communities and their issues need to be well understood by the government agencies, emergency responders, NGOs, and researchers that may be involved. These relationships cannot be built quickly; discussions take time, and trust is developed over time.

Furthermore, key informants talked about having a community engagement process in provincial disaster and emergency planning that acknowledges and respects Indigenous cultural protocols and knowledge and includes their meaningful involvement in the planning and decision-making of plans and/or policies. Figure 1 below presents the recommendations for disaster and emergency planning for Indigenous communities across the phases.

Table 2. *Framework for Indigenous Disaster and Emergency Planning.*

Aspects of an Indigenous Model	Description	Recommendation
A holistic understanding of health and wellness	Indigenous people do not separate physical, mental, and spiritual health, nor do they separate human health from that of the rest of the earth. Health is also a function of the past, the present (emergency) and the future, as is healing. Elders have an important role to play in all aspects of emergency management for a Nation.	Cultural competence and respect of Indigenous views of the world, ways of knowing, values and ethics need to be brought to a framework. It is incumbent upon settlers to prepare themselves rather than ask Indigenous people to do the teaching. The Truth and Reconciliation Commission reports and recommendations should be studied. Understanding among settlers of the roles of Elders is necessary.
Community-led emergency plans	Includes Indigenous knowledge and capacities; community ownership and control; self-determination is an underlying principle. A designated leader to enact the plan in the Nation is a key asset.	Indigenous communities will vary in the history of governance; nevertheless, mutual respect must be experienced when outsiders provide assistance in plan development. The Federal Government must do better in plan development. In Alberta an Indigenous Emergency Response Plan is needed that coordinates various sectors and is developed in collaboration with Nations.
First Nations can expect the same rapid response and return to pre-emergency standard of living as non-Indigenous peoples	There are no inequities in indicators of a successful emergency management (e.g., time to NTNs, followed by time to new or refurbished homes, number of suicides).	Federal and provincial jurisdictional issues need to be clarified in the best interest of reconciliation. Current inequities in health status and standards of living exist and need remediation before equity can even be imagined. Resilience and capacities need to be identified and strengthened with community input. The Siksika First Nation MOU deserves evaluation.
Contractors and others selected by outside governments or organizations are screened for capacity to provide a culturally safe process (e.g., in delivery or evaluation of a government program, service provision)	Cultural competency among service providers outside the nation, including NGOs and government agencies is needed, including respect of Indigenous cultural protocols, local knowledge, historical sensitivities, oral traditions of story-telling, and so on.	Identify people who are respected by First Nations; encourage corporate and other organizations to develop the capacity to work well with First Nations; take First Nation complaints of lack of respect seriously.
A community committee comprised of community leaders and established by the community should be supported.	In this case study the Rebuild Committee and the	Financial support of this work is necessary to recognize that First Nation leaders are often over-committed before the

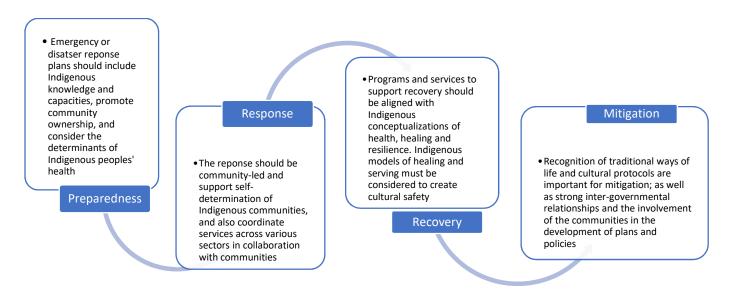|		
Terms of Reference for committees are an important first step.	SNWSC were models of leadership capacity enacted.	emergency, and are likely stressed by the community impacts themselves.
A good communication system to community members	The Nation must identify what works for its members and lead the communication strategy.	Consultation may or may not be needed; resources for this can aid the processes.
Plans need to be written to respect the Indigenous worldview, way of knowing, and values.	Academic and settler jargon may not represent the First Nation worldview (e.g., psychological needs). Many Western concepts separate the mind, body, land etc. and also are focused on individuals rather than communities. Indigenous identity is very collectively oriented. Words have power.	Indigenous models of healing and serving must be considered to create cultural safety. Community recommendations should be incorporated.
An Indigenous framework will recognize that colonialism and racism still exist and are to be discouraged. Daily micro-aggressions exist before and after a disaster.	Processes of colonialism and racism are understood and responsibility to end these is articulated.	The Truth and Reconciliation Commission recommendations for knowledge and skill development require continued attention.
The inequitable health status is addressed and the need for enhanced attention to the well-being of sub-populations is recognized. Burn-out may be quicker or different in Indigenous service providers.	A plan or service for non-Indigenous sub-populations may not be acceptable nor accessible to Indigenous sub-populations (e.g., ill seniors, children and youth, mentally ill, addicted, violent).	Preparedness requires greater attention to successful programs to reduce health inequities faced by First Nations.
Children and youth must be a focus of an Indigenous Emergency Management plan.	In addition to facing health inequities, children and youth are greatly valued in Indigenous communities. Indigenous philosophy makes decisions with the next seven generations in mind.	All plans should assume that children need additional and appropriate support.

Figure 1. Disaster and Emergency Planning for Indigenous Communities Across Different Phases

Discussion

The Siksika Nation's work to mitigate the impact of the flood followed a holistic or socio-ecological model that took the determinants of population health into consideration, even though the construct of "determinants of health" was not generally vocalized. This is in keeping with the understanding that Indigenous peoples generally have a socio-ecological view of health and well-being that incorporates physical, social, mental and emotional, and spiritual balance (Castellano, 2015, p. 34-35) and includes all elements in their environment. Within social and political domains, colonialism must also be counted as a significant determinant of Indigenous peoples' health (de Leeuw et al., 2015, p. xi) and a source of structural violence.

Community control over what services are provided and to whom enhances community health through "the sense of individual and collective efficacy and pride" (Kirmayer et al., 2000, p. 614). Self-determination is a powerful counter to the oppressive legacy of colonization, enabling community-level healing in addition to yielding more effective services. Cultural continuity (e.g., self-governance, cultural facilities) is associated with resilience (Chandler & Labonte, 2003). Thus, resilience is related to First Nation self-determination. From an Indigenous perspective, resilience also comes from the interplay between spirituality, family strength, Elders, ceremonial rituals, oral traditions, tribal identity, and support networks (HeavyRunner & Marshall, 2003), and relationships to the land (Andersson & Ledogar, 2008). This understanding of resilience may include Treaties and traditional systems of belief and practice passed on through generations. Indigenous resilience is also based on Indigenous peoples' capabilities focusing on success rather than overcoming challenges alone (McGuire 2010). It is a strength-based concept that builds on assets rather than emphasizing deficits, and it is relational in that individuals are considered part of a larger system of capabilities and challenges (Kirmayer et al., 2007).

Siksika First Nation had a robust governance system, with community participation in elections for Chief and Council, including the willingness of members to run and to serve. The Tribal Manager played a key role in transitioning between the old and new Chief and Council following the election that occurred five months post-flood, and is a well respected for his leadership and respect for community strengths. Experienced people were available to take on coordinator roles when needed. Further, transparent financial management and reporting was common practice, even though financial decisions were sometimes contentious. Often, staff and managers were directly impacted by the flood, with some living in temporary housing; however, they met the challenges and did their best for the Siksika community.

The robust governance was exhibited in the creation of the Peacetime Emergency Plan in 2005 and the preparation that was done at that time for future emergencies. The person in charge of the plan knew what to do and was given the authority to act when the 2013 flood occurred. This resulted in no lives lost and only minor injuries in a potentially life-threatening emergency. The Siksika leadership were then ready to begin the processes of recovery and rebuilding the community, strengthening it if possible. Jurisdictional disputes between provincial and federal governments, as well as the timing of the Siksika Nation election created delays in getting underway, and Siksika leadership often received criticism for delays that were beyond their control, but never publicly owned by the other governments. The lack of federal government involvement in the MOU between Siksika Nation and the Government of Alberta leaves questions about the future of this approach to policy development.

It was a commonly shared belief that managing the emergency and recovery was an opportunity presented by the Creator to build on community strengths and to increase the community's capacity to move into the future. In a philosophy of self-determination, that future would be designed and implemented by the Siksika First Nation. While the Nation was open to outside assistance, there was also a conscious effort to limit the access of those from the outside who might see the disaster as a chance to 'get a foot in the door' or benefit the outside organizations as much or more than Siksika members. There was also a need to limit the number of outsiders developing flood response projects within the Nation, as coordinators, staff, and the people of Siksika were then put in the position of taking care of new people and guiding them, preventing duplication, and averting burn-out for staff and service-overload for the evacuees. Another opportunity seized by Nation members was to look at how 'siloed' administration of services limited benefits to Nation members.

Despite there being differences among Siksika members based on clan, religious beliefs, neighbourhood, or history, the predominate language and philosophy was of one community, one Nation working for the best possible outcomes. In part this was maintained as residents were free to express concerns, complaints, and different points of view. In addition, every effort was made to keep all Nation members informed. Based on the successes achieved, it is likely that Siksika Nation will come out of the disaster stronger than before.

Chandler et al. (2003) argued that resilience is portrayed as the confluence of several input factors (e.g., self-governance, education, the presences of cultural facilities, and health) and that the effectiveness of these resilience-promoting factors may be optimal in one situation or event, but limited in another. In Siksika First Nation, resilience-promoting factors embedded in the Community Wellness Plan were an interplay between spirituality, family strength, Elders, ceremonial rituals, support networks, and intergovernmental collaboration. Members of our research team are, to this day, working with the Siksika community on resilience-promoting interventions, as mental health and social issues continue to linger in the community post-flood. One such intervention involves the participation of youth from the community in arts-based projects focused on mental health promotion (Henderson, Montesanti, Williams, & Crowshoe, 2018).

Prior to the flooding, the Alberta government deferred to the federal government on Indigenous matters relating to housing, education, employment, and health care. As part of their coordinated flood response, the Alberta government intervened to promote the social and mental health of First Nations peoples. Within days of the flood, First Nations were notified that the government flood response would include affected reserves and First Nations would be considered for provincial funding. As a result, a new relationship was forged between the provincial government and Siksika Nation, which required careful negotiations and mutual understanding. A number of forces can stall relationship-building efforts, including institutional inertia, the lack of a policy framework to structure action, and the memory and lasting consequences of past conflicts. There is no guarantee that this government-to-government relationship will retain any currency beyond the 2013 flood response. The MOU deserves more study in terms of the opportunities, challenges, and outcomes it has created.

Conclusion

The health and social impacts experienced by Indigenous peoples and communities after a disaster is a significant, but under-studied public health issue. Our study helps to fill key knowledge gaps on disaster and emergency planning, recovery, and mitigation in Indigenous communities. This case study of the flood response in Siksika Nation provides important lessons for a framework for Indigenous emergency planning. Such a framework requires new inter-governmental relations be created by all partners to develop an appropriate emergency response that moves beyond rigid conceptions of federal, provincial and First Nation responsibilities.

We devised a framework for Indigenous disaster and emergency planning to respond to the health and social impacts in a community that arose from our study findings. The framework has been accepted by the Siksika community and presented to Alberta policy makers and service providers with the intention to inform future decision-making for disaster and emergency planning in First Nations or other Indigenous communities. Through effective knowledge translation, this framework will inform policy decisions related to emergency management among Indigenous peoples and will influence health and social policy and service delivery in the face of disaster. Research underway by members of our

research team to study the health impacts from the 2016 wildfire in Fort McMurray to Indigenous residents and communities in northern Alberta provide opportunities to apply lessons learned from the flood in Siksika First Nation and to build on the Indigenous public health framework for disaster and emergency response.

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Building on Strengths: Collaborative Intergenerational Health Research with Urban First Nations and Métis Women and Girls

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Abstract

Little research has focused on how Indigenous girls and their familial female caregivers negotiate issues pertaining to wellbeing and decision-making practices. To address this gap, we employed a novel intergenerational Indigenous partnership methods using various decolonizing action and arts-based activities, to allow participants to guide and modify the direction of the research throughout data collection. We report on three separate activities: a physical game to address concepts of wellness, a memory game that focused on harm reduction and an art project that explored self-esteem. Within each of these activities, female family members and girls worked together to unpack issues of importance within their lives. We conclude that a flexible participatory research design within an intergenerational setting can meet not only the proposed research objectives, but participants' ever-changing questions and concerns pertaining to health and wellbeing, while still producing rich data to answer important research questions.

Keywords

Introduction

Ideally, Indigenous health research aims to develop and use strengths-based methods. These methods need to simultaneously provide opportunities to: meet academic objectives, have academic rigour, appeal to participants, and meet participants where they are at, as opposed to where researchers think they ought to be. Strengths-based methods create spaces where participants can explore issues that are of importance to them, feel comfortable engaging with the methods being used, and, where possible, create opportunities for skill building. In 2015-16, we undertook a participatory strength-based study with girls (ages 8-12) and female familial caregivers to explore health and wellness. The main objectives that guided the academic component of the study included: the exploration of individual health decision-making practices; and barriers to the uptake of knowledge translation products, especially those with best-practice guidelines. A key finding was that the methods used need to engage participants, and by extension patients, on multiple levels.

Background

The last five years have seen many important milestones within the Indigenous and non-Indigenous landscape within Canada that promote strengths-based platforms for change. Many of these stem from efforts to acknowledge the legacy of harms caused by colonial and neocolonial practices and policies. Idle No More (2012-2013) called public attention to land sovereignty and Indigenous rights. The Truth and Reconciliation Commission report (TRC, 2015) called public attention to the legacy of the residential schools and shed public light on issues and experiences that have too long been silenced. The Missing and Murdered Indigenous Women and Girls Inquiry (2016) has raised public awareness about racialized violence. In October 2017, the Canadian government announced that a financial settlement will be offered to status First Nations and Inuit children who were part of the sixties scoop (Tasker, 2017). Indigenous peoples in Canada and elsewhere are demanding that treaties be honoured, traditions valued and positive changes take place.

We argue that research processes can either perpetuate or counter past and continued harms embedded in policies, which entrench power imbalance and undermine families' integrity. We believe that ensuring decision-making opportunities for participants are a central tenant for research methods used, and helps ensure that participating in research is not causing more harm than good. Conducting research that seeks to disrupt harmful practices while gathering pertinent data is largely shaped by the methods used. In this article, we present the results of a study that combined multiple methods in order to create an intergenerational workshop aiming to foster meaningful dialogue. The research design was informed by Indigenous research methods including a shifting of power relations and the incorporation of traditional knowledge (Funston, 2013; Rothe, Ozegovic, & Carroll, 2009; Walker, Fredericks, Mills, & Anderson, 2014). These are different from decolonizing methods that aim to disrupt the status quo (Adelson, 2009; Duran, Duran, Yellow Horse Brave Heart, & Yellow Horse-Davis, 1998; Episkenew,

2009; Linklater, 2014; Prussing, 2014; Schwan & Lightman, 2015; Tuhiwai-Smith, 2006), although the two can be used together.

Participatory and qualitative methods complement Indigenous and decolonizing methods, especially in research that aims to create a suitable space that is accessible and acceptable for ethical research (Kovach, 2009; Tuhiwai-Smith, 2006). By combining decolonizing, action (Chambers, 2002; Wang & Burris, 1997), and community based research methods (Blumenthal, 2011; Minkler, 2005), we created a vibrant space for data collection with children and adults about health and wellbeing to take place.

Methods

Participants were recruited to take part weekly in a seven-week long workshop, referred to as "Girls Night Out" through the distribution of posters and word of mouth at non-profit organizations that work with both women and children within the city. The workshop was conducted on three separate occasions between September 2015 and March 2016 (university ethics approval H2015:169). Participants were recruited based on self-identification as an Indigenous female primary familial caregiver (mother, grand-mother or female relative, or foster mother) of a girl between the ages of 8-12 years willing to commit to attending a weekly workshop with her child, or children, for the duration of the program. Participants took part in a 2-3 hour weekly activity program that included provision of a meal.

Adults provided written or audio recorded consent for both their participation, and that of the children within their care who participated in the study. Girls provided written or audio recorded assent before data was collected. Participants were reminded throughout the seven weeks that they did not have to participate in any activity that they were not comfortable being a part of, and that their participation did not need to be included in the data collection process. If either adult or child participants did not want an element of their participation included in the data, they were asked to inform the lead researcher or research assistant either verbally or in writing (e.g. by text), at any point during the research process and the month following the completion of data collection. Given the historical erasure of Indigenous identity (e.g. a photo labeled only as plains Indian woman), participants were provided the option of having direct quotes attributed with the name they were known by within the research process or a pseudonym. All participants requested that their first names be used when depicting results. As women collectively referred to all girls as "my girl", or daughter, regardless of the familial relationship with the girls, the term daughter is used in this paper to refer to the adult-child relationship. Each data collection period ended with a community feast. At this feast, adult participants received a $50 honorarium and girls received a gift valued at $20 to thank them for participation. In addition, participants received a certificate of participation, individualized storybooks and a workshop-specific workbook.

The research objectives were determined collaboratively with the advisory committee, and workshop objectives were developed with participants on the first week of data collection. The advisory committee was comprised of members from the Manitoba Metis Federation Health and Wellness Department, and professors on Cooper's PhD dissertation committee. The workshop was divided into twenty-minute segments, though participants often took longer than anticipated to complete an activity. A typical evening would begin with an icebreaker activity or game; followed by a game used to generate a discussion activity; a craft; dinner, which typically took forty minutes; another craft or game; and a closing discussion and planning for the following week (see a detailed session guide for the nutrition night found in Appendix 1). Participants determined key themes for exploration such as self-care, nutrition, and personal safety. Participants also provided insight into the kinds of activities they would like to undertake and questions they would like to address.

Data collected included photographs (n = 877) taken during the workshops and of art projects, videos (n = 99, total video time: 3 hours, 14 min and 39 seconds), audio recordings (n = 19, total audio time: 7 hours and four minutes), and 60 hours of participant observation (field notes were completed). Many participants were uncomfortable speaking on camera or when the audio recorder was turned on, especially about challenges they were facing or questions they had about specific skills or access to services. Participants had the opportunity to identify key themes that emerged each week and were provided with initial thematic descriptive findings prior to the commencement of further academic data analysis or writing of any academic publications.

Data was organized using NVivo 9 M. An inductive process was used to analyze the data. A coding guide was developed using data driven themes (e.g. nutrition, self-care, family), as well as informed by different theories to better understand participant experiences (e.g. gender, colonization, harm-reduction). Transcripts and descriptive notes were coded, and re-coded for consistency (Braun & Clarke, 2006; Guest, MacQueen, & Namey, 2012; Hankivsky et al., 2014).

Relationship

The research was overseen by an advisory committee comprised of academics and members from the Manitoba Metis Federation-Health & Wellness Department. The research and workshop facilitation team was comprised of the lead researcher and research assistant with a background in child development, with a focus on complex traumas. The researchers did not have any relationship with the participants, however some of the participants knew each other prior to participating in the study.

Results

When participants expressed interest in the study, they were told more about what their participation in the study would involve; namely, that they would be asked to regularly provide input

about the content included in the weekly workshops to ensure that everything met their ever evolving needs and interests. It was explained that the experience of participating in the research study would be interactive and engaging for both adults and children, where we (researchers and participants) could actively learn together. Participants were also told that the aim of the workshops was to provide opportunities for them to do activities they enjoyed together not only as members of families, but as a community of people participating in the research process. In addition to research objectives, a series of workshop objectives were developed with participants (women and girls aged 8-12) on the first week of each series of workshops. Workshop objectives included: 1) creation of a workshop that highlighted opportunities for intergenerational programming and relationship building; 2) exploring the importance of health and happiness for First Nations and Metis girls and their female familial caregivers; 3) providing skill-building opportunities to understand public health messaging; and 4) providing a supportive space for personal growth and increased interest in wellbeing and health literacy. While the workshop objectives were complimentary to the research objectives, they were not the same. Activities designed specifically to meet workshop objectives did not always lend themselves to data collection. We will focus on how participant identified objectives were embedded into three data collection methods used: a medicine wheel game, a memory game and an art project that engaged popular media. Participants were offered the option of having their name associated with direct quotes or being anonymous. Within this paper, the lack of names associated with direct quotations is a response to the ability to attribute names in group discussions when multiple children and adults are talking simultaneously rather than a reflection of the wish to remain anonymous or not.

Participant Characteristics

All participants (24 women and 36 girls) identified as First Nations, Metis, or both and lived within the urban centre. All of the girls were registered at public schools, although attendance varied. Most of the adults were employed or were attending school full-time. All of the women reported that they had completed high school and the majority of women reported at least some post-secondary education. Most children had father-figures who were actively involved in their lives, and all participants had close ties to extended relatives. Family income ranged from under $10,000 to over $100,000 CDN with most families earning between $50,000-74,000 CDN.

An Intergenerational Space for Data Collection

There were two key issues raised by participants that changed the way that the workshops were initially envisioned by the advisory group: the inclusion criteria; and the ability of girls to be central participants in all aspects of data generation and workshop programming decisions. Initially, this research was to be Metis-specific. In the initial phase of advertising the study, potential participants

noted that their families and communities are comprised of both First Nations and Metis citizens. In addition, they noted that it is essential to work collectively within urban centres to address the needs of Indigenous peoples. As a response, they requested that anyone who self-identified as Indigenous be invited to participate. The other modification participants requested was the equal involvement of girls in all of the activities. The initial design involved participation by girls in some research activities with their caregivers during the first half hour of the evening workshops, eating dinner as a group, and then moving onto completing other non-research related activities in a different part of the space with a trained childcare staff. Women voiced that the girls were old enough to understand why decisions were being made, often stating that they had become parents when they were not much older than the girls in the group. Women also discussed how they would like to have the opportunity to do some of the non-research related activities, such as making soap or playing tag with the girls. Women determined that the perspectives, experiences and priorities of girls were valuable and that the study design needed to be modified to ensure that everyone had the opportunity to participate fully throughout the entire evening. The study design was modified accordingly. All participants were involved in determining topics for discussion, activities that should be completed and areas in which they would like to see skill development opportunities. Girls also completed all the same activities as the adults, either independently or with the adult they came with. This allowed for rich results that provided a point for comparison between the perceptions of adults and girls. Women would ask girls to answer questions, guide discussions and complete activities first, and then would provide commentary on what the girls had shared.

Increasing Opportunities for Self-Determination, Reflection and Knowledge Exchange

Within this study, both women and girls often seemed to feel uncomfortable acting in decision-making capacities. While the research team anticipated a certain level of unease, and that the length of time to complete activities may differ based on individual participants needs and interests, for example children with shortened attention spans or adults with lower literacy levels, the extended time seemed to result from challenges in making decisions. Even the act of choosing a colour for a name tag during week one was challenging for some participants. As the weeks went on, everyone learned to freely praise one another, and to build upon their experiences in the study, such that the process of decision-making became less daunting for participants. The phrases 'I dunno' and 'no one asked me these things before' were replaced by overt decisions, such as 'let's eat now and do the game later'. Reassurance for decisions made was given and participants became more comfortable and confident with the process of public self-determination within the context of the workshop.

It was difficult for participants to actively participate in planning. Many adults and girls expressed that they had not had the opportunity to provide input into activities conducted within a formal setting before. Adults also asserted that beyond planning for major activities, such as career changes or the purchase and renovation of homes, they did not spend a lot of time thinking about the smaller choices in daily life. Women indicated that a primary reason for attending the workshop was the

ability to learn what they can do to be happy, healthy and safe. Women in each group explained that they did not have confidence in their own capacity to make decisions that would lead to these results, or to teach their children the tools necessary to reach these ends.

Many of the activities conducted within the workshop emerged from expressed challenges or knowledge gaps identified by participants. Participants were aware that part of the researcher objectives were to learn about what their priorities and interests were, in addition both women and girls identified that they were participating because they wanted the workshop to be a space of engaged learning and relationship building between women and girls. The skill level within the groups varied extensively. Activities were designed with the intention of resonating with Indigenous knowledge and approaches to learning. These activities provided the opportunity to better assess what the barriers were that led to gaps in knowledge or practice, and to provide the opportunity for capacity building and growth.

Medicine Wheel Game: Addressing Balance and Wellbeing

The concerns that led to the development of this activity involved group consensus about a gap in knowledge following a session about self-care. Participants noted a lack of understanding about the difference between emotional and mental health. These are two distinct categories on the medicine wheel, according to one commonly used interpretation of the medicine wheel, and are important aspects of wellbeing. Many participants identified with the medicine wheel and saw it as a key cultural component to share among family members and communities to support and strengthen relationships.

To address this issue, a medicine wheel that could be tossed around the room was created. Participants stood in a circle, and when they caught the medicine wheel they provided an example of something they do for the quadrant they were holding. Examples pertained to emotional health, physical health, mental health, and spiritual health. Participants provided commentary on the issues raised. This was a good activity for participants to also begin conversations about items they found challenging to discuss, such as what they do for their emotional wellbeing.

> Researcher: What do you do for your body?
> Girl: I eat healthy stuff.
>
> Researcher: What do you do for your spirit?
> Woman: I take walks with my daughter.
>
> Woman: To get your mind working? What do you do for your mind?
> Girl: I dunno.
> Woman: What do you do at school?
> Girl: I draw.

Girl: For your emotion?
Woman: For my emotions? I have a nice shower or a nice hot bath.

By using a medicine wheel, this activity provided a starting place for women and girls to discuss finding balance in their lives through a culturally relevant and often used image. While the image of the medicine wheel was drawn numerous times by participants, the multiple teachings associated with the medicine wheel was less familiar. Once participants began to name their experiences and perspectives, they were able to identify areas in their lives that they felt could be improved.

Memory Game: Addressing Gaps in Knowledge about Basic Hygiene Supplies

During a self-care night, participants made soap and painted their fingernails. Participants raised questions about the difference between liquid and bar soap. Initial questions were answered in the moment, but as people continued to talk, it was recognized that this was a larger gap within the knowledge base of multiple participants. Girls also discussed challenging risk-taking activities associated with the use of every-day objects, such as self-harm and substance abuse. Within the moment, no positive or negative response was provided, and participants were redirected to another activity. To try to address gaps in knowledge in a respectful way in the following week, participants, the lead researcher and the research assistant played a modified version of the memory game called 'Kim's Game'. This is a common game played by youth groups in Winnipeg. The majority of girls were familiar with this particular memory game. A number of household items commonly found in bathrooms were brought. These included, but were not limited to: hair ties, cotton balls, Q-tips, nail polish, hand soap, body wash, Band-Aids, feminine hygiene supplies and nail clippers. Participants had the opportunity to identify and ask questions about what the items were before the game began. Everyone sat in a circle around a selection of about twenty items. Within a typical 'Kim's Game', participants would look at the items and then close their eyes. All items would be covered, often with a sheet, and then participants were asked to list all they remember. The game was adjusted, and an item was removed by a girl while other participants closed their eyes. Participants had to identify the missing item. Discussion followed about the item, what it was used for and when it should or should not be used. The following excerpt discusses the uses for cotton swabs (referred to within this context by the brand-name Q-tip).

Researcher: What's missing?
An array of answers, then…
Girl: The Q-Tip.
Woman: Good job, kiddo.
Researcher: When do you use Q-Tips?
Girl: For ears.
Girl: If there's something in there …[points to her ears].
Girl: Ear wax.

Woman: After your shower.

Researcher: Is it good to use those in your ears?

Yes/No Collective response from women and girls.

Researcher: No, you're not supposed to. Why are you not supposed to use Q-Tips
in your ears?

Woman: Cause it pushes it down.

Researcher: What can happen if you push the wax and stuff down further?

Girl: If you push it down too far it could actually rip your ear.

Woman: Eardrum.

Girl: You could get an earache.

Girl: I watched this YouTube video. You can actually put them in those clip
bobby pins and then you can put them like little dots in your hair.

Girl: Eye shadow.

Girl: To put on lipstick.

Girl: Nail polish remover.

Researcher: Cleaning other stuff that's hard to get into right?

Woman: You can clean the keyboard.

Collective response from women and girls: Oh, ya!

Researcher: Can you reuse Q-Tips?

Collective response from women and girls: NOOO.

Researcher: Okay. I'll have to remember that.

Girl: You have to throw it out.

A researcher, acting as a workshop facilitator, would ask various questions about the items to encourage open discussion. Participants followed this lead and questioned the use of items. This activity provided the starting point for dialogue on a number of different issues such as access to feminine hygiene supplies, risk behaviours that girls may potentially engage in to be able to access female hygiene supplies which further led to a discussion about virginity, menstruation, and pregnancy. Participants discussed how they did not have all the items used in the game. Participants discussed why they might or might not use an item and what the barrier was. Barriers identified included cost, knowledge of what an item is, as well as relevance to daily lives. An important part in the decolonizing process is the ability to find ways to unpack tacit knowledge and experiences (Kovach, 2009). This exercise provided the opportunity to address gaps in knowledge that were potentially dangerous. It also provided the opportunity for self-determination and the sharing of knowledge.

People like Me: Media Representations and Self-Determination

The concern that led to the development of this activity was the lack of positive visual representation of Indigenous women in media, namely: if a girl does not see herself in the images in popular media, what standard of beauty is she expected to live up to? Participants did not find the

existence of a standard of beauty problematic, but they were uncomfortable with the lack of diverse representations. Two weeks prior to the commencement of data collection, a First Nations woman from Alberta was crowned Mrs. Universe, with an active Indigenous rights platform ("Cree Woman from Alberta", 2015). Many participants discussed this as a positive step for the recognition of Indigenous women as emerging leaders in re-defining beauty. Participants then discussed within this context how they were encouraging their daughters to begin to audition for acting and modeling jobs, but deconstructing this notion was initially beyond the scope of this research. This changed following concerns both adult and girls raised over the written statement by one of the 9 year olds: "I'm pretty, but I don't think I am".

A variety of magazines, including active living, fashion, nature, household and children's magazines, were collected. Girls and women cut out pictures of images they liked and images they did not like. Women talked about how being able to explain why you like or do not like an item is an important skill for girls to develop. The images people liked were glued to the outside of a blank journal to make a collage. The images people did not like were glued on a piece of paper that girls identified as something they did not want to keep in perpetuity, unlike their journals.

While cutting out pictures, participants discussed standards of beauty, Photoshop, and realistic expectations. The images that were included on the journal covers included some fashion accessories. Most of the items were food, animals, nature, and activities that could be done together. When girls discussed the images, they selected things they liked. The importance of imagination, pride and belief in themselves became evident.

> Mila, girl: I could survive on a desert island. I have mad [amazing] skills.
> Mila's mother: What skills?
> Mila: I have the skill that if I get hungry I can wait a long time.
> Mila's mother: That *is* a skill. What if you had your bow with you, what could you do with that?
> Mila: I could shoot animals to eat. Like wild pigs.

Images on the negative poster included pictures of girls or women who did not look like they were being active, such as women draped over furniture or wearing very high heels. Other images included medications and other items that should not be marketed within magazines aimed at young adults or the general public.

> *We didn't like it because it's an advertisement for nail polish and I guess you*
> *don't need a top coat for it. The girl is topless with her hands in front of her chest*
> *and it says in big bold font 'go topless' we just don't think it's a good image for*
> *young girls.* (Kandace, adult. Summarizing a group conversation).

Girls wanted to discuss things they liked to do, and they wanted to talk about how their interests and expectations matched with popular discourse. The ability of women to reflect critically on the images presented within popular media, while thinking about the self-esteem of girls was salient for participants. Women reported that they had not thought about discussing these ideas with their daughters before. Girls talked about things they like to do, such as running, climbing, hunting and eating pancakes, verbalizing that they did not want to look like the women in the magazines who might not be able to be self-sufficient. This discussion led to the need for more realistic images of women and girls. Girls identified that being pretty means being able to look like you can do anything you want to do. Participants would like to see more Indigenous women and girls leading full, happy, successful lives in popular media imagery. At the end of the activity, women reflected on their observations, both of media and of their daughters' responses to images. One mother hoped her daughters would become models and be able to influence the depiction of Indigenous women through that method, whereas the other mothers would like their daughters to be able to critically examine the images they see and the feelings those images instill within them. Decorating the outside of a journal as a discussion point of what makes them happy, what they are good at, and what they are proud of set tone for the type of information that they reported writing in their journals. The mothers gave the journals to the girls, and the girls reported sharing the information that they wrote with their mothers, as there was a joint sense of ownership over the journal since the collage on the outside of the journal was created collectively by girls and their female familial caregivers.

Limitations

This project was conducted with women and girls age 8-12. All children lived with family members. While it is plausible that these approaches and findings could apply to girls of other age brackets, boys, and children who are not living within family contexts, more research would need to be conducted to verify these assumptions. Participants self-identified as First Nations and Metis living within an urban space on the Canadian prairies, as such generalizability of findings to rural and remote communities, the general population, other Indigenous groups, as well as other minority groups should be done with caution. Participants self-selected to participate in this study, demonstrating a desire to be involved in a project that focused on intergenerational experiences and health. As such, there may be a bias in terms of who agreed to partake in the study. The results did not appear to vary due to family size, age of caregiver, socioeconomic status, employment status or education level and all participants noted personal skill development and improved family relationships throughout their involvement in this study.

Discussion

One of the greatest predictors of health and wellbeing is the ability to have both individual and collective self-determination (Aboriginal Children in Care Working Group, 2015; Reading & Wien, 2009). The Canadian Constitution enshrines the right for women to have their voices heard and recognized. Although their cultural traditions are protected (Government of Canada, 1982), voices often remain silenced, as women, as Indigenous women, and as Indigenous peoples (Martin, 2012). It is only in the past fifty years that Indigenous women have started to see and document changes as they strive to reclaim legal autonomy within Canada (Dorion, 2003; Green, 2007; Welsh, 1991). Within this study, participants were encouraged to take ownership of the research space, to help shape the direction of the study and to determine what they needed in order to be satisfied with participation. Self-determination ultimately improves both mental and physical health, as people are able to make decisions that better reflect their needs (Canadian Reference Group World Health Organization Commission, 2006). Within this study, voicing decisions and making choices proved difficult for many of the participants. While it is impossible to empower someone, as empowerment must come from within, it is possible to provide skills, tools, and opportunities through which a person can voice his or her thoughts, experiences and engage in active decision making (Kirmayer et al., 2003; Rappaport, 1995; Williams & Ferber, 2008). Participants discussed their concerns more readily as relationships formed both with the lead researcher, research assistant and one another.

The question of how to improve cultural continuity among families and communities proved to be an interesting point of discussion. Cultural continuity is recognized as a protective factor to ensure health and wellbeing (Chandler & Dunlop, 2015; Chandler & LaLonde, 2009) and was an issue that families wanted to discuss within the research setting. Historically children were raised within communities and would have a large support-network within their communities of adults they could turn to for assistance as they navigated their environments, both physical and relational (Carrière-Laboucane, 1997; de Finney, 2014; Henderson, Dinh, Morgan & Lewis, 2015; National Collaborating Centre on Aboriginal Health, 2015, Rink, Ricker, FourStar & Hallum-Montes, 2016; Welsh, 1991). By working together, participants and researchers were able to create a research environment where participants could, and would, provide advice to one another, answer questions and determine next steps. Children and adults were able to grow together and gain new skills, both tangible skills and knowledge as well as tacit skills learned from engagement with one another, such as different ways to engage in a positive way within family units. The more involvement female caregivers have with their daughters, the better girls are able to focus, and the lower the rates of aggression (Tramonte, Gauthier & Willms, 2013). Girls will mirror what they see (Benn, 2013). As the weeks passed, participants became more vocal about what their interests were. They began to openly identify challenges they were experiencing, such as limitations with health messaging and with public advertisements, especially those that encouraged the objectification of female bodies rather than encouraging skill building and self-esteem among young women. Unpacking the barriers to knowledge uptake, such as a lack of representative images found

within public communication materials was an aspect participants indicated was key for them to gain new information and share knowledge both within and outside the research workshop environment pertaining to self-determination and decision-making practices.

Conclusion

Involving participants in an ongoing decision-making process whereby their priorities and goals are the focus of research is a crucial step to understanding the health and wellness interests of Indigenous communities. Their involvement is also essential to understanding needs and to continue to work together towards addressing participant visions for what research within intergenerational spaces can, and should be. Within this study, girls and women took a lead role in identifying the contexts that were important in addressing and prioritizing the content for weekly activities. Initially, this proved challenging for many participants. Creating a research space where people were encouraged to voice their opinions was essential (Cooper & Driedger, 2019). This space provided a venue for shared learning. It also provided opportunities to address challenges individuals identified within their lives, for growth in confidence and self-determination, and pride in community.

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Appendix 1.

Nutrition Night Session Guide.

Length of activity (minutes)	Activity	Data Collected	Skill Building Opportunity
Before the start and the first 10 minutes	Children prepared "apple smiles" for desert while participants arrived. This involved cutting up an apple, and placing peanut butter and mini marshmallows between two apple slices to create a "smile"	Photographs Capacity building	Cooking skills
5	Discussion about how we might describe food	Discussion about food qualities	
10	Matching game- a picture was taped to each person's back. They had to figure out the object taped to their backs by asking questions. Once participants knew who they were they would find their commonly matched pair. Food pairs included milk and cereal, veggies and dip and soup and crackers	None	Relationship building Communication skills
20	Participants helped prepare food -Women wanted to learn how to de-bone chicken, so this skill was covered. -Girls prepared a salad -Participants learned/reviewed how to make stock out of the leftover "garbage" (chicken bones, skin, vegetable peels etc.)	Field/observation notes	Cooking skills
20	Astronaut Activity- participants learned about how food is planned and prepared for astronauts traveling to space. Families were asked to plan two days worth of meals if they were going to go to space. Flyers from local grocery stores were provided. Participants cut out pictures, drew pictures and wrote down words to plan meals for their space adventure.	Meal plans were photographed to be reviewed for food choices	Meal planning, using coupons to budget.
40	Dinner: teriyaki chicken, rice, salad and "apple smiles"	None	

15	Tooth Brushing Game: each family was given a package of cookies. Participants ate as many cookies as they could in 30 seconds. Note: as this activity was after dinner, most ate between 1-3 cookies. Videos were taken of girls (and some adults) showing off their "disgusting mouths" filled with cookie crumbs. Participants were given tooth brushes and toothpaste and given 2 minutes to brush their teeth. "After" videos were taken. Participants examined each other's teeth to see how good a job they did and then discussed knowledge about oral hygiene. Every participant was a "winner" and got an oral hygiene related prize such as a toothbrush holder or dental floss.	Video of mouths assess brushing knowledge. Video recording of discussion. Field/observation notes	Women were surprised at the lack of proper teeth brushing for their daughters. Participants were surprised to learn about oral hygiene practices. Participants were happy to get new toothbrushes.
10	Examining Eggs. Hard boiled eggs had been placed in containers containing either milk, juice, water, coffee, or cola earlier in the day. The eggs were removed one by one and participants discussed their observations. A discussion about how eggs are similar to the enamel on teeth and the importance of brushing teeth daily finished the activity.	Video discussion recorded Field/observation notes	Tangible discussion about the importance of brushing teeth In future weeks, milk and water consumption increased and juice decreased. Adults discussed how girls were drinking more milk and water and less pop and juice at home. This change spanned the duration of the workshop. It is unknown if it continued after.
5	Closing and overview of the following week	Field notes	Ability to determine specific requests for the following session and evaluate the current week.