APPLYING INDIGENOUS WAYS OF KNOWING AND HEALING TO CLINICAL MENTAL HEALTH WORK

by

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Abstract

This practicum report details my experiences as a mental health clinician working at an Aboriginal Child and Youth Mental Health Services office located on Lekwungen Territory on South Vancouver Island, British Columbia. It includes an articulation of my theoretical framework and approach to social work practice, a literature review, and some discussion of my practicum learning goals, activities, and tasks. My main practicum goal centers on learning about Indigenous ways of knowing and healing as they relate to improving (mental) health and wellness. This practicum and report do not include research data, and instead focus on sharing the knowledge and skills that I acquired while further developing my clinical social work practice framework.

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Chapter One: Introduction

There is a great deal of evidence that supports the increasing need for mental health support services for Indigenous people and communities (Furgal, Garvin, & Jardine, 2010; Harrison & Carver, 2004). There is also a great deal of controversy regarding best practices for service delivery and the people who are best equipped to provide it, particularly when faced with the reality of inadequate resources and funding. To provide culturally relevant services that do not further colonize Indigenous people, consideration must be given to the nature of services, characteristics of service providers, and methods of service delivery.

For my final MSW practicum, I secured a placement at Aboriginal Child and Youth Mental Health Services (ACYMHS), which operates as part of the Ministry of Children and Family Development (MCFD) in BC. My placement was based out of the ACYMHS office located in Esquimalt, BC, on traditional Lekwungen Territory. The team at this office works with many Indigenous communities in the southern part of Vancouver Island. In addition to gaining clinical skills, I had the opportunity to gain knowledge about Indigenous approaches to health and healing and insights into how best to offer culturally relevant services when working with Indigenous people and communities.

This practicum report has seven chapters beginning with this introduction. Chapter Two focuses on my theoretical orientation. Chapter Three offers organizational information about ACYMHS. The literature review in Chapter Four provides information about the provision of child and youth mental health services and offers an introduction to Indigenous perspectives and approaches to health and healing. Chapter Five includes a discussion about my practicum goals, activities, and learning. Chapter Six explores implications and recommendations for practice, while Chapter Seven includes a short conclusion.

Chapter Two: Situating Myself as a Social Worker in the Mental Health Field

While frontline experience provides a foundation for building a social work practice framework, an understanding of the underpinning theory creates a more solid foundation upon which to build. Mullaly (1997) asserts that "perceptions are never theory-free because they are based on certain fundamental assumptions about the nature of people, society, and the relationship between the two" (p. 100). As a social work student, explicitly situating myself within the context of my practicum allows me to create a theoretically-informed practice framework that will help me practice with intention.

Practicing with intention includes analyzing the language that we use. There are many different terms used to describe Indigenous populations including First Nations, Aboriginal, and Indigenous. Terms that may be considered acceptable by some Indigenous groups or individuals may be offensive to others. Terminology is important and "can be critical for Indigenous populations, as the term for a group may not have been selected by the population themselves but instead imposed on them by colonizers" (UBC, 2009). Terminology plays a role in the reclamation of identity and culture for many Indigenous individuals and communities.

I have chosen to use the term Indigenous because it has gained prominence as a term that many Indigenous people are using in an international context in relation to movements that are striving to reclaim Indigenous rights on a global scale. The preference by many Indigenous people to use this term is also reflected in the symbolic change made by the recently elected Liberal federal government as they renamed the relevant ministry from Aboriginal Affairs and Northern Development to Indigenous and Northern Affairs. It is still important to acknowledge that the term Indigenous is not derived from any Indigenous language or traditional practice. Although "it is very much a term that Indigenous people

have worked hard to define" (UBC, 2009), not all Indigenous people embrace it. Throughout this report, I am including terms such as Aboriginal and First Nations when they appear in agency names and quotations from the literature.

Theoretical Framework

At the core of my social work perspective is the belief that individuals, groups, and communities are the experts of their realities and, as such, best equipped to identify, define, articulate, and address their capacities, needs, and goals, especially as they pertain to issues of power and social change. This approach is congruent with structural social work practice because it focuses on helping individuals increase their level of functioning while also gaining insight into the impacts of the systems in which they are located (Mullaly, 1997).

My perspective on social change is heavily influenced by a desire for social justice and informed by theories of anti-oppressive structural social work, contemporary feminism, Indigenous approaches, and virtue ethics. Both the Canadian Association of Social Workers (CASW) and the British Columbia Association of Social Workers (BCASW) codes of ethics address the responsibility of social workers to pursue social justice (BCASW, 2011; CASW, 2005). An anti-oppressive structural social work approach is ideal for this pursuit because it "is a form of social work practice which addresses social divisions and structural inequalities" (Dominelli, 2002, p. 24). The goals of the anti-oppressive practitioner, from a structural social work perspective, include working with people to develop and implement intervention strategies that counteract the negative effects of oppression, provide opportunity for personal empowerment by building on the strengths of individuals, and advocate for fundamental, long-term institutional and structural change (Mullaly, 1997).

As part of my structural practice, I analyze differences in power relations through a contemporary feminist lens that allows me to focus on class, race, ethnicity, sexual orientation, age, and the intersectionality of these and other aspects of identity. Feminist critique also emphasizes that the personal is political (Snyder, 2008; Turner & Maschi, 2015). I believe in linking the personal to the political by explicitly connecting the micro to the macro and linking casework to community work.

Indigenous approaches also influence my practice. This is particularly relevant when working with Indigenous communities and individuals, and also applicable to my practice in general. Before describing this approach, it must be noted that there is no such thing as "the" Indigenous approach to practice (Heinonen & Spearman, 2006). Indigenous approaches take into consideration the political and historical contexts of colonization, as well as the ongoing impacts of such. They incorporate a macro level analysis while honouring the needs and goals of clients and communities, thus attempting to address both the "personal and social wounds of colonization" (Heinonen & Spearman, 2006, p. 259).

Also central to Indigenous approaches is the concept of mino-pimatisiwin, which roughly translates to the notion of the good life. "The good life is the goal of living life fully, learning, and healing. This growth and attempt to reach the good life is not just an individual focus—it also involves the family and community" (Heinonen & Spearman, 2006, p. 244). Helping means "assisting another in his or her process of healing" (Heinonen & Spearman, 2006, p. 257) and, as such, the importance of relationships between clients and workers cannot be overemphasized. Indigenous approaches emphasize "eliminating the expert role, maintaining humility, demonstrating centeredness, acknowledging the spiritual, listening,

being patient, using silence, and speaking from the heart" (Heinonen & Spearman, 2006, p. 251).

Regarding my practice, the underlying principle that links the aforementioned approaches is virtue ethics. While principle-based ethical approaches emphasize actions and the impartiality of decision making, virtue ethics places greater emphasis on character traits and relationships (Banks, 2006). Virtue ethics is a contemporary approach to ethical decision making that lends itself well to structural anti-oppressive social work, hence its support by feminists and Indigenous peoples (Banks, 2006). Virtue is shaped by our social environment, and virtue ethics is not so much about determining right from wrong as it is about bringing the personal into the decision making process. In essence, virtue ethics implies that a practitioner must also live in accordance with virtuous practice principles (Blum, 1994). Godway and Finn (1994) state that self-awareness and accountability are necessary in order to take a moral position on an issue but are not needed to the same extent when following codes and rules. They suggest practicing ethics from the "space between," which involves transcending our reliance on a code of ethics to regulate behaviour and, instead, to measure accountability by doing that which is needed on a case by case basis and going beyond the language of the code. I believe that ethics are at the core of social work practice because they inform all actions, particularly when working from a structural perspective that incorporates the belief that the personal is political. Applying virtue ethics to my practice allows for further exploration of how I am located in, and can best work for, my community.

Self-Location

My conviction that the personal is political leads me to approach every personal and professional decision I make from a total cost perspective where financial, social, and environmental costs are considered. I have a hard time seeing any personal or professional action (or inaction) as being neutral. Everything I do brings me closer to, or further from, the type of world I wish to help create. Linking the personal to the political also results in an understanding of my own areas of privilege and oppression, thus affording me the opportunity to be a more effective ally to people who are part of oppressed groups to which I do not belong (Bishop, 2002). By engaging in the process of self-locating, I am able to recognize how my "personal history, emotions, idiosyncrasies and ideological stance, motives, capabilities, and limitations" (Turner, 2002, p. 26) influence my approach to practice.

Locating myself as a social work student is an essential aspect of this practicum placement. My self-location as a structural social worker who engages in an anti-oppressive and feminist approach to practice influenced my critical analysis throughout the practicum. My view of social problems, and the behaviours that result from such, is rooted in the theories of social constructionism, claims-making, social democracy, and oppression (Creswell, 2003; Loseke, 1999; Mullaly, 1997). I also believe social work needs to create opportunities for empowerment (Delgado, 2000), conscientization (Friere, 1973), self-advocacy, capacity enhancement (Delgado, 2000), and, ideally, structural change. I value inclusive, participatory, and empowering processes and I support the right to self-determination for people of all ages, including children. I am also very interested in change

processes and spend a lot of time exploring what it takes for people to move from a place of apathy to empathy and increase their level of engagement in social justice issues.

"Location exposes the researcher's [in this case practitioner's] current context as details about the researchers such as where they are from, their race and gender, who they are connected to...become revealed" (Absolon & Willett, 2005, p. 118). As a middle-class, heterosexual, able-bodied, and educated woman of colour, I experience a great deal of privilege in society. As a woman of colour and mother of mixed-race children (my husband is white), I have insights into the impact of racialization on child and youth development, although not as a person of Indigenous ancestry. As a practicum student, I had the privilege of learning from Indigenous children, families, and communities. It also meant that my involvement was on a temporary basis and this was a limitation in terms of building connections and gaining trust.

Ethical Considerations for this Practicum

I believe there are some ethical considerations that I needed to examine at the outset of my practicum placement. Although all practicum placements tend to be of a temporary nature, this had some significant implications for me as a non-Indigenous student who worked within Indigenous communities. The temporary and short term nature of my placement was a limitation because forming relationships and establishing trust in Indigenous communities takes time.

Even though I did not initiate a formal research project, I think it is wise to explore ethical research practices with Indigenous communities. Because research relationships "continue to reflect the historical power relationships between Indigenous and non-Indigenous peoples" (Davis, 2004, p. 4), I am very cognizant of incorporating the many

suggested ethical guidelines that maximize the possibility of an empowering process. To this day, Western knowledge and research practices are advancing into Indigenous communities and, without any consideration for their unique world views, producing and disseminating knowledge with little concern for the negative impact it has on the people of those communities (IPHRC, 2015). The urgency for change and the contempt for Western research that is felt by many Indigenous peoples are described by the following comment made by Mohawk scholar Marlene Brant Castellano: "They took away our children. They took away our languages. Now they want to get inside our heads and take our knowledge!" (Davis, 2004, p. 3). As such, I was very mindful of the approach to and implications of any learning processes that I initiated, even if they were through other ACYMHS clinicians who already had established relationships with Indigenous community members.

This introduction to some of the ethical issues related to conducting respectful information gathering activities in Indigenous communities illustrates that, even though I felt comfortable with the idea of trying to facilitate culturally relevant mental health services, following proper protocols increase the chances of being well-received by the community.

Previous Experience with CYMHS

In March of 2007, I started working as a support worker at the Child and Youth Mental Health Services (CYMHS) office in Terrace, BC. At that time, CYMHS served all children, youth, families, and communities in the Terrace and surrounding regions because ACYMHS had not yet been created. In October of 2008, I went on maternity leave for eighteen months after having my first child. I returned to work on a part time basis in April 2010 for a few months and then stopped working outside of the home.

During the two years I worked at CYMHS in Terrace, I was often invited by Indigenous youth workers in nearby Indigenous communities to create and deliver individual and group mental health prevention and psychoeducational programs to their children and youth. When this happened, I always suggested a collaborative approach in an effort to create programs that were based on the input of community members because I believe they are the experts of their realities and best able to articulate their needs. Throughout the planning and delivery phases of these projects, I continually asked youth, adults, and youth workers for their input regarding possible activities. The response I usually got was one that encouraged me to provide services in the manner with which I happened to be most comfortable and competent. As a result, the bulk of my activities incorporated a very Western lens, terminology, and approach. For example, I focused on issues of anxiety, worries, fears, self-esteem, mood regulation, the relationship between thoughts, feelings, and actions, and finally, how all of these things impact our choices regarding helpful and impairing coping strategies. The services I provided were also grounded in a harm reduction approach, particularly when working with youth. Although I did address issues of colonization and oppression, I did so as an outsider.

Often, I employed some participatory activities that were based on theatre of the oppressed methodologies, as well as small and large group discussions. Food was provided and the sessions were typically well received and generated a great deal of discussion and sharing. Although I often strived to include children, youth, adults, and Elders in many aspects of program creation and delivery, I noticed that most, if not all adults and Elders stopped attending after the first few group sessions. While I see the value of youth-only sessions, the intention was to incorporate an intergenerational perspective. My team leader

and I thought this would probably increase the chances of longer term improvements in community health as well as provide greater opportunity to incorporate more culturally relevant activities and learning that could be shared by adults and Elders. I remember wondering why I was having difficulty engaging adults and Elders in the process on a longer-term basis despite my belief that their involvement is integral to long term community health (Harrison & Carver, 2004).

Although the youth were very engaged and the feedback from youth and youth workers was extremely positive, I often had a nagging feeling that I should be providing services that incorporated more of an Indigenous world view. At the same time, I felt that it was completely inappropriate for me to do so since I am not of Indigenous ancestry. I did not want to engage in any cultural appropriation or attempt to use methodologies, activities, and terminology that were not mine to share. That said, I also felt that there was much value in the Western activities I facilitated and the evidence of such was shared through feedback from the youth and youth workers.

During that period, I had numerous questions including the following: Are there better ways of providing prevention, education, and treatment services to Indigenous communities? If so, what are they? Is it better to offer inter-generational groups or youth-only groups? When offering intergenerational groups, why do adult and Elder participants often stop attending while the youth continue? Can we incorporate an Indigenous world view in these groups? How? Should CYMHS even be providing these services or should they be provided by members of the Indigenous community? How can I combine Western and Indigenous world views in the area of mental health? We were invited into these communities because community members felt they lacked resources from within the

community to provide their own services. If this is the case, how can we identify and enhance the capacity of community members to provide their own clinical mental health prevention and treatment services to their youth?

Over five years have passed since I worked at CYMHS and I feel fortunate that I was able to revisit some of these questions. I have been out of the field for over five years and, although I have had some opportunity to examine this topic from an academic perspective, this practicum offered me the opportunity to revisit some of these questions as a social work student in the role of a practicum clinician. In addition to gaining clinical skills and knowledge that were outside the scope of my former employment as a support worker, I was able to learn more about Indigenous ways of healing from a team that strives to incorporate this lens into its clinical and support work.

Chapter Three: Organizational Information

Child and Youth Mental Health Services (CYMHS) and Aboriginal Child and Youth Mental Health Services (ACYMHS) are still relatively recent creations. In 2002, the Ministry of Children and Family Development (MCFD) was supported by the Ministry of Health Services to begin Phase 1 of a planning process to implement programs that would ensure adequate and accessible mental health services for children and youth living in BC (Still & Stevenson, 2006). In 2003, BC became the first province in Canada to implement a five-year Child and Youth Mental Health Plan (the Plan) through the creation of Child and Youth Mental Health Services (CYMHS). These services, which continue today through MCFD, doubled the amount of funding available for child and youth mental health services in the province. The Plan also expanded the spectrum of available services "to include mental health promotion, prevention and reduction of risk for mental health problems, and the introduction of earlier evidence-based interventions" (British Columbia, 2010, p. 3).

In order to ensure adequate services to all children, the Plan recognized some key challenges to service provision for Indigenous children and included, as a primary objective, "the development of effective CYMH services for Aboriginal children, youth and their families" (Still & Stevenson, 2006, p. 1). The First Nations Health Plan was created in 2006 and aimed to improve Indigenous health and close the gap between the wellness of Indigenous children and other British Columbians (British Columbia, 2010).

According to the most recent ten-year plan to address mental health and substance use in BC, the goals of the Plan include: improving the mental health and well-being of all British Columbians; improving quality and accessibility of mental health services; and reducing overall economic costs incurred by private and public sectors as a result of mental

health and substance use issues (British Columbia, 2010). The overall vision statement that guides the Plan is:

> Children, youth and adults from all cultures in British Columbia achieve and maintain sound mental health and well-being, live in communities free of problems associated with substances, access effective support to recover from mental health and/or substance use problems that may develop over the lifespan, and lead fulfilling lives as engaged members of society without discrimination when these conditions persist. (British Columbia, 2010, p. 6)

Description of South Vancouver Island ACYMHS

Since the Plan is province wide, it covers a large geographic area comprised of urban and rural regions. Each MCFD region underwent its own process to determine how best to serve local Indigenous communities. Some contracted out Indigenous service provision to local Indigenous agencies and others created ACYMHS as another program overseen by MCFD. The South Vancouver Island Region, which includes my current home town of Victoria, BC, did the latter. My placement took place at the ACYMHS office that serves Indigenous people living in South Vancouver Island. Of the five Vancouver Island regions, the South region has the smallest geographic area, the highest total population, and the second highest Indigenous population on the island. It has both urban centres and reserves and, therefore, requires a practice approach that serves the needs of urban and reserve-based populations. The land-based Indigenous communities in this region include Beecher Bay, Esquimalt, Pacheedaht, Pauquachin, Songhees, Tsartlip, Tsawoutm, Tseycum, and T'Souke (Still & Stevenson, 2006).

The ACYMHS office that serves South Vancouver Island is based in Esquimalt, BC, which is located on Lekwungen Territory. The team leader, Daniel Casey, MSW, was my practicum supervisor. The team has clinicians with MSW degrees, as well as clinicians with other graduate level degrees, and I was able to work with many of them based on their schedules and availability. The Esquimalt team also has support workers, a nurse, a psychologist, and a psychiatrist that work with the clinicians to support the various communities. Since the office serves urban and reserve based children, youth, and families, the clinicians are considered to be outreach clinicians. Depending on their specific regions, clinicians spend varying amounts of time in the main office versus in their respective communities of work.

My practicum began in June 2015 and was completed by the end of October 2015. I had to organize my practicum around my husband's work and vacation schedule because I am a stay at home mom of two young children and we have no extended family nearby. For the months of June, September, and October, I worked on my practicum for approximately 24 hours per week while my husband was able to arrange a flexible work schedule. He also drew on his vacation time in July and August so he could work a reduced work week. This allowed me to spend an average of 35 hours per week on my practicum for those two months. I was so incredibly grateful to have found a placement that offered such flexibility to a practicum student as this was the only way it was possible for me to complete a practicum in such a short timeframe, without having to incur a large amount of childcare debt.

Chapter Four: Literature Review

There is an increasing amount of awareness in mainstream society and academia about the prevalence and impact of mental health issues across all stages of human development. There is also an increasing abundance of research about Indigenous, Western, and integrated approaches to health and wellness. This literature review will explore mental health service provision in the context of my practicum placement at ACYMHS while focussing on Indigenous service delivery as discussed in the literature.

Historical Context

The National Aboriginal Health Organization (2015) defines Aboriginal Peoples as "a collective name for all of the original peoples of Canada and their descendants." It includes First Nations, Inuit, and Metis peoples. In Canada, "between 1996 and 2006, the Aboriginal population grew by 45%, compared to 8% for the non-Aboriginal population" (Furgal et al., 2010, p. 323). This statistic is encouraging because it shows that Indigenous communities are still growing in spite of all the harms that have been inflicted upon them. It also underscores the urgency of providing effective health services to Indigenous communities so they can heal from historical trauma and return to living with abundant health and wellness.

Any discussion of Indigenous mental health must be placed in the context of the historical and ongoing process of colonization. Before colonization, Indigenous people lived in the place now called Canada for thousands of years with social structures that offered opportunities for individual development within the context of community and environmental connections (Malone & Stanley, 2013). Colonization resulted in the intentional destruction of these social structures along with a loss of land, cultural identity,

and access to cultural practices (Cannon & Sunseri, 2011). Residential schools tore families apart, and added to the trauma of the cultural genocide experienced by Indigenous people. Although the combined and cumulative effects of this intergenerational trauma continue to be experienced by Indigenous people today, their resilience also continues to grow.

"Indigenous populations are fragmented and suffer acculturation and oppression as a result of colonization" (Harder, Rash, Holyk, Jovel, & Harder, 2012, p. 138). Indigenous communities tend to experience disproportionately worse health outcomes, including higher rates of mental illness and chronic diseases across age (Rikhy, Jack, Campbell, & Tough, 2008). Indigenous families and communities experience greater poverty than other Canadians and more Indigenous children live in single parent homes. Both of these factors are associated with poorer childhood health outcomes (Werk, Cui, & Tough, 2013).

"Poor health among First Nations youth and adults has been linked to social determinants including education, housing, infrastructure, employment, social capital, and economic status" (Barwin, Shawande, Crighton, & Veronis, 2013, p. 325). Indigenous communities fare worse in these social determinants because of colonization and ongoing racist policies and legislation. Barwin et al. (2013) assert that "the struggle for self-determination and control may be the underlying cause of poor health in many Aboriginal communities" (p. 325) because feeling disempowered is also considered to be a social determinant of health.

Racism and discrimination, as well as the historical impact of assimilation through forced residential school attendance, are ongoing effects of colonization and acculturation (Harder et al., 2012). Whether on a systemic or individual level, racist policies and discriminatory perceptions impact the health of Indigenous individuals, families, and

communities. Since "colonization around the world was commonly both brutal and subtle" (Guerin, 2010, p. 62), it is vital that service providers have a clear understanding of our colonial past and present in order to meet the needs of Indigenous people.

It is also important to understand the unresolved historic trauma that resulted from culturally genocidal policies that were implemented by our government, as well as the "historical loss of social and kinship structures and systemic racism" (Malone & Stanley, 2013, p. 434). The process of healing from posttraumatic stress is well understood now and involves three stages: establishing trust and safety, remembering and mourning, and reconnecting with oneself and others (Herman as cited in Archibald & Dewar, 2010, p. 12). Healing from historic trauma involves similar stages but is even more complicated so "learning about, mourning the losses of, and reconnecting with family, community, culture, and traditions are significant parts of the healing process" (Archibald & Dewar, 2010, p. 12).

Although Indigenous communities have had numerous challenges forced upon them, I agree with Tait (2009) that "alarmist arguments that characterize Aboriginal communities as dysfunctional and pathologic ignore the historical resilience and resistance of Aboriginal peoples in the face of adversity brought on by European colonization" (p. 214). It is important to remember that most of the mental health and addiction issues experienced by Indigenous people were inflicted upon them and, as unhealthy as they may seem, they have served as coping strategies that have allowed the population to survive and, slowly but surely, begin to thrive again.

Defining Mental Health

The World Health Organization (WHO) defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"

(WHO, 2014). It defines mental health as "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community" (WHO, 2014). According to the CYMH Plan (2003), mental health includes "all aspects of human development and wellbeing that affect emotions, learning, and behaviour" (p. 2) while a mental health problem is defined as "any emotional or behavioural condition that may cause significant distress and impair functioning, but not to a degree that meets diagnostic criteria for a mental disorder" (CYMH Plan, 2003, p. 2). The Plan continues by describing mental disorders and mental illness as interchangeable terms that mean "any emotional, behavioural, or brain-related condition that causes significant impairment in functioning as defined in standard diagnostic protocols such as the American Psychiatric Association's Diagnostic and Statistical Manual (DSM) (APA, 2000)" (CYMH Plan, 2003, p. 2).

According to Baskin (2007), Indigenous world views are relatively generalizable across Nations and are defined as "the foundation or lens by which peoples look at the world and include values and ethics" (p. 1). She asserts that the conventional rules of mental health service provision must be challenged if we wish to make such services culturally relevant. The Indigenous view of mental wellness is holistic and incorporates "being in a state of balance with family, community, and the larger environment" (Khan, 2008, p. 7). Effective treatment programs take place within the context of family, community, and environment by drawing on their strengths. Since Indigenous world views do not see mental illness in the same manner as the Western world view (Baskin, 2007), the issues that surround Indigenous service delivery are extremely layered and complex. It is insufficient to suggest that

culturally relevant service provision can be attained by having Indigenous people provide services that are essentially a replication of Western programs. This is oppressive and serves only to perpetuate colonization.

Prevalence of Mental Disorders in Children and Youth in BC

It is hard to get an accurate picture of how many children in BC experience mental health issues or disorders because there is still a lack of awareness about the realities of child and youth mental health. Childhood mental health is an interesting phenomenon in the sense that adults have a tendency to normalize and pathologise the same set of symptoms and behaviours depending on the specific variables of any given situation. People may describe aggression, hyperactivity, moodiness, and fears as normal parts of childhood in some contexts, while labelling them as mental disorders in others. If parents come to the conclusion that their child's behaviour is impairing enough to cause difficulty, they may not seek professional help due to fear or stigma. If they do want to seek assistance, they may not know where to find it.

Although exact numbers are difficult to obtain, there is enough evidence to indicate that at least fifteen percent of children under the age of eighteen experience at least one mental disorder. The CYMH Plan (2003) lists childhood mental health disorder prevalence in the following order going from most to least prevalent: any anxiety disorder, conduct disorder, attention-deficit/hyperactivity disorder, any depressive disorder, substance abuse, pervasive development disorder, obsessive-compulsive disorder, schizophrenia, Tourette's disorder, and any eating disorder. It is believed that close to 1000 children in BC experience even the least prevalent disorder. It is worth noting that this number may be a low estimate for several reasons including the fact that some clinicians and clinical teams have

philosophical issues with using tools such as the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* and, therefore, do not use the aforementioned disorder classifications. The aforementioned figure is almost certainly lower than the reality because many children are neither identified nor being offered services that could help alleviate their suffering.

Indigenous children and youth are some of the unhealthiest in Canada with suicide rates five to six times higher than non-Indigenous youth (Barwin et al., 2013). While this statistic is accurate and troubling, it is important to recognize that such high rates of suicide do not occur in all Indigenous communities. There is evidence that there are lower rates of suicide and sometimes an absence of them altogether in communities where there are protective factors such as a strong sense of culture and ownership of community (Chandler & Lalonde, 2009; Kirmayer, Tait, & Simpson, 2009). Since the Indigenous population is growing faster than the rest of the Canadian population, it is even more important to understand the causes of health issues among Indigenous children and youth and find effective ways to support them in improving their health and wellness.

Components of Mental Health Service Provision

Within mental health services, support and assistance can come in the form of prevention services, community capacity building, and providing treatment and support. The CYMH Plan (2003) suggests an increase in all three areas. Prevention services focus on implementing public education programs that help people recognize mental health issues earlier so they can be addressed before they become more impairing. Public education can also help reduce the stigma associated with mental health problems. Prevention services can

also include activities and approaches that help children, families, and communities build upon and increase protective factors.

Community capacity building is included in the Plan through activities such as providing mental health consultation services to agencies, schools, and organizations that already work with children and families. There is also a focus on reaching out to cultural groups that tend to use mental health services on a less proportional basis than others. The Plan includes increasing the types of collaboration and resources that will help Indigenous communities develop their own mental health programs based on their specific cultures and needs, while also ensuring timely access to government mental health services that are culturally competent.

Regarding treatment and support services, the Plan aims to improve: access to timely and evidence based mental health assessment and treatment services that are effective and culturally relevant; effective coordination of services across health sectors; and the provision and monitoring of evidence based practice standards across all provincial regions.

Reported Challenges for Indigenous Communities in BC

After implementing the Child and Youth Mental Health Plan (2003) across the province for three years, a new Aboriginal Child and Youth Mental Health Implementation Plan (2006) was created for each provincial region. Its purpose was to serve better the needs of Indigenous children, families, and communities based on some identified challenges. This new plan acknowledged that Indigenous children have not been served well by health and social programs. It reported that Indigenous leaders and communities need support to develop their own approaches to child and youth mental health service design and

implementation. It also reported that Indigenous leaders prefer increased focus on community capacity building and prevention services than individual clinical care.

The new plan also identified program coordination and funding as challenges because Health Canada funds health programs for Indigenous people while the provincial government funds CYMHS programs. Aboriginal Child and Youth Mental Health Services (ACYMHS) was created to address the aforementioned challenges and became fully operational in 2008. Since many social and health problems in Indigenous communities result from the loss of Indigenous culture and self-determination due to historic and ongoing colonization, their resolution requires social and political change (Khan, 2008; Kirmayer, Simpson, & Cargo, 2003).

In addition to the aforementioned reported challenges, Vukic, Gregory, Martin-Misener, and Etowa (2011) found the following gaps in mental health services for Indigenous people: "a lack of culturally relevant services; concerns about Western labels for mental illness such as depression; and concerns about culturally appropriate questions to assess mental illness" (p. 66). Another reason for the lower use of mental health services by Indigenous people is the difference between Western and Indigenous understandings of health, with research suggesting "that this is partly because most services are based on non-Indigenous conceptions of health and healing" (Stewart, 2008, p. 49). This will be discussed in more detail later in the literature review.

Indigenous Service Providers

Effective, sustainable, and culturally-relevant Indigenous prevention and treatment services are integral to increasing the health and vitality of Indigenous communities. The Ethics Guidelines for Aboriginal Communities Doing Healing Work (2000) articulate the

position that, despite the positive contributions of non-Indigenous people, it is up to Indigenous people to develop their own healing programs in order to meet their specific community needs. Wilson (2009) highlights the importance of spirituality, counselling, and a connection to Indigenous identity that can be developed by using Elders in various types of prevention and treatment programming. She also states that a number of government agencies are providing Indigenous-focused healing programs and curricula in areas such as education, corrections, and health. Issues of trust, multigenerational trauma, and racialization play an enormous role in Indigenous addiction and mental health, and there is evidence that suggests Western practices bring with them a risk of further alienation, especially when they do not take into consideration the unique cultural contexts of Indigenous youth (Vukic et al., 2011; Wilson, 2009).

Research shows that the effectiveness of prevention and treatment programs in Indigenous communities increases when traditional models that incorporate spirituality and ceremonies are implemented (Galanter & Kleber, 2004). I feel strongly that such programs must be facilitated by Indigenous leaders who are in a position to share relevant teachings and guide such processes. A holistic Indigenous mental health strategy links youth to their schools, families, and communities (Valentine, De Jong, & Kennedy, 1998; Vukic et al., 2011). This is easier to achieve when local people are involved in creating and sustaining such links since this may facilitate the "local control [that] is necessary to respond to community needs and promote collective efficacy and pride that contribute to positive mental health and well being" (Baskin, 2007, p. 4). Despite all the aforementioned reasons as well as my belief that Indigenous service providers are the ideal, the majority of the South

Vancouver Island ACYMHS team is composed of service providers who do not have Indigenous ancestry.

Non-Indigenous Service Providers

While I agree completely that Indigenous service providers are often best suited to deliver services to Indigenous populations, I was another non-Indigenous practitioner while on placement at ACYMHS. I had to be cognizant of the implicit and explicit impacts of this aspect of my identity. When working in Indigenous communities, particularly as an outsider, it is important to question the very definition of "mental illness." In fact, when working with individuals of any culture, I must remember that "what may be viewed as a mental health problem from one world view [or by one individual] can be seen as a positive, healing spiritual experience from another" (Baskin, 2007, p. 1). Equally important is the practice of positioning the client or service user in context so as to work effectively from a structural social work perspective. Since mental disorders including substance abuse have been best explained by "factors of acculturative stress and a history of political and cultural oppression" (Altar, 2008, p. 7), systemic issues must be addressed in order to create solutions that do not result in residual services when dealing with such complex and layered issues.

Another concept that is vital to the delivery of culturally sensitive clinical services is an understanding of the intersectionality of client identities. Identities, by their very nature, are fluid and dependent on time and space. As such, clients must be approached as unique individuals, regardless of the communities with which they associate at any given time. Practicing from a postmodern social work perspective recognizes the "multiple contexts that characterize the lives of [Aboriginals]" (Sands, 2001, p. 143). I believe it is important to

draw on best practices while also considering how best to use such strategies with any given client or group based on their articulated needs and wishes. Sands (2001) lists a number of postmodern feminist practice characteristics that I try to incorporate into my practice including a focus on partnerships, clients' voices, individual and cultural differences, and a "consideration of the social context before constructing a diagnosis of psychopathology" (p.123). It is also valuable to approach counselling as a non-linear process where, regardless of the chosen modality, fostering an authentic therapeutic alliance that is based on trust and client self-determination is of paramount importance.

According to Morrissette, McKenzie, and Morrissette (1993), a "framework for the development of an Aboriginal model of social work practice can be constructed around four key principles" (p. 91). These include: recognizing the existence of a distinct Indigenous world view; developing Indigenous consciousness regarding the impact of colonization; incorporating cultural knowledge and traditions as an avenue for retaining Indigenous identity as well as collective consciousness; and using empowerment as a practice method. (Morrissette et al., 1993). I aim to apply these principles to my general social work practice and also to my clinical practice with Indigenous children, families, and communities.

Autonomy and self-determination also factor into my reluctance to choose, independently and without consultation, either Western or Indigenous approaches when offering services to Indigenous people. I believe all individuals should be provided with several options in order to make informed decisions. Offering limited options based on the ancestry or ethnic origin of any group assumes homogeneity that does not allow an accurate reflection of individuals within the group. "An evaluation of the context, culture, and preferences of the client is necessary in delivering effective therapeutic interventions"

(Graham, 2013, p. 501). Some competencies that facilitate "culture-centred services include: self-awareness, understanding the world view of our clients, using appropriate intervention skills and techniques, and involvement in organizational developments" (Arthur & Stewart as cited in Malone & Stanley, 2013, p. 433).

One additional reason why I value a collaborative process, especially as an outsider, is based on my belief that all Canadians have been impacted by colonization and that it is the responsibility of each of us to engage in the process of de-colonization (Baskin, 2007). This is a core value of mine and, in order to practice accordingly, I have a responsibility to offer my skills and services to these communities in a manner that is determined by Indigenous community members. Prevention and treatment services in the area of addictions and mental health are inextricably linked to the process of colonization and, in order to be effective, will need to be approached with a goal of de-colonization. This can only happen with community input.

Heterogeneity and Client Preference

Since there is no such thing as a homogenous Indigenous identity, it is worth examining the heterogeneity of Indigenous populations and client preference before beginning a discussion about Indigenous ways of knowing and healing. Within the Canadian context, there is much diversity among Indigenous communities. Since this diversity impacts worldviews, it also influences how different Indigenous communities understand and approach mental health and illness (Vukic et al., 2011). "An evaluation of the context, culture, and preferences of the client is necessary in delivering effective therapeutic interventions" (Graham, 2013, p. 501).

There are many helpful considerations when working with individuals and groups, regardless of ethnic ancestry. Many of these are also relevant to working with Indigenous communities. Since culture is fluid and all individuals identify as belonging to one or more cultural groups, it can be argued that all interpersonal interactions are cross cultural in nature. The concept of polyvocality, meaning multiple voices and realities (oxfordreference.com, 2011), is of utmost importance when working with people in a clinical capacity since there is no such thing as "the" Indigenous experience or reality. Not only is it wise to take the time to learn about the culture of a given Indigenous community, it is also useful to take the time to explore the degree to which a given client identifies with that culture. The key, once again, is to engage in a non-judgmental process that starts "from the client's perspective, [and helps] the client work through the problem in culturally congruent terms" (Sands, 2001, p. 151).

This fluidity of identity also means that individuals and groups may identify with more than one culture at any point in time and this may change over time. Even individuals who come from apparently unique and distinct cultures may identify more strongly with a new culture of their choosing. This implies that "every person possesses such a distinct collection of experiences that (s)he could be considered a unique one-person culture" (Arthur & Collins as cited in Graham, 2013, p. 502). Morrissette et al. (1993) assert that "an individual's identification with Aboriginality is influenced by the family system and the surrounding social reality" (p. 95). In essence, each individual, family, and community may report different preferences for support and treatment.

Swift, Callahan, and Vollmer (2011) state that client preferences should be a core aspect of evidence based practice because incorporating preferences into determining

treatment approaches improves treatment outcomes. Evidence shows that there is a preference effect, whereby people are less likely to discontinue therapy prematurely and more likely to display better outcomes if their preferences are matched (Graham, 2013). In addition to meeting individual preferences, matching cultural preferences to treatment types is also beneficial. There is evidence that mental health services are more effective when they are targeted to a specific cultural group (Smith et al., 2011).

The three main types of client preference—role preference, therapist preference, and treatment preference—are integral components of evidence based practice, especially in conjunction with clinical expertise that is based on the best available information (Graham, 2013). "Individually tailored supports acknowledge the uniqueness of sub-cultures within the Aboriginal culture, thus promoting responsive, culturally safe interventions" (Rojas, 2014, p. 89).

Although focusing on the differences between Indigenous and Western worldviews as they relate to mental health and wellness comes with the risk of overgeneralizing individual, family, and community differences and preferences, I agree with Vukic et al. (2011) that ignoring them "is unethical and immoral as Aboriginal peoples fight the legacy of colonization to regain a sense of balance and harmony within their collective historical identity" (p. 66).

Indigenous Ways of Knowing

It is difficult to translate the term "Indigenous knowledge" into English and describe Indigenous ways of knowing. According to McGuire-Kishebakabaykwe (2010), Indigenous knowledge "is a diverse and elusive term. Indigenous knowledge is a living process. It might be a thing or a body of knowledge, but to indigenous peoples, it is much more than this" (p.

126). She continues that it is a way of life and a relationship with all aspects of life. "It is combined thought of the land, the people, and metaphysics, that is, dreams, vision, spirit, and the emotive" (McGuire-Kishebakabaykwe, 2010, p. 126).

Although there are some challenges and complexity to defining Indigenous knowledge, Kassam and Graham (1999) offer some key attributes to help those who collaborate with Indigenous communities. These include:

- recognizing that Indigenous knowledge is context specific and both related to and contained within people who live in a specific region.
- It is cumulative and based on the sacredness of the past and tradition.
- Those who hold this knowledge are aware of the wisdom of their generation and those that preceded them.
- Neither the knowledge nor those who hold it are homogeneous.

One tool that is often used to describe Indigenous knowledge and ways of knowing is the Medicine Wheel. There is controversy surrounding the use of the Medicine Wheel as a tool for Indigenous ways of healing and knowing. For some Indigenous people, its widespread use is another example of colonization. The Medicine Wheel is a symbol that comes from the Plains and Anishinabek people and it is associated with different teachings for different Plains communities (Vowel, 2011). Some scholars such as Andrea Bear Nicholas describe "how completely our people have been fooled into believing that the medicine wheel is somehow part of our traditions, especially our spirituality" (Nicholas, 2012). She states that it was only introduced to some Indigenous communities within the past fifty years and she wonders, "how in the world could it represent the knowledge of our elders [Maliseet, Mi'kmaq or Passamaquoddy], if none of them ever heard of it until

recently?" (Nicholas, 2012). Some Indigenous people "can accept it as a modern symbol" (Vowel, 2011) but do not want it to be considered a part of all Indigenous people's traditions "as though all natives have some cosmic link to this teaching" (Vowel, 2011).

I recognize the complexity surrounding the use of increasingly popular tools such as the Medicine Wheel in relation to Indigenous healing in different regions across Canada. The reason I choose to include it in this report is because the clinicians at ACYMHS indicated that they have been encouraged to incorporate the Medicine Wheel, while remaining cognizant of its origins, by many of the Indigenous people in the surrounding communities. Although people from different regions may use different symbols and representations, the main principle of the Medicine Wheel appears similar: all knowledge is contained in the circle (Vukic et al., 2011). The idea that everything in life is contained in the circle differs from the Western notion of life having a beginning and end. "The circle represents the totality of existence, the interconnectedness of relations, and is symbolic of life" (Vukic et al., 2011, p. 69). The interrelatedness of all things in the universe is central to Indigenous knowledge.

It is also important to understand how a given culture acquires knowledge. Indigenous knowledge comes from relationships with other living things and a connection to the land (McGuire-Kishebakabaykwe, 2010). It always ties back to the core value of interconnectedness. For many Indigenous communities, the creation of knowledge was and continues to be both a personal and collective process. It is informed by personal responsibility and relationship to community and it can be found in many places and through many different ways of knowing (Manitowabi & Shawande, 2011; McGuire-Kishebakabaykwe, 2010).

According to Graham (2013), "To consider how a specific culture acquires knowledge is a clue to determining the treatment preference of that culture" (p. 502). Since knowledge acquisition has individual and collective aspects, so may preferred forms of treatment. Since so much knowledge is acquired experientially from others, experiential learning remains a preference to this day for many Indigenous peoples (Stonechild, 2006).

Storytelling is one form of experiential learning. Since time immemorial, knowledge acquisition relied heavily on the sharing of stories (Kassam & Graham, 1999). Unfortunately, Western science has had the power of deciding which findings are considered to be universal knowledge and which ones are considered less legitimate (McGuire-Kishebakabaykwe, 2010). "Our story telling traditions are disregarded as ritual practice and our philosophies are seen as superstitious" (McGuire-Kishebakabaykwe, 2010, p. 124). I agree with Graveline (2004) regarding the need to "acknowledge Spirit as vital" (p. 106) and to reintroduce spiritual and ecological ways of knowing (Graveline, 2004). We rely so much on our rational, cognitive abilities and interpretations that we forget about the many other ways of knowing; the other ways in which our bodies and spirits communicate with us and help us heal.

I believe that learning about Indigenous knowledge and ways of knowing comes with responsibility. I agree that it is "important to retain the integrity and meaning of indigenous knowledge when using it in scientific frameworks" (Rikhy et al., 2008, p. 113) such as clinical counselling. Some scholars believe that Indigenous knowledge can provide an alternate discourse that has the power to fill in Western knowledge gaps (McGuire-Kishebakabaykwe, 2010). It is also possible that "examining a specific community's

response to colonial intrusions may shed light on broader indigenous colonial challenges and solutions" (McGuire-Kishebakabaykwe, 2010, p. 128).

Indigenous Understandings of Health and Wellness

Jennings and Lowe (2013) draw on several articles to describe a global view of Indigenous health and wellbeing that can be applied to the Canadian context. Indigenous health and wellness are based on the concepts of spirit, context, mind, and body. Spirit refers to the protection against negative forces in the universe, as well as a person's intuition, grace, dreams, and personal gifts (Jennings & Lowe, 2013). Stories and symbols are also part of spirit because many Indigenous people consider them to be spiritual in nature. The concepts of spirit and spiritual are not related to a God "but to say someone or something has spirit or soul and that we are all related is significant" (Vukic et al., 2011, p. 69). Context includes an Indigenous person's culture, family, tribe, community history, as well as environment and even environmental factors such as the weather (Jennings & Lowe, 2013). Mind encompasses a person's memory, judgement, and emotion, while body includes the genetics, nutrition, age, chemistry, and overall physical condition (Jennings & Lowe, 2013).

Indigenous perspectives on health and wellness are linked to "finding one's unique place in the universe and experiencing the continuous cycle of receiving and giving through respect and reverence for the beauty of all living things" (Jennings & Lowe, 2013, p. 522). As mentioned earlier, there are Indigenous peoples who view illness and dis-ease as a result of disharmony or imbalance with self and surroundings. Jennings and Lowe (2013) discuss other findings that describe Indigenous perceptions of illness to be linked to "a loss of one's soul, a state of being cursed, a passage in one's life, or fate" (p. 522). In the Canadian

context, cultural genocide created a loss of balance for Indigenous individuals and communities.

Another Indigenous perspective on wellness involves the "physical, emotional, mental, and spiritual aspects of a person in connection to extended family, community, and the land" (Vukic et al., 2011, p. 69). There is a huge discrepancy between the aforementioned perspectives on health and mental illness and the Western view which often focuses on understanding and altering brain functioning in order to treat mental health issues (Vukic et al., 2011). Although there is value in this knowledge, it may not be as holistic an approach as needed when supporting Indigenous people's health and wellness. The Indigenous perspective is not linear and goes beyond the notion that symptoms exist within an individual because it places much more emphasis on the interdependence of person and environment (Jennings & Lowe, 2013).

Traditional Indigenous Approaches to Healing

The Report of the Royal Commission on Aboriginal Peoples (1996) describes traditional healing as the practices that were used by Indigenous people to promote health and wellness based on beliefs that predate the dissemination of western, scientific medicine. These include the use of herbal medicines, ceremony, counselling, and seeking the wisdom of Elders (Barwin et al., 2013). They include "sweat lodges, smudging, talking circles, healing circles, and Indian medicines" (Henderson as cited in Rojas, 2014, p. 33). According to Archibald and Dewar (2010), traditional healing encompasses "culture, language, history, spirituality, traditional knowledge, art, drumming, singing, dance, and storytelling, as well as knowledge specific to the healer's area of expertise and the type of healing being undertaken" (p. 15). Reconnecting through traditional creative arts has the

potential to play a key role in healing for people who have been disconnected from their culture and traditions (Archibald & Dewar, 2010).

Jennings and Lowe (2013) raise the point that the Western healing paradigm is limited in the way it can negotiate the kinds of events that European centred scientists consider "anomalous, inexplicable, or nonexistent" (p. 522). Since the Indigenous approach to healing is more holistic and communal, it makes sense to ask individuals and communities to express their views and ideas for healing. This will be elaborated upon later when discussing knowledge exchange approaches. The Western approach of seeing mind and body as distinct repeatedly comes up as an issue because traditional approaches to healing involve the interconnectedness of all aspects of individuals with their surroundings as influenced by historical and political factors. Since there are significant cultural and historical differences within Indigenous communities, "health education programs that focus on a static health and illness concept, may be in opposition to Indigenous culture" (Jennings & Lowe, 2013, p. 523).

Challenges to Integrating Indigenous and Western Ways of Healing

As evidenced thus far, the differences between Western and Indigenous approaches to knowledge, health, and healing can be very difficult to reconcile. Gone as cited by Vukic et al. (2011) summarizes these differences as "individual egoistic enlightenment versus interpersonal relations or 'life lived in a good way'; secular versus sacred therapeutic orientations; and the ascription of illness as endogenous rather than interpersonal" (p. 65). Despite these differences, many scholars and practitioners are supportive of scientific inquiry and approaches to healing if Indigenous ways of knowing are included meaningfully in the inquiry process.

There are others, however, who are uneasy about the idea of integrating the two approaches because they are uncertain whether traditional approaches are validated by the Western medical system and its practitioners. Barwin et al. (2013) assert that some scholars believe it is not possible to integrate the two systems because they have fundamental philosophical differences. There is also the legitimate criticism that mainstream mental health services do not address issues of self-determination of Indigenous people even if they do accommodate cultural differences (Vukic et al., 2011).

Further challenges to integrating Indigenous and Western approaches involve the emphasis often placed on the biomedical understandings of mental illness. Neurobiological explanations do not include the concepts of spirit and interconnectedness with land and community. Furthermore, Walkup as cited by Vukic (2011) cautions that "neurobiological explanations of childhood psychiatric disorders are often used to support the use of psychotropic medications for childhood psychiatric disorders" (p. 71). Although there are times when this is necessary, the concern many people have is whether children are medicated too often. In traditional cultures, where children were not forced to attend school where they are required to sit still and follow orders for the majority of their days, parents and Elders were able to foster children's natural gifts and temperaments in empowering ways that were useful and added value to the community.

Despite all these concerns and challenges, the reality is that there are many non-Indigenous practitioners working at government and medical agencies who are providing services with the aim of helping Indigenous people improve their health and wellness. I agree that "Aboriginal youth can benefit from the knowledge and wisdom of both understandings of mental health and illness" (Vukic et al., 2011, p. 65). I also appreciate the

way the authors explain the three ways in which traditional and Western mental health systems can operate: in isolation of one another, in parallel directions, or in collaboration with one another. Many studies conclude that "an eclectic and flexible approach to healing is fundamental because not all clients are grounded in Traditional ways or Western ways" (Vukic et al., 2011, p. 70). The rest of this literature review will highlight various approaches that offer opportunities for integration of Western and traditional Indigenous ways of healing.

Introduction to Collaborative Approaches

In order to combine effectively Indigenous and Western strategies for the treatment of mental health issues, Duran, Firehammer, and Gonzalez (2008) state that an awareness of the oppressive "psychological development of many Western-trained mental health practitioners is an essential component of the process of liberation psychology" (p. 289). Psychological liberation is a process whereby counselors, educators, and researchers modify their training and practice strategies in order to focus on soul healing (Duran et al., 2008). This approach is relevant to prevention and treatment programs as well as community capacity building. Also vital is an understanding of historical trauma and the ability to help Indigenous people reframe it into an act of resistance that requires strength and cultural power that they may not even be aware they possess (Baskin, 2007).

According to Baskin (2007), the presenting mental health issues that Indigenous people most often bring to the attention of service providers include depression, anxiety, suicide attempts, and alcohol and drug misuse. As with the general population, the biopsychosocial model can be used to understand how concurrent physical and psychological symptoms can develop when an individual is dealing with multiple stressors

at the same time (Sands, 2001). There are a number of treatment methodologies that can be used to increase overall health and functioning by addressing such symptoms and disorders. According to Altar (2008):

> Due to the paucity of controlled studies, it is not yet possible to easily identify treatments of choice that might be different from those that are effective with Canadians in general. This should not be an excuse to ignore evidence-based treatments of choice being delivered and appropriately adapted to the First Nations populations. Being different is no justification for being deprived of the treatments what may work best for all or most (p. 8).

I believe it is possible to provide services that incorporate Western and Indigenous world views because both paradigms have value. Although I used to think that diagnostic labeling and medical language are inherently oppressive, I no longer do. I have trouble with the assertion that such an approach is definitely alienating to all members of non-Western cultural groups (Duran et al., 2008). My experience in the field thus far leads me to believe that, based on the inherent diversity that exists within Canadian and Indigenous contexts, it is more ethical to provide various options that allow people to choose the approach that resonates with them. The key is to ensure that even standardized, Western approaches meaningfully incorporate Indigenous understandings and client and community preferences.

Despite the absence of one single effective approach, there are increasing examples of collaborative practice described in the literature that show how two world views can come together and overcome some of the differences described thus far. Vukic et al. (2011) describe one clinic that uses a shared care model where the staff prioritizes establishing and maintaining mutually respectful and collaborative working relationships with local

traditional healers. They also collaborate with other agencies to offer culturally relevant services and programs to address challenges clients face that may be related to education, employment, housing, finances, and factors related to colonization, racism, and residential schools. In the year prior to the clinic opening, seventeen individuals resulted in fifty-four separate hospital admissions. After one year of collaborative service, there were three individuals who accounted for five admissions (Vukic et al., 2011). Barwin et al. (2013) found that, when workshops are offered in collaborative health programs, they need to occur more frequently in order to empower youth and adults to share their traditional knowledge.

Strategies for Incorporating Indigenous Approaches

As illustrated throughout this literature review, interconnectedness and overlap are key aspects of Indigenous perspectives on knowledge, health, illness, and healing. It makes sense, then, that the collaborative strategies that are shown to have positive health outcomes will also have some level of overlap. It is difficult to dissect and differentiate each aspect and discuss it in isolation. That said, there are some recurring themes in the literature that warrant further discussion as they provide much insight into strategies that may be considered valuable by children, youth, families, and communities. They include knowledge exchange, identity, culture, Elders, land, traditional medicine, and the arts.

Knowledge Exchange

I will begin by discussing the concept of knowledge exchange because I believe it is a core strategy that underpins all of the others. The Canadian Institutes of Health Research (CIHR) defines knowledge exchange, or knowledge transfer, as "a broad concept, encompassing all steps between the creation of new knowledge and its application to yield beneficial outcomes for society" (CIHR, 2011). Rather than focusing on one-way

communications such as brochures, reports, presentations, newsletters, and websites, knowledge exchange encompasses a two-way exchange of knowledge and can take place between people who hold different types of knowledge. Some examples of knowledge exchange strategies include participatory action research (PAR), various forms of media, storytelling, talking circles, and community gatherings (Rikhy et al., 2008). I would add that engaged conversation, whether during assessment or treatment, or outside of clinical practice has the potential to encourage knowledge exchange since "it is a strategy that increases the probability of evidence-informed decisions to improve health" (Rikhy et al., 2008, p. 109).

Two-way knowledge exchange strategies value the contributions of all parties and are, therefore, more likely to affect changes to policies, practice, and individual and community behaviours. The key, again, is for service providers to recognize and incorporate the value of Indigenous knowledge. Rikhy et al. (2008) assert that knowledge exchange is successful when it is dependent on the context in which the exchange takes place and the manner in which it is facilitated. Knowledge exchange can facilitate dialogue that can identify individual or community issues and possible solutions. As such, different knowledge exchange strategies may have different results in different Indigenous communities. Since the ultimate goal is to improve individual, family, and community health, true knowledge exchange strategies are one mechanism for empowerment. Even if it is not possible to incorporate some of the strategies with entire communities, mental health clinicians can change their approach to prevention, assessment, and treatment services by incorporating the core values of two-way knowledge exchange.

In one study, Jennings and Lowe (2013) wanted to give youth an opportunity to voice their own definitions of health in order to inform a cultural framework for health programming. The study used photography as a strategy for knowledge exchange. Not surprisingly, the results of this study showed that the students described different photos as being healthy or unhealthy than expected through a Western lens. What is worth noting is that the youth classified certain photos as being unhealthy when community Elders thought they would be associated with health. This knowledge exchange strategy resulted in the creation and sharing of new knowledge between members of the same community.

There are several principles for successful knowledge exchange and community-based research: "cultural appropriateness, inclusion of Elders, awareness of historical antecedents, empowerment, respect of indigenous knowledge, cross-cultural communication, and long-term commitment" (Rikhy et al., 2008, p. 110). Knowledge exchange offers an avenue for collaborative practice with individuals, families, and communities that can result in the creation of culturally relevant mental health programming and treatment goals and plans. The role of researchers and practitioners is to offer approaches that empower Indigenous people and communities (Jennings & Lowe, 2013). "Effective, evidence-informed interventions, combined with innovative and appropriate knowledge exchange strategies, hold promise as a way of improving health outcomes in Canada's Aboriginal population" (Rikhy et al., 2008, p. 118).

Identity

The theme of identity appears throughout the literature on improving the mental health of Indigenous children and youth. The effects of colonization and acculturation discussed earlier resulted in a fragmentation of culture that has had a negative effect on the

formation of identity, self-esteem, and purpose for many Indigenous children and youth (Harder et al., 2012). Indigenous children and youth are similar to many other immigrant, refugee, and youth of colour who experience the effects of racialization such as trying to navigate between two different and, sometimes, contradictory, cultural values. A major difference is that they are dealing with the ongoing and cumulative effects of internal colonialism on their cultural identity while also navigating the continuing tensions between Indigenous and mainstream values (Kirmayer et al., 2009).

Identity formation and being able to say who you are and what you believe "is critical in generating meaningful and needed indigenous-based histories that can transform how we, as Aboriginal peoples, think about ourselves and our location within this place called Canada" (McGuire-Kishebakabaykwe, 2010, p. 119). The importance of the relationship between cultural identity and mental health is often absent when discussing mental health promotion regarding Western youth. The focus in the West is more often on youth development of self-identity rather than cultural identity (Vukic et al., 2011).

Cultural identity can help promote resiliency in Indigenous children and youth. There are studies that show cultural identity is one of the most important factors in the facilitation of healing and recovery for suicidal youth (McCormick, 2009). By including knowledge exchange strategies on the topic of identity and cultural identity, youth can explore how they see themselves, with which culture(s) they feel most connected, and use this knowledge to inform treatment goals and plans.

Culture

In addition to its importance in the exploration of youth identity, exploring and connecting to culture may promote youth mental health in other ways. Many scholars and

practitioners encourage the importance of helping youth to gain awareness and understanding of multigenerational trauma and how this impacts the context of their lives. This view is very consistent with anti-oppressive and structural social work strategies that encourage helping people to work on their personal wellness while also learning about the impact of systemic issues (Mulally, 1997).

Practice strategies that are described as "culture as treatment" (Malone & Stanley, 2013, p. 434) refer to techniques that have been found to counter social pathology that is induced by trauma. Examples include "group healing techniques, family involvement, incorporation of spiritual and cultural ceremonies, use of medicine wheels, and story-telling" (Malone & Stanley, 2013, p. 434). The cultural continuity theory links a lack of cultural connectedness to current alarming Indigenous youth suicide rates and proposes that a productive and connected cultural community may buffer against suicide (Harder et al., 2012).

Elders

Another recurring theme when exploring the topic of improving Indigenous child and youth mental health is the role of Elders. This makes complete sense when working with knowledge exchange strategies that value Indigenous ways of knowing and healing. Although much was lost when the Canadian government made it illegal for Indigenous peoples to practice their culture and ceremonies, some aspects of stories, ceremonies, and teachings were able to be passed down through generations.

The inclusion of a central role for Elders and traditional healers is a key component of culturally based approaches. According to the AHF (2005), culturally based approaches to healing are holistic and include "a central role for Elders and traditional people, use of the

structure of the circle and outdoor physical setting, traditional teachings and medicines, storytelling and ceremony" (Vukic et al., 2011, p. 70). Since Elders are considered to be the knowledge holders in their communities, it is important to consult with community members to identify the individuals they consider to be their Elders. This ensures that the correct Elders are approached by service providers (Rikhy et al., 2008).

In the photography study by Jennings and Lowe (2013), initial photo categorizations were shared with Elders and they were able to share their agreement, disagreement, and concerns from their perspective. This type of knowledge exchange and consultation provided a different historical and contextual perspective than the one offered by the youth. It also offered an opportunity for sharing of knowledge across the generations so each could learn more about why some of the things the youth characterized as unhealthy were connected to health in previous generations. This type of knowledge exchange also offers an avenue for more learning about cultural history. "When service providers are able to consult Elders and each other they may be, as was the case for us, more able to creatively serve community needs" (Malone & Stanley, 2013, p. 437).

Land

Connection to land has been an ongoing theme in this literature review. The interconnectedness between all aspects of individuals, communities, and environment is at the core of Indigenous ways of being, knowing, and healing. When exploring ways of incorporating Indigenous ways of healing into work with Indigenous children, families, and communities, it is valuable to examine "indigenous views of resilience that may be land and/or place based within an indigenous knowledge framework" (McGuire-Kishebakabaykwe, 2010, p. 120). Like always, this is something that may or may not

resonate with each person but it is worth exploring when creating programming and treatment plans.

If connection to land factors into client preferences, then it is again time to use knowledge exchange strategies to figure out how to incorporate this value. Gone (2007) explored the ways in which Indigenous people use physical landscapes to heal. It can be as simple as going for a walk in the woods or on the beach. Working with Elders and other traditional healers may provide historical insight into how "people used different physical landscapes for different illnesses and different landscapes held different plants and animals that were used in the healing process" (Mashford-Pringle, 2011, p. 155).

Jennings and Lowe (2013) discuss the value of modifying food sovereignty programs for use with Indigenous communities. Food sovereignty programs not only focus on food production as it connects to geography and climate, they offer opportunities for empowerment and control over local food production. This also offers potential for exploring issues such as access and control over land and offers opportunities for traditional teachings, as well as growing and consuming healthy food. Even if started on a small scale, food growing programs can create opportunities for community engagement, decision making, and connection.

From a structural social work perspective, connection to land links to topics such as self-determination and self-government. Approaching problems from this paradigm may be the key to re-establishing healthy communities. Whether on individual, community, or nation levels, the importance of the physical and spiritual relationship to the land is a key component of Indigenous world views (Barwin et al., 2013).

Traditional Medicine

Learning about and using traditional medicine may resonate with some individuals, families, and communities. Based on their research findings, Barwin et al. (2013) assert that "the practice of traditional medicine, as one aspect of self-care, represents a significant element of self-determination" (p. 324) that may contribute to the health of Indigenous peoples. When Manitowabi and Shawande (2011) asked Anishinabek adults to describe the meaning of traditional medicine, each of the forty-three study participants referenced the concept of holism, which is a core aspect of Indigenous culture. The participants described holism as a necessary element of traditional healing and a core aspect of their identity as Anishinabek. They also framed healing as a lifelong process.

Barwin et al. (2013) discuss the role of traditional medicine in self-care. In the clinical context, self-care refers to maintaining personal health through proper nutrition, good hygiene, and using strategies that limit health hazards while promoting good health. Barwin et al. (2013) assert that traditional approaches to self-care, such as those employed at the Noojmowin Teg Health Centre incorporate life skills that include traditional medicine gathering. Not only do clients reap the physical, emotional, and spiritual benefits of being in nature, they gain control over their health decisions through gathering medicine. Traditional medicine gathering is location specific and would require the sharing of knowledge from Indigenous community members who have this expertise.

Arts

The final recurring theme I will discuss is the integration of the arts as an Indigenous approach to healing. "While Indigenous societies have acknowledged the healing power of visual art, dance, music, drama, and storytelling for millennia" (Archibald & Dewar, 2010,

p. 1), the Western world has only recently begun to recognize their therapeutic benefits. Not only can arts activities be incorporated into therapy (arts-in-therapy model), evidence indicates what people have known for generations: arts activities have healing benefits in and of themselves (arts-as-healing) (Archibald & Dewar, 2010). This applies to creative arts activities regardless of whether they are Western or Indigenous in nature and include music, dance, storytelling, writing, and painting to name only a few. "In addition to the knowledge and skills acquired in learning an art or craft, there were numerous opportunities for personal growth" (Archibald & Dewar, 2010, p. 10).

In the Indigenous context, Archibald and Dewar (2010) found that the aforementioned two models, arts-in-therapy and arts-as-healing, were not encompassing enough. They found that, while these two models did a good job of explaining the healing benefits of the creative arts, the picture was not complete without the addition of a third model in relation to Indigenous people: "Holistic Healing Includes Creative Arts" (p. 6). They included this because many study participants situated arts within a frame that includes culture, spirit, and holistic healing. This again illustrates the interconnectedness between traditional healing, arts, and culture.

Indigenous peoples used storytelling and mythology to guide their mental, emotional, spiritual, and physical lives since time immemorial (Wesley-Esquimaux, 2011). Since they were a people who had many oral traditions, storying was one of the main ways to pass on teachings and explore issues related to health. Sadly, as was the intention of colonialism, the repetition and sharing of myth and story became less and some stories were abandoned and forgotten. At one time, the telling of a single story from beginning to end could last through the winter months (Wesley-Esquimaux, 2011). Stories were once the

main tool used to regulate social norms and behaviours but they became replaced by other methods of social control such as ostracism and physical punishment. There is, however, an ongoing process of the reclamation of storytelling, oral traditions, and narrative healing by Indigenous peoples locally and globally (Graveline, 2004).

The study conducted by Archibald and Dewar (2010) not only provides strong evidence for the link between creative arts, culture, and healing, it also shows that "when given the freedom to choose, community based healing programs overwhelmingly include creative arts" (Archibald & Dewar, 2010, p. 1). There is also increasing evidence that shows the value of using creative arts in the healing of trauma (Archibald & Dewar, 2010; Graham, 2013).

The strategy of using creative arts to resolve and heal from trauma is worthy of further discussion. In the Canadian context, the horrific legacy of residential schools on individual and community health is known as a historic trauma. Historic trauma is the result of the cumulative effects of the many losses that Indigenous people experienced: "from the loss of lands, resources, and political autonomy to the undermining of culture, traditions, languages, and spirituality. These losses are experienced across time and generations" (Archibald & Dewar, 2004, p. 2). It makes total sense, then, that the Indigenous led restoring and reclaiming of creative traditions related to language and culture have a positive impact on improving mental health.

Graham (2013) discusses the ways in which trauma impacts the body and brain, and the role of the arts in trauma healing. He asserts that since trauma attacks all of the senses, experiential sensory-based therapies are needed to recover. Arts based therapies are especially useful to process the parts of trauma that cannot be made sense of with language

alone. Graham (2013) continues that expressive arts therapies and integrative approaches are a legitimate treatment option for Indigenous people living in Canada and are typically consistent with client preferences.

There is evidence (Perry, 2008) that trauma alters the neural pathways in the lower part of the brain and some researchers believe that the only way these pathways can effectively be accessed is via therapy that elicits rhythmic, somatosensory experiences. Some such activities include music, which is rhythmic auditory, art which is tactile, dance, and other repetitive activities that are visual or tactile in nature (Perry, 2008). This type of expressive healing of trauma has been used for thousands of years by hundreds of Indigenous cultures (Archibald & Dewar, 2010; Graham, 2013). It is another strategy that is consistent with Indigenous approaches and increasingly supported by Western evidence-based research. Since trauma has physical, emotional, psychological, and spiritual impacts, the Indigenous Medicine Wheel model can also be used to resolve trauma. I agree with Graham (2013) that practitioners who wish to inflict no further harm by supporting colonialist ideologies, need to incorporate "client preference when counselling Aboriginal clients both as an ethical responsibility and as a social justice issue" (Graham, 2013, p. 509).

Possible Treatment Adaptations, Strategies, and Tools

The remainder of this literature review will focus on the examination of some specific treatment interventions that are used at ACYMHS for certain mental disorders.There are many ways to adapt traditionally Western treatments to make them more relevant to some Indigenous people. Language alone is very powerful. Duran et al. (2008) suggest using terms such as "spirit of sadness" (p. 290) instead of "depression." I would argue that it is wise to offer both options and allow clients to choose that which resonates

best with them so as to avoid making inaccurate assumptions on behalf of a very heterogeneous group of people. This is also consistent with client preferences. Duran et al. (2008) also state that Indigenous clients prefer to have a relationship with a disorder instead of feeling like they are the disorder. I find that this is often the case for many clients regardless of ancestry. For example, many anxiety programs encourage clients to view their anxiety as an entity that is separate from themselves as they learn strategies to better manage it. The key, I believe, lies with giving all clients a meaningful choice regarding perspectives, terminology, and treatment options for any given mental health issue. Duran et al. (2008) suggest incorporating strategies such as constructing genograms and using "cognitive-behavioral helping strategies in ways that accommodate…other relevant cultural metaphors" (p. 293).

Interpersonal Therapy (IPT) is an evidence-based treatment for depression. One aspect of IPT that is congruent with the realities of many Indigenous clients is its recognition of the interpersonal and social contexts that can lead to the development of depression. IPT is very much dependent on the fostering of a relationship between the therapist and client. This modality can certainly be adapted to include extended family and other cultural facets that are important to individual clients.

Cognitive Behavioural Therapy (CBT) is a treatment modality that is effective for the treatment of both depression and anxiety. CBT addresses distorted thoughts through cognitive reframing and exposure activities (Sands, 2001). CBT also includes relaxation training and, based on client preferences, can include meditation and spiritual components. Consistent with CBT, Duran et al. (2008) assert that many Indigenous communities already engage in the practice of "watch[ing] their thoughts" (p. 293) as a method of changing

existing cognitive and behavioural patterns. This is another area where changes to Western terminology may result in more engagement of some clients.

Regarding substance abuse, the reasons for its existence are as varied as the individuals who struggle with it. One point worth noting is that many Indigenous people believe there are genetic reasons that result in their inability to hold their liquor even though there is no conclusive evidence to support this belief (Sands, 2001). In order to conduct client-centred treatment, it is important to work with such individuals using a harm reduction or abstinence approach that is consistent with their preferences. People who are dealing with a dual diagnosis of both a mental and substance use disorder can also be offered traditional and Western approaches to healing. This is another area where a biopsychosocial and postmodern approach to treatment may allow clinicians to better respond to the needs of such clients (Sands, 2001).

Finally, when doing trauma work, interventions must be sensitive to the loss of power that was felt by clients while respectfully encouraging their attempt to regain a sense of control (Sands, 2001). As already discussed, it is also important to address generational historic trauma and its possible long term wounds and impacts. One additional way to do so is by using the liberation counselling strategy of creating a tribal, community, or family genogram, as suggested by Duran et al. (2008). This activity may help some clients locate themselves historically in the context of a specific trauma and, as a result, they may be able to "stop self-identifying as a 'defective Indian'" (Duran et al., 2008, p. 290). This is one tool that may help some clients better understand the systemic issues that have impacted their lives.

Conclusions

Traditional cultural approaches to healing are extremely valuable tools that can help clients resolve their mental health problems and increase their level of functioning, especially when facilitated by the expertise and knowledge of community members. By supporting and encouraging traditional healing ceremonies for those clients who choose such, service providers can increase the likelihood of intergenerational involvement in the healing process. At the same time, there is also much value in many Western modalities. Methods such as Jungian and Rogerian therapies, IPT, CBT, and motivational interviewing are very much adaptable to Indigenous cultural contexts. The key to competent and culturally relevant service delivery lies with the practitioner. Attitude, curiosity, authenticity, and competency are all vital and cannot be outweighed by any treatment methodology on its own. I agree with Altar (2008) that "the knowledge and tools of Psychology may be both a blessing and curse when we get wrong how a First Nations client is both different and the same as other clients we serve" (p. 9).

All of the aforementioned approaches, strategies, and tools are consistent with a socioecological framework as described by Jennings and Lowe (2013). From a socioecological perspective, service providers implement knowledge exchange strategies with clients, families, and communities to learn how they define health. Practitioners also consider the interplay of sociopolitical and historical contexts. This approach is consistent with structural social work and can help create programs and treatment plans that address Indigenous health and wellness "from a complex interactive perspective" (Jennings & Lowe, 2013, p. 535) that focusses on intrapersonal, interpersonal, and communal factors that incorporate Indigenous world views and traditional ways of healing.

Chapter Five: Practicum Goals, Tasks, and Learning

Although I have experience working as a support worker, I have not worked as a mental health clinician. I was keen to learn how to provide clinical services, especially in an environment that relies heavily on outreach. My overarching learning goal for this practicum was to learn how best to work with Indigenous children, families, and communities while using Indigenous and Western approaches to health and healing. This chapter summarizes my practicum goals and activities and provides some discussion of both.

Before beginning my practicum, I anticipated the need for flexibility regarding my learning goals and activities for several reasons. My practicum supervisor is the team leader for the South Island ACYMHS team and, as such, is only able to carry a caseload of one or two clients at any given time. It was agreed that I would shadow and receive mentorship from him as well as three other ACYMHS clinicians, one of whom is the team psychologist. Since all the clinicians work in an outreach capacity, many of them see limited clients at the office. Many also have flexible work schedules that involve conducting intakes, groups, and sessions in the evenings. Often, their outreach schedules change with very short notice, especially when working with clients and families who are dealing with crises. My part time practicum schedule was very dependent on limited child care options and required that I be home in the evenings. As such, I did not have the level of flexibility for shadowing clinicians that is ideal in this type of placement.

My practicum needed to take place between the months of June 2015 and October 2015 in order to complete my degree within the allowed timeframe. As is the case with many CYMHS and ACYMHS teams across the province, this proves to be the slowest time of year for clinicians. Many school programs and treatment groups end in June and start up

again in late September and early October. Many children, youth, and families leave town for holidays for different periods of time over the summer. Even if they remain in town, many children and youth take a break from mental health services over the summer. Clinicians, especially those who provide outreach services, typically meet students at their schools during school hours in order to facilitate treatment consistency. When school closes for the summer, many of these students take a break from receiving services. Many youth and families also report that their mental health issues are exacerbated while students are attending school due, in part, to the oppressive nature of schooling and its additional demands and stressors. They report improvements in health and functioning over the summer holidays and choose to take a break from services.

Many clinicians also take holidays in July, August, and early September. As mentioned in Chapter Two, these were the months when I had additional family supports for childcare and needed to complete the majority of my practicum hours. Although my availability and less-than-ideal practicum timeframe presented some challenges, I was fortunate to be placed with a number of clinicians who made the effort to consider my practicum goals as they managed their workloads. They demonstrated flexibility by trying to plan their schedules so they could offer shadowing opportunities to me and they assisted me in many other ways to ensure that my practicum experience was still rich and full of learning.

Learning Goals: Knowledge and Skills

My practicum proposal included five learning goals regarding the knowledge and skills I wished to develop. They included:

- Increasing my understanding of evidence based best practices in the areas of child and youth mental health prevention, assessment, and treatment services
- Increasing my knowledge about local community resources
- Developing intake, assessment, and treatment skills with Indigenous children, families, and communities
- Gaining knowledge and understanding of approaches to Indigenous healing as applied to (mental) health
- Learning how to integrate Indigenous and Western ways of healing

The aforementioned goals have a great deal of overlap and were met through a variety of learning activities. The main activities that enabled me to meet my learning goals included:

- Shadowing clinicians
- Participating in case consultations
- Attending team meetings
- Training opportunities
- Conducting literature reviews on related topics

By participating in each of these activities, I gained different insights that I was able to synthesise in order to meet my learning goals. These learning activities will now be discussed in detail.

Learning Activities

The following learning activities are now described in further detail: shadowing, case consultations, team meetings, and literature review.

Shadowing Clinicians

Shadowing offered an excellent introduction to the many aspects of clinician job responsibilities. I was able to observe and participate while clinicians conducted the following: intake assessments for individual and group service eligibility, full assessment interviews with children and families, clinical interviews with parents, and individual therapy sessions. I was very fortunate to shadow clinicians who encouraged my active participation right from the beginning. This allowed me to offer insights and ask questions that added to the therapeutic process. Clinicians also scheduled time to discuss and debrief afterwards which further added to my learning.

Even though shadowing was a key learning activity that I wanted to pursue, I was very cognizant of the fact that I was an unfamiliar outsider to the children and families with whom the clinicians were working. In order to ensure that no client felt pressured into agreeing to my presence, I made sure that clinicians asked clients for their permission before the beginning of the session. If a client agreed over the phone at an earlier date, the clinician asked again before the session began. I would always make sure that I was in a different office so clients could give an honest response. Although there were some clients who agreed to my presence, there were many that did not. I expected this to be the case, especially when considering the historical context of Indigenous experiences with researchers and outsiders. The clinicians told me that there were many clients they would not even approach about having me observe because rapport and trust building was going so slowly that they did not want to jeopardize such. I completely understand the many reasons why Indigenous clients may reject the presence of an unfamiliar observer and always placed

the importance of the rights of clients and the therapeutic relationships over my practicum needs and goals.

Shadowing became an integral aspect of my practicum due to the nature of the caseloads that existed during my practicum. The majority of each clinician's caseload consisted of complex cases that require longer term involvement. When I worked at CYMHS in Terrace, BC, there were quite a few clients that only needed services for approximately eight to twelve sessions, especially if their presenting issues were relatively straight forward (anxiety, mood, social skills, anger management, etc.) and if they were otherwise healthy and well supported by their parent(s) and family members. Due to the nature of the issues being faced by the majority of the children and families at my practicum site, there were few, if any, straight forward cases available for me to take on, especially given the amount of time I had remaining once I had completed adequate orientation and shadowing.

Although my relatively inflexible schedule was one factor, the other reason why I was unable to carry a caseload of my own was the lack of availability of appropriate cases. As part of my learning tasks, I became familiar with the waitlist and assisted with some waitlist management. The majority of issues faced by the children and youth on the waitlist were significant and complex. Often, the family situations necessitated longer and more intensive interventions, families were dealing with acute issues as well as the cumulative effects of ongoing post-traumatic stress disorder (PTSD), or parents and/or youth were hesitant about committing to treatments, especially since they knew I was only there temporarily and their case would be transferred to another clinician upon my departure. The intake clinicians and my supervisor agreed that it would not be in the best interest of

ACYMHS to give some of these complex cases to a student (even with additional supervision). They also did not think it would be in my best interest due to the complex nature of client issues and the risks inherent in some of them, including suicidality. Although a part of me wanted to pursue such cases, I understood the hesitation on the part of my supervisor and agreed with his reservations. If I had more time or if there were some simpler cases on the waitlist, it may have been possible but such was the reality of the time constraints of this practicum. I was able to conduct some aspects of assessments and provide some psychoeducation and skill development sessions related to managing anxiety and regulating emotions. Despite these limitations, the shadowing opportunities offered a great deal of learning.

Shadowing offered one avenue to meeting my learning goals. By observing and participating in sessions with different clinicians, I was able to increase my understanding of evidence based best practices, learn more about local community resources, develop my intake, assessment, and treatment skills, and gain insight into some of the ways in which clinicians integrate Indigenous and Western approaches to healing based on the needs and preferences of clients.

Case Consultations

Case consultations were another integral aspect of my practicum. They became an invaluable source of learning in light of the aforementioned challenges that limited shadowing opportunities and prevented me from being able to carry a caseload. Case consultations were a regular component of weekly team meetings. I was also fortunate enough to be able to participate in case consultations on an individual basis with clinicians. During case consultations, clinicians would present the details of a case that they were

working on and ask for feedback and suggestions from other team members. Consultations could happen at any stage of service provision and explored issues related to intake, waitlist management, assessment, treatment, referrals, and termination.

Case consultations were especially useful in helping me learn more about applying Indigenous ways of knowing and healing to service provision. Clinicians examined ways in which clients and families could be supported by local Elders, ceremonies, and community connections. They also used Indigenous and Western lenses in the process of differential diagnosis and treatment planning when discussing presenting issues such as hallucinations. From a Western perspective, visual and auditory hallucinations are often seen as impairing symptoms that could be indicative of mental health concerns such as psychosis. Sometimes, this was the case with clients. Other times, the hallucinations were not considered to be of concern because, from an Indigenous perspective, they were being experienced by a youth who was being visited by spirits, for example. In these cases, sometimes a youth did find the visions to be impairing. If youth did not want the visions to continue, they were able to seek assistance within their community and be part of ceremonies that would help them to end such visions. This is just one example of ways in which case consultations offered an opportunity for clinicians to discuss different ways of approaching various presenting issues.

Case consultations were useful in helping me to meet all of my learning goals. By participating in case consultations with individual clinicians and the entire team, I was able to ask questions and observe the process through which clinicians attempted to use best practices that were culturally relevant to individuals and families. I was able to increase my understanding of evidence based best practices in areas of intake, assessment, and treatment. I learned about formal and informal community resources, and gained insight into some of

the ways in which clinicians integrate Indigenous and Western approaches to healing based on the beliefs held by youth and their families and the specific presenting behaviours.

Team Meetings

Weekly team meetings were attended by clinicians, support workers, and the team leader. During the summer, team meetings occurred biweekly and the turnout was smaller due to staff holidays. In addition to the weekly case consultations discussed earlier, team meetings provided an opportunity for the staff to come together and discuss various logistical issues pertaining to their work. Intake clinicians updated the team regarding waitlists, clinicians discussed issues such as psychiatry referrals, and staff examined needs for groups and outreach services. Since the South Island ACYMHS office serves areas as far as Sidney on the peninsula and Port Renfrew on the west coast of the island, these meetings were an opportunity for all staff to connect on a weekly basis. There are some clinicians and support workers who only come into the Esquimalt office for team meetings and this provides an opportunity for camaraderie and connection with other team members. It is also an opportunity for staff to debrief and process the challenging issues they deal with for much of their work. Periodically, training opportunities also took place after team meetings. I was able to participate in CBT for OCD training as well as training about brief treatment and therapy with youth and families.

In addition to weekly team meetings, the team leader and two clinicians who shared intake responsibilities met for weekly intake meetings. These meetings were less than an hour in duration and provided an opportunity to discuss any new referrals and intakes and manage the active waitlist. Although the team has a long waitlist, they maintain contact with youth and families on the waitlist and alter their position on the list as needed. If acute issues

arise that make immediate services a priority, they are connected with a clinician. If referrals to other community resources are beneficial in conjunction with, or in place of, ACYMHS services, then such referrals are made. Participating in these meetings was a useful experience and furthered my learning and knowledge base.

Literature Review

As a practicum student, I valued the opportunity to read and learn about the topics that I was interested in exploring. When I used to work at CYMHS in Terrace, BC, there was limited time available for acquiring new learning through film and literature. This is often the case in the majority of social service positions. Even though practitioners know the value of prevention work and furthering their own learning, such tasks often take a back seat to treating acute issues and crisis management due to funding constraints. As a practicum student, I was afforded the luxury of creating my own learning plan, in consultation with my supervisory committee, and I made sure that I included a large focus on furthering my learning through an exploration of academic literature, websites, and documentary films. The topics I focused on included Indigenous ways of knowing, Indigenous perspectives on health, and Indigenous ways of healing. Although my focus was on the Canadian context, there are patterns and similarities that exist across global Indigenous populations.

While it is impossible to detail all the learning that transpired through the process of literature reviews, some of the insights I gained are included in the Literature Review and Implications and Recommendations chapters of this report. During my practicum, the Truth and Reconciliation Report was released. Some of the findings from that report are used to guide the recommendations included in this report.

All of the aforementioned practicum activities offered avenues towards meeting my practicum learning goals. By combining these activities with opportunities for self-reflection, I was able to synthesise my learning and apply it to my evolving practice framework. Journal writing, weekly self-evaluations, and regular check-ins with my practicum supervisor and mentoring clinicians allowed me to stay focussed on my learning goals and meet them.

Chapter Six: Implications and Recommendations for Practice

While spending a few months in a practicum placement certainly offers a lot of experience and valuable insights regarding the field, it is not enough to gain an in-depth understanding of all the factors that affect clinical practice with Indigenous children, families, and communities. For this final chapter, I will draw on my practicum experiences and the literature review to discuss implications on my own practice framework in the area of Indigenous child and youth mental health service provision. The recommendations section will synthesize some of the recommendations that were made by the Truth and Reconciliation Commission of Canada (TRC) in May 2015.

Implications for My Practice Framework

Now that my practicum has come to an end, I have the opportunity to reflect upon my experiences and decide how I will incorporate new approaches and tools into my future practice. In addition to incorporating the strategies included in the literature review portion of this report, I have acquired a number of new process tools that I believe will be valuable in working with Indigenous individuals and groups in both prevention and treatment capacities. I find myself wondering whether using tools and strategies that draw upon the arts, in particular, may result in increased, longer term participation from youth, adults, and Elders in the communities.

I realize now that I may not have been using many expressive arts activities while working in Terrace due to my concerns that they are not perceived as being "clinical enough." Although I used to draw on Theatre of the Oppressed (Boal, 2002) methodologies for group work, I relied more on talking than experiential strategies. After being introduced (and, in some cases, re-introduced) to various artistic tools, I am confident that their use has

the potential to increase the effectiveness of my practice because many of these activities honour ways of knowing and sharing that are not limited to spoken language. My social work practice framework has always included consciousness-raising, popular education, and embodied learning strategies and I must admit that, while working in a clinical capacity in Terrace, I began to doubt their effectiveness. I now look forward to reintegrating these methodologies into my practice because they appear to be consistent with the Indigenous healing approaches and ways of knowing discussed in the literature review.

Consciousness-raising empowers people by encouraging them to increase their insight into the intersectionality of gender, race, class, and other issues that impact their lives. Consciousness-raising activities often involve groups and aim to increase critical awareness regarding the links between the personal and the political, or the micro and the macro. As such, consciousness-raising is central to clients' abilities to gain a critical awareness of society and culture (Graveline, 2004; Sowards & Renegar, 2004; Travis, 2014; Turner & Maschi, 2015). An immense amount of insight and understanding can come from the honesty and pooling of experiences when a group of individuals who are interested in such exploration gather in a room together (Sarachild, 1978; Turner & Maschi, 2015). By sharing stories, describing their own realities, and studying the situations of each other, participants may feel empowered to engage in self-determined personal and political actions that aim to address the oppression and resulting mental health symptoms they experience in their lives. By realizing that their experiences are not isolated, people may begin to eliminate feelings of self-blame, increase self-esteem, and start to feel like they are entitled to many positive opportunities (Graveline, 2004; Sarachild, 1978; Snyder, 2008). This, in turn, may increase their ability and desire to pursue such opportunities, regardless of the messages they

have received, and most likely will continue to receive, from their immediate families, peers, or society at large.

Closely related to consciousness-raising are the methodologies of popular education and embodied learning. Freire (1973) conceptualized popular education as a pedagogy that affords adults the opportunity to come together and achieve critical consciousness through the process of conscientization. With this critical consciousness they can then act in ways that intentionally challenge systems of power, privilege, oppression, and colonization. Through a continuous process of action and reflection, participants can use these concepts to address the intersectionality of their experiences.

Embodied learning is practiced via methodologies that engage the body, mind, and spirit (Bondi, 2014; McKenzie, 2006). By using movement, song, and theatre, embodied learning practices incorporate the whole person and honour and validate alternate ways of knowing. This methodology is considered integral to feminist praxis and is an additional approach that may empower the people I work with to engage in the processes of personal and social change in ways that are relevant to their realities.

Some of the specific tools that I now plan to use when conducting prevention and treatment services with individuals and groups may include journaling, canvas/collage making, life maps (Sociodynamic-constructivist-counselling.com, 2008; Strydom & Herbst, 2007), dance and movement activities, drawing, and theatre activities. Each of these tools offers some confidentiality and allows clients to choose their level of disclosure. Life maps will be especially useful as an intake and treatment planning tool that will allow for a great deal of information gathering while encouraging a natural flow in conversation. I am also looking forward to using play therapy concepts when working with younger clients.

Bibliotherapy (Jack & Ronan, 2008; Pardeck, 2014) principles are also valuable and, when working with Indigenous groups, can be extended to include oral story telling. I am hoping that introducing these tools will allow for more culturally relevant, client-directed, and, perhaps, intergenerational participation and service provision.

Recommendations

Shortly after I started my practicum, the Truth and Reconciliation Commission of Canada (TRC) released its final report to the public. Since its publication, there has been increased media attention on the historical and present day realities of Indigenous people and communities across Canada. It seems fitting to focus on the TRC Calls to Action Report (2015) for the recommendations section of this practicum report.

The TRC separates its Calls to Action Report (2015) into two sections, Legacy and Reconciliation, and includes a total of 94 recommendations. Under the Legacy section, there are 42 recommendations subdivided into the following sections: child welfare; education; language and culture; health; and justice. Although it is difficult to completely segregate each of the aforementioned areas in practice, there are several recommendations that relate specifically to improving the health of Indigenous people and communities.

Within the health section of the recommendations, the TRC touches upon many of the themes that are presented in this practicum report. The first recommendation stresses the need for all levels of government to recognize that current Indigenous health issues are a direct result of policies that have been and continue to be intentionally implemented by previous and current Canadian governments. The TRC calls upon governments to implement health care rights in accordance to international and constitutional laws that also respect Treaties. The TRC also calls upon the federal government to consult with Indigenous

people to create measurable goals that will identify the health outcome gaps that exist between Indigenous and non-Indigenous people in Canada and then put in place strategies to close such gaps. Specifically, reference is made to suicide, addictions, mental health, and the availability of appropriate services. In order to address and close gaps, the TRC also calls on the federal government to rectify jurisdictional disputes by acknowledging the unique realities of Metis, Inuit, and off-reserve Indigenous populations.

The TRC advocates sustainable funding for healing centres so they can address effectively the physical, emotional, mental, and spiritual harms caused by residential schools and colonization. In order to do so, the TRC calls for authentic recognition of the value of traditional Indigenous healing methods and the inclusion of Indigenous healers and Elders as requested by Indigenous clients and patients. It calls for all levels of governments to ensure greater numbers of Indigenous health care professionals, better retention of Indigenous service providers in Indigenous communities, and mandatory cultural competency training for all health care service providers. The TRC also calls for the mandatory, skills-based education of all medical and nursing school students pertaining to Treaties and Indigenous rights, the history and long term impacts of colonization and residential schools, and Indigenous teachings and healing practices.

Although these recommendations may seem obvious to those who work in the field, there are several obstacles to their implementation. While I am cautiously optimistic that our newly elected Federal government will follow through on campaign promises regarding the implementation of TRC recommendations and fostering nation to nation relationships with Indigenous peoples, it will require a great deal of work and a significant increase to funding on many levels. Although a full discussion of obstacles and possibilities is beyond the scope

of this report, a brief discussion of implementing the TRC recommendations can be discussed in the context of Organizational, Practical, and Academic challenges (Rojas, 2014).

In her thesis, Rojas (2014) describes the perspectives of child and youth mental health clinicians who strive to integrate mainstream approaches to mental health with traditional Indigenous healing practices. She discusses the implications and recommendations of her study in three areas: Organizational; Practical; and Academic. In the organizational realm, Rojas (2014) discusses human and budgetary resource deficiencies as a barrier to offering integrated services to Indigenous people. This is, and has always been, the case in all social service fields. We often see cuts to prevention, outreach, and other services due to inadequate funding and this is the case even when services rely solely on Western methods and do not even attempt to integrate Indigenous approaches. Budgetary constraints will be one of the main barriers to the implementation of the TRC recommendations. In order to prioritize true reconciliation and improve the health and wellness of Indigenous people, there will need to be significant changes to the way in which budgets are created and administered, especially when considering the current push for austerity on local and global levels. The very types of services (and populations) that are currently undervalued by society and governments are the ones that will need to be prioritized.

Rojas (2014) also addresses the practical issues of incorporating Indigenous approaches to mental health service provision. She describes how clinicians are often seen as the primary knowledge holders in Western approaches when they are actually more like guides that strive "to support the client through respectful partnership in discovering and

exploring the knowledge and strengths he or she already possesses" (Rojas, 2014, p. 89). In order to practice in this manner, additional time is required and the lack of such is another consequence of inadequate funding to mental health services. All of the recommendations made by the TRC (2015) require a reallocation of government funds in order to be implemented in a meaningful and sustainable way.

The TRC (2015) and Rojas (2014) address the role of academic institutions in improving culturally responsive practice in all health care fields. "The role of academia in supporting the development of innovative, culturally sensitive practitioners is one of undeniable importance" (Rojas, 2014, p. 89). Although there is a separate section of recommendations related to education in the TRC Report (2015), the importance of education cannot be overstated as it is necessary in order to meet many of the report goals. Education is not limited to classrooms and an accurate awareness about the cumulative and long-term effects of historical and ongoing colonization across all segments of the Canadian population is vital. Although budgetary constraints are a significant barrier to implementing the TRC recommendations, so is a lack of collective, social will. Society as a whole will need to demand that recommendations are implemented in a timely manner. Otherwise, the potential for true reconciliation vanishes and the entire TRC process becomes more of an exercise in disclosure by those who were harmed (Maracle, 2014) and lets those who inflicted the harm and those who continue to benefit from it off the hook.

Chapter Seven: Conclusions

Completing this practicum placement at ACYMHS provided me with an opportunity to refresh and further develop my clinical social work skills and my social work practice framework. I was fortunate to be able to explore deeply my interest in Indigenous ways of knowing and healing. By shadowing and consulting with several members of the ACYMHS team, I was able to learn a great deal from their diverse experiences, personalities, and approaches to practice. Having the luxury of time to examine academic literature, Indigenous fiction, websites, and films was also invaluable to my learning process. Although the temporary and short-term nature of my placement resulted in some limitations regarding direct client services and integration into the local Indigenous communities, I am grateful for the flexible approach to learning that I was able to pursue.

At this stage of my life, I am uncertain when I will return to paid work outside of the home, whether future employment will be in the mental health field, and, if so, whether I will be offered an opportunity to work with Indigenous families and communities. Regardless of how things unfold, the learnings from this practicum experience, especially as they relate to the value of non-Western ways of knowing and healing, will inform my social work practice framework as well as my approach to parenting and living.

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