THE POWER OF STORIES: THE EXPERIENCES AND WELL-BEING OF MENTAL HEALTH PROVIDERS WORKING IN NORTHERN SASKATCHEWAN COMMUNITIES

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Abstract

This project explored the experiences and impact of working as an outsider mental health provider (MHP), not from the community, delivering trauma-informed care/counselling in northern Saskatchewan First Nations communities (NSFNCs). Although there is some research regarding the implications of providing trauma-informed services in northern Canada, very limited information exists about Saskatchewan. With increasing demand for Health Canada-approved MHPs to deliver trauma-informed care/counselling in NSFNCs, it is important to tap into their experiences and insight. MHPs typically work within isolated settings in NSFNCs and describe the work as both inspiring and tragic. Although MHPs love their work, the people and the communities, many have discontinued northern trauma work due to isolation and job demands, as well as a lack of support for safety and well-being.

This project utilized an embedded mixed methods research (MMR) design guided by participatory narrative inquiry (PNI). A participatory approach supported the involvement of participants in all aspects of this project including co-creating their stories and jointly developing recommendations. Through collaborative efforts, I was able to work with ten female social workers that are Health Canada-approved MHPs who have worked as an outsider in a NSFNC. Individual and group semi-structured open-ended narrative interviews were carried out in three phases revealing the following major themes: complexity of the work, lack of safety, awakening/transformation, the power of relationships, reconciliation, the impact on well-being, lessons learned, and the need for supports. The construct of well-being was not defined at the onset of this project but instead emerged through participants' stories. As such, participants described well-being qualitatively, as balance or overall wellness in relation to their life and work. This included, but was not limited to, the physical, emotional, spiritual, psychological/mental, and relational aspects of their life. In addition, work/life well-being was examined quantitatively using the Professional Quality of Life Scale-5 (ProQOL-5), which measures compassion satisfaction and compassion fatigue (burnout and secondary trauma). Results of the ProQOL-5 scale uncovered that 60% of participants had high levels of compassion satisfaction (enjoying one's job); 70% experienced low levels of burnout (unable to enjoy their job and be productive at work); and 70% experienced moderate levels of secondary traumatic stress (distress as a result of indirect trauma).

By understanding NSFNC trauma work and its impact, MHPs are better equipped to make evidence-informed recommendations to protect the well-being of individuals, to reduce isolation, and to improve the quality of the environments in which they work. The recommendations were to adopt a team approach; address safety concerns; improve management/MHP relationships; develop a trauma-informed training curriculum specific to NSFNC work; make improvements to the MHP approval process and hiring guidelines; and expand access to professional supports, including a ‘community of practice’. This, in turn, could help to attract and retain experienced MHPs, thereby improving the quality of services to facilitate healing for and with NSFNCs.

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I want to acknowledge the part of me that refuses to give up easily and is forever guided by the question, “Where does your spirit want to be”? I would like to thank my family, which surrounds me, and is me. I am grateful for my loving husband Ken who, without fail, has listened to my endless chatter and has been supportive and understanding throughout this project. Ken has taken care of me with the most wonderful meals and hugs. To my children Madison, Mollie, McKenna, and Merik, as well as my sons-in-law Brendan and James, I appreciate the time you took to listen to me, and for the fact that you promise to call me Dr. Mom. To my grandchildren Asher, Jacob and those yet to come, thank you for your gift of play and reminding me there is more to life than work. And lastly, to my parents Gladys and Ed who have always encouraged me to pursue my goals. I could not have accomplished this project without the love and support of my entire family.

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This project received funding from the Saskatchewan Centre for Patient-oriented Research (SCPOR). SCPOR works with a variety of organizations to support patient-oriented research and utilizes the expertise of patients to guide the research process. This financial

support allowed me the opportunity to travel to meet with participants and carry out the project interviews, in both individual and group formats.

Most importantly, I want to extend my sincere gratitude to all of the participants in this project. Your tireless commitment is the reason for its existence. To the Community Advisory Committee, your efforts throughout this project, including what is yet to come, is so very important. Specifically, for carrying the participants' stories forward to assist in developing improvements to their work environments in NSFNCs, including continued discussions regarding establishing a 'community of practice'. Lastly, thank you to my editor Diane Leigh for your contribution to this dissertation.

Dedication

To everyone who shared their amazing stories:

I am forever humbled and changed.

Your love for the work, the people and northern communities is from the heart.

To everyone who has worked as a mental health provider in northern Saskatchewan.

To the northern Saskatchewan First Nations communities.

that have taught us so many lessons to carry forward in our lives.

To the many people who are now gone from my life, but I know guide me every day.

To Lorraine Thomas, my friend, my colleague.

You always believed in me and supported my goals.

I wish you were here to share the joy.

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Abbreviations

- Community Advisory Committee (CAC)
- Community-based Participatory Research (CBPR)
- First Nations Inuit Health Branch (FNIHB)
- Mental Health Providers (MHP)
- Mixed Methods Research (MMR)
- Northern Saskatchewan First Nations Communities (NSFNCs)
- Participatory Narrative Inquiry (PNI)
- Patient-oriented Research (POR)
- Professional Quality of Life Scale (ProQOL-5)
- Saskatchewan Association of Social Workers (SASW)
- Saskatchewan College of Psychologists (SCOP)
- Secondary Traumatic Stress (STS)
- Secondary Traumatic Stress Disorder (STSD)
- Somatic Experiencing® (SE®)

Chapter 1

Introduction: Healing the Spirit of Northern Saskatchewan Mental Health Providers

"The healing journey and spirit of the helper is just as important as that of the one seeking help. In order to help in a good way with a good mind, helpers need to be cared for and care for ourselves".[1]

This quote awakens me emotionally to feel both empathy and compassion for all individuals in a helping role. More specifically, I want to acknowledge the hard work and dedication of all the helpers working in northern Saskatchewan's healing systems. This project will tell the stories of mental health providers (MHPs) working in northern Saskatchewan First Nations communities (NSFNCs). Professional MHPs are most often social workers, nurses and psychologists.[2,3] They must be registered with a legislated regulatory association.[4] In Saskatchewan, MHPs deliver short-term trauma-informed care/counselling to First Nations Treaty clients with approval through Health Canada, First Nations Inuit Health (FNIH) or longer-term directly-negotiated contracts with Indigenous communities.[5] Trauma-informed care focuses on understanding and responding to the effects of trauma for both counsellors and clients through a strength-based process of empowerment.[6] In this project, First Nation is termed as an individual that is Inuk or "registered under the Indian Act" and is eligible for health services from Health Canada.[7] To understand this project, I must begin by introducing myself to you, the reader.

1.1 My Positionality in This Research Project

Through the teachings from my Indigenous colleagues, I have learned that positioning myself is a decolonizing relational method of introduction. This is a way for people to understand me in the context of my relationships, and the location or area that I came from. I am a 55-year-old woman with a blend of genetic makeup - mostly of Eastern European descent with Nigerian roots from both my parents. I have been married for 35 years, have four children and two grandchildren. I grew up in a farming community in southern Saskatchewan, lived in Prince Albert for 28 years, and since September 2018 have proudly called Saskatoon my home. I have filled many roles and have enjoyed many experiences in my career, including employment with the Saskatchewan Government in the field of Corrections and Social Services. I also work as

Sessional Lecturer at the University of Regina (Faculty of Social Work). I recognize my position in this project as both a Health Sciences PhD (Candidate) and a Registered Social Worker in private practice. As a social worker for the past 29 years, I also acknowledge that I have a professional obligation to use my power in ways that support the needs of the client and promote social justice.[8]

This research project has been influenced by my work with First Nations communities in Saskatchewan. For the past 14 years, I have provided direct mental health services including trauma-informed care/counselling to First Nations communities in Saskatchewan. Furthermore, I have worked with six First Nations communities in central and northern Saskatchewan to support the development of community mental wellness teams to assist in community crisis trauma support. I have provided short-term crisis counselling and longer-term support in a number of NSFNCs. I am considered an outsider, as I do not live within any of the First Nations communities for which I provide or have provided services. In addition, I do not speak the local Indigenous languages. As an outsider, it informs my work and this project in that I have been invited into the First Nations communities in which I have worked as a guest of their community. Therefore, I must carry out this project with the utmost respect as a guest in their home.

Other than my own experiences, the stories of MHPs working in NSFNCs were, for the most part, unknown to me. I knew how difficult it was for me to talk about my stories due to confidentiality and community privacy agreements. I was also afraid that I might traumatize others if I shared the horrific stories I have heard, or the situations that I have directly experienced. As a clinical social worker approved as an MHP by Health Canada, as well as having delivered trauma counselling for 14 years, this project holds great importance to me personally, professionally and academically. Although I carry many of my own stories, my role in this project was to support participants as they shared their stories. I felt it was inappropriate to share my story within this project. Therefore, I listened to their stories, helped them to make sense of them and will be part of advocating with them for change. Thus, my story and experiences are for another time and place.

In order to support hearing and understanding the stories of participants, a Community Advisory Community (CAC) was co-created to guide all aspects of this project. Therefore, in order to understand how this research story began, I will discuss the process by which the CAC

was formed. More importantly, I will explain how the CAC guided the research questions, the methodology, the analysis, and the recommendations that evolve from this project.

1.2 Community Advisory Committee

I approached a colleague, Ms. Eveleigh Harris, whom I had known for a number of years to discuss whether she would be interested in participating in this project. Prior to this project, we had a number of conversations regarding trauma work in NSFNCs. It was through these conversations that I became aware of her interest in the well-being of MHPs working in NSFNCs. She agreed to be part of the project and has remained involved throughout, including with the development of the CAC.

In the spirit of the principles of participatory research, a CAC was established to guide the research process. The role of the CAC was to engage with the population and stakeholders to identify priorities in the project and to guide systemic, as well as individual practice improvements.[9] Ms. Eveleigh Harris was the first CAC member and we met in August, 2017 to discuss the project. She helped co-create a successful proposal for our SCPOR funders. In addition, she assisted in developing the research questions, the research questionnaire, and provided ongoing advice throughout the project.

With the ongoing collaboration with Ms. Eveleigh Harris and my supervisor, Dr. Ramsden, three additional members were added to the CAC. CAC members were purposely chosen because of their involvement in organizations responsible for the education and regulatory oversight of MHPs working in NSFNCs. As well, CAC members were chosen because of their individual expertise as it relates to the area of project in this research (mental health provider, First Nation health support, First Nation student education, and legislated regulation expertise). The members were representatives of the organizations for which they work. Potential CAC members were initially discussed with Ms. Eveleigh Harris, as she was the first CAC member. I contacted additional members by e-mail and followed up with face-to-face meetings to discuss the project. The CAC was established when everyone had been fully informed of the project and agreed to participate. The CAC was comprised of the following individuals: Shauna Eveleigh Harris (Mental Health Therapist); Dr. Carrie LaVallie (Trauma Support Therapist and Assistant Professor, First Nations University of Canada); Dr. Tara Turner (Associate Professor, Indigenous Social Work Program, First Nations University of Canada); and

Karen Wasylenka (Executive Director, SASW). I met with all CAC members on May 16, 2019 (two members in-person, and two via Skype). An in-person meeting of all members was scheduled for March 24, 2020 but had to be cancelled due to COVID-19 restrictions. Our last meeting was held remotely via Zoom on June 11, 2020 with all members present. I have met in-person with CAC members on a number of occasions since October, 2017, including eight meetings with Ms. Eveleigh Harris. Regular contact and updates have taken place with the CAC every six to eight weeks via in-person, phone or e-mail contact to keep members engaged and informed of the project. In addition, Dr. Tara Turner was also a member of my Research Advisory Committee (RAC) and attended three meetings. This allowed the CAC and RAC to work more openly and collaboratively.

This project has been completed in partnership with the CAC. All decisions were made transparently and in collaboration with the members. The CAC was instrumental in decision-making regarding the research questions, methodology, research design, and methods utilized to carry out this research. Thus, the CAC will be instrumental in taking the recommendations from this project forward to agencies directly involved with training, approval and regulation of MHPs working in NSFNCs.

1.3 Research Questions

This project sought answers to the following questions: 1. How, through the lived experiences of female outsider MHPs working in NSFNCs, can we better understand the impact of delivering trauma-informed care/counselling (e.g., secondary trauma) and how can we initiate opportunities to improve supports? 2. How can sustainable supports be co-created with participants, including a ‘community of practice’ to protect/improve the well-being of MHPs working in NSFNCs; to improve the quality of their work environments; and, in turn to improve the quality of services for clients?

1.4 Gaps in the Literature and Current Research

There were gaps in the literature in the following areas: 1. Research specific to the lived experience of outsider female MHPs working in NSFNCs. 2. Research on the impact of trauma-informed care/counselling on the well-being of female outsider MHPs working in NSFNCs.

3. Research developed through a participatory process with MHPs to co-create solutions to protect their health and well-being, including a sustainable 'community of practice'.[10]

Although the literature suggests the needs/well-being of MHPs working in northern First Nations communities in Canada is important, research to date is limited regarding their experiences[2,3,11]. This included the impact of the work (i.e., secondary trauma), as well as the coping strategies utilized.[2,3,11,] O'Neill and colleagues[12] argue we must hear the stories of MHPs working in northern Canada including NSFNCs in order to better understand the impact and what supports are needed to improve the environments within which they work, and in turn to expand the services available to clients. This information was not meant to undermine the knowledge of First Nations communities; it merely suggested that MHPs were part of a collective network of knowledge (e.g., nurses, universities, and government) who could work together to improve trauma-informed care/counselling services. The knowledge gathered through this project with participants' and the Community Advisory Committee will contribute to improving the environments within which the participants and other MHPs work in northern healing systems.

Prior to this project, MHPs working in NSFNCs had shared with me the fact that they gave everything (i.e., time, energy and compassion) to this work and as a result, were unable to sustain a balance between their work and personal lives. Although they cared deeply about their clients and the community, they were also struggling with issues such as sleep disturbance, anxiety and inability to sustain long-term trauma work. Given that MHPs in northern Canada carry high trauma caseloads, they hear extremely graphic client stories that can result in personal and professional emotional distress or secondary trauma.[2,13] Secondary trauma includes MHPs having negative beliefs regarding their safety, as well as feeling exhausted and disconnected from others (family, friends, and clients).[14]

MHPs delivering services in NSFNCs have also reported feeling alone in their work due to the insular nature of contractual employment, and wanted to share their stories. As such, FNIHB developed a Policy in 1994 indicating that because MHPs are "generally working alone, without supervision or any collegial consultation, he/she must be fully qualified and currently registered/licensed with the appropriate provincial College/Association to which he/she is professionally accountable".[11] Frequently, MHPs delivering trauma-informed care/counselling in

NSFNCs were outsiders, meaning that they were not members of the community to which they travelled to provide services. With a lack of studies about the experiences of MHPs delivering trauma-informed care/counselling in NSFNCs, along with Indigenous communities requesting increased access to MHPs, it was of great interest to me to explore their experiences. This project was crucial to exploring this gap. The purpose of this project was therefore to understand the lived experiences of outsider female MHPs delivering trauma-informed care/counselling in NSFNCs, and its impact; thus, co-creating recommendations for sustainable supports for the health and well-being of MHPs, and to improve the environments within which they work, including a 'community of practice'.

1.5 Understanding the Role of Mental Health Providers in Northern Saskatchewan

The following information is based on my own knowledge as well as on the informal reporting from MHPs delivering trauma-informed care/counselling in NSFNCs. MHPs have two general paths to providing services in NSFNCs: the first, as short-term crisis supports through contracts with First Nations Inuit Heath (FNIH), and the second, through direct annually-negotiated contracts with Indigenous communities.[5] MHPs also meet with northern Saskatchewan First Nations clients outside of their northern communities at their own private offices that are located throughout Saskatchewan. MHPs require approval from Health Canada to provide services; once approved, they are placed on a publicly-available list.[4] Currently, only First Nations Treaty clients are eligible to access the services of Health Canada-approved MHPs. As such, if a crisis occurs in a First Nations community such as an unexpected death (i.e., suicide or homicide) or a natural disaster, the community must apply to FNIH to access mental health services. A FNIH-approved MHP is contacted, either directly by the First Nations community or by FNIH, to provide crisis support for a specific number of hours. FNIH provides the MHP with details of the crisis situation and the name and phone number of the First Nations community contact, who will provide further details of the crisis or situation, as well as arrange for accommodations, if required.

Driving distance to NSFNCs is often lengthy on poorly-maintained roads, or MHPs must fly into the communities. Because MHPs usually travel in from outside the community, little is known about the community including its history, community supports, the language, or geographical details.[2] When MHPs arrive in the community, they meet with clients in a variety

of locations such as the health office, school, people's homes, or even in the MHP's vehicle. Initial community crisis counselling is generally completed by one MHP, either through individual one-on-one sessions or a group debriefing process. Generally, each community will indicate how they would like the debriefing to take place. Once the crisis debriefings have been completed MHPs recommend referrals to appropriate resources if additional support is required. This includes, but is not limited to an Elder, Traditional Healer, Holistic Wellness Worker, or to an outside resource such as psychiatry.

Trauma-informed care/counselling is a job expectation whether it involves providing crisis support in a First Nations community or for a longer-term contract. This training is generally acquired through specialized certification programs such as Critical Incident Stress Management or Somatic Experiencing®. MHPs may be working in the community when a trauma event occurs, and as a result may witness the event, or will attend the scene shortly thereafter. This may include a homicide or suicide scene with the body still present. Since family members of the person who had died, as well as community members may also be present, this situation can be very distressing to the MHP.

Because MHPs work as independent contractors, they do not receive health benefits such as access to an Employee Assistance Program that would include counselling supports or debriefings. MHPs must arrange these supports on their own, even though they have gone through an approval process with Health Canada and receive all their funding from them. In the past, Health Canada provided supports for MHPs through information sharing and networking at annual gatherings, but this is no longer available. As a result, MHPs have shared with me that they feel a disconnect from other MHPs in the region, as well as from Health Canada.

MHPs are a highly-sought resource and most often have a generalist-type education such as social work in order to respond through a lens of cultural awareness to a broad spectrum of client issues.[15-17] One of the approval requirements for MHPs is that they be registered with a professional regulatory body such as the Saskatchewan Association of Social Workers (SASW) or the Saskatchewan College of Psychologists (SCOP).[4] Practice competency requirements for all MHPs lies directly with each of these legislated regulatory bodies.[4] In Saskatchewan, social workers registered with SASW require a Bachelor of Social Work or a Certificate in Indigenous Social Work from the University of Regina, or an affiliated program (none of which require

clinical training or trauma-informed practice requirements).[18] Psychologists registered with the SCOP require a minimum of a Master of Psychology, as well as the required clinical training and supervision.[19]

Information specific to MHPs working in NSFNCs is lacking. After a comprehensive review of the literature, only one study included information regarding MHPs working in Saskatchewan, which was conducted in 2015 by the Assembly of First Nations (AFN).[11] In this report, First Nations mental health service users requested trauma-informed practice training for MHPs, as well as for solutions to retaining MHPs long-term.[11] In addition, MHPs reported being committed to delivering trauma supports to First Nations communities.[11]

Information was also found on the development of mental wellness teams (MWTs) in NSFNCs.[16] MWTs were developed in 2015 in Saskatchewan to increase locally-trained trauma-informed care resources, which had the potential to reduce demands on MHPs.[20] MHPs are a part of these teams in NSFNCs. Although Hill and colleagues[20] provided an overview of the benefits of the MWTs, the report provided no specific discussion about the impact of the work, nor the supports needed by the team members which included MHPs. No new or updated information has been released since that time.

1.6 Barriers to Delivering Mental Health Supports in Northern Saskatchewan

Northern Saskatchewan's population covers a large geographical area with many barriers that limit access to mental health services. According to the 2016 Canadian Census (Division 4718), the population in northern Saskatchewan (all land north of Waskesiu) was 37,064 with almost 90 percent (34,807) identified as Indigenous.[21] More than half of the Indigenous peoples in northern Saskatchewan (almost 19,000), live on-reserve.[21] Much of this northern population accesses health services in La Ronge and Prince Albert which, for many northern communities, is accessible only by air.[22]

Adding to the complexity and demands placed on MHPs, The Northern Saskatchewan Health Indicators Report found injuries to be the leading cause of premature death at a rate of 44 percent, or twice the provincial rate.[23] Suicides made up 25% of the deaths due to injury, which was three times the provincial rate.[23] As such, the high number of premature deaths created a greater demand by NSFNCs for outside trauma supports such as MHPs. As a result of the

disproportionately higher number of suicides, the Federation of Sovereign Indigenous Nations (FSIN) requested increased mental health supports.[24]

It is also important to understand the importance of building long-term relationships in northern communities, particularly for those who are from outside of the community. Moss and colleagues[22] argued that partnerships based on trust were crucial to working together to create relevant changes to service delivery in northern communities in Canada, and that "made-in-the-North solutions have the greatest potential to resolve issues of access". Securing long-term MHPs in the north continues to be a challenge. For example, the AFN has highlighted that maintaining consistent mental health support services, particularly in remote First Nations communities in Canada, has been an ongoing challenge.[11] In September 2017, the FSIN reported that few Health Canada-approved MHPs were accepting new referrals/clients, thus further limiting mental health services to First Nations peoples in Saskatchewan.[25] Therefore, examining the unique experiences of MHPs working in NSFNCs and their lessons learned was imperative in order to understand what supports were needed to sustain their capacity for long-term service provision.

In order to understand MHPs' lived experiences, the implications of the work, the mitigating factors, and support recommendations, it was important for this research project to fully engage participants. This knowledge was necessary to make collaborative evidence-informed decisions to transform the way MHPs are supported in the work being done in NSFNCs. To date, information is limited regarding the impact of trauma on MHPs working in NSFNCs, and the appropriate responses needed to support them. Evidence-based, co-created, sustainable improvements to the environments within which MHPs work will help to protect MHPs' well-being, and in turn improve the services available to clients. The findings generated from this project will provide crucial information from MHPs that can inform direct trauma-informed care/counselling agencies that approve and contract their services (e.g., First Nations communities and Health Canada); professional legislated regulatory associations such as SASW, as well as universities that provide training for MHPs. Therefore, the purpose of this project was to: 1. Explore how delivering trauma-informed care/counselling in NSFNCs has impacted/changed female outsider MHPs, as well as how they make sense of the work. 2. Identify needed supports to mitigate the work demands and impact on well-being in order to provide sustainable trauma work within isolated northern healing systems. 3. Begin to co-create

a sustainable ‘community of practice’ to support MHPs in order to improve the environments within which MHPs work in NSFNCs.

1.7 Synopsis of the Chapters

I will provide an overview of relevant literature in Chapter 2 regarding the impact of providing mental health support services in the north inclusive of well-being, psychological distress and secondary trauma, historical overview of Indigenous trauma, trauma-informed practice, and the need to develop well-being supports for MHPs. In Chapter 3, I discuss this project’s philosophical underpinnings of the need for a relational process to generate knowledge and support transformation. Therefore, the philosophical paradigms (social constructionist and transformative) are utilized as a foundation to anchor this project. As such, an embedded mixed methods research (MMR) design developed through participatory narrative inquiry (PNI) supports the gathering of qualitative and quantitative data through a collaborative process. PNI weaves together community-based participatory research (CBPR) and narrative inquiry to support authentic engagement of participants at all levels of the research process. Further, I will explain how narrative interviews and the Professional Quality of Life Scale (ProQOL-5) were utilized to gather participants’ stories to answer the research questions. I also outline the purpose of this project, as well as the research questions and the gaps in current research. In Chapter 4, the results and findings are presented through the categories and themes brought forward by participants, which are supported by their rich quotes. Chapter 5 details the findings of this project in relation to previous research, as well as an overview of the limitations of this project. Finally, Chapter 6 features the conclusions, reflections and recommendations brought forth by the participants.

This project was a reflection of experiences at a particular time in the lives of the MHPs. As you read, take time to absorb the stories and reflect. I also encourage you as the reader to decide how these stories might resonate with you.[26] This project is a relational/interactive/cooperative process that could not have been created in isolation. The path forward for each of you as you read is now with a community of MHPs; you are no longer alone. We are all part of this journey forward. I wrote this document in partnership with participants from this project and the CAC. We want everyone to know that knowledge can be generated and translated through an authentic collaborative process where everyone is engaged in all aspects of

the research process, including the documentation and dissemination of results. The next section is a review of the literature pertaining to these topic areas, as well as a critique of its limitations. This process will help to support the need for this project, and its relevance.

Chapter 2
Literature Review

The following discussion provides an overview of background information and literature directly relevant to this project. The primary areas of review include: health and well-being; primary and secondary trauma among healthcare providers; history of intergenerational trauma in Indigenous peoples in Canada; well-being of MHPs working in northern Canada; understanding trauma-informed practice competency; and individual, organizational and collective supports required for the well-being of MHPs.

2.1 Understanding and Defining Well-being

Although well-being is understood within this project through participants' stories, it is equally important to provide a broader overview of the construct. Delivering trauma supports in NSFNCs can have both positive and negative implications on the well-being of MHPs. Well-being appears to be so intertwined with the constructs of health and mental health that the terms are often used interchangeably. For example, the World Health Organization (WHO) defined health as "a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity".[27] The WHO defined 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".[28] These definitions suggest that health, mental health and well-being are much more than just our emotional and physical state. As well, Elder Jim Dumont concluded that balance and connection at "the physical, the mental, the emotional, and the spiritual—are all necessary to mental wellness at the individual, family, and community level".[29] Further, having a sense of purpose, hope, belonging, and meaning leads to mental wellness in our lives.[29] Therefore; mental health, health and well-being are interconnected and broadly defined.

2.2 Psychological Distress and Secondary Trauma Experienced by Trauma Counsellors

MHPs generally deliver trauma-informed care/counselling to First Nations communities that report high levels of mental health distress, but with limited access to resources.[30-33] Trauma-informed care/counselling mainly involves listening to clients' trauma stories that contain graphic details of horrific stories of abuse, cruelty and violence.[2,34-36] Empathy involves

one's capacity to create space to understand the emotional pain of another person/individual, but is also a central path for the shared trauma stories of clients (primary) to impart onto the therapist (secondary).[37] This can have a cumulative effect on MHPs, including physical and psychological distress similar to that of their clients.[38] The resulting distress or secondary trauma due to trauma-informed care/counselling is generally described in the literature under the overlapping constructs of: vicarious trauma, secondary traumatic stress (STS), traumatic countertransference, burnout, compassion fatigue, and compassion satisfaction.[14,36,39,40] Vicarious trauma involves the therapist thinking that the world is unsafe, experiencing a loss of confidence and self-sufficiency, and difficulty connecting with others because of their involvement with trauma clients.[14,38] Whereas, countertransference was described in the literature as an MHP's reaction to a specific client based on their own traits, as well as on their own unhealed trauma.[38,41] Compassion fatigue applies only to individuals who work in the professional role of helper (e.g., a therapist), and is defined as a loss of empathy for one's client.[14] Burnout is feeling exhausted and disconnected, and can be experienced by anyone (not limited to trauma therapists).[14,38,42] Elwood and colleagues[14] reported that utilizing multiple definitions and measures of secondary trauma resulted in contradictory findings between studies, and that consistent definitions and measures are needed. This issue also created challenges in comparing results between studies. As well, inconsistent definitions for the construct of secondary trauma makes it difficult to pinpoint what psychological supports might be required for MHPs' well-being.

In this project, the construct of STS was used to describe secondary trauma, and is defined as the distress experienced by a therapist as a result of repeated exposure to the traumatic stories of others.[13] This definition is consistent with the definition used in the ProQOL-5 measure, which was utilized in this project.[43] STS symptoms can develop rapidly and, if gone unchecked, can intensify into secondary traumatic stress disorder (STSD), which is much like Post-Traumatic Stress Disorder.[44,45] In addition, the secondary emotional and psychological implications of trauma-informed care/counselling can extend beyond the MHP, to include negative implications for the worker's family, as well as others they are close to.[37, 46-48] Studies indicate even though MHPs may experience the psychological effects of STS, they may continue to work, which can be unhealthy for themselves, their clients and the communities in which they provide services.[34,49]

Westman and Bakker[46] stated that there has been increased interest in research specific to the well-being of healthcare workers. Of particular interest is the implications of indirect trauma exposure, [14] especially for MHPs working in remote locations in Canada.[12] Indirect trauma exposure and secondary mental health effects encompass cognitive shifts and psychological distress[40] Psychological distress involves: upsetting or lack of feelings, somatic issues, addictions, compulsive actions, increased startle response, and the inability to carry out normal activities.[40] Cognitive shifts include: inability to trust; loss of freedom; thinking you are in danger; and believing you unable to protect yourself .[40] MHPs who deal primarily with traumatized clients are reportedly more likely to experience secondary trauma.[49,50]

Results of a quantitative study conducted in the southern United States discovered that more than 70% of social workers providing trauma support experienced at least one symptom of STS (avoidance, arousal, or intrusion).[49] As well, 15.2% of social workers in the study met the criteria for post-traumatic stress disorder, which was almost double the lifetime rate of 7.8% reported in the general population.[49] Trauma counselling involves supporting clients through a healing process that can be emotionally and psychologically challenging for MHPs; as a result, experienced MHPs may resign their jobs.[49] Therefore, a review of STS and the contributing factors will be examined next.

2.3 Factors Contributing to Secondary Traumatic Stress in Mental Health Providers

As of August 2020, the majority of Health Canada-approved MHPs working in Saskatchewan are female.[51] As well, according to SASW, the majority of Registered Social Workers (RSW) in Saskatchewan in 2020 were female.[19] Despite these statistics as well as studies utilizing mostly female participants, very few examined the specific role of gender.[49,52,53] Dahle[54] indicated that social workers were most often women, and as such, a more thorough review of the role of gender must take place. Studies have also indicated that female MHPs may be at an increased risk of experiencing STS specific to the constructs of compassion fatigue and burnout.[52,55] Furthermore, female MHPs have also reported more health concerns such as allergies or digestive problems compared to their male counterparts.[56]

Hensel and colleagues[36] conducted a meta-analysis of 38 published studies. They found significant STS risk factors to be: worker's age, years of experience, personal history of trauma,

size of one's trauma case load, personal supports, and work supports. Further STS contributing factors also included the number of hours worked each week, work stress, limited coping skills, and hearing trauma stories.[35,50] In a study of 152 MHPs, the strongest work-related predictor for STS was being new to the profession.[57] As well, findings in a study of 80 trauma therapists indicated that STSD was positively correlated with a therapist's level of emotional reactivity (propensity to respond intensely); it was negatively correlated with sensory sensitivity (response to low stimuli) and believing that they had supports.[47]

MHPs may find it difficult to leave client stories behind as a result of their own unresolved trauma history.[35,58] Collins and Long[40] reported that MHPs with an unresolved trauma history might over-identify with their client's trauma story and pull away from their client to protect themselves; thereby undermining the therapeutic relationship.[40] As well, how closely a therapist relates to their client can impact their own level of emotional anguish. For example, one study examined how a First Nations counsellor who attended residential school might be impacted by a client describing their residential school trauma.[59] Although there may be emotional implications for an Indigenous counsellor, they are likely the most effective because their personal insights can be woven into any approach used.[60] Morrisette and Nadan[59] determined that counsellors with similar trauma experiences to their clients can reduce their risk of secondary trauma if they focus on client solutions and resiliency. Stewart[60] maintained that a strong healing/empathic relationship is created when client and therapist share a common history, culture and world view. To mitigate secondary trauma, a therapist with a trauma history similar to that of their client must be able to define empathy boundaries in order to maintain their own well-being and capacity to work effectively with their clients.[58] As well, a Call to Action set out by The Truth and Reconciliation Commission (TRC) was to increase Indigenous healthcare professionals, retaining their services in communities and "providing cultural competency training to all healthcare professionals".[61] When providing counselling support to Indigenous peoples, it is key to possess knowledge regarding the forced assimilation, of the continued systemic inequalities that still exist, and of the resulting trauma.[60] Although this history may be unknown to MHPs or to their Indigenous clients, it is imperative for them to be aware of the history in order to contextualize the circumstances that have created the trauma in NSFNCs.[60]

2.4 History of Indigenous Peoples in Canada and Intergenerational Trauma

Indigenous peoples in Canada have been subjected to a purposeful strategic process of colonization.[62] A key instrument in this process was the Indian Act of 1876, which merged all legislation related to Indigenous peoples and laid the means by which Indigenous peoples would have their identity taken from them. [63] Although Indigenous leaders signed treaties as a way to provide security for their people, the Government of Canada viewed the treaties as a way to take over land ownership to begin a process of assimilation.[52] Reserve lands were held by the Crown in trust, and all Indigenous peoples legally covered by these agreements were made dependents, like children, under federal government control, without citizenship rights.[64] The primary way of assimilating Indigenous peoples was by forcing their children to attend residential schools and to undermine cultural and spiritual beliefs; thus, destroying strong family kinship bonds.[63] Not only did Indigenous children experience various forms of abuse while attending residential schools, but they also felt abandoned, resulting in the destruction of crucial familial relationships.[65] Forced assimilation created mass trauma at both an interpersonal and an intergenerational level, and as a result continues to be experienced by First Nations peoples in Canada.[62] Colonial practices that inflicted trauma on Indigenous peoples also included removing children from the care of their parents in what is referred to as the 60s Scoop.[66] The practice of forced removal of Indigenous children from the care of their parents continues today. In the 2016 census, Statistics Canada reported that more than 90 percent of youth in Saskatchewan's criminal justice system were Indigenous.[67] In addition, MacLean's published a news report in April, 2017 citing that 87 percent of children in Saskatchewan's foster care system were Indigenous.[68]

Colonization has resulted in the intergenerational traumas and health issues experienced by Indigenous peoples in Canada. *The Truth and Reconciliation Commission of Canada: Calls-to-Action* recommendation was designed for the Government of Canada to acknowledge that current health issues experienced by Indigenous peoples have occurred due to the federal government's political decisions including forced attendance at residential schools.[61] Reflecting on and understanding the impact of systemic racism on Indigenous peoples creates allies who help share important information needed to lobby for decolonizing healthcare policies and service delivery.[69] Colonization has also shaped the health system of First Nations communities, as well as access to funding for MHPs to deliver trauma counselling to NSFNCs. FNIH (through Health Canada) evolved from Saskatchewan's Treaty Six "Medicine Chest Clause".[66] Through

this agreement, the federal government maintains responsibility for First Nations public health initiatives.

2.5 Well-being of Mental Health Providers Working in Northern Regions in Canada

Although research specific to the experiences and well-being of MHPs in northern Saskatchewan NSFNCs has not been conducted, MHPs--both formal (psychologists, social workers, and nurses) and informal (family support works and community counsellors)--were studied in the Yukon, British Columbia, Alberta, Northwest Territories and Nunavut using a four-phase three-year research design.[2,3,12] In Phase 1 of this project, a narrative inquiry of eight MHPs indicated both positive and negative aspects of remote northern trauma work such as feeling emotionally drained, yet also feeling more compassion.[2] As well, northern MHPs living and working in the community, and MHPs traveling in from outside the community, reported feeling pressured to work long hours resulting in them feeling as if their work had taken over their life.[2] Additional studies found that MHPs who were unable to balance the demands of trauma work with other parts of their life reported quitting their job or leaving trauma work all together.[36,70]

Working in isolation was found to be one of the most significant challenges in remote northern trauma work, often resulting in limited collegial support and insufficient clinical supervision.[2,3,12,17] O'Neill[2] argued that the demanding nature of remote northern trauma work compounded by working in isolation may increase an MHP's vulnerability to secondary trauma. Although few remote northern MHPs reported being familiar with the concept of secondary trauma, many identified associated factors such as loss of compassion and feeling exhausted due to a lack of sleep and being in a constant state of hypervigilance.[2] Northern MHPs also reported high levels of distress due to the magnitude of their clients' trauma, as well as struggling to meet the needs of both their clients and their own.[2]

Further research carried out by O'Neill and colleagues[3] found that MHPs working in northern Canada are assigned high trauma case loads with clients who have complex needs. Although MHPs reported being committed to their clients and communities, they faced challenges such as limited self-care resources, insecure program funding and high rates of staff turnover.[3] O'Neill and colleagues[12] then completed a meta-analysis of all their qualitative findings and found MHPs working in remote northern communities needed specific

competencies to carry out this work in order to be able to mitigate the effects of secondary trauma. These included "cultural competence, generalist practice, trauma-informed practice, finding ways to make full use of limited resources, and sustaining strategies".[12] O'Neill and her colleagues[12] also found that MHPs in isolated northern communities who wanted to work effectively and sustainably, as well as independently with minimal resources, needed humility and confidence, which can be difficult as a new worker.

2.6 Struggling to Fit in as a New Mental Health Provider

Workers who are new to working in northern communities often reported feeling culture shock and experienced difficulty fitting in early on.[71,72] MHPs, both outsiders (those who travel in) and insiders (usually community members who reside in the community) faced trust issues with their clients.[12] For example, Indigenous clients reported negative perceptions of non-Indigenous therapists working in their communities, which may be one reason why new workers face challenges trying to fit in.[59] At the same time, insider MHPs reported being initially rejected in their role of helper due to their own history in the community and/or being seen as knowing too much about people in the community.[12]

It was particularly important for outsider MHPs to learn about the community by talking with the Elders and residents in the community.[12] To build trust with clients and work with the challenges of delivering mental health services in isolated settings, outside practitioners had to adopt a generalist trauma-informed approach.[12] For example, MHPs in remote locations often find themselves at odds with their professional Codes of Ethics; particularly confidentiality and dual relationships due to the nature of close-knit communities and their own efforts to connect and fit in.[12,16,17,36,73]

MHPs needed to be trained in trauma-informed care to identify symptoms of trauma, and to determine appropriate intervention methods for both client and helper.[12,74] As well, agencies needed to work together to develop programs for health workers, which included the necessary education and direct practical experience in rural placements, along with sufficient funding for travel and accommodations in order to better prepare them to work in a rural setting.[12,74] By meeting the needs of MHPs, the necessary supports required to deliver long-term services in northern communities can be provided.[8] The isolation of remote practice needs to be addressed

so that workers, as well as practicum students in rural communities, can be supported to successfully carry out the work.[75]

A recommendation from the AFN was to establish a process to support "existing and future providers from Western-trained programs in developing cultural safety, trauma-informed practice approaches, harm reduction skills, as well as a deep historical understanding of First Nations health, ongoing colonization, intergenerational trauma, and its effects."[11] It could be argued that training such as trauma-informed practice could be beneficial to the well-being of both insider and outsider MHPs who provide trauma counselling in NSFNCs.

2.7 Trauma-informed Practice Competency in Remote Northern Communities

MHPs working in remote northern communities in Canada have identified wanting to incorporate trauma-informed practices into their work as a strategy to support and protect their emotional and psychological well-being.[12] Trauma-informed practice competency includes understanding the symptoms of trauma, the impact on clients and helper, methods of treatment,[74] and the self-care needs of practitioners.[76] Supporting MHPs to participate in training not only helps them to stay current in their skills, but also provides them relief from the daily stress of clinical practice.[76] Being trauma-informed includes "having cultural competence regarding the traditions and practices of any specific culture. When working with Indigenous peoples/First Nations, an understanding of their cultural practices is essential in promoting and understanding the healing process".[77] As well, crisis-based responses to mental healthcare requires an "informal caring network which includes family members, Traditional Healers, and friends".[78]

Shepard and colleagues[79] wrote that we need to recognize the significance in building trusting relationships with Indigenous clients. Further to building strong relationships, MHPs must also have a broad understanding of "the traditional worldview of Aboriginal People".[80] There is a concern that "without adequate understanding and respect for Aboriginal cultural and values, the therapist may mistakenly try to change core cultural values of Aboriginal clients".[80] The lack of knowledge or understanding that a multitude of Indigenous values and world views exist could result in unknowingly causing additional distress on the person seeking help.[80] McCormick[80] suggests a potential solution is to develop a relationship or partnership that is balanced, complementary, and cooperative. To not only provide safe services to their clients, but to protect their own well-being, MHPs must be trained in "cultural competence, cultural safety…

and trauma-informed care".[70] The study conducted by O'Neill and colleagues[12] determined that protecting the well-being of MHPs was instrumental to supporting their ability to provide services over the long-term. Health providers need to engage in a process of self-reflection regarding their personal values, as well as their cultural principles when working with Indigenous peoples.[22]

2.8 Strategies to Support and Protect the Well-being of Northern Mental Health Providers

Although northern communities have difficulty retaining MHPs, there was an overall lack of information on what was needed to support their emotional and psychological well-being to carry out this work.[81] In "Native American teaching it is told that each time you heal someone you give away a piece of yourself until at some point you require healing".[82] This statement resonates with the importance of supports, particularly in a role in which conveying empathy is crucial. MHPs in their helping roles in northern Canada have identified needing formal supports such as clinical supervision, networking, debriefings, secondary trauma training, expanded client resources; as well as informal supports such as family and friends.[12,83,84] In addition, MHPs have identified needing case loads that contain a mixture of both trauma and non-trauma clients in order to prevent STS.[57]

Further, in a mixed methods longitudinal study, lower rates of secondary trauma were found in members of a multidisciplinary trauma recovery team with a positive team experience, staff supervision and support.[83] As well, Goodwin and colleagues[85] argue an interdisciplinary team approach should be a job expectation for mental health workers in northern Canada to not only meet the needs of the community, but also to reduce their own isolation from professional supports.

An additional method of supporting practitioners has been identified as a 'community of practice'.[86] The term 'community of practice' was established by Jean Lave and Etienne Wenger,[10] and was defined as "groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly". Further, it needed the following attributes: a common purpose or concern for those involved; participants must create relationships that support their capacity to learn and offer learning to others; participants are professionals working together to build capacity by sharing solutions to reoccurring issues; and a forum to discuss their experiences and methods of practice.[10] 'Communities of practice' support

the growth of innovative methods of practice and encourages people to improve their skills.[86] An effective method of evaluating the need for a 'community of practice' is by hearing peoples' stories to obtain the necessary information in order to understand the needs of individuals working in diverse settings.[86]

Self-care was also a significant factor in the well-being of MHPs, and must be acknowledged.[76] Nelson-McEvers[87] defined self-care as learned patterns of action and strategies carried out by people to preserve or protect their overall health. Self-care was also strongly associated with the capacity to adapt to challenging situations.[88] Further, it required MHPs to find ways to detach from their clients' trauma stories, as those who are able to do so were the least negatively impacted by their work.[89]

Trauma workers have indicated that they want increased supports to protect them from STS.[90] In a scan of over 4000 citations referencing MHPs reporting compassion fatigue, STS and/or vicarious trauma, very few examined the capacity of support strategies to prevent or mitigate secondary trauma symptoms[90] Further, to protect workers from STS, it may be necessary to screen potential employees to determine their suitability for trauma work and require employers to develop supports for health and well-being in the workplace.[58] MHPs require confidence, competence and compassion, with the emotional capacity to cope with the demands of trauma work.[58] Those with higher levels of perceived competence in their skills were less likely to report burnout or compassion fatigue.[91] Compassion satisfaction is fulfillment from assisting others in their job, positive relationships with co-workers, and the ability to support workplace wellness (and more broadly, in one's world). All of which may help to protect workers from compassion fatigue and burnout.[43] It could therefore be argued that being competent in one's skills including being trauma-informed were crucial to providing trauma support to clients in northern communities, and helped to protect MHPs from STS.

In summary, making evidence-informed practice recommendations to mitigate the emotional and psychological impact of working in NSFNCs requires an in-depth understanding of the lived experiences of MHPs. Although this background review provided valuable information to help guide this project, it also indicated an overall lack of information specific to MHPs in NSFNCs. Individuals with lived experience are the experts in understanding and transforming their work because they know the specific nuances of their situation.[92] In order to

better support clients in healing their trauma, counsellors themselves require safeguards in their workplaces to shield them from STS.[70] More importantly, the Mental Health Commission of Canada cited [93] "labour laws, occupational health and safety, employment standards, workers' compensation, the contract of employment, tort law, and human rights decisions are all pointing to the fact that employers must provide a psychologically safe workplace".

The emotional needs and well-being of MHPs working in NSFNCs was a legitimate concern and arguably requires psychologically safe workplaces. Exploring the needs of MHPs in NSFNCs will provide key information to understanding what supports they require in their role as helpers. With this knowledge in mind, an important first step was to understand the impact of trauma-informed care/counselling on MHPs. This allows MHPs to make evidence-informed decisions to identify what is needed to support their health and well-being, and in turn, improve the work environment within northern healing systems. Without hearing their stories, the information that is critical to understanding the impact of the work and what is needed to support them is lacking. It was imperative to give MHPs working in Saskatchewan an opportunity to share crucial information so that others can understand the challenges of working in NSFNCs and the impact of the work on the health and well-being of these individuals, as well as to identify what is needed to support them being able to sustain trauma work over the long-term. Thus, this project will bridge this gap in the literature.

Chapter 3
Research Methodology

The primary focus of the project was to work in partnership with participants by building a trusting relationship to gather their stories, and in turn to transform the way they were supported in their work as MHPs in northern Saskatchewan. Therefore, the following paradigms provided a foundation for this project: social constructionist (realities are created through the interplay of relationships) and transformative (research changes both the researcher and participants; knowledge is collectively generated).[94] In order to work within social constructionist and transformative paradigms, it was imperative to adopt a methodology that supported building strong relationships with participants. As such, to answer the research questions in this project, an embedded MMR design incorporating both qualitative and quantitative methods was anchored within PNI. PNI supported a process for participants to work collaboratively with me to develop methods for data collection and analysis.[95,96] PNI supports participant engagement throughout the research process, including generating meaningful and beneficial recommendations for change.[95] PNI also supports both qualitative and quantitative means of gathering stories.[95] Furthermore, qualitative research is inductive and deductive, allowing patterns to emerge from the data and then refined through a continual iterative process between the researcher and the data, as well as with participants.[97]In order for you, as a reader, to understand the research process, I will outline how the chosen research methods were guided by the social constructionist and transformative paradigms.

3.1 Guiding Philosophical Assumptions: Social Constructionist and Transformative

For the purpose of transparency, I will explicitly state the philosophical assumptions of this project specific to methodology (process by which we acquire knowledge), epistemology (theory of knowledge/how we know reality), ontology (theory of reality/what is real), and axiology (values of the researcher).[97,98] The epistemology of a qualitative approach supported the building of trusting relationships with participants (MHPs) in this project in order to gather in-depth information/knowledge regarding their unique experiences and to reflect individually, as well as collectively, on their meaning.[97] This project's ontology is that a multitude of realities exist that are relationally/socially co-constructed and transformed as a result of our experiences/interactions, including those that occurred during this project.[94,97,99] The axiology or

beliefs I bring to this project, and their implications are also openly discussed in this Dissertation. As such, I bring all my life experiences as a social worker and an MHP working in a NSFNC to this project. In addition, each participant adds their own life experiences. It is through this interaction that participants were able to co-construct their stories and make recommendations.

3.1.1 Social Constructionist

Through a social constructionist paradigm, truth or knowledge is generated relationally through interactions between people, the broader world, and as part of a research project.[100,101] Therefore, the lived experiences of MHPs are seen as a product of their influences at the individual and societal levels. Collaborative engagement was also incorporated throughout this project to capture stories directly from MHPs working in NSFNCs, while recognizing the knowledge and biases of both myself and the participants.[101] Therefore, within this project, I documented my position as being female, a researcher, a social worker, and an outsider MHP working in NSFNCs. This background knowledge provided me with valuable insights to guide this project and to build a safe, supportive, collaborative, transformative climate to engage with participants. Participants stated that they appreciated knowing that I understood what they were talking about, and indicated that they felt at ease sharing their stories. In addition to understanding what influences our perspectives, it was also important to understand how generated knowledge can be utilized in a transformative way.

3.1.2 Transformative

The philosophical underpinnings of a transformative paradigm were based on collaborative participation; co-created identification of barriers/challenges and a collective process for advocacy and change.[102] Everyone in the project was transformed/changed as a result of the relational nature of the research, the generation of new information and the circumstances during which the research took place.[103] A transformative perspective fosters a process for participants and the researcher to work collaboratively to co-create a safe/supportive environment and to gather sustainable knowledge based on the following strategies: to share the generated learnings/knowledge; to build awareness and capacity at the individual/group level to create meaningful results; and to co-create practical outcomes/recommendations.[104]

I will now provide an overview of this project's research design, methodology and methods. This information will help you as the reader to understand how this project was developed through a social constructionist and transformative lens to support a participatory process with participants and the CAC. Please refer to Figure 3.1, as it provides a visual summary of the research process to guide you.

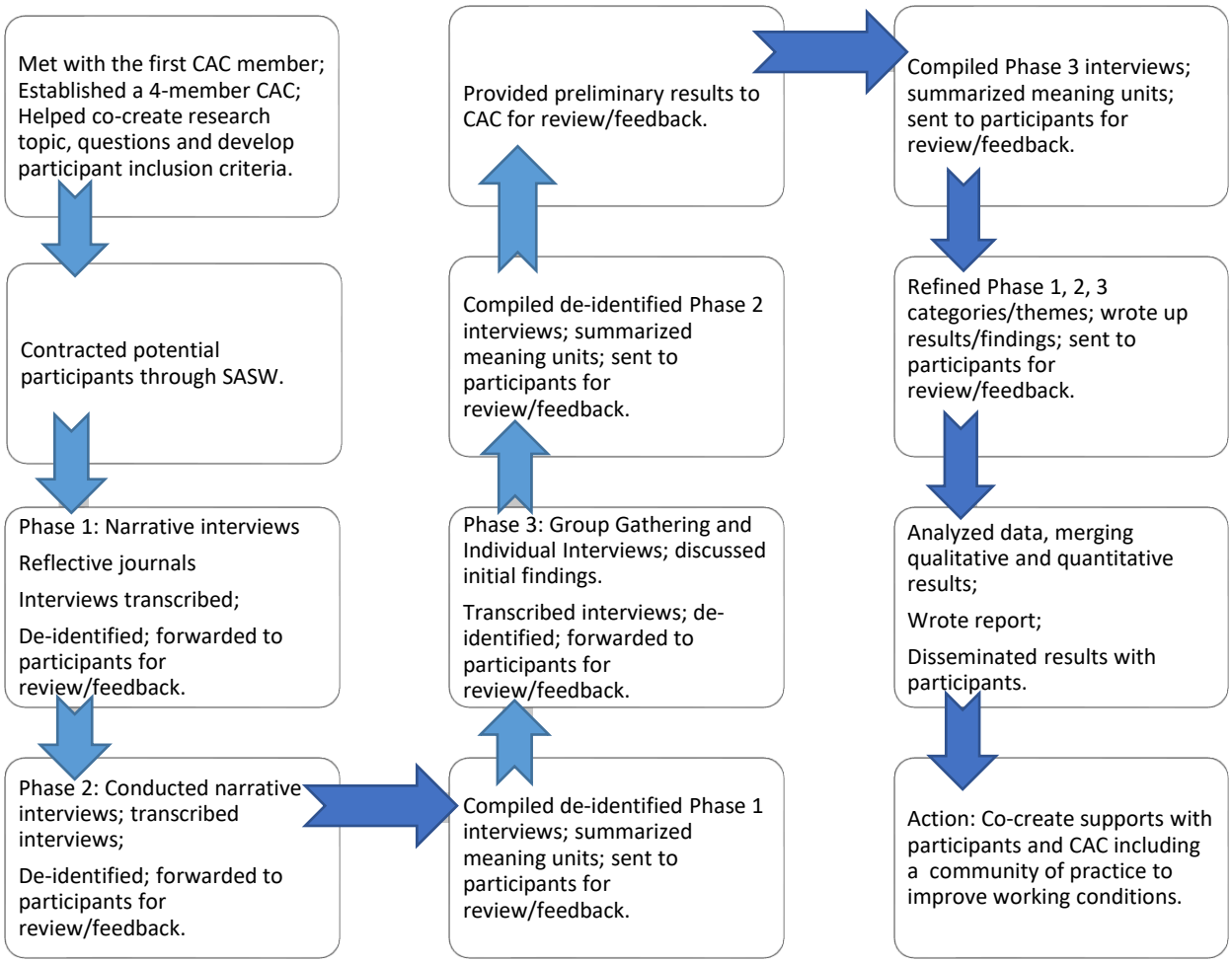

Figure 3.1: Research Design Process Summary

3.2 Embedded Mixed Methods Research Design

An embedded MMR design was utilized in this project. In an embedded MMR, two types of data (associated with one another) are collected, such as quantitative data, which compliments the qualitative data, with results combined to better understand the findings.[105] Embedded MMR is a convergent design that contains data from both methods collected during the same interview, analyzed separately, and then merged in the results.[106] The most often used definition of MMR is gathering data in a project through quantitative and qualitative methods, and then bringing findings together for analysis and interpretation.[107] MMR provides a process for merging qualitative and quantitative methods to generate innovative, validated and contextually-based findings about health.[105]

MMR historically emerged in a number of stages, beginning with the formative stage from 1959 to 1979 to the reflective stage between 2003 and 2011.[102] Combining qualitative and quantitative methods were viewed, for the most part, as acceptable until concerns of compatibility emerged in the 1980s.[108] MMR continued to evolve over the years and is currently recognized as a distinct method that can be utilized to combine qualitative and qualitative methods.[106,107]

MMR designs have complexities that might be better suited for more experienced researchers.[102,106,109] A number of steps are unique to MMR, including data collection methods, timing of their collection, the way data strands are analyzed, and the way results from each strand are integrated.[105] Integration is most often used in MMR instead of triangulation.[110] Integration is the point at which the findings from each method used in the study are linked.[111] Integration can take place during the data analysis phase of a study or at the conclusion.[112] Because there appears to be no clearly-defined method for integrating results in a MMR study,[113] the location where the strands of the study are integrated is very flexible, and will depend on the project's questions.[111]

MMR is innovative, and as such it supports collaboration and building relationships, much like CBPR, which can lead to transformation.[114] Using MMR creates an opportunity to gather the information needed to understand the impact of working in NSFNCs as an outsider MHP, that could not have been answered by a stand-alone qualitative or quantitative project.[106,115] In addition, the design of embedded MMR supports examining similar variables so

that the results can be compiled and presented with much more confidence/accuracy than using only one method.[113] Qualitative data collected through narrative inquiry provided in-depth stories about MHPs and the impact of their experiences; while quantitative data provided information specific to rates of compassion satisfaction and compassion fatigue.[43,106,116]

3.3 Participatory Narrative Inquiry

PNI was created by Cynthia Kurtz[95] who encouraged participants to work with their stories, emotions and beliefs to understand their experiences in order to make informed decisions. Within PNI, participants determine what is important in their story, provide the interpretation, and discover emerging patterns.[95] To better understand PNI, an overview of its principles will be discussed:

- PNI supports participants to work collectively in order to make more effective choices.
- The PNI process needs to be engaging and fun.
- The goal of PNI is to connect participants' stories to their intended recipients (agencies and policy-makers).
- Participants are the experts regarding their own experiences.
- Researchers should not interfere with participants' stories, such as removing key aspects including emotions, or melting the stories down into one story. Disagreements and differences of opinions should be supported, as they lead to innovative ideas that would otherwise be missed.
- The needs of participants are most important in a project; therefore, be creative and adjust the process as warranted.[95]

In light of the above, PNI was utilized throughout this research so that I could create a safe space for participants to share their stories and begin discussions on how to take them forward to the appropriate agencies and policy makers.[95,117] How narrative inquiry and CBPR are merged within PNI will be further discussed to help you as the reader to better understand how I utilized these approaches to more effectively support/encourage participants to be actively involved in the research process.

3.4 Narrative Inquiry

Narrative inquiry is the study of a particular phenomenon, through a person's stories and lived experiences.[97] Narrative stories are collected with participants through a co-constructed process that emerges from both the researcher and the participant.[95] Narratives are an individual's story about their experiences and can be retrieved through a number of methods such as interviews and journals.[97] In this project, the narrative stories of participants, specific to their experiences working as MHPs in NSFNCs, were gathered through individual and group in-person, semi-structured interviews.

The level of information shared by participants in narrative inquiry will depend on whether the researcher has created strong trusting relationships with them.[118] Participants can be identified and supported to be co-researchers in a project, as the knowledge generated is their understanding of the phenomenon under project.[119]

People will sometimes separate themselves and their stories from the broader surrounding contextual information.[120] Therefore, in narrative inquiry, researchers work interactively with participants to generate not only the story, but to include both their personal and broader contextual information (e.g., time, place and history).[121,122]

Peoples' told stories can awaken the emotions of the listener, helping them to better understand the actions of the story-teller.[123] Thus, a story is not only about the speaker, it is also about the listener. Wang and Geale[124] explained that "Narrative inquiry is not simply storytelling it is a method of inquiry that uses storytelling to uncover nuance. Stories heal and soothe the body and spirit, provide hope and courage to explore and grow. The process of storytelling a fundamental element in narrative inquiry, provides the opportunity for dialogue and reflection, each intertwined and cyclical".

Within narrative inquiry, researchers must be transparent and truthful with participants, as well as with themselves, about their stories.[121] Clandinin[125] stated: "We, as inquirers, need to pay close attention to who we are in the inquiry and to understand that we, ourselves, are part of the storied landscapes we are projecting…We are living and telling of who we are, and are becoming, as we begin our narrative inquiries with participants…These initial inquiries into who I am, and am becoming, in and through the narrative inquiry, allow us to come to the questions of justification: the personal, practical, social, and theoretical justifications that allow us to

respond to the "so what?" and "who cares?" As such, narrative inquiry provided a process for gathering participants' stories. At the same time, I was careful not to share my story and limit my responses to avoid interfering with or influencing how participants' stories were told. To support participant involvement in the process of developing this project, a community-based participatory research (CBPR) approach was utilized.

3.5 Community-Based Participatory Research

CBPR supports working with communities to strengthen their capacity for better health outcomes.[124] Community in this project is defined as outsider female MHPs who have delivered trauma-informed care/counselling in NSFNCs. As discussed earlier, although I am a member of this community, I see myself in the role of researcher in this project.

CBPR recognizes the significance and strengths of community, and honors respectful full partnerships in all aspects of the research process.[96] As such, CBPR fits within the collective goals of this project as follows: to understand MHPs lived experience, to identify what is needed to support their well-being and improve the quality of their work environments in NSFNCs, and to establish a process for action in order to move project recommendations forward. Further, the principles of CBPR include:

- Community - as part of a person's identity (individual and collective);
- Must add to the assets and relationships of a community;
- Builds partnerships throughout all phases of research;
- Knowledge generates action;
- Creates an empowering environment;
- The process is iterative as well as being cyclical;
- Looks at health from an individual and broader social system perspective;
- Creates knowledge that is beneficial to all involved with partners reviewing information prior to it being forwarded to publication. [126]

Therefore, CBPR creates an environment to not only answer the research questions, but also creates synergy through a collective process that could not be accomplished individually. Partnership synergy is defined as bringing together the ideas and abilities from each person to reinforce the collective and lead to transformation.[127] Lasker and Colleagues[127] referenced a 1989

report in which Gray determined that synergy transcends from a productive discussion of divergent ideas amongst a group of people leading to more innovative ways to solve problems than by working alone. Furthermore, collaborative thinking is also transformative.[127]

Within participatory research, creating knowledge through interpretation (self-reflection and dialogue) provides people the opportunity to understand each other both emotionally and intellectually, and to connect at a deeper empathic level.[128] Interpretive knowledge leads to relational knowledge, which supports building long-lasting relationships.[128] Long-lasting relationships between participants supports a collective process for transformation - much stronger than individuals acting alone.[127]

3.6 Patient-Oriented Research

Funding for this project was obtained through the Saskatchewan Centre for Patient-Oriented Research (SCPOR). Patients include, but is not limited to "individuals with personal experience of a health issue and informal caregivers, including family and friends".[9] In the context of patient-oriented research (POR), it must be stressed that not everyone experiencing distress enters into the patient role. In this project, MHPs are professional therapists having more indirectly entered into the role of patient due to their risk of experiencing high levels of distress as a result of their role in the context of NSFNCs. This project focused on the impact of the work on the well-being and strategies to support MHPs. In order for a project to be considered POR, it had to meet the following criteria:

- It must be inclusive and engage patients and their perspective throughout the project.
- It must have adequate supports and be flexible to ensure that patients are provided with a safe space to be involved.
- Everyone's input and expertise are acknowledged as having value, and is respected.
- Everyone (patients and researchers) works together to identify not only problems, but to co-create/co-build solutions; while working cooperatively towards their implementation.[9]

The method by which this collaborative methodological process is brought together will be discussed next.

3.7. Building Meaningful Participatory Social Constructionist/Transformative Research

The research design, the methodology and the methods were chosen in this project through the social constructionist and transformative philosophical underpinnings. As stated at the onset of this dissertation, to answer the research questions and acquire the co-created knowledge to fill the gap in research and answer the research questions, a relational/interactive/ cooperative process was needed. This was instrumental as a foundation in order to collectively generate recommendations and begin developing supports. The participants and I want everyone to know that knowledge can be generated and translated through an authentic collaborative process where everyone is engaged in all aspects of the research process, including the documentation and dissemination of results. The epistemological and ontological factors informing this research were as follows: knowledge was generated through an inclusive participatory process where relationships can endure beyond the research interview; the research and the transformation must be meaningful for the researcher, but more importantly for the participant - otherwise, one could interpret the research process as one-sided and a form of exploitation. Therefore, an embedded MMR design was employed utilizing PNI to authentically support the voice of participants to better understand their experiences and to make recommendations to transform the way they are supported in their work.[129] PNI was utilized throughout this project, as it weaves together community-based participatory research (CBPR) and narrative inquiry (refer to Figure 3.2).[95] Further participatory research supports a process for collaboration, which results in empowerment, transformation and healing.[95,130-133] Finally, an embedded MMR design allowed me to incorporate an additional method of inquiry to complement and explain the quantitative ProQOL-5[43] findings in a meaningful way with the narrative interviews.[107]

This project was administered in three phases guided by the social constructionist and transformative paradigms, and a PNI methodology through an embedded MMR design in order to meet the needs of participants in this project and to best answer the research questions.

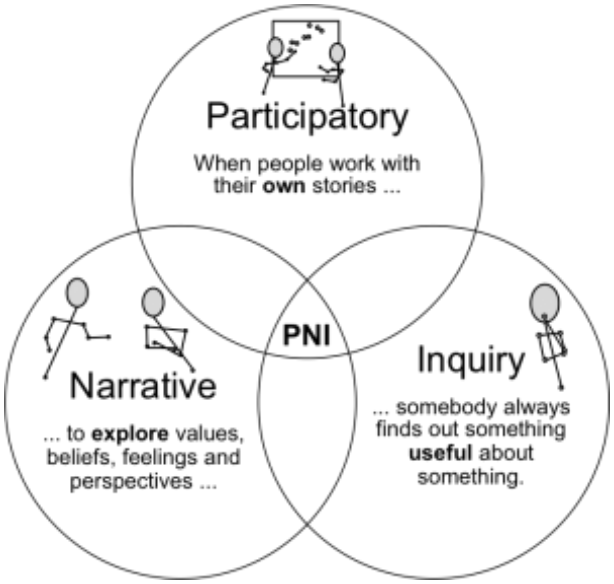

Figure 3.2: How CBPR and Narrative Inquiry fit within PNI [95]

3.8 Purpose of This Project

- To explore how delivering trauma-informed care/counselling in northern Saskatchewan First Nations communities (NSFNCs) has impacted/changed female outsider MHPs; as well as how they make sense of the work.
- To identify needed supports to mitigate the work demands and the impact on well-being in order to provide sustainable trauma work within isolated northern healing systems.
- To begin co-creating a sustainable 'community of practice' to support MHPs in order to improve the quality of the environments in which they work.

3.9 Research Questions

- How through the lived experiences of female outsider MHPs working in NSFNCs can we better understand the impact of delivering trauma-informed care/counselling (e.g., secondary trauma), and how can we initiate opportunities to improve supports?
- How can sustainable supports be co-created with participants, including a 'community of practice' to protect/improve the well-being of MHPs working in NSFNCs, to improve the quality of their work environment, and in turn, to improve the quality of services for clients?

3.10 Gaps in Current Research

There are currently a number of gaps in the literature specific to MHPs working in northern Saskatchewan. This includes research specific to the lived experience of outsider female MHPs working in NSFNCs, research on the impact of trauma-informed care/counselling on the well-being of female outsider MHPs working in NSFNCs, and research in partnership with a community of MHPs to begin co-creating a sustainable 'community of practice' through a process of relational knowledge.[128]

3.11 The Development of Methods for Data Collection and Analysis

As previously discussed, this project initially focused on the PNI principles of CBPR to develop a strong foundation to authentically engage with a "community of participants". This included recognizing their expertise through their stories about their lived experiences, and to co-create recommendations for strategies to support their well-being. In order to conduct participatory research that incorporated an embedded mixed-method design, CBPR, narrative inquiry and POR, it was necessary to utilize PNI in this project.[95] The following is an explanation as to how this process was carried out.

3.12 Sampling Procedures

Through my own observations and consultation with the CAC, it was determined the most typical MHP in a NSFNC was an outsider, female Social Worker. MHPs providing trauma-informed care/counselling in NSFNCs are most often women with a Social Work background, who travel into a community in which they do not reside to provide services. Therefore, upon recommendation from the CAC, only women were interviewed in this project. A sample of ten female MHPs who identified an interest in the topic of the project were selected to provide in-depth narratives that could only be accomplished with a limited number of participants.[134] Therefore, it was decided to utilize a purposeful sample of ten female outsider MHPs.[135] It was important that the sample size be small enough to allow for multiple narrative interviews, while at the same time support the building of safe trusting relationships over time, with the goal of generating rich data.[136] Inclusion criteria was as follows: social workers registered with the SASW; FNIH-approved; previously worked in a NSFNC (north of Prince Albert); and travel into a community to work (not a resident of that community). Participants were invited to take part in this project until saturation was reached, meaning no new information was emerging from the

sample.[137] Saturation appeared to be reached with a sample of nine MHPs as familiar patterns were emerging with no apparent new information. This was confirmed with an additional participant interview, increasing the project's final sample size to ten. This purposeful sampling strategy focused on individuals who would most typically experience the phenomenon under examination.[135] This sampling decision was based on recommendations from the CAC, informal conversations with MHPs, and my own informal observations. On March 14, 2019, I forwarded a recruitment e-mail to SASW. The administrator with the SASW forwarded the following e-mail to all registered social workers in the province of Saskatchewan, requesting that participants who fit the inclusion criteria contact me.

> Good morning,
> Wanda Seidlikoski Yurach, an SASW member is taking on a research project as part of her requirements to completing her PhD in the Health Sciences Program, Department of Medicine at the University of Saskatchewan. She is facilitating a community-based participatory research project on developing a community of practice to support the well-being of mental health providers working in remote northern Saskatchewan First Nations Communities. She plans to interview female registered social workers approved as mental health providers by First Nations Inuit Health Branch that have travelled into remote northern Saskatchewan First Nations communities (north of Prince Albert) to deliver trauma-informed care/counselling.
>
> If you are willing to participate or require further information, please contact Wanda at was933@mail.usask.ca

Within the first four hours, fifteen people had responded to the e-mail and within the first 24 hours, 17 people had responded. I reviewed all the e-mails from potential participants and responded to each of them. Individuals who met the inclusion criteria were forwarded a consent form outlining the details of the project (Appendix A). If I was not sure if an individual fit the inclusion criteria, I responded with a follow up e-mail requesting further information. Individuals clearly not meeting the inclusion criteria were sent an e-mail thanking them for their interest and were asked to contact me if they had any questions. For example, two males responded to the recruitment e-mail. Because of the overwhelming response to this project, I would suggest broadening the inclusion criteria in future studies.

3.13 Data Collection Procedures

A series of three interviews were conducted with each of the ten participants in three phases, which took place between April 2, 2019 and January 4, 2020. This included in-person individual and group interviews, phone interviews, and e-mail correspondence. I made every effort for the interviews to be in-person, but with MHPs living throughout Saskatchewan phone calls and e-mailing was required in Phase 3 of this project. Multiple interviews were needed to build the necessary rapport and relationships with participants to gather the rich information required to answer the research questions.

Participants were provided with a $50 gift card as an honorarium each time they were interviewed; as well as payment for mileage, meals and parking, if needed. Even if participants withdrew at any time during the each of the interviews, they understood they would still receive the honorarium. Refreshments and a light snack were made available during the interview. A meal was also provided to participants during the group gathering.

Since all ten MHPs participated in every phase of this project, I had a participant completion rate of 100 percent. It was important for me to create a safe communicative space in this project so that participants would be willing and able to share their stories.[117,138,139] To accomplish this, I needed to take the necessary time to create a safe space for participants to authentically engage in this project. CBPR was used to create a safe space for collaboration and partnerships throughout all phases of this research space.

3.14 Creating a Safe Communicative Space

It is important in participatory research to create a safe space for open communication and meaningful discussions with participants.[22] In order to conduct interviews and build relationships within this project, it was necessary to develop a psychologically-safe communicative space.[117,138,139] Building psychological safety involved encouraging participants to take part, and nurture their confidence and capacity to self-reflect.[139] A communicative space provides a place of safety for participants that supports open dialogue for reinterpreting the lived experience of the phenomenon being studied.[22] Developing a safe space in participatory research means creating an environment that is welcoming, with each person's attributes and skills being recognized, all the while encouraging people to engage in a process of critical self-reflection.[140]

In this project, I took the following necessary steps to create a safe communicative space to support participants to share, and to reflect on their stories:

- Provided interview information and consent forms to participants prior to the first interview.
- Informed participants that taking part in the project was voluntary.
- Participants were encouraged to choose their interview location.
- Took time at the beginning of each interview to build rapport and ensure participants were comfortable.
- Asked permission of the participants to audio-record the interview, and let them decide on the starting point of the audio interview.
- Provided a list of counselling supports to each MHP during the first interview.
- Requested that all de-identified interviews be reviewed by participants; once they agreed on its accuracy, they made the decision to sign off on the transcript release.
- Co-created data analysis and results with participants using PNI.

3.15 Methods of Data Collection

3.15.1 Narrative Interviews:

Through discussions with the CAC, it was decided that participant interviews would be narrative, semi-structured and open-ended. In-person narrative interviews provided support for MHPs to tell their stories, and to reflect on the meaning of their experiences. It also encouraged exploring innovative methods to improve their work lives, as well as the work lives of other MHPs working in NSFNCs.[99,141] Narrative interviewing is a familiar process to MHPs, as they typically spend much of their time listening to client stories. Therefore, data was collected through interactive, semi-structured open-ended interviews utilizing narrative inquiry to co-construct the stories of participants.[97] Interview questions were not provided to participants in advance of the first two interviews (Appendix D). A more free-flowing authentically co-constructed narrative discussion may not have occurred if the interview had been more structured/scripted.[142] In-person, semi-structured, open-ended interviews were conducted to gather in-depth information from participants to understand the impact of this work, to comprehend how they make sense of their work, and to identify what supports were needed to support their well-being and-improve the environments within which they work.

According to Reissman,[143] stories, when shared with others, are not exactly as they took place but are instead our interpretation; how we integrate or put the story together and how we make the story interesting to others. In addition, relationships are key within an interactional approach in order to co-create or build stories together, as well as their meaning.[143] These emerging stories are the focus of the project, specifically how participants make sense of their lived experiences and responses, as well as how these stories create knowledge and our identity.[144] Kurtz[95] concluded that we co-create stories by breaking down the barriers or bubbles that contain our realities (refer to Figure 3.3). As such, when we generate a story with another (researcher and participant), the story develops through a reflexive process of co-creation.[121] The process of co-creating stories in this project was carried out as follows: I met with participants in a location of their choice and took time to build a rapport and create a safe space for participants' stories to be told.[140] Building a safe space supported participants' stories to move beyond their own enclosed reality bubble (held within themselves) to that of a shared story (outside of themselves), co-created in a relational process with me.[95] This process of breaking down reality barriers was carried out not only with each participant, but also with the merging of the collective stories from participants; thus, generating a new co-created collective story of participants' experiences moving forward.

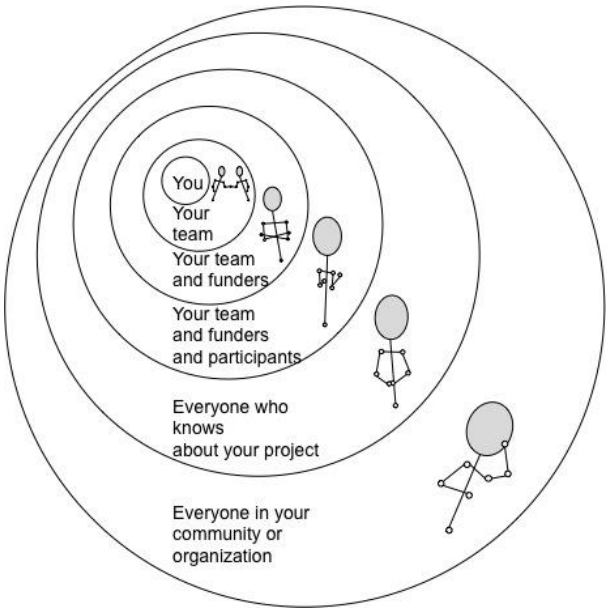

Figure 3.3: Reality Bubbles[95]

A general format or structure was established prior to the first interview to create space for building rapport and safety to encourage the participants' stories to emerge. The structure of each of the narrative interviews was based on the work of Jovchelovitch and Bauer[145], as follows:

Phases	Rules
Preparation	Exploring the field Formulating examinant questions
Initiation	Formulating initial topic for narration Using visual aids
Main Narration	No interruptions Only non-verbal encouragement to continue story-telling Wait for the coda
Questioning Phase	Only "What happened then?" No opinion and attitude questions No arguing or contradictions No why-questions
Concluding talk	Stop recording Why questions allowed Memory protocol immediately after interview (make notes as soon as possible following the interview)

3.15.2 Self-reflection Journal:

Participants were also asked to engage in a process of personal self-reflection through journaling, which was completed at the discretion of each participant. A journaling notebook was provided to participants at the end of their first interview. The journal provided an opportunity for participants to further explore their thoughts, feelings and interpretations regarding their experiences as MHPs in NSFNCs, and to also reflect on being part of this research project. Participants were encouraged to protect the confidentiality of clients and communities by ensuring that no identifying information was included in the journal. I also completed a self-reflective journal throughout this project, which served as an opportunity for me to reflect on the various aspects of the project. This included acknowledging my own thoughts and feelings in relation to hearing participants' stories, and giving myself space to process this information. This

was an opportunity for my own self-care. It was also a means to reflect upon the reasons for each decision made in the project such as methodology, data collection, transcription, analysis, and the way that research processes and findings were documented.[146]

Participants were asked about their reflective journal at the second interview, and then again after the third interview. Although participants stated that the process was helpful for them to reflect on their own thoughts about the process, for the most part, they felt it was easier to e-mail me if they wanted to provide me with additional information. Therefore, no reflective journals in whole or in part were returned to me. I, on the other hand, found reflective journaling useful for my own need to reflect on and document each step of the research process.

3.15.3 Professional Quality of Life Scale- 5

The ProQOL-5[43] is a quantitative measure of quality of life regarding one's work, specific to compassion fatigue (includes subscales of burnout and STS), as well as compassion satisfaction (enjoyment you get from feeling competent in your work). It is comprised of 30 questions using a five-point Likert scale (1 being never, and 5 being very often - see Appendix G). Compassion fatigue applies only to individuals who work in a professional role such as a therapist, and is defined as decreased capacity to convey empathy to one's clients as a result of the demands of direct client contact.[14] Further, compassion fatigue is a secondary stress reaction and secondary traumatic stress (STS) is a construct measure of secondary trauma.[44] STS specific to one's job generally develops quickly, resulting from something perceived as traumatic such as hearing a client's trauma story, and can include feeling fearful, problems sleeping, intrusive images, and avoiding situations that trigger thoughts of the trauma.[121] Burnout, on the other hand, generally develops slowly and is connected with a lack of joy in one's work, as well as an inability to be productive at your job.[121] Participants were invited to complete the ProQOL-5 during their second interview. How all of these methods of gathering data in this project were utilized in each phase is outlined in Figure 3.4.

Figure 3.4: Embedded MMR and Participatory Narrative Inquiry - Phases, Methods

3.16 Data Collection Phases

3.16.1 Phase 1 - Narrative Interviews:

Participants who fit the inclusion criteria and agreed to participate in this project were contacted by e-mail in March, 2019 to arrange a time and location for their first in-person interview. Interviews were initially approved by the University of Saskatchewan Behavioral Research Ethics Board (Reh-REB) on March 8, 2019 to take place in the following locations: University of Saskatchewan, Suite 201B, 115 2nd Avenue North, Macro Building, Saskatoon; and Suite 205, 20 14th Street West, Medical Building, Prince Albert. A Beh-REB Amendment was approved on May 1, 2019 so that interview locations could be expanded to meet the needs of participants. Expanded locations included participants being interviewed at their work office and/or home office, all of which were private locations to insure confidentiality.

In Phase 1, ten individual interviews took place between April 2, 2019 and May 14, 2019. Participants were invited to take part in an in-person interview (approximately 1-1.5 hours); the interview was audio-recorded and later transcribed. To create a safe space, each interview began with introductions and a bit of small talk. For many participants, this was the first time they had talked to anyone about their work as an MHP in NSFNC. As such, their first interview was an opportunity to debrief somewhat. Because I was meeting with participants for the first time and we were just getting to know one another, I took things slowly. Once participants indicated they were settled in and comfortable, I provided an overview of the project and interview process. I then reviewed the consent form, which I had e-mailed to potential participants prior to the interview. I asked participants if they agreed to taking part in the project and having their interview audio-recorded. Upon agreement to participate, the consent form was signed off. I then requested permission to turn on the audio recorder and begin the formal part of the interview. The questions asked in each of the interviews are set out in Appendix D.

The following format was utilized in the first and second narrative interviews to create an open, uninhibited safe environment to hear participants' stories:

- I asked participants directly about their story as MHPs working in NSFNCs.
- I used minimal words of encouragement such as umhmm; okay; and is there anything more? I also answered any direct questions such as, Do you know this person?

- I asked for clarification and further information when there was a natural pause. Questions included: How many years did you work in that community? Can you please describe a typical day?
- There were no 'why' questions during the audio portion of the interview. These were left until the "concluding talk" portion.
- The last question asked before the audio was turned off was, Is there anything, you wish you had been asked in the interview that was not covered? This question was recommended by the CAC and led to a rich discussion as a result of this far-reaching question.
- To complete the interview, the audio recorder was turned off and an informal "concluding talk" discussion took place. This brought the interview process together and ensured the participant was feeling okay before leaving the interview.[145]

The audio-recording device was not turned on during the informal discussion, which allowed for a more relaxed free-flowing conversation to emerge. Participants sometimes used this opportunity to share a bit more of their story, while others discussed what they thought about the interview or moved to a more general conversation. With the audio recording off, participants may have spoken more freely because of the sensitive nature of their stories. Josselson[116] reported that every interviewer should end their interview by asking the participant what it was like for them to talk to you using this type of interview process. This question provided a natural transition to a more informal reflective/debriefing process to discuss what went well, how they were feeling, and what might be changed or improved in the next interview. This also allowed me to check in as to how participants were doing before leaving the interview. I always asked these questions during the concluding talk, taking notes at this time or immediately after the interview. Two examples of recommended changes by participants were to reduce the lighting in the room and to use the word "path" instead of "background" when asking the following question: "Tell me about your background (path)", and "How did you become interested in providing trauma-informed care/counselling in remote northern Saskatchewan First Nations communities?" Two other participants suggested that a question be added about the impact of this work, and what MHPs do for self-care. These were the same questions already scripted into the Phase 2 interviews. This, I would argue, validated that the questions co-created with the CAC were appropriate.

As indicated earlier, participants were provided with a notebook at the end of the first interview to engage in self-reflective journaling throughout the project. Again, it was their choice to journal, to determine what they wrote about, and to decide if they wanted to share any of the information with me. MHPs were invited to provide any components of their journal they wanted to share after Phase 3 of the project. Participants were also given a handout on counselling and debriefing services for Prince Albert and Saskatoon, should they require further support (Appendix E). In addition, they were also told that they could contact me if they experienced any distress resulting from the interview.

All audio-recorded interviews were transcribed by me, de-identified, and then e-mailed to participants for review. De-identified meant blackening out any identifying information specific to names, places, agencies, etc. before being returned to participants in a pdf format. This was an added layer of assurance that anonymity was being adhered to with participants. Once participants agreed on the accuracy of the transcripts, they signed the Transcript Release Form (Appendix C), which they forwarded back to me.

3.16.2 Phase 2 - Narrative Interviews + ProQOL-5 (embedded into interview):

I contacted participants by e-mail to schedule their second interview. Phase 2 interviews took place between September 9, 2019 and October 5, 2019 with each of the ten participants. The second phase took place approximately four months after the initial interview. Participants were invited to take part in a follow-up in-person interview (approximately 1-1.5 hours), also to be audio-recorded. Prior to the second interview, participants were e-mailed a copy of their first interview transcript to review and edit as deemed appropriate. Participants decided where they wanted to be interviewed that supported the creation of a safe space. All interview locations met the requirement of being in a private/confidential setting. The interviews were in-person; open-ended and semi-structured with a number of pre-determined questions. Prior to beginning this interview, I reviewed the consent with participants again and received verbal consent to proceed. I started the second interview by asking participants if their first interview transcript accurately reflected what they wanted to say. Although everyone said their transcript was an accurate reflection of their story, a few participants asked if they could expand on some of their responses from their previous interview.

The second interview questions focused more on reflecting, understanding and sensemaking versus simply describing their experiences. I needed to conduct multiple interviews to build rapport and create a safe space to obtain in-depth responses from participants. This was supported by one participant, who stated that the second interview allowed for "the deepening process, and that maybe some people wouldn't be ready to have this kind of conversation in their first meeting". As well, participants said they needed time between interviews to think about and reflect on their experiences.

During the second interview I provided a bit more prompting to get answers to the questions and to get to the meaning and sensemaking of the stories about their work. After a series of open-ended questions, I turned off the audio-recorder in order to have the participants engage in completing the ProQOL-5, [43] which measures compassion satisfaction and compassion fatigue (burnout and STS).[43] I inserted the ProQOL-5 midway into the second interview in order to minimize influencing the participants' responses regarding the impact of the work (refer to Figure 3.5).

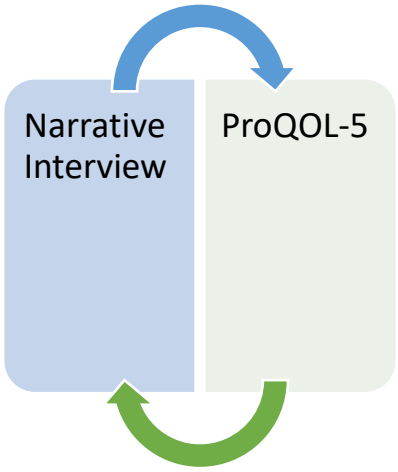

Figure 3.5: Administering the ProQOL-5 Through an Embedded Process

Once the ProQOL-5 self-administered questionnaire was completed, the audio was turned on once again to discuss their results. The narrative interview resumed and participants were asked questions about the impact of their work, as well as their informal and formal supports. Participants were once again asked if there were any additional questions they wished they had been asked during the interview. The interview ended with the informal "concluding talk". All audio-recorded interviews were transcribed and de-identified by me, and then e-mailed to

participants for review and feedback. Once participants agreed to the accuracy of the transcripts, they signed the Transcript Release Form, which they forwarded to me.

3.16.3 Phase 3 - Group Gathering/Individual Interviews:

Phase 3 of this project took place approximately two months after the second interview. All ten participants were invited to take part in a group gathering in Saskatoon on December 13, 2019. Those unable to attend were able to submit their responses to the Phase 3 questions via a telephone interview or e-mail. Prior to the group gathering, participants were e-mailed a compiled summary of the first interview in the project to review and provide feedback. The participants were also e-mailed interview questions in advance of the group gathering, as per their request. Initially, eight MHPs confirmed their attendance, but due to short notice crisis work requests and last-minute schedule changes, only four individuals attended the gathering. The purpose of the group gathering was to bring participants together to connect, interpret the data, and identify roadblocks and well-being support strategies for MHPs, including discussions on co-developing a 'community of practice'. The group gathering was audio-recorded and lasted approximately three hours. Participants unable to take part in the group gathering, or those who chose not to participate, were given the opportunity to be interviewed individually.

The gathering was co-facilitated by myself and my supervisor, Dr. Vivian Ramsden, to allow me to fully engage in the process. It should be noted that inviting a co-facilitator into the gathering process could change the dynamics of the interview. I discussed a co-facilitation process with the participants, and they provided their feedback to me. At times in group sessions, participants become very involved with one another and talk about things they might not normally discuss, which in turn can leave them feeling vulnerable or ashamed, even though the information shared is substantive to the project.[95] I recognized that bringing people together in a group would have some challenges including confidentiality and individuals feeling unsafe or vulnerable; therefore, I reached out to every participant individually to discuss this.

Introductions took place when individuals arrived at the group gathering, and lunch was served. I reviewed the consent process, and once people were settled and agreed to begin, the audio recorder was turned on and discussion began. Phase 3 responses were also gathered through phone interviews with three participants, and e-mail correspondence with three other participants. I received the final e-mail response from Phase 3 of the project on January 4, 2020.

I transcribed the audio-recorded group gathering and typed notes during the phone interviews. The group gathering transcript, phone interviews and e-mail responses were de-identified and e-mailed to participants for review. Participants also signed a Transcript Release Form.

3.17 Data Transcription

Although there is a lack of standardized guidelines for transcription, the individual preferences taken by the researcher must be explicitly stated.[147] As well, your chosen method of transcription should be based on the purpose of the project.[145] I listened to the audio-recorded interviews to be fully present, and then transcribed them verbatim to attain a complete analysis of participants' stories.[118] I personally transcribed each interview verbatim to truly get to know and understand MHPs' stories, and the emerging commonalties between stories. Even though the process is tedious. much can be learned by transcribing data, because it provides an opportunity to become very familiar with the data by becoming immersed in it.[145] I tried to transcribe each of the interviews within a week of the interview.

Guest, Namey and Mitchell[141] argued that the best way to transcribe an interview is verbatim, including every noise, word and gesture. Therefore, with the purpose of this project being to understand the lived experience of MHPs, the impact and determining needed supports, it was crucial to include details in the transcription such as pauses, emotions (tears), anger, voice volume, laughter, every umm/ahh; nonverbal communication such as hand gestures. After transcribing an interview, I would review the transcript while listening to the audio recording to ensure my transcription was accurate. This process resulted in more than 700 pages of transcribed text data.

3.18 Creating a Participatory Narrative Mixed Method Data Analysis Process

Although I discussed interviewing, transcription and data analysis as being separate, they are not; rather, they are connected through a constant state of interplay.[141] Gehart and colleagues[101] explained that statement in the following quote: "Data analysis is the process of making meaning, is a practice of a discourse community that occurs recursively throughout the research process rather than just post-data collection… The process of meaning-making starts when one is deciding to delimit and define the research problem, when one is gathering and reviewing the "pertinent" literature, when one is gathering data and throughout the process of writing. Each interaction in the research process is a decision point in which we make sense of

the data we have at hand. Thus, in collaborative research, data analysis cannot be separated from the data-gathering process itself.…The seemingly innocuous process of researcher and interviewee trying to understand each other is where new meanings, understandings, and realities are created. Thus, the researcher is not getting closer to the participant's "true" meaning, but rather working with the participant to negotiate new understandings… through the joint inquiry process, new meanings are negotiated and emerge for both the participants and the researcher".

Narrative analysis focuses on the components of each participant's story looking for themes to be coded, but also keeps the story connected so it can be examined and interpreted.[146] Riessman[148] stated that for narrative analysis to be considered acceptable, it must inspire the reader to see more than the written story. Narrative analysis does not appear to have a clearly-defined process, but instead is a group of approaches used to understand stories captured in text.[146] These approaches include: thematic analysis (focuses on the content of interview), structural analysis (how the speaker tells the story), dialogic/performance analysis (blend of thematic and structural analysis and the broader environment of the speaker), and visual analysis (what is said/written to reveal hidden aspects of the story and speaker).[148] I created a method for analyzing the narratively-generated transcribed data so that MHPs could engage in an authentic participatory process to make sense of their stories, answer the questions in this project, and move forward in taking their stories where necessary to make changes to support their well-being and improve the environments within which they work.

A combination of approaches can be used when facilitating narrative analysis with the understanding there is no real clear distinction between them.[143] To analyze, interpret and give voice to narrative data, it first must be transformed into text then, based on the definition of narrative, the method of analysis is chosen.[143] In this project, narratives are MHPs stories specific to their experiences working in NSFNCs through a co-constructed iterative process (between participants and interviewer; and between participants). The process of data collection and analysis, although complex, was necessary to carry out this project. Participatory research was needed to authentically engage with participants during all aspects of the project to hear their stories and to answer the research questions. As such, I took the following steps with participants in this project to engage in a cyclical, reciprocal, iterative process to support the principles of PNI.[96,101,126,149]

- Stories were co-created with participants through a series of three semi-structured open-ended interviews.
- In Phase 1, participants were asked to talk about themselves and how they got into their work as MHPs. The first interview allowed participants to get to know me and build rapport.
- Transcripts were de-identified (all identifying information blackened out) then e-mailed to participants in pdf format to review. Participants were asked to add, delete or revise the transcript as they deemed appropriate. When the transcripts were deemed to be accurate and acceptable by the participants, they signed a transcript release form. This process was followed after every interview.
- In Phase 2, participants were asked to make sense of their experiences, to discuss the impact, and to develop strategies to remain psychologically available.
- After the second interview, I created a compilation summary of all transcribed interviews from the first interviews. The summary contained all the identified meaning units from the interviews that were quotes, segments of quotes, or a paraphrased phrase. The stories were synthesized while keeping in mind the voices of participants, and their stories needed come through. This document was forwarded to participants by e-mail for review. This process was completed for each of the following interviews.
- The Phase 1 synthesis was e-mailed to participants prior to the Phase 3 group gathering. Participants were also e-mailed the questions for the group gathering in advance. They were also asked to review the first phase synthesis, while keeping in mind the following questions: What are the most commonly identified issues? What are the roadblocks to solutions to those issues? What is needed to move past those roadblocks, specifically looking at self-care and wellness for MHPs? What are the most commonly-identified strengths of MHPs?
- At the group gathering with four participants, initial findings were discussed. Participants collectively discussed their stories and their strategies for change, and made suggestions as to whom the stories should be forwarded in order to make changes. Participants also answered the questions they were e-mailed in advance in regards to the first phase initial meaning units.

- Everyone who was unable to attend the Phase 3 group gathering was e-mailed and invited to respond to the questions either via a telephone interview or e-mail.
- Analysis was a cyclical process beginning with me generating meaning units. This involved highlighting statements/segments that stood out from the transcripts in each phase, generally in the form of direct verbatim quotes. This information was forwarded to participants for review and feedback, thus supporting a process for clarification and interpretation by participants.[101]
- Based on participant feedback, I then refined the meaning units into codes and categories for each of the phases. The refined categories were sent out to participants for further review and feedback. I then compiled the categories from all phases of the research project, leading to further refinement into themes when appropriate.

Participatory Narrative Inquiry (PNI) was utilized to gather and make sense of participants' stories about what it is like to work as an MHP in NSFNCs, and to think about taking their recommendations for desired changes to the people and agencies responsible for their implementation.[95] A series of phases takes place in the PNI process: collection (participants tell their story about a topic); sensemaking (a group activity or on their own to look at the broader story); return (all the information gathered from participants in the previous phases are provided to participants); planning/catalysis (use of mixed-methods to determine patterns in the stories, and how they are interpreted); and intervention (an action phase through the process of story-telling to practical outcomes/transformation - refer to Figure 3.6).[95] We make sense of stories by converging them and then bringing people and their stories together to create something greater than could have been developed individually.[95] This project has created a safe space by inviting MHPs into a 'community of practice' working together to improve working conditions that could not be attained through individual efforts alone.[10] PNI helped to bring together a group of individuals who came into the project for a variety of reasons and were then able to work collectively to generate a broad range of ideas and solutions to identified issues. The collaborative process of PNI was used in this project to co-create the stories of MHPs, to clarify the context in which they carry out their work, to understand the way they make sense of their experiences, and to engage in a process of transformation and healing that involves building a 'community of practice'[10] (refer to Figure 3.6).

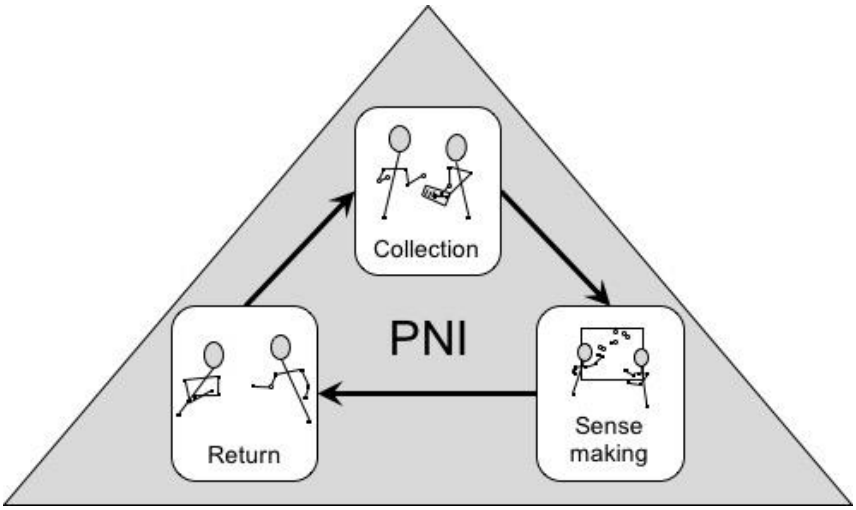

Figure 3.6: Three Phase of PNI [95]

3.18.1 Keeping the Stories Intact:

Participants' stories are central to narrative inquiry and must be kept intact to be understood; therefore, components of the story are needed versus reducing it to thematic coding components.[148] One must also take into account the unit of analysis (entire narrative or sections) as well as the content of the narrative (what occurred, why, and with whom; as well as the meaning of the story).[150] Context is also important because it can have a significant influence on how reality and knowledge are socially constructed.[144] Therefore, in order to analyze the narratives generated in this project, I needed an interactional approach that extracted meaning from the content (what is conveyed in the story) as well as the context (how it is conveyed / relational dynamics).[143] Participants wanted to maintain their stories without compromising anonymity; therefore, I analyzed the transcripts (unit of analysis) in a holistic way (the entire story) by utilizing PNI while examining the interplay between content, context, and themes. How this was able to be accomplished will be described in more detail below.

3.18.2 Content Analysis

Content analysis is a reflective method of continually refining the data into smaller portions of text (meaning units), coding the data (naming the meaning units), categorizing (grouping of codes), and themes (meaning or interpretation of content that is latent).[151] Content analysis includes the following steps: read the transcribed interview a number of times to get to know it; break down your transcribed data into smaller units and refine the meaning units

(smaller portions of text); create codes; and generate categories and themes.[151] The first step I took in this process was to review all transcripts generated from each of the phases a number of times. I then broke the data down from the first phase into smaller segments comprised of participants' quotes. This compiled document of the first interview was forwarded to participants for review and feedback. I followed this procedure for all three phases of the project. Once this was completed, I moved on to creating codes and generating categories.

3.18.3 Generating Codes and Categories:

Coding is a fluid process, in which you identify anything interesting or relevant, create a new code to highlight that which had been discovered or instead add it to an existing code, all the while refining the process as needed to answer the research questions.[152] The process of coding, categorizing and developing a theory is not a linear process, but rather an iterative process that begins with open coding while working towards more discriminate coding, reflecting the deconstructed concepts that are identified; they are then reconstructed into something new and improved.[149] Braun and Clarke[152] stated that codes were adequate when they sufficiently grasped information about the data, and also allowed you to interpret the data. Flick[149] described the following process for coding and building categories:

- Code openly to express data as a concept with narratives grouped together (word or sequence).
- Bring codes into categories that fit the phenomena being uncovered in the data specific to the questions being asked in the project. It is preferred that the categories emerge from the participants' narratives because they are closely linked to the actual data.
- Open coding is flexible in that it can be done narrowly with each sentence, or more broadly with the entire transcript. This will depend on one's preference, the data and the question to be answered in the project.
- Categories that appear to merit additional exploration are carried forward and elaborated.
- Categories are refined: grouped together and integrated. Using a brief description of the story, connections are made to the phenomena under project as well as the categories that have been created. Using a process of constant comparison, the

linkages and connections continue until patterns emerge and the context to which they are applicable.

- This process is considered complete when saturation is reached in that no new information emerges (with the understanding that one has the ability to re-enter).

After receiving feedback from the participants, I then went through the meaning units (smaller portions of text) and began to develop codes from each phase of the project. I then e-mailed participants the initial codes for each phase for review and feedback. Afterwards, I brought the codes into categories, and the categories into themes, until nothing new appeared. I tried to use words or phrases that were generated by the participants as the process for creating each category. I felt this would allow the participants' voices and stories to come through. For example, some of the categories that began to develop and were used by participants were: isolation, lack of safety, and lessons learned. After initially developing these categories, I then sent them back to the participants for review and feedback, which was then used to determine how to move categories into themes. Initial themes were then e-mailed to participants for review and feedback. Each category/theme was supported by quotes from the transcripts.

3.18.4 Narrative Thematic Analysis:

Narrative thematic analysis, similar to content analysis, focuses on narrative content (trying to keep the story intact); while at the same time moving through a continual process of review starting with generating initial codes and leading up to the discovery and a write-up of themes.[148,153] Thematic analysis is a flexible process that works well with complex detailed data, and allows for interpretation and meaning-making.[154] Themes also provide answers to specific questions including: "why, how, in what way or by what means. Therefore, theme names include verbs, adverbs and adjectives, and are very descriptive or even poetic".[151] Narrative thematic analysis supported a process for identifying themes (when appropriate). Although participants identified some themes in the project, data remained at the level of categories more often than not. In order to better understand the categories and themes that emerged while keeping participants' stories intact, it was necessary to include contextual information within the analysis.

3.18.5 Narrative Contextual Analysis:

It is important to focus on this central question when analyzing narrative data contextually: "How does this person, in this context, come to give the account she/he does? How is it constituted? What psychological processes are at work in it? What does it do?"[120] In order to answer this, I needed to review the transcribed interviews in entirety for relational dynamics and overarching themes of the entire interview, keeping in mind societal norms that might influence this process.[120] Lemke[155] argued, "What matters is when and for what it is a context, when and for what it is relevant to constructing/construing the meaning. Contextualization relations are meaning relations; they are the relations we construe/construct to make something meaningful. They tell us what to relate it to, and in what way, and under what circumstances. All meaning is relational. Nothing has meaning in and of itself. Something has meaning only in terms of how we relate it to other things and how we contextualize it. A description of how and when these contextualizing relations are made in a community is a complete description of its meaning system". Therefore, all things constitute context and is based on our own processes or patterns of referencing which is a reflection of our individual and collective experiences in life.[155] As such, each participant will have their own values and beliefs in relation to their own life experiences. With this in mind, I reviewed the data transcripts for references specific to MHPs' values and beliefs, and how they related to working with Indigenous peoples. This included factors that impacted their capacity to work in a NSFNC such as not being well-received as an outsider MHP. I also looked for references specific to MHPs' understanding of Indigenous peoples' history in Canada and intergenerational trauma, current and historical colonial practices in First Nations health services delivery in Canada, and reconciliation processes. I also searched for references to trauma-informed or anti-oppressive practices, and cultural awareness. Therefore, when utilizing narrative contextual analysis within the data, I was drawn to any text from the transcribed interviews that might highlight meaning for an MHP in relation to their work in NSFNCs.

For MHPs in this project, integrating contextual narrative analysis appeared to be a good fit, since social work values focus on the individual in relation to the systems that surround them, which can impact a worker's ability to engage with their client.[120] Narrative inquiry also provided a method for transformation specific to practice, client interaction, communities, and policies.[120]

3.19 Participatory Narrative Inquiry Qualitative Data Analysis

Although the content, context and themes of the stories were important, there was still a piece missing in the analysis. I found this missing piece within PNI. Participants using PNI were encouraged to engage in analyzing their narratives, which can vary from responding to questions or being part of a group gathering to further exploring broader implications of the project.[95] It was crucial for participants to be actively involved in the research processes in order to provide authentic, accurate documentation/reflection of their stories about working in NSFNCs.[156] It was not only the stories that were important, but also ensuring that they were able to convey these stories to the people, agencies and policy-makers who could assist in carrying out the changes/ transformation as recommended by the participants.[95] It has been argued that qualitative researchers must always stay focused on their goal to facilitate change.[157] Therefore, I not only heard the stories of participants (co-researchers) to understand their experiences, but also assured them that together, we will use this information to transform how MHPs are supported so that they can continue providing services in NSFNCs.

3.19.1 Sensemaking and PNI:

Sensemaking is a process of examining what is important in our decision-making processes, and how we might come up with innovative solutions that are both practical and exciting.[95] Participants were given an opportunity to meet with one another and share their stories. As a group, participants are likely to discuss issues that could generate unpleasant emotions.[95] Part of the process of sensemaking is interpreting these emotions and, in turn, exploring what is needed to improve one's circumstances.[95] Because sensemaking is a cyclical process, anyone reviewing the research (including participants) should be able to follow the process without difficulty.[95] Sensemaking occurs at every level of a project from contact to recommendations in order to foster improvement or change. Research carried out by Kurtz[95] concluded that four key components were needed in sensemaking (refer to Figure 3.7), as follows:

1. **Contact** – People in the project are informed of, and agree with, project goals and are full partners. Participants meet as a group and are able to connect with the stories of their colleagues.

2. **Churning** – Participants' stories are brought together through multiple meetings using different methods of engagement. This process helps to generate original ways of thinking and doing.
3. **Convergence** – In this stage, everyone's ideas/stories are brought together through a process of construction, deconstruction and reconstruction. As a result, we are able to discover new and innovative ideas. Bringing ideas and stories together creates something greater than when attempting to achieve it on our own, and is more likely to be successfully implemented.
4. **Change** – To improve our capacity to make decisions collaboratively, it is important to understand that sensemaking in PNI is ultimately about transformation. Hearing people's stories allows us to see the experiences in a different light, and in turn transforms how the stories are told moving forward. Effective collaboration can lead to a ripple effect that occurs as a result of changes that began with the PNI research. This can include reaching other people and organizations, and might lead to improvements in policies, funding and resources.

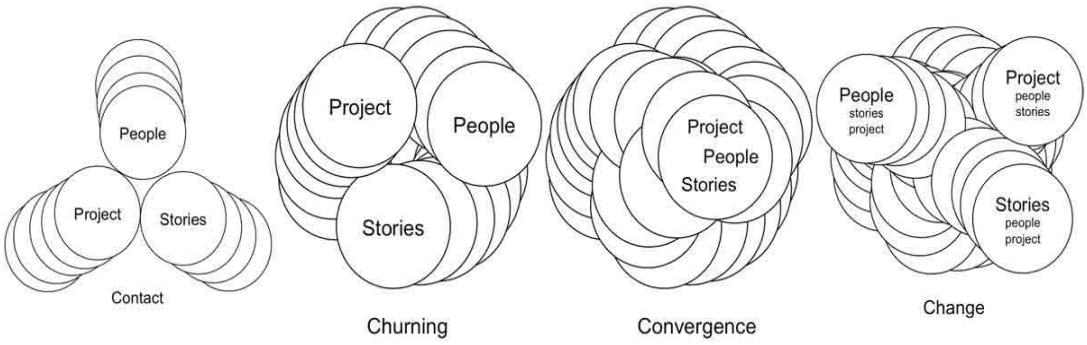

Figure 3.7: Sensemaking in PNI - Transformation and Change [95]

3.20 MMR - Integrating Quantitative and Qualitative Results

The levels of compassion satisfaction and compassion fatigue were analyzed through descriptive statistics in a broad sweeping process to protect the anonymity of participants, as the sample size is very small. The results of the ProQOL-5 were then used as a method of introducing the constructs of compassion satisfaction and compassion fatigue with the goal of generating discussion with participants. For example, participants were able to explain why they

enjoyed their work rather than simply reporting their responses numerically. This provided a process to enhance the quantitative results to better understand participants' ProQOL-5 responses.[102] The qualitative data (narrative interviews) and quantitative data (ProQOL-5) were analyzed independently, and subsequently merged or integrated within the results section of this project; this information is presented in Chapter 4.

3.21 Rigorous Documentation of the Research Process

In qualitative research, it is imperative to be transparent when documenting and explaining the methods utilized throughout the research process.[147] Therefore, in order to accomplish rigor in this project, I have provided a detailed description of the research process including data collection and analysis.[94] I have also kept a journal documenting each of the steps that were taken, and the reasons why they were taken. As well, as previously discussed, all steps were followed to ensure that saturation was established in this project.

Rigor is also about being ethical as a researcher, which includes how we conduct the interview, how we react to participants, and how we make sense of the data.[158] The relational process of PNI required me, as the researcher, to take steps to build trust, respect boundaries, acknowledge power issues. and be flexible in meeting participants' needs.[158]

3.22 Validation Strategies

Creswell [97] defines validation as the way we determine the accuracy of our project results (reflection of what is conveyed in the data), and recommends that at least two validation strategies should be utilized in a project. I used three validation strategies in this project; member-checking, prolonged engagement with participants, and collaboration with participants.[94,159] Member-checking is defined as having participants review how you analyzed the data to instill exceptional standards and integrity in the research.[152] I engaged participants at every stage of the project to confirm that the data was being analyzed accurately.

I was involved with the participants for over a year in order to build trust and rapport, and subsequently to better understand the context of their experiences.[94] In order to gain the required level of connection and time to discuss all interview questions, I needed to meet with participants a number of times.[160] I also worked collaboratively with all participants throughout the research process, including analyzing their stories through a mutually-agreed upon participatory iterative

process.[94] Participants were involved in all aspects of this project. I engaged in a very transparent process with participants and provided them with copies of their transcripts, compiled interview documents, initial meaning units, coding, categories, and initial results for their review and feedback. Kvale[147] states validity should include the following components:

- The research must be foundationally sound with clearly-stated theoretical underpinnings.
- The research design must be appropriate, and the knowledge generated should benefit the participants.
- Participants need to be honest in their stories, and a process in place to check their accuracy. There must also be a high standard of transcription.
- We require an appropriate review of the data with accurate explanations.
- A clear overview of validation strategies must be provided and with whom you consulted and their role.
- Written results must accurately reflect what has been discovered in the project.

Construct validity within an MMR project, particularly for a convergent method such as embedded MMR, must also be established.[159] The ProQOL-5 has an adequate level of construct validity with more than 200 publications (over 100 used the ProQOL-5 or a previous format) and in excess of 100,000 web-based documents.[43] Although each of the constructs in the ProQOL-5 are measured individually, the inter-scale correlations indicated a "2% shared variance (r=-.23; co-σ = 5%; n=1187) with Secondary Traumatic Stress, and 5% shared variance (r=.-.14; co-σ = 2%; n=1187) with burnout".[43] Further Burnout and Secondary Traumatic Stress, although being distinct concepts, had a common feature of distress and demonstrated a shared variance of "34% (r=.58; co-σ = 34%; n=1187)".[43]

I also engaged in a process of epistemological reflexivity in order to evaluate my own assumptions and beliefs, and how they might impact the credibility and accuracy of the research.[101] Although my role in this project was that of researcher, I had to acknowledge and reflect on my own thoughts as an MHP. As a reflective practitioner, my journal was instrumental in facilitating my engagement in a process that allowed me to review my own thoughts and pre-conceived ideas as an MHP.

3.23 Credibility

In order to create a research process that was credible, I worked with participants to co-create data analysis processes that met the participants' needs.[161] To accomplish this, I created a unique method of data analysis that was grounded in PNI, content analysis, thematic narrative analysis, and context analysis. Accountability was also built into this project through participants, the CAC, the Research Advisory Committee (RAC), and me. The results were credible because they were grounded in the stories of participants. Multiple open-ended interviews took place during this project, resulting in an enormous amount of transcribed data. I believe that I provided a combination of pre-determined and innovative methods of analysis in order to establish credibility in the results of this project.[160]

3.24 Ethical Considerations

A Certificate of Approval was obtained from the University of Saskatchewan's Behavioural Research Ethics Board (Beh ID 851) prior to beginning this project.

Anonymity and confidentiality were safeguarded at all times, which was very important because participants are contract workers with annually-renewed contracts with NSFNCs. In light of a general lack of job security, it was important to protect individuals so as not to compromise the capacity to secure contracts as a result of participating in this project.

As this was the first time that most participants shared their story, it was imperative that I design a safe and trusting communicative space. I made sure that it was a supportive space, that the discussion occurred over multiple interviews, and that it was a trauma-informed process. At the same time, all participants ultimately decided what part of their stories was to remain in their transcript. Because participants were involved in all segments of this research, their right to decide whether or not to participate was truly expanded. Finally, all participants were provided with a list of supports, and were invited to contact me to discuss any possible negative responses to each of the interviews. The following statement was included on both the Beh-REB application and the Participant Consent Form:

> Risks expected are no greater than would be experienced in your role as a mental health provider. If you experience any level of distress, you may contact the following resources for follow up counselling and debriefing services. In Saskatoon, you can contact the Community Adult Mental Health programs by

contacting centralized intake at 306-655-7777. In Prince Albert, Adult Mental Health referrals can be accessed through the Toll-Free #1-888-765-6055 or by calling 306-765-6055, with Walk-In Services located at 2345 10th Ave W, Prince Albert. The confidentiality of participants will need to be protected to prevent negative implications for independent contracts with communities. Information regarding your well-being relating to secondary trauma will be gathered, which may bring forward emotional responses.

Chapter 4
Data Analysis and Sensemaking

This chapter provides an analysis of the multiple interviews held with participants. I begin with an overview of the contextual information about participants. I then go on to describe how the relationships between myself and participants developed in this project. This is followed by an overview of the participatory analysis process, and how categories and themes were generated with each strand of data. I then discuss the categories and themes that emerged, and describe the way the quantitative data from the ProQOL-5 is integrated with the qualitative narrative interview data. I conclude this chapter with the categories and themes that are specific solutions to the roadblocks or challenges of the work. To lend to the richness of the findings of this project, each of the categories and themes is illuminated by participants' quotes from the individual and group interviews. This provides a well-harmonized exploration of the impact of MHP experiences in NSFNCs, which underscores the much-needed supports.

4.1 Interview Participants

Ten participants took part in this project. When asked about their background, they provided the following contextual information: All MHPs in this project were female social workers, eight of the ten were non-Indigenous, with five or more years of counselling experience prior to working in NSFNCs. Everyone had a Bachelor of Social Work (BSW), seven had a Master's of Social Work (MSW), and everyone had some level of trauma training such as somatic experiencing (SE®). Participants had fifteen or more years of mental health work experience, with 3 to 24 years of experience working in NSFNCs. All participants were outsiders, meaning that they travelled into the communities to which they provided services, and none were members of their work community.

4.2 Analysis

I worked with participants over the course of almost a year to co-create, analyze and make sense of their stories. Kurtz[95] argues that sensemaking is the most important aspect of PNI, as it encourages participants to understand and generate change from their stories. Multiple in-person interviews, phone calls and e-mails were required to develop a trusting sustainable relationship with participants who then shared their incredibly rich stories. Once the stories were

shared and participants were confident that their transcripts were accurate, we began a collaborative iterative process to analyze the vast amount of data generated through the interviews. Participants worked with me to determine the commonalities, codes, categories, and themes in this project. Because PNI guided this collaborative data analysis process, participants were in charge of deciding their level of involvement in the analysis. All participants provided some level of feedback, though the level of input ranged from providing input at every opportunity to more infrequent responses. As well, the method of feedback varied from phone calls, texts or e-mails. As discussed in the previous chapter, data analysis involved the integration of content analysis, contextual narrative analysis and thematic narrative analysis. The results of this process are captured in the following discussion, beginning with the significance of the stories themselves. For many of the participants in this project, the process of simply talking about their work was something new. The reasons for their silence will be discussed next.

4.3 Silent About the Work – We Are Finding Our Voice

"My loyalty is with the community because I see their capacity and I see that the outside people...They just don't get it. They don't understand the day-to-day stuff and so I feel protective. I guess of the community…I can say it to my close colleagues my frustrations cause, I know it will stay there. It's a way for me to figure it out and get rid of it and see if there's stuff I can do to create change within my work-place".

For many participants, recounting their experiences in NSFNCs for the first time was difficult for a number of reasons. They discussed the reasons why they have been silent. Firstly, their contracts stipulated that they must refrain from speaking about the community in a negative way. Secondly, MHPs are very loyal and protective of the First Nations communities in which they work. Thirdly, they explained that it was engrained early on in their career to refrain from speaking negatively about their employer (agency). One person said, "You're taught to keep your mouth shut", while another stated:

> "I think that's been drilled into me since I first went into the profession. And especially being in the system, we speak as one voice. You're not allowed to speak

outside the system or say anything about anything - ever. I've just …not questioned that".

MHPs recognized that they need to tell their stories to support their well-being and improve the quality of their work environment in NSFNCs. In order to share their stories, participants said they needed to feel safe. Therefore, creating a safe space for participants in this project was crucial. At the same time, MHPs indicated their stories had to be shared respectfully due to their loyalty to the community. Participants said they felt safe and as a result, agreed to share their stories. The following are the themes that emerged from their told stories.

4.3.1 The Power of Stories - Collective Stories Normalize and Validate:

"It's an interesting thing to feel validated by yourself. Cause usually we're looking for validation from outside people but to read this thing - to feel validated by it and then to also really understand that it was myself talking - that's something else".

The first theme that emerged from participants' narratives was the power of stories, both individual and collective. Participants described a process of self-validation, transformation, healing, and normalization as a result of telling and reading their stories. They explained that reading their collective stories helped to normalize how they were feeling about their work in NSFNCs, and that it was empowering to share their stories and hear the anecdotes of others for the first time. One person described reading the compiled stories of participants for the first time as follows:

"When I first read through it, I cried. I teared up and what my thoughts were, was This is so big. This job we do is so big. It's so big emotionally and spiritually and intellectually, and we're all so little (laugh) and we go into these communities just so vulnerable and so I think that's what got me. And there was a lot of things that I don't think I even talked about that I don't know if I've even just pushed them down, forgotten them. Hopefully I've dealt with them and let them go, but there was a lot of trigger memories coming up as I read … other people's stories…Oh ya, I remember I had a similar thing. So, it strikes me…we're all going into these different communities separately but we're having such similar experiences".

Stories can be powerful and awaken our emotions and senses, leaving a significant mark on both the reader and teller. This particular story stood out as an example of how certain experiences significantly impact MHPs working in NSFNCs. These powerful stories will also likely awaken your senses and leave a lasting impression for you as the reader. This story describes an MHP spending time with a family in their northern First Nation's home during a relative's wake:

> "She was the first dead body I ever saw in someone's home laying on the ground, wrapped in a blanket, that not every family has the money to have a big fancy coffin, and in this situation this poor woman, she was on the ground (pause), and so people were coming in and kissing her and blessing over her and praying over her and so I went in and …helped them lay down the cardboard. They put cardboard down into the homes of the wake so that people aren't trudging dirt and sand on their floors. It's very practical. It makes sense. And so, here's where I am. I'm not doing clinical therapy. This is sort of my first understanding of not even an understanding but I think maybe it's the first time I questioned (pause). How am I helping? How do these people in particular need help…am I offering support? My presence, a virtual stranger, they've never met me before. I'm a white person in their home when they're grieving (pause) and preparing for the funeral and the wake of their loved one and I'm helping put up plastic flowers and lay down carpet and making coffee".

This story moves you into the reality of MHPs working in NSFNCs, and the situations they have encountered.

4.3.2 Life Learnings Instilled Empathy/Compassion/Curiosity:

"I just always really strongly identified myself as an advocate working alongside community members to make their lives better".

Participants described how their early life experiences instilled a strong capacity for empathy, social justice and advocacy. One person described that her early experiences made her "very good at compassion for others". Half the MHPs said they went into social work because of an early awareness of the suffering of others. For example, one person grew up near a First

Nations community, so from a young age, was aware of their many challenges. This generated her desire to enter a helping career and eventually work as an MHP in a NSFNC. She described beginning her work in a NSFNC as follows: “I just absolutely loved them, loved the community. Felt an affinity for the pain. It just felt like it was something that I was supposed to do”. For herself and others, working in NSFNC felt like it was where they were meant to be.

Half the participants described having a sense of curiosity about working in NSFNCs, with one person stating, “My curiosity has always got the better of me…but I guess I was curious about my own potential”; while another said “One of the things I think that’s been really strong for me throughout my whole career is my curiosity. I wanna know what’s going on, and I want to know how it works, and I want to know why it, works”. It appears that a sense of curiosity supported individuals to be open to learning and understanding people from cultures outside of their own.

Prior to working in NSFNCs, eight of ten people were employed in agencies with limited employee well-being supports, and where policies and their treatment of clients of these agencies did not align with participants’ values and beliefs. For example, one person described her distress working for one of the agencies by saying “that just about killed me because of how unjust it was”. Another recognized early in her career that Indigenous peoples were over-represented as clients in the agency for which she worked. What eventually led people to seek out work in NSFNCs was that their values did not align with those of the agencies at which they were employed. Participants also indicated that the values of First Nations communities were more in line with their own.

4.3.3 Short-term Crisis Work Chaotic and Ineffective:

Eight of ten participants began providing crisis support in NSFNCs, which led to long-term annual contracts with communities. Most (90%) were employed full-time, and on days off would provide crisis support in NSFNCs. Although participants were initially nervous about their decision, they eventually quit their agency jobs to provide long-term trauma-informed care/counselling as contractors in NSFNCs. One MHP explained her emotions regarding this decision, as follows:

> "Really scary, really hard, but it was this freedom because it was exhilaration because…I could see that I can leave (workplace name). Maybe I can go and do some really important work. Meet some really interesting people".

MHPs felt they had more control over their work in NSFNCs, and also were well-paid. One MHP said, "I had my own autonomy and I could be compensated for the work I did and had flexibility as well", with another saying "It's a great way to make a living". Unfortunately, the crisis support role in northern communities was described as "just putting out fires". MHPs felt pressured by (name of agency) to see as many clients as they could when undertaking crisis work. But meeting with clients was difficult when the community in crisis did not have time to organize their crisis response. One MHP recalled, "They (community) want to secure the funding and I get that. But it's just so disorganized… sometimes you don't see people". Another person described the first time she went into a community to provide crisis support:

> "It was a bit chaotic when I first went in because… nothing was under control. And everyone was in a panic. The expectation is we would be doing home visits and so I needed to be able to find these addresses and be able to navigate through the different communities on the reserve. Handed a list of names that were considered to be at risk. And in some cases, it was trying to find addresses and phone numbers and going to their homes and knocking on the door".

The common description of the process was that of "parachuting" into NSFNCs to take on crisis work, and being faced with a number of obstacles due to the community being in shock and disorganized. MHPs were also unfamiliar with the community, the culture, the language, and the resources. As a result, they preferred longer-term employment in communities.

4.3.4 Benefits of Long-Term Work:

Overall, MHPs want to provide sustainable, long-term effective services in NSFNCs such as: counselling youth, supporting to teachers, giving presentations, and organizing programs such as "social emotional kinds of things" in the school. They also explained that "Staying in a place for a long period of time made a huge difference", and that it is required for "community development programming and mental health therapy". They also said, "You're helping in a meaningful way. In a way that's going to be stable down the road". MHPs in longer-term

contracts were better able to build the necessary relationships to provide trauma-informed care/counselling, community work and sustainable change within NSFNCs. Participants went on to discuss the obstacles and benefits of being an outsider MHP, and the impact on well-being.

4.4 Being a New Outsider Mental Health Provider – The Obstacles

"Racism and dislike of outsiders is also an issue".

A number of obstacles were identified by outsider MHPs travelling into a NSFNC, such as: being new and uninformed, isolation, racism (racial prejudice), and communities in general not liking outsiders. Although MHPs used the construct of racism, they described it in terms of being called out by community members as being white. One MHP talked about going into a NSFNC for the first time: "Sometimes it's a little awkward when you first go in as every community's a little bit different… Every community has their own personality". Another said it was her first time, being "cautious and apprehensive about what I had to offer. I really wasn't sure about how I'd be embraced at all…I've been pleasantly surprised around that". Other MHPs described travelling into a NSFNC for the first time, as follows:

> "I can remember… not having a frickin clue really what I was doing… I didn't have a lot of training…I was still pretty green… it was probably 20 years ago… They had me in a room and they probably worked pretty hard to get about 10 people there… we're sitting in a circle … and I have a flip chart… I had a pointing stick if you can imagine and I was pointing at this flip chart with my pointing stick (laugh) and the people were looking at me like what are you doing (speaks slowly) and I looked at them and thought, what am I doing? When I saw the look on their faces I just sat down. And then we just talked. And so that was a really super strong and good and lasting lesson for me".

> "When you just plop into a community and plop back out, I can just imagine as somebody living in that community, looking at me. I look pretty white you know thinking who are you to me and what do you want".

> "Lots of nervousness initially. Obviously fell into some stereotypes about the community and about the people even before I went. And it's nothing I think I could have found on the web or researched. You just have to go and you have to

> experience to know… I think it's important … to acknowledge that I am an outsider, be up front about that. Let them know my background".
>
> "When I got off the plane in one of the communities, I was given a lot of dirty looks, you know definitely treated like an outsider. You have to be a little bit thick-skinned to tolerate some of that at first and understand the historical reasons why it's like that…I can be a little sensitive sometimes so those things can be a challenge for me".

Participants said NSFNCs mistrust outsiders, particularly those perceived to be working for a government agency. Overall, it takes time to feel comfortable in your role as a new MHP and to gain the knowledge needed to establish relationships in NSFNCs.

4.4.1 Lack of Knowledge About the Community and its Culture:

New outsider MHPs talked about having very limited knowledge of the culture and language of the NSFNC they began working in. One MHP described it as "culture shock because it's not your culture…and …they're not familiar with you". Four of ten MHPs said that because they did not understand the culture or language, they assumed that community members were angry with one another. As time went on, they realized the teasing and loud voices were normal cultural behavior/interactions and language of the NSFNC people. One MHP explained the following:

> "I think my biggest fear when I first started there is that they talk aggressive to each other. That's how they talk and I wasn't used to that… I'm like, Okay, actually, they're talking nicer to me than each other, so they like me. But I had to understand their own traditions and their own way of interacting with each other and not take everything personally".

Participants talked about being initially nervous going into a NSFNC for the first time. The way MHPs were received by the First Nation community varied, and not everyone felt welcome when they first arrived.

4.4.2 The Way You are Received by the Community Varies:

One MHP stated, “I’ve always been very fortunate to be welcomed” whereas others sensed that “people were not very friendly”. Another described how she felt as a non-Indigenous person going into a NSFNC, as follows: “Like, who am I? I’m this white girl, this professional … I always kinda felt I better just be quiet (voice got quiet), but they’re just very inviting, very friendly”. Yet another said, “It was hard because you’re just coming in, you don’t know how it all works, and you don’t really know what’s going on – you’re, kind of on your own”. One MHP explained that when going into a community for the first time, particularly in a crisis situation:

> “You don’t know exactly what kind of situation you’re walking into. Like what exactly is going on here? What exactly is being asked of me? You don’t know the personalities of the people that you’re working with …You just go in with a kind of … beginner’s mind… not coming in as the professional who knows it all”.

Although all participants were consistently apprehensive going into a NSFNC for the first time, the stories about how they were received by the community varied. As well, the negative responses seemed to occur most often when outside MHPs first arrived in the community. At the same time, some participants said they will always be seen as outsiders, no matter how long they are in a community, and this has led to ongoing barriers and safety concerns. For example, as an outsider, you were generally discouraged from being in a personal relationship with anyone from the community. One MHP described how a worker from outside the community was fired because of engaging in a dating relationship with a community member. She cited the reason as being “the whole community is your clientele...so you should not be dating anybody from the community”. As a community member, this would not have been an issue.

4.4.3 Not Always Kept Informed:

At times, outside MHPs were not informed of issues that directly impacted their safety, such as a boil water advisory, forest fire, or an office closure due to a threat of violence. MHPs were also unaware of emerging situations in the community such as a missing person, death in the community, or an office closure due to a funeral. One MHP described feeling scared and alone because she was not aware of what was going on with a fire near the community.

> "It was at night I was in bed and I could just hear this howling wind and there was a forest fire just around the lake. And I'm like holy crap and nobody called me to say are you okay… stuff like that nobody tells me".

Other times, MHPs were directly impacted by a serious incident in the community, and were then expected to carry out the crisis support process. One MHP recounted the following situation:

> "A fellow threatened to come into the band office and shoot us all…nobody told me. Everybody left the building and I came back after lunch and went oh that's weird - where is everyone?… A bullet hole was through the building and… it was the first time in my … professional experience where I was doing trauma follow-up…with everybody, although I too had been a victim of this very threat".

4.4.4 Distrust of Outsider Government Agencies:

MHPs stated that NSFNCs see them as outsiders representing a government agency with a western, colonial view. Even though MHP were excluded from announcements, they believed that it was more of an oversight versus being purposely excluded as an outsider. One MHP talked about how both she, and the community in which she works, do not trust outsiders.

> "Everybody on the outside just… leave us alone (name of agency). Go away - we don't need you. You don't understand what goes on here. You get involved and it either causes harm or is meaningless. So just go (said a bit louder and with emotion)".

It is interesting how most MHPs in this project had some level of distrust of agencies from outside the NSFNC in which they worked. As social workers, they have been taught to examine the world through a critical anti-oppressive lens. For example, one person said social work gives you the necessary back drop to understand the oppression, racism and systemic issues facing NSFNCs. She also explained working as an MHP in First Nations communities, "In some ways, it's no different in terms of what it means to me to be a social worker". While another MHP said "I always write (job title as) Community Social Worker because I feel that's my perspective, the ecological perspective…I've never run a clinical practice". Participants indicated that although there are obstacles to being an outsider, focusing efforts on relationship-building

and being your true self was instrumental to effectively carrying out this work. At the same time, there are benefits to utilizing MHPs from outside the community.

4.4.5 Benefits of Outsider Mental Health Providers:

"Some of their communities are so tight and so small, and some of them don't feel safe or comfortable to talk to other people within their own communities".

MHPs discussed NSFNCs wanting outside mental health supports because workers from the community and their clients have close ties. One MHP said, "Often times, they're related or good friends … so then we need to bring someone from outside of that team to the community to help. So, I drive in and I drive out". Another shared the following:

> "There's been a lot of relief in having people who come and then they go. And aren't rooted in the community that they're from maybe don't know as much history or aren't part of the gossip mill…I feel like that's been a real positive thing, actually. Which is exactly what I thought it wouldn't be".

MHPs were surprised that having someone from outside the community is what clients want due to trust issues with community members. One participant also talked about how outsider MHPs can assist in reconciliation efforts with the community. She said "outsiders helping is de-colonial, so it is important to me when they trust - it's huge." She went on to explain that building trust is not easy because of certain barriers such as "racism, or being an outsider, or being white". What is important is that outsider MHPs must build trusting relationships with clients and the community before attempting reconciliation efforts.

Building those relationships are not always easy. One MHP described being a new worker in a NSFNC, and how community members were initially unhappy about receiving services in the community instead of being flown out to access outside services. She took the time required to build relationships, and the community eventually accepted her. Participants also discussed factors that could help mitigate the obstacles that get in the way of developing trusting relationships in a community.

Participants felt they would always be considered an outsider in the First Nations communities in which they worked, with one person saying, "I'm aware that I'm still an

outsider". MHPs said that as an outsider, you have to be your authentic self and work from the heart when building relationships in NSFNCs. "I'm not having to reach in and pull out somebody that I didn't know was there. I'm able to reach in and find that person that I really am, and kind of work from that".

One MHP who mentors people wanting to work in the north said "teaching them (new MHPs) to work from here (points to her heart). You know… from the heart". Other participants shared similar teachings:

> "Somebody said to me just talk from your heart. When you talk from your heart, everybody here will listen. But if you talk like a typical white person, everybody will just tune you out. And I never forgot that. It's true, not just with Indigenous peoples. Probably with everybody, but I think that's kind of how I am anyways. So, people receive me pretty well. Once I get past that I'm white... once we actually talk and sit together and share our hearts, they get that and I think it's been a growing experience to learn more about this particular cultural group".

> "Well, it's one of those walking in two worlds… there's benefit…I feel a sense of connection to them and some of them feel that connection back… I think I've proved myself to the majority, and so to do that you have to be fully… authentic all the time… you can't actually try to fit in because that scene is phoney. Like even in the plopping into the northern communities, you have to, just be who you are".

The social workers in this project recognize that their work expands beyond the scope of individual clinical support, and that there many positive aspects to working in NSFNCs.

4.5 Positive Aspects of the Work – Transformation/Gratitude/Beauty

"I'm a changed person, I'm a better person".

"I have (changed) because of this work, and something that I'm grateful for is that I have deepened the level of my living…that's a real blessing…superficial kinds of things just don't matter…my own relationships, really treasuring them".

MHPs discussed how working in NSFNCs has changed them for the better, with one person saying "I hope that they make me better. That's what I hope and that's what I strive for". Although MHPs work through tragic situations and provide crisis support, they also take part in celebratory community events such as land-based camps, gospel gatherings, winter carnivals, treaty days, and cultural events such as Pow Wows. One MHP said "I have met the most amazing people and just had such a learning …and appreciation for Indigenous culture". Another talked about having experienced events that were difficult to explain, as told in this story:

> "There was another suicide …they invited me to speak at the funeral. You know… they had a wake and funeral in their gymnasium…The most beautiful thing I've saw… you know the flowers, the way everything is set up. So, they had her casket and it was just beautiful all around you know… the flowers and the pictures and everything. And it was a large room, there were a lot of people. And there was a large circle, and everybody you know… waiting to go and visit her casket. And as they moved around and there was a drum beat, a butterfly came in and it flew over her casket, and then it went to the circle that was coming around, and it flew and it touched on every person in that circle and then it flew out. Nobody said a word, but everybody saw it (spoke slowly and quietly and began to cry). Those kinds of things, to me, they make those experiences just priceless. It's amazing to experience some of the things that I've experienced".

4.5.1 Awakening Spirituality:

All participants stated that working in NSFNCs strengthened their spirituality or created an opportunity to develop a sense of spirituality. With one person saying "Spiritually - it strengthened me". They said activities in First Nations communities begin and end with ceremony and prayer, and as a result "you start having a different way of thinking about - you know – spirit. Or what does that mean? So, it's definitely informed me spiritually". Another said, "I think it's grown my spiritual beliefs or values or practices to do what I'm doing right now with them". MHPs indicated their own spirituality was an important support in their life, with one person saying, "I have to believe that there's a higher power that's gonna pull me

through this", while another said, "I needed to keep my spirituality very strong because that's what kept me grounded" MHPs also included spirituality and prayer in client sessions, with one person describing the following:

> "I prayed with people. Spiritually, said lots of prayers with people… hearing the stories just enriched my faith in God - that he really is taking care of all of us, and he's given me what I need and the words that I need to speak when I don't know what words to speak".
>
> "I'm always talking about spirituality. Not my spirituality, but the clients' spirituality, and being able to bring that conversation into the clinician's space…and if we don't, we're leaving a very important part of their healing at the door of the therapist's office. Cause that's their resiliency or a big part…it creates a beautiful conversation and then it helps them remember to have their own faith. … it's a huge, huge part of their resiliency…and that's therapy, that's therapeutic…it took a lot of courage for me to go way outside my comfort level and figure out how to integrate all of that…and then I'm doing it".

Providing trauma-informed care/counselling in NSFNCs has strengthened participants' spirituality. It also led one MHP to question how God can have people deal with so much suffering. She said, "I question why, how can this occur… There's that saying: 'God only gives you as much as you can handle' - I don't know about that".

4.5.2 See the Beauty and Resiliency in Front of You:

"There's something about the north…it's the nature, it's the water, it's the land, it's the trees, it's the people, it's the culture, it's the history".

"The marvelous resiliency of human beings when I look at some of these stories".

Participants talked about the beautiful landscape of the north, and how they enjoyed being in nature. One person explained that in a NSFNC, you are "near the water, in nature, spiritual" while another described the beauty of the landscape as "extraordinary". MHPs also talked about focusing their efforts on direct client work in NSFNCs, and looking for the resiliency and beauty in people. People enjoy being witness to clients' stories and experiences, while at the same time

acknowledging their capacity to thrive and heal. One person described it as "sifting through the sand to find the pearl… and to find where that resilience is". While others said the following:

> "I feel blessed and I feel gifted in what I can do in terms of helping people and seeing the potential of healing. I think that has kept my passion there and the motivation to continue doing the work".

> "So many people are so entrenched with the trauma, that it takes so much courage for them to be able to even bring it up and talk about it. I can really understand the courage that it took for people to sit down and talk about it".

Participants emphasized that it is a choice to look for people's strengths instead of their weaknesses, "trying to find the health in them (clients) and the belief in healing, and that whole balance between connecting with nature and spirituality". Another said the following:

> "One of the things that I find is more prevalent or conscious in the people in the north is spirituality…that is really resilience - right? The essence of a person's soul and ability to heal".

Others talked about looking for resilience as "getting back to what's beautiful". While another MHP described her role as "more of … a peaceful presence than it is to try to solve all their problems…very much strength-based". MHPs believe they have a choice to look for the beauty and resiliency in the people, the community and the landscape. Therefore, if you look for strength and beauty, that is most likely that is what you will see. Participants also talked about their strong connections to the people and the community.

4.5.3 Power of Connection with the People and the Community:

> ***"The human connection is so powerful… I feel very honoured of how I've been welcomed into the community and welcomed into people's stories, and that's honestly life-changing for me…It's probably the most rewarding work I've done".***

Participants emphasized the importance of connecting with their clients to build trusting relationships to hear their stories. One MHP said a "Sense of connection… it makes me feel what I'm doing matters. And that's all I care about really". While another said,

> "I've had some really powerful and beautiful moments with people over the time that I've been in this particular community…I feel better at the end of the day knowing that even if one person I saw that day feels better, even a little bit, then I've done something".

MHPs indicated that although building relationships is the most important and rewarding aspect of the job, it requires time and patience to nurture its development. One person said, "There is always something that I have in common with them (clients) always", while another said "I fell in love with the pure honesty of the people… just loved meeting the people". Another described being in a community for the first time, and just taking her time to get to know people, "Walking around the community a fair amount. Just chatting with people. Went to the graveyard and I found a couple of clients in the graveyard".

One person said building relationships and being connected in a community are important, although not everyone does this. She said, "Some struggle to understand that and make that effort. And I would think often feel a little bit more on an island". People identified obstacles to MHPs establishing relationships in the community. One participant said, "The biggest barrier is sometimes coming in and acting too familiar too quickly with the community and members, or coming in like I have the answers". It appears MHPs need to make these connections in order to reduce the implications of feeling very isolated.

MHPs overall love the community in which they work, the people and the work. They want to be a part of the NSFNC they work in. One MHP talked about being in a community for so long, she has become a part of her clients' stories.

> "I have been in one community for the past 25 years and when I go there it feels like I'm going home…This community feels like my away community, and I would like to make a community for myself locally".

People said that working in First Nations communities is where they seem to fit best. One MHP said the following:

> "As a non-Indigenous person in an Indigenous community, you don't really fit there and you don't fit in the non-Indigenous community because you're so immersed in the ways… of thinking, ways of being, ways of feeling. So even though I don't

fully fit, I'm a lot more comfortable there (Indigenous community). The work is a better fit for me than it is in non-Indigenous organizations and communities."

MHPs also talked about the importance of building relationships with staff in the community and "collaboration". Other MHPs talked about needing to build relationships with members of the community members and staff, with one person saying "I'm friends with my co-workers". While others explained the following:

> "I think we need to take the initiative to really connect with the staff who are doing work up there. And be cautious about coming off as judgmental, or that we have something to offer that they don't…be humble and offer support and help".

In order to mitigate feelings of isolation, it is imperative MHPs become connected with the community. Building connections requires a conscious purposeful effort on the part of MHPs. You need to spend time in the community to build the necessary connections in order to build trust so that you can effectively do your work. MHPs said building these connections gives them a sense of belonging, and is welcomed by the community.

> "Being able to celebrate and grieve with the people and being out in the open. Going out to the…store to buy groceries or whether it's going to a kindergarten graduation. Or whether it's going to a funeral or going to a wake and sitting and praying with the people… they notice…or going to church on Sunday with them… I really do believe that they knew that I loved them and that I made time for then and that they mattered at the end of every session".

MHPs said that although building these connections is imperative for doing this work, it also gives them a sense of satisfaction because they feel their work is appreciated.

4.4.4 Feeling Appreciated:

Although feeling appreciated was not an expectation, it provided a sense of belonging or acceptance. One MHP said there is an announcement on the local radio station or Facebook when she arrives in the community.

> "People look forward to you coming... I'm really appreciated… the one day I came in and I phoned the person on-call and said okay I'm in and she said oh ya I

knew that 10 minutes ago. And I said well why? and she said because so and so …saw your car come in and so they told so and so and… they phoned me. I'm coming in … and they're actually letting everybody know. And that to me makes me feel really good. But it also makes me feel really good when clients come to me voluntarily and want the help".

All MHPs talked about their experiences in NSFNCs in terms of relationships. Although acceptance in the community was slow, it was key in their ability to carry out their work within the community. MHPs went on to describe the roadblocks or challenges to carrying out trauma-informed care/counselling in the communities in which they work.

4.5 Roadblocks and Work Challenges Impacting Mental Health Providers' Well-being

"I mean, the analogy of you're alone on an island is really what it can feel like - right. Cause you have to problem-solve ... There are no other services".

"Isolation in the work, being away from our own home, not always sure what to bring or how to get needs met, needing support from locals and staff to bring us into the loop on whatever is going on and help to keep us safe and informed'.

4.5.1 Isolation: Lack of Supports and Resources:

All participants discussed being geographically and relationally isolated while working in NSFNCs. The factors which contributed to their feelings of isolation and its impact on their well-being were discussed by participants at length. Every MHP in this project talked about isolation, and a lack of services and resources in NSFNCs being a significant challenge. MHPs said they needed these resources to carry out their work. Four participants said they felt as though they were an island, with one person saying,

"When you're living in a community in isolation, you have to be 'on' all the time… I don't think that a lot of people understand the tremendous amount of responsibility that's placed on you… to help these people… they have no place else to go".

MHPs have limited supports in the community, with one participant explaining that everyone comes to you, but there is never a time you get to talk with someone about how you are

feeling. She said, “Anybody that’s having any kind of trauma or any kind of conflict - they come to you. There’s never a time where you go and sit down and talk to anybody else”.

MHPs said that for the most part, they are the only mental health support in the community, so therefore they are expected to see everyone no matter what the issue. One participant explained the following situation:

> “I don’t like to do couple’s therapy. It’s not an area of interest for me. So, I’ve done it because when you’re the only person in the community; you do whatever is called for… because (name of agency) won’t pay transportation for people to see a therapist in another location if there’s a therapist in the community”.

MHPs were frustrated with provincial agencies creating barriers for federally-funded northern Saskatchewan First Nation peoples to access their services. One participant described “having to beg or get mad (at provincial systems/agencies) …to get these people to move so I can get the help my clients need…that’s the biggest challenge for me”. Another said,

> “I work in very isolated communities; there’s no resources available and so therefore you’re it. And you are at the beck and call of, or at the mercy, I guess of provincial services that aren’t really happy about federal people needing provincial services. And so, I guess one of the things that I find extremely frustrating is trying to get … people additional services that they need”.

MHPs had to know which resources community members felt safe to access. MPHs employed by agencies viewed as safe and helpful might not be perceived in the same way by community members. One MHP said, “My clients won’t even go to the doctors and nurses in their community”. This is one of many examples of the complexity of accessing resources for clients in NSFNCs. One MHP said resources for suicidal or psychotic patients is limited to RCMP barracks. Not being familiar with resources in a community created additional stress for outsider MHPs. MHPs needed to know the resources in their communities, as well as the complex process to access services outside the community. They needed to know “how to get someone out of the community to be medi-vac’d if they were psychotic or suicidal”.

MHP felt resources were scarce because, although mental health was important, it was not always addressed. If the resource was not there, MHPs would advocate for it. One MHP said,

"they know as a community, as a band office, as a school that mental health is a priority and is important. But it's one of those things easily …overlooked". For example, MHPs struggled to find space to meet with clients in the community, especially in regards to providing services to students at the school. With one MHP describing the following:

> "For the first year I was there, there was no place to really meet with the students…but if you're not there nagging and pushing and even offering to lay the floor yourself, it doesn't get done… But we finally have a little closet that we use".

4.5.2 Lack of Collaboration and Teamwork:

"In the north mental health is one person, me… that's it nobody else".

Being without a team and providing crisis oversight to multiple community tragedies all appeared to contribute to isolation and stress being experienced by participants. Although all MHPs worked with other people in NSFNCs, only three said they worked as part of a team. One MHP described the following situation, "I consider myself to be part of a team of therapists there, even though I never see them because we're on different weeks…you're really on your own in a lot of ways". Another said, "I get to work with a couple of people two or three times a year; that's amazing for me cause, I always do it on my own…it's such a huge relief". As well, MHPs working as part of a team were still expected to oversee a crisis in the community.

An additional roadblock was a lack of cohesion or teamwork among agencies and services in the community. This lack of coordination between services created additional challenges and stressors for both MHPs and their clients. For example, MHPs were not informed of upcoming programing, training or healing events in the community. There was also an overlap in services/programming being offered in the community.

All participants shared the feeling that not working with a team (or within a supportive team) contributed to the isolation. Some MHPs were unable to continue working in the north due to the isolation. One person described the following situation: "I just feel like I'm done … let the new people grind it out, I just don't want to be a lonely island in the north anymore. It might have been different for me had I had supports, had I worked on a team". Working without the support of the team appeared to magnify the demands of the job and, as a result, some MHPs

made the decision to leave northern work. The isolation was compounded by a number of other roadblocks or challenges such travel demands, which will be discussed next.

4.5.3 Travel Demands:

"I've driven in terrible conditions and terrible roads with accidents and fatalities. Sometimes that's a real challenge and scary for me."

Outside MHPs generally fly into NSFNCs, or are required to drive long distances on poorly maintained roads. The travel is both emotionally and physically demanding. One person described travel as follows:

> "There's the worry and the stress of driving on icy roads. There are all kinds of things that connect with that. You're alone in a vehicle, and if you end up lost…that is a stressful piece of the work even though you haven't even got to work".

Participants also discussed the preparation required to travel into a NSFNC, e.g., booking flights, meal planning, shopping for supplies, and packing supplies including food, toiletries, clothing and counselling/training resources. One MHP described preparing to travel to a community: "The hardest part - packing up your stuff and your food and everything and lugging it up, lugging it back". MHPs would generally fly in on Monday and fly out on Friday around 6 pm, with flights taking approximately four hours. Sometimes participants were not able to fly home at the end of their shift due to unexpected bad weather. One person shared this experience:

> "The flight flew over us at 8 o'clock pm … and you had to go back to your suite, unpack everything, and stay for two more days because there's no flight out until Monday… So apparently that happens quite often in change of season…it's tough when your family's waiting for you and you've got things to be at and do, and can't get home".

Another MHP still doing this work said, "Travel is tiring and it's wear, and tear on your vehicle". Driving long distances takes a physical toll on your body. One person said, "I drive a lot so physically it's affected me …your hips, your shoulders", while another said, "It's taxing and I'll end up with a sore back all week. It takes a while to recover and I'm getting older".

MHPs also talked about road conditions being stressful, “It’s winter, there’s a blizzard, and I’ve got to drive, and it’s the dangers. Or there’s a lot of animals on the road or it’s hunting season”.

MHPs used the term “anticipatory anxiety”, which involves the stress they experience even before they get to the community and start their work rotation. Participants describe having one week in and one week out, with very little downtime at home. Therefore, you are in a constant cycle of fatigue and anticipation because you do not have enough time to recover before returning to work. Getting ready to leave one’s family for up to three weeks at a time was one such anticipatory factor. For others, the travel became too much for them and as a result, they quit working in NSFNCs. One MHP stated “I got tired of travelling…being away from home”.

4.5.4 Being Away From our Families:

Outside MHPs generally stayed in the community because of the distance they had to travel, which meant being away from family and friends, sometimes for extended periods of time. One person described the following: “I’ve made lots of sacrifices in terms of my own family life to be able to do this work. And because it’s isolated, you can’t drive back and forth”. MHPs with young children said it was difficult to work in northern communities, especially without a support system (e.g., a partner). One MHP said, “I could see that as a huge barrier for people who have young families. That just wouldn’t be plausible for them”. Another said “I stopped … for quite a few years going out remotely to do emergency work because I just …couldn’t… my job was to raise my child”. The isolation is much broader than just being away from your family, it is also about the overall demands of the job.

4.5.5 Work Demands Can be Overwhelming:

“It is not unusual for me to see between 23 and 28 people within that 5-day period, plus doing evening groups. So, it’s a long week”.

The work demands can be overwhelming, with one MHP saying on any given day, she did group work, crisis support, probation client follow-ups, walk-ins, and scheduled future appointments. Others said they write proposals, grant applications and reports, as well as facilitate community workshops on such topics as trauma, bullying prevention, anxiety, suicide prevention, and grief and loss. One person said, “My phone would ring all day long”. While another said, “I felt like I just can’t do this one more minute”. Another said, “Usually people are

talking to me before I get into my office. It's super busy there's a lot of need and there's a lot of people ready for change". MHPs also work in a variety of locations in the community, "It's not unusual for me to be at the community centre, be in a home, be at a school. Wherever I'm needed to go, I go" was reported by one participant. Much of the work is therapy in an office with a client, as explained by one participant as follows:

> "I'd still have to say 90 percent of my time is sitting in a chair doing therapy. And I literally would interview all day long… So, typically I would end up interviewing from 10 in the morning til 6 o'clock, and then I'd walk away…I would pray that there would be a no-show".

Most participants talked about having large case loads, with one person saying, "My case load would run at about 80 active files". As well, MHPs described dealing with a lot of death and loss within NSFNCs, with many occurring over a short period of time. MHPs said they need a lot of recovery time when they return home after being in the community, with one saying, "It's an intense job so when you come home you need the three weeks to just bounce back and go and do your own supervision and stuff and then go back to work again".

4.5.6 Work is Mainly Crisis-focused:

"I found out very quickly that a lot of my work initially, and still today, was crisis to crisis. I'll come to you and talk to you when I'm in crisis."

Much of their work is crisis-based, even in a long-term contract, with one MHP saying, "The same people coming …They come when they're in crisis or they come cause they're always in crisis". While another said, "People are dealing with crisis after crisis after crisis, and they just assume you're just gonna carry on". Another talked about looking for the client's strengths, even during the crisis, is so important even though it is challenging.

> "How do you then build those little pearls those little resources - right?... I think that is more challenging in the north because so much of the work is crisis-oriented. You go from crisis to crisis to crisis to crisis, and there's very few clients that'll hang in to do the real work".

One MHP said that her work of providing trauma-informed care/counselling was structured to be crisis-based because of the challenges she experienced with management. She explained, "Management did not support community development work by mental health therapists. Therapists' work was set up for crisis work. Therapists were not asked for their input in community projects". As well, MHPs deal with a lot of crisis because they are involved in much more than mental health issues. One MHP explained that this includes "medical situations because they are the only ones that medicine has". For example, MHPs attend crisis scenes such as a suicide or homicide with the body of the deceased still present, and then struggle to process the situation. All participants described dealing with very difficult situations in NSFNCs and, for the most part, having no workplace supports to debrief with. Below is one MHP's story:

> "Luckily, the family had cut him down. He was covered up with a blanket or a bedroom sheet and then I just did crisis management with the other family members that were still intoxicated and raging and crying…But when I went back to the clinic, one of the senior nurses…said to me What do you need today? And the tears started in my eyes. And I said, I think I just need to go sit at the lake. Let me just go connect with the water and nature and detach from this horrible tragedy".

4.5.7 Dual Roles and Job Expectations:

"Lots of double binds…you're just in a dual role with everybody".

All MHPs talked about the "importance of connections with people" and of developing strong relationships within a community. At the same time, there was a need to keep a certain degree of distance. One MHP reported,

> "I have to be very careful of where I socialize and how I socialize. I don't socialize in the communities because every time you say hi to somebody in the store, somebody else thinks you're talking about them. And so, I'm very careful that I only socialize when there's large groups, like down at the schools".

Most MHPs reported being in dual roles working within isolated NSFNCs and as a result, having boundary challenges. All participants provided counselling support to work colleagues in the community, with one describing the following dual roles:

> "I am friends with some of my co-workers, whom I also see as clients. We have little rituals that help us. We'll be visiting or talking about work and they'll slip into talking about something personal. And I'll say Are we changing roles now? And they'll say Yes. And I'll say Okay, just a minute, and I'll put the sign on the door that says Do not disturb".

Establishing boundaries, although challenging, was described as being imperative to carrying out this work and to reducing its impact on well-being. One MHP talked about learning how to set out stronger boundaries with her clients. She described taking on too many of her clients' issues, doing too much of the work, not setting her own boundaries, and lacking awareness regarding her own co-dependency. She eventually realized the following: "Like that's your shit, not mine. I get that - I know that". It was important for MHPs to be able to have clearly-established boundaries in order to do the work in a way that mitigated the impact of the work and protected their well-being. In addition to healthy boundaries, MHPs also said they needed to feel safe to do good work. MHPs discussed many factors that created safety, and a lack of it, which will be discussed in more detail in the following section.

4.6 Safety Concerns – Need Safety to do the Work

"I think that we can't do the work unless we're safe. But we do the work even though we may not feel safe".

MHPs described needing to feel safe to effectively do their jobs. A major roadblock to MHPs' well-being and capacity to do their work is a lack of safety. One person said, "Generally, there is not enough support and safety. Teamwork would be better". As well, one MHP said, "I know of a therapist that had been killed in one of the northern communities a few years back…people from there did say that …you gotta be careful". Many participants talked about going into potentially unsafe situations such as a client home visit. For example, one MHP encountered the following situation: "One sometimes has to kinda size up how safe a home visit is… I mean, her partner had walked in on other home visits, and he was quite abusive". Another MHP said, "You don't know who's in the home and what's gonna happen".

Additional safety concerns included not being able to sleep at night when in NSFNCs. For example, one MHP described hearing gun shots during the night. The next day, discovered

that they had a ‘dog-gone day’ which is known to residents as a day when they eliminate all the roving dogs in the community for their own safety”. Others said the following:

> “Just so tired and so drained and so unavailable and angry and needing order…So, I didn’t sleep because I’d never felt safe. Not thinking that anyone would break in necessarily, but you know the nervous system… I don’t feel safe. And… my digestive system was so messed up, cause the cortisol in my body was so high”.

> “In general, what I didn’t like about working in the north, were the safety issues. I like to walk around…I like to do about at least an hour walk when I can. And I was told Don’t go walking in the community - it’s not safe. Use the treadmill”.

People also described that they were uninformed about the level of trauma in NSFNCs, and described how it’s changed them. One participant described how working in the north had changed her perception of the world being safe. She described having an “ever-present threat to my own personal safety… You never knew who was walking through your door, and so security was an issue”. Three of the ten MHPs described constantly worrying about danger in the world around them, “always assessing for danger always assessing for the possibility of threat”. Other MHPs said they now have more anxiety about moving out into the world, with one person saying that they are “always aware of their environment and attuned to people’s suffering”. Another talked about working with clients who were sex offenders and as a result, being “really affected, and feeling that children were not safe”. As a result, MHPs said they were careful about what they watch on television. For example, one MHP said, “I don’t watch movies that are horror movies or violence or entrapment kind of stuff…I listen to it all day”. The work of MHPs in northern communities not only impacted their sense of safety while in the community, it also appeared to impact their broader life.

4.6.1 Gender and Safety:

Most participants reflected on whether being a woman in the biological sense impacted their fears regarding safety when working in northern communities. For example, one participant talked about how male MHPs revealed that they do not have similar “threats or fears or consciousness”. She went on to describe how this may be as a result of “the difference around power differential and physical power…and women being objectified”. Another MHP talked

about safety concerns resulting from “sexual harassment from some of the men” from the community. As well, dealing with male clients was sometimes an issue, described by one participant as follows: “One of my first male clients was really womanizing, and this was hard to navigate and feel safe”. Participants acknowledged that as women, their safety concerns might be different than they would be for men in this role.

4.6.2 Accommodations Not Always Safe, Private or Predictable:

MHPs flying into NSFNCs were generally assigned a place to stay with efforts made “to get you the same spot each time so you can leave some things”. Some MHPs said their accommodations were acceptable, with one person describing it as “awesome”. Other MHPs experienced anxiety due to not knowing where they would be staying, or who they would be staying with.

> “You’d get to these communities, and nobody tells you where you’re staying, where you’re going, how to get there, who to talk to. You really have to ask lots of questions to whoever you can. All the different communities, I’ve had to bring different things and nobody’s told me”.

Sharing accommodations was an issue because many MHPs wanted to be alone after a long day working with clients, and did not want to provide therapy to a roommate. Other MHPs indicated they were introverts, with one person saying, “I had to over-ride my need to be alone and my introversion”. For the most part, MHPs had no control over where they stayed in the community. They want access to private and safe accommodations when in community, and need “a stable residence to be able to disengage and be surrounded by comfort”.

One person said she “felt resentment because at one point, they wanted to put me outside the fenced-off clinic compound and I had to fight to not have that happen”. MHPs have encountered serious threats to their safety, including people being attacked in their housing complex. Further, MHPs said that after one such threat, no one checked on them or provided them access to support, such as a debriefing. Another person described being part of a large-scale community crisis and not having access to well-being supports until she returned home. She said “You come home, and that’s when you take care of yourself”. Additional examples of safety threats included going into a home and discovering the client is holding a knife. Another described the following situation:

> "Sitting up with my back against the door cause people had broken into my unit trashed the place…and I'm supposed to sleep in this mess and then go start work the next morning…which I think then makes it more personal… feeling your own sense of safety being threatened".

4.6.3 Bullying, Racial Prejudice, Lateral Violence:

"I feel like I was completely burnt out by the time I left the north…it had everything to do with the lateral violence".

MHPs described being bullied as a new worker in a community and not getting the support that they felt they needed from their co-workers. One MHP explained the following situation:

> "There's competition for these jobs…lack of working together as social workers… Staff from there…scrutinizing what I had done instead of supporting each other…bullied by some of the staff, and just little comments or put-downs, or the way they would glare at me or really nobody came to see me".

People also described management's behavior in NSFNCs as being disrespectful and "abusive" at times. One person said that as a result, "it's tiring…or I don't feel safe today. Or I don't feel comfortable, or I don't know what's gonna happen. Is this person getting fired, today? There's just a lot of dynamics". One MHP was particularly disturbed by how management treated one of her colleagues, and got the RCMP involved. She said management "didn't show any compassion at all". She went on to explain the anxiety and fear she experienced as a result of this situation:

> "I was flying back to a community and there was an RCMP truck parked at the airport and the lights were flashing, and my heart started beating and I thought I was gonna faint. I thought they were there to pick me up - that I had done something wrong - that management now was gonna throw me in jail. And I just for months had this irrational anxiety every time I saw the RCMP".

MHPs felt burned out due to ongoing conflict regarding boundaries with management, such as in the following scenario:

> "You have to stick strong to your code of ethics because they'll (management) ask you to cross the boundaries at any given time to suit them. So, they don't have to take any accountability for you being exhausted or you being not paid for what you're doing… The abuse that I was taking from upper management - it was horrible".

MHPs also reported being subjected to racial prejudice in NSFNC workplaces. Participants described how they acknowledge their white privilege, as well as understand and invite this discussion to take place. One MHP explained the following:

> "I have white skin and am perceived to have had white privilege. I'm consciously aware of that in the process. Lots of times, I will invite that as part of the process. So, what's it like to sit with me as a white woman? And then sometimes, there'll be some projection of anger; sometimes there'll be some acknowledgment. Well, you're different, right around the trust or the respect as I bear witness to their story. Again, that's that kind of having to hold the reality of two worlds (long pause)…Being conscious of the fact that I do come from what is perceived as white privilege…and as a society we weren't subjected to oppression".

> "There's some discrimination because I'm white…There's some shots fired. I've gotten way better at dodging the bullets - like that's about oppression too - that's not about me, you know. So, it depends though, how tired I am and how pissed off I am about something - how well I dodge. You know sometimes I take a shot. But I have good people around me, that we have built relationships over the years".

Acknowledging one's race, culture and privilege, and inviting this into the counselling space in a supporting trusting way, was important for both MHPs and their clients. MHPs who had experienced racial prejudice acknowledged that the behavior by NSFNC members was from a position of oppression, and was not taken personally. Although people did not directly confront the issue of bullying or lateral violence, everyone agreed this behavior was not okay. Bullying behavior was described in general as inappropriate comments and a lack of inclusion. With a lack of job security due to annually-negotiated contracts, it was difficult to deal with these issues

directly. Participants explained that for job security, they needed someone from the community to advocate for them, such as a Director that understood an MHP's job.

4.6.4 Factors that Mitigate Female MHPs Safety Concerns:

Having allies within the community, such as someone in a leadership role, helped to reduce safety concern issues. Being in a community on a long-term basis and having a predicable, secure, private place to stay also helped to mitigate MHPs' feeling a lack of safety. Being in a NSFNC for a long period of time helped to provide a sense of belonging and safety. One participant explained that when a person is in a community on a short-term basis,

> "We're in sort of a threat response…there's a bigger impact on our body and our system and our psyche. Staying in a place for a long period of time made a huge difference …because …there's those basic needs met of belonging of safety you have a sense of settled…We're meant to socialize. We're meant to engage. We're meant to be part of something. And when we are … parachuted in, we can do the work but there's a bigger impact on ourselves if we don't feel safe. And so, I think the roadblock is… that precarious worker …where you're sort of dropped in, and it's…where I'm staying. I've lugged all my things with me. My food and toilet paper and sheets and towels…. and I may be staying with someone or not. And if I am staying with someone, that person's a stranger who I'm sharing physical space with, and that person may or may not end up getting therapy (from me)".

4.7 The Work has Impacted MHPs Relationships with Family and Friends

"I think they (my family) are more knowledgeable through my experience".

All MHPs admitted that the work impacted not only themselves, but their family and friends as well. Most participants (nine out of ten) described feeling emotionally unavailable to the people they are close to, such as family members or friends, as a result of providing trauma-informed care/counselling in NSFNCs. One MHP described being "tired and exhausted, and not wanting to take care of others in my personal relationships". MHPs also talked about needing to mentally prepare themselves to travel up north and, as a result, not be mentally or socially available to friends or family. One MHP said "about three days before I went up, I would like

zone-out…I wasn't necessarily emotionally or socially available to my friends and family". She went on to say, "There were times that I would have like rage outbursts, and it wouldn't be about anything that was happening at home".

MHPs also described not wanting to participate in activities with "other people" and wanting to be at home enjoying "quiet time/alone time". Eight of ten participants said they spend less time with their friends since working in the north. One person described staying connected with friends as follows: "We would talk and we would get together when we could, but they knew that when I was at home, my focus was my husband and my kids…and they were respectful of that". While another spoke quite frankly about not having the energy to connect with friends,

> "Some of my friends are more self-absorbed…. And so, some of the relationships are just tiring. As a result, I don't do well engaging socially with people during the week. Cause by the end of the day, I'm done. Like I really feel done being … I won't say being nice… but the energy around connecting with people. Some people gain energy in relationships, others feel drained. And I'm one that feels drained, ironically".

Participants occasionally felt frustrated because they couldn't talk to the people close to them about the work due to confidentiality and the trauma stories being so horrific. At the same time, some participants felt that friends and family did not always understand their work in NSFNCs because "it's so complex". While others said:

> "My family and friends don't really know or understand what I do. My friends… know that it's my passion and it's something I needed to do…We were a very traditional white family…this is really foreign to them".

> "People will say to me, Well, you keep going back - nothing's changed. Why do you keep going back? And my answer is always, Is there anything I'm going to say gonna change your mind on how you feel about the work that I do? And chances are 9 times out of 10 - it's No. And I say I have nothing to prove to you. You're not the people that I'm working with. I don't have to prove to you that the work that I do is valuable… people don't understand working in community".

4.7.1 My Friends are all Social Workers:

As a result of the complex nature of the work, MHPs were more likely to connect with people in the profession with similar beliefs. One person said, "My friends often are people who do the same work". While another explained the following:

> "My friends are all in the same business as me…I don't know people outside my little world and I don't want to… I don't hang out with people that aren't of the same mindset really, and they get what I'm talking about and they talk to me the same. I wish that circle was bigger and I was - we were all- less busy because I think if we hung out together more, we could nurture each other more…so my relationships with my friends are solid".

It appears that as a result of their work in NSFNCs, MHPs want and need alone time with their immediate family members when they get home (spouse and children). People said some of their friends and family do know the history of colonization in Canada, but are not making any efforts towards reconciliation. One participant said she is unable to enjoy time with her extended family because they do not understand, nor want to learn about the suffering experienced by Indigenous people. As a result, many of the social work participants in this project sought out friendships and support from other social workers. At the same time, participants understood that their expanded understanding of Indigenous people became part of the teachings to their families.

4.7.2 Awakening Our Families' Moral Conscience:

Six of ten participants reported that working in NSFNCs has enhanced their family's understanding of social issues and people's suffering. One person said her child was more worldly and "aware of social issues from a young age… wanted to go and give homeless people cookies and mitts…always felt kindly". Another MHP talked about how doing this work also created an awareness of how much our own families have. One person said I have reminded my children "You ain't got no problems… you have so many blessings". Also, MHPs partners learned to understand and appreciate the north, with one participant saying that her partner "learned a lot about northern life through me and through my pictures". Although participants learn a lot, and in turn, teach their family a lot, being away from home also carries feelings of regret and guilt.

4.7.3 My Family Suffered Most Because I Was Away a Lot:

"I stopped going up north because I was missing too many family things".

Participants admitted that their work away from home in NSFNCs has impacted their children negatively. One MHP reflected on her situation as follows:

> "My children have been impacted the most. I think that they missed out on half their life with their mom… I was there 3 weeks but gone 3 weeks. I look back and I think that was a huge sacrifice… That was probably the time where I should have said I'm done. But again, you want to do the job that you love".

Most participants discussed being away from their children a lot and missing out on their lives, including important family events. One person said, "I'm more at work basically than I am at home". MHPs talked about feeling guilty for not being with family members; with one person saying, "It's been a challenge sometimes to have the relationships the way I would like to".

Participants also talked about their family being proud of the work they do, with one MHP saying:

> "They're very proud of me and they love the work I do. They find it really fascinating but this work is impacting me in that …I'm not spending as much time with them…cause I'm away a lot".

In addition, half of the participants said their family worried about their safety when in the north. One person said her children would say, "Mom are you gonna come back?… I'm worried or is the plane gonna crash. Or What if somebody breaks into your house and hurts you"? She went on to describe returning home to her family who had thought she had been in an accident on her trip to a NSFNC. She described her return home as follows: "Seeing people crying and hugging me and saying, Oh my God, I thought you were on that plane".

There are both positive and negative impacts on those around you as a result of working in NSFNCs. What is clear is that this work means a great deal to MHPs, and their families are aware of this. At the same time, MHPs experience guilt caused by the many sacrifices they have made in their personal lives as a result of being away frequently. For MHPs, it was important that people understand why they do the work despite all the obstacles.

4.8 Can't Forget Your Colonial History When Listening to a Client's Trauma

"Your eyes can't be closed when people are right in front of you and telling their story. You can't look the other way and think that this had nothing to do with me, and this has nothing to do with our history, and our government, and our churches, and our people".

MHPs were asked to self-reflect on their own history of colonization as they listened to their First Nations clients' trauma stories. Participants generally paused before responding to this question, or asked me to repeat it. This question in particular led to a great deal of rich discussion. For example, one person said, "I don't want to think of myself as a colonizer, although I know that I am". MHPs said they could not ignore the history of colonization in Canada and the resulting trauma to Indigenous peoples. With one MHP summarizing it as follows: "Having to hold the reality of both experiences and acknowledge what it's like for the other person to be on the receiving end of being …seen as the oppressor. And how do you then get to be the helper?" Another said,

> "I feel like it is just a really raw and genuine opportunity to sit with it. To acknowledge it. To sometimes feel the heaviness of it. Of the sense of responsibility. Of some of the shame that's attached to it and should be attached to the history that we have in Canada. But I also feel a deep sense of hopefulness. When I sit with people and they can embrace me as they do and share with me as they do just as another human being across the table regardless of my history, regardless of my color, regardless of my ethnicity. You know of what they might think of initially …the history of how they've been treated. It just really inspires me to be hopeful that we are moving in a better direction. But that there's so much to be done".

One MHP said that she is aware of her colonial history, and that everything she says or does is filtered through this lens of awareness. While others said,

> "I know white people are identified as part of the colonial side, and so it's about always keeping that in the back of my mind. That every single thing I say and do needs to be filtered through that lens".

> "I don't even realize that I'm the white person in the room. But they realize that I'm the white person in the room. …I find that 9 times out of 10, I'm always recognized as the white person… They have that respect for me and what I do, but they recognize that I'm white".

Another talked about how her way of looking at her colonial history has changed over time in her career:

> "Earlier on, I had a lot of European guilt…I'd feel people were angry and they'd stand up and say…you white people - and I felt under attack sometimes. Cause I was a minority now in that group and even though I fully understood what they were saying, I didn't hold myself responsible for all that. You know all that damage and I understood it, and I knew the history of it. I made it my business to learn it".

One MHP indicated that examining her own history has allowed her to discover experiences that support her compassion for Indigenous people. She said, "I looked at … the history of my family, my ancestors and I think I'm set up to be passionate about other people going through some of the similar processes and where it's left them". Another talked about the influence of an Indigenous grandmother, saying, "I think that the Indigenous woman in my heritage has more impact on me than I consciously know, and so I think that whatever knowing got passed through that vessel".

MHPs expressed having mixed emotions. For example, one MHP described loving the people close to her, while at the same time acknowledging they did things that were not okay as colonizers. Others asked the following self-reflection questions: "Can you be colonized as a white person?" and "Do I have prejudices that are causing or prohibiting me, causing me some of the trauma or prohibiting me from doing the work"? This process of self-reflection appeared to be a way for MHPs to determine what barriers could stand in the way of being effective in their role as an MHP working in a northern community. People also worried that they might unknowingly say something that would upset people in community, and stated the following:

> "Makes me a little sheepish because I over-think…if I say this or that, how will that be construed, or what does that mean to them coming from me - right? A middle-class, white woman, who's never had that history".

While another reflected on being a non-Indigenous woman teaching Indigenous people and coming to terms with what she had to offer. She explained the following:

> "I'm a white person teaching Indigenous peoples how to work with Indigenous people. I think that's f###. And then I think, No - it's not. This is where I am... this is where I was put. This is where I found myself…people tell me I'm good at it… people get valuable information that they can use in their lives. What am I apologizing for?... I'm just doing what's in front of me to do as best as I can - I do it with love and care in my heart".

Half of the participants talked about growing up in a position of privilege, and how this could be utilized within the community. For example, participants acknowledged that their position of privilege gives them access to resources and supports that might be difficult or challenging because of racism for community members to connect with. One MHP explained:

> "I guess my attitude is I need to use my white privilege to the benefit of the people in the community. Because I'm very well aware of my white privilege, I can be part of the solution, not necessarily part of the problem".

Participants not only felt that they had to acknowledge their privilege, but they also had a choice to use it in a way that was constructive.

4.8.1 Systemic Racism is an Overpowering and Exhausting Barrier:

"The outside dominant society. I'm always surprised and oh my God racism or just ignorance, just not understanding... racism is so much alive".

Agencies that are supposed to protect First Nations peoples have instead done things to hurt them, for example a deceased family member laid on a garage floor for identification. One MHP talked about how political systems were developed in the south and are being implemented in the north without regards for their way of doing things. She went on to say,

> "What really explains that systemic racism is just that everything is developed with a southern perspective… I feel so much for northern people that have to fight for their equal rights…We try to fulfill the same services, but that system doesn't fit…What really impacted me is how our southern system does not fit in the north, and how hurt everybody still is".

Another MHP shared a story about changes in food policies at a northern clinic where she worked:

> "There was this man who would go fishing every morning and would bring fresh fish for the patients. Then take them to the kitchen and it was local people cooking, and also caribou. People from the north - when they come down to the south - they don't feel very well living on southern food. He was supplying those things…through his kindness and his efforts he was taking care of the patients of the hospital (said slowly). Now (pause) a provincial health dietician comes and what happens? …Get rid of that. You can't have that. You know what we ended up eating? What we call mystery meat".

Another MHP said that dealing with systemic issues is exhausting, and explained the following:

> "What wears me down is the organizational stuff that's always worn me down. The injustice, the top-down, people at the top making decisions for people that they don't have any idea what their lives are actually like. That's been heaviest on me my whole career…now I'm not fighting that fight as much as I used to. I'm putting more attention just on what I can do, and doing that to the best of my ability, which I think is good and bad".

Systemic issues appear to be exhausting and for some MHPs, they are no longer able to continue in that role after a certain point.

4.8.2 Feeling Powerless to the Politics:

"Sometimes, I feel I can't, effect change as much as I would like…Sometimes, I find myself doing a whole lot of maneuvering in a day within band politics".

All participants expressed concerns that political and system issues can get in the way of supporting a client's healing. They felt powerless in these systems, with one person saying, "I'm completely helpless. I plant seeds whenever I can with whoever I can about stuff. But you're mostly voiceless in that". While another described the following:

> "Feeling bogged down by the system…dealing with a lot of political crap…those power and control issues that go on really do bother me…Everybody's so territorial and if we could just work together... it would be so much better for people involved… and just makes me angry…I have to learn how to deal with that too because, you know, I can't change the political scene".

Although most participants loved working in NSFNCs, they felt that politics, agencies and managers were difficult to deal with. People described not being invited to gatherings organized by the agency they worked for. One participant described her job as "incredible demand but lack of inclusion". Participants also claimed that they want to be here because they love the job and love the people … but… they dislike the people they work for". While another said,

> "I felt like I was always proving myself to the management up there because I wasn't worth my value. I wasn't worth the money they were paying me. It was all about the money that they were paying me".

For the most part, MHPs felt powerless in both local and broader political systems. They are so busy with the demands of the job, that it overwhelms them to even think about these system challenges. What is evident is that as social workers, they have a background that seems to help them to understand the systemic issues impacting NSFNCs. Therefore, it is not a lack of awareness, but instead they feel helpless or powerless to change the systems. The next theme was the meaning of the work in NSFNCs.

4.9 Meaning of the Work: My Destiny, Making a Difference

"I think part of my journey on the planet in this life time is to help people and care about people so, I'm doing what I am".

Some participants said the meaning of their work was doing good work with clients and wanting to make a difference. One MHP said, "My reason for going into this field was for the

good. If I'm not making a difference and I feel like I'm not making a difference, I shouldn't be here". A participant explained that working in a NSFNC was "very fulfilling in a lot of ways and feels like she can make a difference much more than sitting at her desk in an office". Another said doing good work meant making a difference in lives of their clients in NSFNCs, with one participant stating,

> "I feel like I'm making a difference. And it's only a depressing story until you can see a person grow and begin to get empowered, and their lives get better and they feel better. And that's why I do what I do. Because I like bringing people from dark places into lighter places, and that's how I see myself…Feeling like they got something. They might feel a little bit better. They're a little bit more empowered".

On occasion, clients meet up with an MHP years after they have worked together and convey their appreciation for their efforts. One participant reflected on her client telling her "I just remembered how much you believed in me". She said she doesn't always remember her clients because of the large number of people she meets, but that they remember her and the impact she had on their lives. Therefore, the work is meaningful when MHPs feel they have made a difference, or when they have positively impacted the lives of their clients.

This work was described by a number of participants as being more than just a job, with one person saying, "I feel like I've had a calling and that I've found it…I feel really blessed". People said it was where they were meant to be, with MHPs saying, working in NSFNCs is "absolutely fulfilling and encourages others to get into this line of work". Another said, "I think I was destined to do this work because of how I was brought up…it is important because it means I'm being true to myself".

4.9.1 Creating a Safe Trusting Space for Client Stories and Healing:

"You sit with them… hold the space and help them identify or recognize that this process can be different than the neglect they've had growing up…You believe in someone and hold that space, and see them to help them heal".

Most MHPs discussed holding space that is safe and healing for their clients' stories, with one saying, "It's about letting them be in the moment, and letting them sit and cry in a place

that's safe where they're allowed to". Others explained that it's about letting clients know they can trust you; "that everybody's needs matter" and having "the heart" for this work. Others described the following:

> "It's humbling that they trust me to come to me and tell me the story. Numerous times I've heard I haven't talked about this in 20 years and I'm telling you for the first time. And it's like this complete breath of whoa, and humbleness, and that is an honor for me".

For some MHPs, creating a safe space and honoring clients' stories also meant praying during the session. One person explained the following:

> "I feel a sense of richness inside that people have honoured me with the trust to share those things with me. I'm quite spiritually-oriented. While people are talking, I'm in a sense praying I'm visualizing I'm asking our Creator to work with us".

4.9.2 Stepping Out of Your Comfort Zone:

Participants explained that doing this work in a good way meant doing things differently and stepping out of their "comfort zone". One person expressed the following:

> "This work means to me taking a risk … It means taking myself out of my comfort zone. It means challenging myself to see what is helpful when I really wasn't sure. Taking the risk of possibly being rejected or seen as not helpful. I think personally and professionally it's meant a lot. It has taught me a lot. I feel it's brought me back to the basics of helping other people and listening to other people and honouring each other's story - which is I think why I was drawn to the work in the first place".

4.9.3 Supporting Building Community Capacity:

MHPs support empowering First Nations to utilize community members to carry out mental health supports, but also acknowledge the complexities and challenges. Participants talked about the importance of building capacity and needing to ask ourselves "What are we doing to build capacity"? One MHP said, "I really feel strongly that my passion is to be a community-based therapist". Another felt that the meaning of the work was "community

development". One MHP said, "I think the most important piece for me is to be able to build capacity in either the person individually that I'm working with or working with a community…it's not about necessarily just focusing on one-to-one therapy". Another participant explained the following:

> "It's stories of overcoming, and how people have struggled and helping is part of their story…the piece that I really work on is helping clients find their own truth and their own happiness … I can really understand the courage that it took for people to sit down and talk about it. Not that I didn't respect it as a younger therapist, but as an older therapist being able to understand life more…It's a really humbling experience, but it's also a…tremendous responsibility to help them through that trauma and not keep them stuck… when there is a trauma, they want us to run and do the critical incident stress debriefing. And then it's all on us, and what I've tried to teach community is that if their family is together and they're grieving together it's okay. We don't have to interrupt that. We don't have all the answers. They were able to heal without us. They were able to deal with the initial trauma without us. We don't always have to run and be the centre of attention to the trauma. That we have to allow them as a community to take care of each other. And I really feel that that's a piece that isn't necessarily respected enough…When there's a trauma … there's healing … without me in there".

4.9.4 Learning from MHPs Experiences:

MHPs spoke about having insight that might be helpful to the community, with one saying, "I think a lot of people can learn from the therapist in the community about how to provide really consistent follow-through with programming and with clients". One MHP similarly said, "We are professionals with skills to offer and with privilege to have the ability to handle things too", Another stated:

> "I have a new found respect for the work that I have done in my profession … not necessarily from the context of how I was able to provide service for somebody, but the things that brought me a sense of purpose - a sense of accomplishment - a sense of success".

4.10 Making Sense of the Trauma: Reconciliation and Repair a Collective Responsibility

"I think I would probably make more sense out of it if I had done social work in some war-torn country".

"To me, the way I make sense of it is everybody's still suffering from trauma -- mass trauma! Some are doing better than others… we are still in the beginnings of the healing process".

Participants talked about being responsible to help in the healing, with one MHP explaining, "I think we owe it to people, because my ancestors did some pretty rough rotten stuff to the ancestors of the people I'm serving". Another indicated, we need to "make the repair that's necessary because a lot of damage was done…by contact. So that's part of how I make meaning of it… little changes you see over a life of looking back". Another person commented that,

> "This is the time of peace and reconciliation, and this is a two-sided endeavor. Governments need to work hard to make amends for past wrongs, but also those with privilege need to do the work around that, and everyone needs to be aware of systemic racism. Both sides need to take steps to enjoy the fruits of peace and reconciliation".

Another MHP said, "Making sense of it is helping the people. And know that when somebody is suicidal, it doesn't matter what time of day it is… if I'm here and I can help, I'm going to help". Another said,

> "Communities hurt by oppression… it's really about lighting that fire within individuals, and really a lot of it is about helping people to relearn how to get along…. how to nurture one another… They're still speaking from their own oppression".

One MHP asked this question "Are we getting anywhere? What are we doing here? Recently…we've had death after death, and they were not natural deaths…It's so woven into my fabric". It appears that MHPs have been impacted by the losses in the community and that it has somehow become a part of who they are now.

All participants recounted how their own history helped them align (or be an ally) with First Nations peoples. One person claimed that "We struggled in some similar ways", while another discussed being poor, as well as experiencing trauma and oppression in her own family history. For example, relative's names were anglicized by teachers or changed to secure employment in Canada. MHPs felt that their experiences have supported their capacity to work within First Nations communities. One MHP shared her thoughts, as follows:

> "Everything you have experienced has led you to where you are now…My own colonial story took me to feel a sense of bond and empathy with others who were cast out…My own experiences certainly did teach me a lot…I don't think we necessarily have to suffer in order to learn. But maybe that suffering really lends itself to some really good empathy".

For one MHP who talked about how her parents taught her about the importance of working together, she recalled, "My parents taught me about our collective wellness and our collective responsibility towards each other". MHPs said the communities they worked in acknowledged them as allies, with one MHP saying "They (community members) would call me a white Indian because so much of my story and their story was living off the land". Another stated that she worked hard to understand and relate to her clients' perspective, explaining that "The more I saw things from their point of view …I was feeling it how the people told me they were feeling it". This openness to understanding and empathizing with clients carried into being open to discussions about colonization in therapy sessions.

One MHP said she would discuss colonization in a session if a client was open to it. Clients were in charge of deciding whether or not to discuss colonization. MHPs said they needed to have a learner's mind with clients. Another explained, "I always kind of feel it out to see where they're at with that, and what they're knowledge base with that is, and introduce it a little bit at a time". One MHP shared the following:

> "I constantly have to do the work around privilege in that environment, and I have to be conscious and mindful. And even when I am extremely mindful or extremely conscious, I can say things that I shouldn't have said… they are my teachers…They are-telling me what they're experiencing. And I just do my best to meet them there…It's hard to be in a decolonial role".

Although it can be mentally challenging, MHPs reported that they must work through a decolonizing lens at all times in NSFNCs. An additional theme was the gravity of the emotional impact of the work.

4.11 The Emotional Impact of the Work – Feeling Helpless and Hopeless

"It's draining sometimes, it's shocking sometimes, it's heart-breaking a lot of the time". "It's hard to separate my work life from my personal life".

One MHP indicated that what she sees and hears in her work in NSFNCs "makes her question humanity", while others described feeling helpless in their capacity to facilitate change. One MHP explained, "The trauma is impossible to describe", while another said, "I sometimes envy the people that haven't seen the ugly in the world". MHPs work with clients experiencing complex trauma such as multiple losses one after another, often complicated by addiction. One MHP said, "Because there is so much raw pain and loss and disconnection, it's hard to fathom. So, it impacts me emotionally".

One MHP said as a result of this work, she felt a sense of hopelessness, and explained, "I have definitely felt my own self - like I don't want to live in this world anymore". People recognized when the work was getting to them and that for their own well-being, realizing that they needed to take a break from the work and get their own help. MHPs described the work as being "really heavy". One person said, "When I'm listening to their trauma, you know, I really do have to debrief because their trauma is real and it's huge and it's sometimes unimaginable", while another admitted,

> "I have felt hopeless. I have felt helpless. It has (long pause), you know, I think of the word or the concept of moral injury of how it is injurious to my morality as a good human being to think of all the things that people do to each other. And what a lot of therapists will say, "You can't make this shit up". There is no scope of the imagination (said louder) to come up with these things that … many people can do to each other. So, it makes me question humanity. There has been a time where … about two years ago when I was feeling … depressed and hopeless, where I wasn't able to see any good thing in the world (said slowly). I often called it not being able to see all the beautiful things…That depression, that sadness, that not

being able to help in the way I really want to; but then also it's underlaid with anger at how people can do this, anger at myself for not being able to change it, and anger at the systems for not caring or not having the resources".

Participants also described feeling as if client stories were sticking to them, while others needed to take anti-anxiety medication. MHPs said they must be healthy for their clients and "recognize that listening and being fully present for another person's story is a step towards healing, and is honestly a gift that we give to one another". Participants then went on to identify how they manage listening to clients' difficult stories to maintain their own well-being.

4.11.1 Needing to Detach:

"I think emotionally, maybe you cut yourself off a bit because you can't change it, you know in a real way. And so, you sort of cut yourself off a bit, a barrier to keep you from maybe hurting so much".

Many MHPs explained their need to detach, or to socially isolate themselves as a result of the work. Participants described the following:

"There's days where I just want to hide, you know. I don't mean at work - I mean in life. Because it can be so perverse. You know you just kind of go How is this even possible that these people are in this political, social, complex situation and they're so isolated? And so that stuff can make me a bit depressed some days".

"I'm either full out throttle or detaching…I used to be able to work 14 hours a day minimal…and now I'm just tired and I think part of that can be emotional drain of the work. Cause sometimes I dread coming to work. It's like I think if I have to listen to one more story or bear-witness to one more story, ….".

"I just couldn't sleep. I was just wide awake in the dark, and that obviously is an emotional response as well. Just allowing myself to kind of numb-out for a minute and just pray".

Another MHP said she is no longer noticing the poverty in the community – she doesn't see it anymore, stating "I've become desensitized to the amount of poverty and some of the stuff that goes on". She talked about how this was brought into her conscious awareness when she

took a new MHP for a drive for the first time in the community. The new care provider said she was shocked by what she saw. It appears that the poverty and hardship in the community can become normalized, or in a way less shocking, because it is what MHPs experience repeatedly in their work.

4.11.2 Difficulty Working with Children:

"I've done a lot of work with children and it's…the hardest part".

People said that working with children and their trauma stories impacted them more so than working with adults. People described having sleep disturbances as a result of working with children, and had to limit the number of children on their case load. One MHP said,

> "Having to deal with a childhood trauma, a child that's died, a child that's been raped….it does come back to me at night. I have trouble sometimes sleeping at night when I've been dealing with children…I know in my private practice that I have to be careful how many children I take".

Another described a particularly difficult situation, in which a child described how they were sexually abused. She indicated she needed to cry and just acknowledge how horrific the situation was. She said, "The impact of that visual image…I cried for probably three hours". MHPs experiences when working with children and their trauma carried a level of emotional distress beyond that of working with adults.

4.12 Quantitative ProQOL-5 Data

The stories that emerged through participants' narrative interviews conveyed a common message: the work is difficult and demanding, but also deeply rewarding. I made the decision to embed the quantitative, Professional Quality of Life Scale 5 (ProQOL-5) within the second narrative interview. The narrative interview complemented or enhanced the quantitative results. The ProQOL-5 also provided an opportunity to measure the impact of the work specific to compassion satisfaction and compassion fatigue (STS and burnout). Although participants did not always use the terms compassion satisfaction or compassion fatigue, they did describe much of the characteristics of these constructs throughout their stories. Therefore, not only did the ProQOL-5 measure these constructs, it also supported a very self-reflective discussion about how MHPs were feeling/functioning as a result of their work in NSFNCs. This was instrumental in

having MHPs attune to and validate their own feelings and needs, versus that of others. Many participants said it was somewhat difficult to reflect on their own needs because, as social workers, they spend most of their time focusing on the needs of others.

Results of the ProQOL-5 self-administered questionnaire found that 60% of participants had high levels of compassion satisfaction,70% experienced low levels of burnout, and 70% experienced moderate levels of STS (refer to Table 4.1). The results indicated MHPs really enjoy their work, find it satisfying and believing that they are making a difference. At the same time, they acknowledged being negatively impacted by the trauma of their clients, experienced through sleep loss, avoidance, and an inability to create clear boundaries between home and work life. In addition, many participants reported that working in NSFNCs was very demanding and left them feeling overwhelmed at times by the complex systems they had to negotiate.

Participants were able to discuss their results, as well as critique the ProQOL-5 scale itself. The ProQOL-5 was described by eight participants as validating their feelings, with one person saying, “I think it’s helpful because what it does is it validates my resilience”. Another person said the ProQOL-5 questions affirmed what she had gone through and as a result, she felt she was not alone. Her results also reassured her that she was doing okay. She said, “I can do the job without putting myself at risk or anyone else…It makes me feel good to know that it’s not just in my head”. In some ways, the ProQOL-5 provided a process for personal insight and self-reflection.

Table 4.1: Professional Quality of Life Scale Analysis

Compassion Satisfaction	Burnout	Secondary Traumatic Stress	Mean
32	27	35	31.3
46	16	20	27.3
45	19	25	29.6
45	18	22	28.3
41	17	23	27
39	28	29	32
38	20	28	28.6
42	25	30	32.3
44	20	23	29
47	21	16	28
41.9 (mean)	**21.1 (Mean)**	**25.1 (Mean)**	**29.34 (Mean)**
Purple – Low 22 or less	**Green – Moderate between 23 and 41**		**Yellow – High 42 or more**

All individuals talked about how the ProQOL-5 results were time-specific. As such, results were dependant on "where you are in time" and "how you are doing at that moment in time". For example, one participant described recently supporting a community through multiple suicides and other deaths. She said "it had gotten to the point where I was, I don't know if I can handle this anymore…that's when I knew I had to take a break and do some self-care". She felt that her results reflected recent stressful events in the community in which she worked. While another felt that her results would be placement-specific "working in the trenches, so to speak" versus working mainly in an office setting. Another MHP described the questionnaire as "a measuring stick" for something that is difficult to measure. At the same time, some participants did not find the scale helpful, with one person saying, "The way that the questions are asked… It

wasn't… getting to the right answer…There seemed to be some assumptions behind it that I would try and deal with if I was gonna give it to a bunch of people".

4.13 Integration of Quantitative ProQOL-5 Data with Qualitative Interview Data

4.13.1 Compassion Satisfaction:

"I love being invited into community. I just love that feeling …you're just part of the community… I'm so blessed to be part of the community, and people are happy to see me".

Overall, ProQOL-5 results and narrative stories showed a high level of compassion satisfaction in MHPs working in NSFNCs. Compassion satisfaction ProQOL-5 scores fell in the range of moderate (40%) to high (60%), with a mean of 41.9, median of 43, and mode of 45. One person described working in NSFNCs as rewarding and fulfilling", while another said "I really do feel satisfied with the work that I do with clients and with the community. I really feel that this is where I'm supposed to be". One person described feeling "confident and competent" in her capacity to work in NSFNCs. While another described her compassion satisfaction score as "a little bit of a confirmation that the work that I'm doing is worthwhile".

A participant who no longer works in the north talked about how her compassion satisfaction score would have been very different if she was still working in a NSFNC. She said,

> "I would probably score on the lowest of the low, I'm sure, if we were talking about the organization… I don't think that you're getting an accurate picture of how I am if I was to answer working in the north".

She went on to say that in her current MHP position, she is no longer working in a NSFNC, and that leaving the north, although difficult, was the right decision. She went on to explain,

> "I feel like I can go home at the end of the day, and feel like I've worked really hard, and that I established really good relationships with people and really respectful mutual loving relationships with clients".

MHPs level of compassion satisfaction included the way participants felt about their capacity to do the work, their enjoyment of the work, connection to the people and the

community, and their level of satisfaction with their supervising manager. People went on to discuss factors that contributed and mitigated compassion fatigue.

4.13.2 Compassion Fatigue - Burnout/Secondary Traumatic Stress:

MHPs acknowledged feeling compassion fatigue, and also discussed what they have done to mitigate the impact. One MHP explained how she deals with compassion fatigue as follows:

> "Compassion fatigue is a real thing. How can you still be compassionate with the people you love if you come home spent? How can you be a good partner or a healthy strong partner or a healthy strong parent? It's pretty hard…staying in the present… use different forms of alternative medicine that actually deal with the whole mind, body, spirit".

Overall results showed a low average level of burnout amongst MHPs who have worked in NSFNCs. Burnout scores fell in the range of low (70%) to moderate (30%), with a mean of 21, median of 20, and mode of 20. Participants described being aware and cautious of burnout, with one person saying "I have some fatigue, but it's not serious yet. But I know I have to take care of it". Another reported that she sees "new health professionals…who are already burnt out, who are already unhealthy". Another stated, "I would see people getting very bitter and unhappy and a lot of times the person would feel that they had no control over their circumstances".

MHPs talked about additional burnout stressors being preparing to travel to the north, Band politics, and a lack of private accommodations in the community. To quote two participants:

> "It's the complexity of packing up, camping for a week, bring my own food what am I gonna wear every day and then… navigating around the neighbors …and then you go to work and there's endless chaos with what's going on…if I were to be burnt out, it's all the other dynamics, politics, etc.".

> "Another factor of burnout …is living with other people you don't know and that forced intimacy…I'm an introvert - I'm really stressed by stuff like that… to be alone after work and before work and stuff - to decompress. I don't get alone time, and so that also kind of burns me out some days".

One person talked about how the political dynamics in the community created neuro-fatigue for her. She explained the following:

> "Neuro fatigue, cause, you are… trying to understand language barriers and all this kind of stuff…that is more, I think, what would be creating some burnout and why I'm apprehensive to take on more days or weeks there".

The implications of not addressing burnout stressors appears to be a factor in whether MHPs feel they have the capacity to work additional days in a community. This in turn, can impact client services. A second component of compassion fatigue being STS will be discussed next.

Overall results showed a moderate average level of STS being experienced by MHPs in this project. All STS scores fell in the range of low (30%) to moderate (70%), with a mean of 25.1, median of 24, and mode of 23. It appears the higher MHPs' level of compassion satisfaction, the lower their level of compassion fatigue. Some participants talked about coming into this work being hypersensitive as a result of their own trauma history. One person described being in community "I would be cautious watching people - tracking people - kind of getting a sense of Are they dangerous or not? Are they intoxicated or not"? She also described having "more anxiety around moving out into the world", adding that, I'm aware…life experiences definitely effect how you see the world". Some talked about "avoiding certain situations" and having a "hyper-startle response". Others said they found themselves shutting down to protect themselves, with one person describing the following:

> "I think for years I had just trained myself to say, just shut it off …and denied the process that probably needed to happen… I would have had to completely shut down, and I didn't want to. Like I wanted to be present for everybody else".

Other MHPs recalled factors, in addition to client stories, that contributed to secondary trauma. Although participants describe it as an indirect trauma, it appears to be trauma directly experienced by the participant. MHPs shared the following examples with me:

> "The secondary trauma that I experienced wasn't necessarily with clients…being almost in a crash (myself)… and to not …even recognize that for days later… but

at the time …you don't necessarily stop and say You need to just ground yourself".

"It all came from the people from the management… that's my secondary trauma… The secondary trauma that I experienced wasn't necessarily with clients…it would definitely be some of the incidents that happened with colleagues, and how they were treated".

One MHP talked about having nightmares with "themes of …danger and threat". Some participants said they avoided watching the news or scary movies. One MHP talked about the cumulative impact of the work. She said,

"What accumulates for me with secondary trauma is the helplessness… kind of vicariously, I feel it too for them… it's a struggle with my own helplessness in the face of their helplessness…The way we're taught in school to intervene is very middle classist…We really have to reinvent the wheel when we're doing the work around privilege, and how we even articulate what comes out of our mouth, and the way we move our body, and what that means. It never leaves my mind, and it never leaves their mind…that is a helpless piece sometimes".

Another explained her secondary trauma as follows: "I think it has been working alone that has caused that, to be honest…I don't have to keep putting myself in the situation that I have a choice about". Another MHP stated, "Despite my not having clients, I still carry some of it…Stories of client's trauma that I've heard that I've had to go and do my own healing on". One person explained how working in NSFNCs has changed her:

"I'm definitely a different person than I was when I first started this. I don't think I understood or realized the amount of trauma that I was going to be introduced to, and so I've really been careful about vicarious post-traumatic stress".

MHPs recognized that it takes time to become healthy as a result of the stories they heard from their clients. Participants acknowledged needing to take appropriate steps to mitigate compassion fatigue so that they were able to enjoy their work. One MHP claimed, "I still get a lot of satisfaction. I've done a lot of things to mediate around burnout or secondary trauma".

ProQOL-5 results appeared to support MHPs feelings/experiences, in that they loved the work, the people, the clients, and the NSFNCs in which they worked. At the same time, they hear very shocking and disturbing stories from their clients that have secondary trauma implications. In addition, the complex and ever-present managerial and political complexities, as well as an overall lack of services, create environments conducive to burnout. The resiliency of MHPs came through in their stories. Many shared crucial lessons they had learned. MHPs want to pass on these lessons to those already working in NSFNCs, as well as to those who are interested in working in the north.

4.14 Lessons Learned to Remain Psychologically Available to Yourself, Family and Clients

"Lessons for me, lessons for the people …not only in the nice happy fluffy positive ways, but in the ways that have been hard, like the hard-learned lessons…Really horrible things happen, but I really do believe that there's lessons in all of it".

MHPs described the meaning of this work as lessons to be learned. As such, the focus of the interview shifted to what participants have done to maintain their health and well-being, and to remain psychologically available to both their clients and their families. Their recommendations or advice were as follows: healthy boundaries (don't let everything get to you; stand up for yourself); balanced lives; going in healthy and staying healthy; gratitude; listening; and working from the heart.

4.14.1 Create Healthy Balanced Boundaries:

"You have to find ways to make your life so that you still have that engagement with family in there. The connection and some boundaries around that time".

MHPs said that as a helper, you need boundaries with your clients, community, friends, and family. Participants had to address boundary issues on an ongoing basis in their work within NSFNCs. One person described having to "work hard every day at making those boundaries". MHPs need those boundaries to protect or shield them from everything that comes at them on the job. For example, one MHP explained:

> "You need a thick porous skin to do this work well. You can't let every little thing get to you, or you're gonna be done for. I think analyzing things enough that you can be helpful. You have to have your eye on the prize, and the prize is doing good work. What I need is to be able to do good work. It motivates me to take care of myself. It motivates me to analyze things. It motivates me to seek support".

MHPs indicated that they needed to have limits on what they were willing to do in the community because the roles and responsibilities could be overwhelming and stressful. One MHP said, "I totally respect people who can say I'm backing away from this because I don't like the way you're treating me, or I can't handle the amount of work that's pushed on me day in and day out". At the same time, people said social workers sometimes do not stand up for themselves, with one person saying,

> "We need to start standing up. I'm worth it…It's kind of a social worker thing too. We have pilly sweaters… and we give all our stuff away. I have this so you can have three quarters of it cause you're hungry too".

MHPs said they find themselves in many blended roles in the community and, as a result, relationships can be messy and blurred. One MHP said "Dual roles and rural social work can put me, or us, in double binds". MHPs also indicated they need balance in their lives, as well as healthy boundaries for their own well-being. One MHP said,

> "I have balance that I didn't used to have…I have way better boundaries than I used to…I'm getting it more than I used to. Cause I used to pick up everybody's shit - right. And then it was my shit …And now I'm like, that's not my shit! Like… I'm getting it".

MHPs discussed their struggles with pressure to be in dual roles in their family, specifically counselling family members. One participant explained the following situation:

> "When we have trauma in our family, I find it difficult because I get words like, Well, you're the counsellor…and I have to make sure that they understand that it's what I do - it's not who I am…I can't take my personal hat off and put my professional hat on when it comes to my family…When there is personal trauma,

> I find …I'm not as traumatized as my family is. I see it as being minor in comparison to what other people do…so I have to be very careful that I don't undermine their feelings".

MHPs indicated they have had to establish healthy boundaries to mitigate the demands of working in NSFNCs. One participant indicated that setting out firmer boundaries resulted in experiencing less fatigue. She explained how this transition to stricter boundaries took place over her career in the community in which she works, as follows:

> "I've grown up since I've been there - more about saying I'm not doing this and I'm not doing that. And I did more at the beginning because I had more energy and I was establishing myself in the community. But now I don't. I work in the evenings in the spring, the summer and the fall, but not the winter…We had a … group and everybody was, What night is it? And I'm like, It's during the day. And we'll do a healing circle one night a month with the Elder that I'm not attending. So, everybody gets something. My boss is so good … stays out of your way and… believes that you know what you're doing and let's you do it. So, some of the community members can either give the impression that they think you're …not doing enough. Or else tell you straight out …and I say… That's all I got… From the SE training mostly, I've learned to be way less defensive… That's all I've got…I'm sorry if it's not good enough for you, I'm sorry that you have to feel that way but I'm not gonna feel that way. I just feel a lot more solid in my own boundaries and my own abilities to say no and to not feel guilty. That's all huge to me".

Another person talked about setting boundaries when sharing accommodations with someone in NSFNCs.

> "I've actually told people, I really don't want to do any listening when I'm done work. I'm not being stuck up…I really don't want to listen. And some people would get quite snooty about that, but that's my well-being".

One MHP talked about having balance in her life and taking time for herself when at home as follows: "making sure that my life is balanced…making sure I'm not caught up in the

busy week…for instance get a housekeeper". It was also important for MHPs to spend time with their family. Others talked about staying healthy by integrating the medicine wheel into their life and "having a balance between adventuring, curiosity, following those paths, and then resting and integrating".

4.14.2 Learn to Listen and Feel Gratitude:

One MHP talked about the lessons learned while working in NSFNCs. She said, "The biggest one was listening. And that I got really good education from some of the First Nations peoples that I met as clients, telling me to Shut the hell up!". An additional lesson learned was to feel gratitude when listening to your clients, with one MHP sharing this lesson.

> "I can feel …. the gratitude - the genuine gratitude. I'm gonna cry now (tears) of people just to be heard. To know that they deserve to be heard and to know that you've heard them and that they know you've heard them...cause lots of them have never been heard they haven't even risked speaking. So then when they speak and they get a little bit close to some hard stuff and you're with them and don't leave. You don't leave in the moment, and you're still there the next day, and you're still there the next week, and you still treat them with respect even if they tell you some really awful things that they've done. It's like it helps them to hate themselves a little bit less… So that's one of the most gratifying - when you sit with someone individually or …in a group…and the hush comes which feels like the spirituality being made known".

Listening in essence can create a spiritual space with your client. MHPs also shared the importance of learning to understand your clients' stories are not yours. You are a witness to someone else's story, but you do not own it. In order to do this, you need to be healthy going into this work and take the necessary steps to stay healthy.

4.14.3 Go in Healthy and Stay Healthy - Be a Stable Healthy Presence at Work:

"Things stick to us when we haven't healed our own crap. If there's something I haven't quite dealt with, somebody else's experience is gonna bother me".

All participants talked about the importance of doing your own healing in order to function well in this work. Another MHP spoke about taking steps to stay healthy to protect herself from difficult client stories. MHPs explained the following:

> "Things stick to us when we haven't healed our own crap. If there's something I haven't quite dealt with, somebody else's experience is gonna bother me. And that's an indication that I gotta do some more work on myself".

> "Going into sessions, I always prepare and I had a mentor that taught me that to always remember that it's not your story. Although sometimes you'll be triggered and it will feel like it's your story…I will have people that will be telling trauma stories and it will resonate with something that I have experienced in the past and that will kind of rise up. And I just notice it and just let it be, but it's remembering that this is not my story. This is this person's story and it's not mine to take on as my own. It's not mine to fix. But I am like a conductor, so I will sit with them, with their pain. The pain can come in me but it needs to come out. So, you need to be grounded. It'll come in but I need to be conscious of that...There is an energy to it and it will come in and it will cleave to the broken pieces that are in you and it can cause some heaviness and some problems if you're not always aware of it. Being cognisant of not just what's happened - not just the story - but also the process of it…When you're doing this work… it's like you were working with radio-active material. You need to have processes and things in place to do your work safely. And I have learned that the hard way actually…I'm very careful with it because I want to be a healthy person coming in. And I know that I'm a wounded warrior so to speak… but the wounded pieces …I know what they are and they're not raw… doing this kinda work… You can't have raw wounds going in here. You've gotta look at that stuff. Going in and staying healthy so that you can be healthy and a stable presence. I like to call it the grace-filled presence. So…they feel safe and you can do some really good work …The wisdom that

comes out of my mouth isn't as important as providing that safe space and being able to let them have that place where they can process it. It can go through me and then I need to learn how to ground myself".

MHPs said they need to find someone they can talk to who understands the job in order to stay healthy enough to do this work.

> "I think that throughout my whole career, I really realize that it's important to take care of yourself. And what feels comfortable and what feels normal and safe for me… I went to regular supervision. I've done my own personal mental health counselling. But it really had more to do with the job than the stress of the job in the far north".

4.14.4 Self-Care:

"Self-care involves support, and sometimes positive feedback and validation from those around us".

Regular self-care was recognized as being very important. Four people talked about having healthy energy, and using such things as Somatic Experiencing® (SE®). One MHP talked about doing SE® on herself while talking with clients. One MHP said that she had to self-regulate, stating, "I have to be the stable energy there so that that person can get through that". Another explained,

> "I'm not crushed by the crushing stuff…I'm not consumed by it…you hear this horrific news and you feel like somebody's kicked you …winded you…since somatic experiencing knowing that I'm gonna straighten up and be okay from the winding…it's not gonna end me…so, stuff doesn't stick to me nearly as much since SE®…The whole SE® way of being…more present, more grounded, more focused, less cluttered. When I'm in with people, I'm fully in. Whatever's going on before or after kind of disappears, and I'm just there in the moment…If I do SE® in a session, I'm not tired…I feel hopeful and lighter and just better".

One person said that to do this work, you need to be "a little more grounded, a little more… sure-footed. A little more objective. But still soft, and still available, and still

compassionate, and still empathetic - but not …get swept up and drawn in, cause I don't think that helps anybody".

One MHP said you need to "be a caring empathizer". Participants also talked about knowing the difference between empathy and sympathy. One person said they wouldn't have been able to continue in this work long-term if they didn't understand the difference. One person stated:

> "I don't think I'd still be in this field how many years later if I hadn't learned to have compassion without having …sympathy. I mean empathy is good. Sympathy not so useful in this field".

MHPs also talked about crying with their clients, or after they leave and are in their own quiet space:

> "It's like, just heart-breaking, and so I do sometimes cry with clients. I'm a very emotional woman so…sometimes I feel so intently a quarter of what they've gone through. But I feel with them and … I don't really apologize for that. And it's never been …perceived in a negative way".

Participants did many things to take care of themselves in order to remain healthy so that they were able to carry out their work in NSFNCS. This included: a "good support system", a good diet, regular exercise, spirituality, hobbies (e.g., gardening, yoga, reading, learning); getting a massage, attending retreats, listening to inspirational speakers, taking nature walks, and travel. One MHP talked about the importance of doing things that don't involve being with people and having quiet time (alone time) by engaging in such activities as: art, poetry; writing; canning or gardening. Others talked about having fun, laughing, spending time with friends and "keeping my social life connected", while another stressed the importance of "close connection with family, church, prayer and meditation". Other MHPs discussed homeopathy, acupuncture, cooking, and "lying on the couch, napping, reading books… down time and detaching… watching Netflix… and just not care". Others discussed "volunteering for a good cause, staying on top of the training, or just focusing on the present". As well, another person said "she felt validated by taking part in this project and reading her own story". Thus, they have indicated that

their participation in the project has been healing for them. For example, taking part in the project reassured some participants that taking time off from trauma work was the right decision.

4.14.5 Take Breaks from Trauma Work:

MHPs talked about taking breaks from the work, especially if you are feeling burned out. One person believed that this means "connecting with my spirituality and disconnecting from giving roles". Some participants took time off of their work in NSFNCs in order to take care of themselves, with one MHP saying:

> "Not doing the work, which is I think, exactly what I needed…To be away from the work, be at home, take care of myself, do a lot of self-care…I think the truth of it is not doing the work….not having done the work has made me able to be creative, be able to be present, be able to be healthy, be able to be the mother, the wife, the daughter, and the friend I want to be because I'm not making myself available to anybody else. Sacrificing those very important pieces if myself".

All participants made the choice to only work part time in NSFNCs. Most (80%) also worked one or two days a week in private practice in their home community. One participant explained her choice to work part-time as follows:

> **"**I purposely don't work five days a week cause I feel like this job is a recipe for burnout… and sometimes you worry …Geez - are you the old social worker that's burned out and you don't even notice it? Sometimes they just retire and die because it's too much".

In order for participants, to be healthy and to reconnect with family, friends and other aspects of their lives such as creativity, they needed to take a break from the trauma work and take necessary steps to get well.

4.14.6 When the Work gets to You Take the Necessary Steps for Wellness:

When you find the work getting to you, reward yourself with an indulgence such as spending time entertaining others, going out for a meal, or spending time with grandchildren, which was mentioned by four participants. Another person described what she did when the work started to overwhelm her:

> "The combination of my education and values and experience and attitude…. I'm cocky, right. I'm like you're not getting me…I'm not giving into this shit… you can't have me. I feel blessed…I'm grateful because of my self-care and my self-talk… It's like the impact on Aboriginal people, Indigenous people who survive and thrive.…I put things in perspective …according to that backdrop of understanding that I have (social work). That's big. That's essential for me. I put my attention on things that aren't tragic and sad often. I soak up the good stuff a lot more than I used to".

Another individual described the following:

> "My belief is I must live a life that brings me to a clear white energy…that process made it so much easier…that process of healing brought me a lot more skills…I'm a lot lighter…I've got more energy, I feel healthier, I feel happier, I'm more calm. There is so much more that I can shoo (brush off), you know - it's not my problem. And I mean you can tell me about something terrible in your life and I will feel it with you. My gosh I would feel it with you but…when we walk away, I'm closing the book on your story. And I'm thinking Oh, that was a really powerful story. When I started… I had a lot of supports and they were valuable. I don't need them anymore. I don't need to be talking to a friend about stuff…If something bothered me, I'd find somebody to talk to or find some help…I feel lighter at this point in my life… It feels like this stuff is easy. I don't know how to explain it…This is about growing up as we go through our careers".

Participants have had to make conscious choices to let go of their emotions and to take time to heal when the work had overwhelmed them. MHPs have had to make very careful decisions about what they bring, or choose not to bring, into their lives.

> "I'm very mindful of the things I bring into my home…so I don't bring violent or sharp things. But I make sure that what I'm choosing to do is read stories of resilience or survivor stories … slow living simplistic strategies. I make sure I eat good food that makes me feel good. I make sure I sleep. I make sure that I am with the people that make me feel good".

4.14.7 Need a balance of Formal Supports and Informal Supports:

"Have somebody that gets it… Because the trauma is impossible to describe".

MHPs described an array of formal supports that they rely on to do this work. This included having a clinical supervisor who understands northern Saskatchewan trauma work. They also talked about needing their own counsellor, colleagues that are accessible, SE® practitioners, and a family doctor.

> "I think in private practice, finding those supports and having a supervisor or somebody with whom you can talk about the work or reflect with is really important so that I can keep myself going in every day".

Some participants felt that SASW could be a support to them, but currently is not. One MHP said, "The Ethics Committee…they don't get this world". MHPs acknowledged that the formal community supports in NSFNCs included the nurse in charge, the manager/boss, and the Chief. Only two of ten participants said they had a supervisor who could provide adequate supervision, which includes "feedback and direction, and who understands what you're doing and why you're doing it". The Chief in the community was a support but one person said, "that support almost had to be a secret". Additional supports in the community were co-workers such as NNADAP workers. One MHP said "When I go into community, I know who my support people are". Being able to identify your supports is very important so that you can connect to resources to combat the isolation and the heavy demands of the job.

MHPs identified informal supports as their family (spouse, children, siblings, parents and in-laws) and friends. One participant said, "good girlfriends are pretty amazing". Although participants said their partners were a good support, some said they "didn't really get all this". At the same time, participants said that they have come to an understanding, and that this does not get between them in their relationship. For example, one person said her partner is a support by taking on more of the household chores such as cooking when she is feeling stressed by her work. MHPs talked about needing a variety of informal supports or a "balance of supports". One MHP explained:

> "I reach out constantly to people who are my herd, and I'm honest about how I feel about whatever and what kind of shape I'm in. I don't try to be all together if

I'm not. And I let people see the vulnerable me and they appreciate it". "I feel like it doesn't stick to me and I don't carry it as I had started to carry it".

Another MHP talked about how ceremony has become a support to her, which includes such things as smudging. MHPs said supports also included their church and spirituality with one MHP saying "I have to believe that there's a higher power that's gonna pull me through this". While another explained that in order to help in a good way, you need to stay current. Another promoted continuing education, which she "claims is a necessary for her health". Others advocated pets as being very important, and even travelling to community with them. One MHP said her pet was important in "regulating nervous system kind of support that we don't necessarily talk about". MHPs also recognized that NSFNC members and their co-workers were also part of their informal support system.

The relationships that developed during this project created a safe space for MHPs to share their stories and in turn, felt validated. Participants were able to work collaboratively to develop recommendations. Furthermore, they have expressed a desire to continue to work collectively to develop a 'community of practice', and to collaborate with the CAC in order to take these recommendations forward to improve the quality of their work environments.

4.15 Recommendations - Solutions to Roadblocks

"It has to be a concerted group effort in for safety sake…to pool those experiences and then present them somewhere. But not just suggestions for change".

"When we start to share, things can happen".

Although most of the recommendations are based on the information gathered in the third phase of the project, many solutions or lessons learned were identified throughout the project. MHPs were asked to identify the following in Phase 3:

- What is needed to move past those roadblocks, specifically examining self-care and wellness for mental health providers?
- What are the most commonly identified strengths of mental health providers?

4.15.1 Teamwork Needed:

"I have really come to have a new appreciation for teamwork".

All participants acknowledged the importance of teamwork, with one person saying "I really miss having a team of other therapists around me that I could talk to". Everyone in this project expressed a desire to do things collectively, "not just one person". MHPs also want to build a support network not only for themselves, but for new providers. One recommendation in NSFNCs is to have "a community crisis team…in the far north where you need it more than anything. It never was important, so it never happened. So, the people suffer".

MHPs indicated that they need access to supports such as: regular debriefings, and to work as a team in the community, such as with a psych nurse. In addition, they appealed for a cross-over of supports (team of MHPs) with programming available on evenings and weekends in the community. One person said "We now have trained a lot of people in the community. So, if there is someone who is suicidal, they can handle it". Participants felt we "need to get agencies working together instead of competing for funding". This would help to mitigate the lack of cohesion between agencies.

4.15.2 Support Needed from MHP Government Approval Agency:

Agencies who approve/contract MHPs need to take responsibility for improving the quality of their work environments, especially for new MHPs. The government agency that approves MHPs working in NSFNCs does not have a current structure for MHPs to meet on a regular basis, nor does it provide them access to any supports. As one person stated, "Mental health providers need to be offered coverage for their own therapy when exposed to trauma. This is currently not made available as a contracted benefit to therapists". Another said, "I think every political leader needs to spend at least a week in a northern community".

4.15.3 Believe You are Making a Difference:

MHPs stated that they need to believe they are making a difference in their work in NSFNCs. Participants also indicated that it was important for them to recognize their strengths, one of which is "resiliency in overcoming shunning, racial prejudice and isolation in new communities. Equally important are their loving kindness and mental health skills with those in their care". This statement speaks to MHPs giving themselves permission to recognize their own

worth, and to acknowledge that their work does make a difference to the lives of people in NSFNCs. To quote the words of one MHP,

> "If a therapist doesn't believe they are making a difference, then they are not in the right place. Anger against the system is okay, but it isn't helpful if you don't use it as a catalyst for working for social justice and systemic change… I believe in planting seeds, and in supporting communities to identify challenges, and to face those challenges in their own way. In time, with consistent support, positive changes become evident, despite the systemic challenges".

4.15.4 Long-Term MHPs Needed in NSFNCs:

MHPs want people to know that they need to have people who are committed to this work, and who understand that they have to give up a lot". As well, NSFNCs struggle to secure long-term experienced MHPs. One person explained the following:

> "Sometimes in the north, they also struggle getting people to go up there. They feel some pride about getting people who have been up there for a long time because they know what they're doing...So as it stands, up north there is no mental health therapists. They haven't hired anybody full-time in the north to come and work because first of all, nobody's gonna come for $50 or $60. And their response is, Well the CEO doesn't even make as much so who suffers? The people… It was a huge disservice they've done to the people. By not sitting and not having meetings with us (MHPs) and not asking us…what really do we do? All you're trying to do is make it better - make the whole system better. And they don't want to hear that. I miss the people, and leaving was a huge sadness for me because it was such a huge part of my life"

4.15.5 Better Screening and Training for New MHPs:

Participants were also concerned about new MHPs working in NSFNCs because they are overwhelmed and have less supports than MHPs had in the past. For example, the government agency in charge of approving MHPs no longer brings them together. As stated by one participant,

> "At one time, years back, (name of agency) used to bring us together regularly. It's been what a couple decades now…what you're talking about (name of agency) is …I think it has to be sort of a concerted group effort for safety sake. And to pool those experiences and then present them somewhere. But not just that - it's suggestions for change**.** And I can see from the feedback I'm getting from the ladies now working in the north nothing's changed… There's a lot still the same…The same crisis is still happening".

Another MHP indicated that this lack of supports for new providers is leading to them feeling overwhelmed. She said,

> "I'm mentoring …new mental health therapists that were hired for the north…One of them - I'm on the phone with her every time she goes up (north). Overwhelmed, she says, I don't know how you did this. It's really striking to me, even that many years after my experience. The same system is there and she actually got less support than I did at the time. At least she's calling me and getting some support".

> "Some of the ones that have been up there for a very long time are clearly struggling with burnout. But I'm more surprised by the new young people coming into that line of work already burnt out, or already skewed, or already pessimistic and negative and cruel. That struggle with any type of empathy or compassion in healthcare professionals - that almost scares me more than the one that's been there for 18-19 years, and has just had it and can't do it anymore."

4.15.6 Need Trauma-Informed Specific Training:

Participants suggested more effective strategies to prepare MHPs to provide trauma-informed care/counselling in NSFNCs needs to be put in place such as at a university level. They also stressed the importance of ensuring that new MHPs are qualified to do the work, and that they are continuing their professional education/training. The reason being that "it hits you when you go in the north - it's like every client you ever had sitting together in a community. It seems like almost everybody is impacted by trauma". Participants also felt that someone must be accountable for the training and support of MNPs working in NSFNCs. One MHP commented,

> "I think (name of agency), instead of taking new people once a year, they should get them together and do the cultural training. Provide some understanding. Do a one-day session around culture shock. Where to go for help. Some basic information. No understanding of the culture…They could avoid some of this and invest in their therapists".

Participants said a serious issue is NSFNCs hiring MHPs with little or no trauma work experience who are not equipped to work with people impacted by trauma in northern First Nation communities. What was suggested was,

> **"**Being cautious as to who is sent up north. We should be… evaluated every 3-6 months. Approval agency needs to be more-strict in their credentials and experience needed. Professionals need to be more collaborative and refrain from being competitive or defensive, as this creates an unhealthy working environment and can be counter-productive for community members".

MHPs made it very clear that working in NSFNCs requires specific education, training and experience including community development, counselling, case management, credentials, and writing reports and proposals. Some participants have been mentoring new MHPs to assist them in taking on trauma work in NSFNCs. MHPs report, "We just throw a lot of therapists into the community and they don't know the people. The community does not know them. Do the people go to them"? MHPs talked about needing a university-level course specifically for people wanting to work in northern Saskatchewan. They also recommended that experienced MHPs could provide input into this training, and each of them indicated that they were willing to do this. Some MHPs recommended that therapists have a minimum of a Master's Degree and clinical experience to do this work. Seasoned MHPs could play an important role in mentoring new therapists. NSFNC members could also take on the role of mentoring new MHPs. One person suggested:

> "Solutions could be getting connected with a local family or two for orientation to the (northern) community. Making sure there is a person to greet us when we arrive and give us instruction on what's going on and direction going forward in regards to the work".

4.15.7 Scheduling Time to Meet with Colleagues and Get Clinical Supervisor:

People talked about using innovative ways to connect with colleagues such as a private Facebook page for MHPs. Another commented on how she feels inspired when she meets with colleagues. Another shared her views how you need clinical supervision by someone familiar working in NSFNCs, as follows:

> "Biggest recommendation would be more support for the mental health provider so they can be oriented to the work needed in the community, and also have ability to care for themselves during their time in community… preferably also experience with mental health supervisor. Someone who knows what mental healthcare looks like, and how it may best be received in their particular community".

4.15.8 Building a Community of Practice:

"Community of practice could be a collective voice. There are mental health therapists that could spear this up… teamwork approach…. Making it better means things have to change".

MHPs believe that improvements to their work environment are more likely to occur through collective efforts. A 'community of practice' could be a way to bring them together. One MHP made the following suggestions about what is required:

> "A trauma support specialist in the community… A community of practice could be a collective voice. There are mental health therapists that could spear this up. Bringing more education and workshops - more of the teamwork approach…. Making it better means things have to change. Losing well-trained therapists because things are not changing… in terms of the system that hired me. You are doing a disservice to your clients when the therapist is not asked".

Although MHPs want to improve their work environment, they recognize that in order to be successful, the plan needs to be a collective effort. Participants recognized that they have somehow been able to carry out trauma-informed care/counselling in NSFNCs despite all the obstacles they have been dealing with. One of the changes being discussed is developing a 'community of practice'. MHPs also discussed the reason why they are sometime reluctant to admit they need help:

> "There is a certain level of vulnerability in doing this. Need to work together in a good way. We are seen as weak if we seek out our own supports and say we need help… We need to do our own self help…need to normalize the way therapists are feeling... We need to support each other. We are not failing… we are doing good work".

Although MHPs recognize the benefits of having a 'community of practice', they are unsure of their level of involvement. "I think that having a format for professionals to reach out for individual or group support would be beneficial. I do not know how well it would be utilized, but having the choice would be an asset, especially when one is struggling". Another said,

> "I would be part of a community of support/practice. Some days I think I would go to a meeting with a group of therapists and sometimes not…It would be important for people to talk jointly. There has been no opportunity to do this. There is an insular nature to this job and as a result, people find fault in themselves. Being human and critical ourselves. If you meet with others, you might now think, Oh my God you felt this way. Normalizes how, It's not just me…it might be the nature of the work or non-support that is part of this. It is not just ourselves. I think not gathering has benefits for certain organizations. There is very little support".

All MHPs in this project discussed feeling alone in their work and needing supports such as a sustainable 'community of practice'. Participants were particularly concerned about new providers burning out early in their career due to the lack of supports.

- Participants indicated that a 'community of practice' would help to reduce isolation, and increase supports, which in turn could benefit MHPs' mental health. For example, a senior person could mitigate and help. Maybe you are new. Need even one good person to connect with, even just a debriefing process.
- It is important for "connections to others going north to do this work so that we together can decide how best to serve the communities in a consistent way".

- “Continued funding and contracts are in place so there is no uncertainty in our work and how long we will be there. But, realistic expectations (are needed) in terms of what can be done in the given time we are there”.

“If we keep doing the work that we think is good work despite all the barriers, despite all these roadblocks, just putting one foot in front of the other…and we just keep doing it because why? Cause I think, we believe in something. We believe in ourselves; maybe we believe that change is possible; that we believe that maybe we can’t affect big change. But it’s just the next person through the door”.

Chapter 5
Discussion

The data generated from this project provides the information and insights required to address some of the gaps in the literature and answer the identified research questions. Embedded MMR design supported bringing together both qualitative and quantitative methods for gathering data. PNI supported the development of trusting relationships between participants and I; as well as between participants. Participants were able to share what it was like to be a female outsider MHP working in northern Saskatchewan because this project was relational and collaborative. Overall, their experiences were both positive and uplifting, as well as demanding and overwhelming. Every MHP described hearing distressing stories from their clients including children, which were especially difficult to handle. An important next step moving forward will be to begin conversations within the NSFNCs in which MHPs work to highlight some of the findings evolving from this project. Participants made it clear that the way MHPs are expected to carry out trauma supports in NSFNCs does not support their well-being and undermines their ability/capacity to provide services. If there is a way to begin this conversation through a process of holding ethical space for each other, maybe this process can begin. What is apparent is that doing the same as what has always been done is not helpful to MHPs, to clients, or to northern First Nations communities.

Given their experiences in NSFNCs, MHPs indicated they had been transformed, including how they see the world and interact in and with it.[162] This included their spirituality, world view and their identity, as well as their understanding of colonization and reconciliation efforts. Transformation was also described by MHPs as viewing their experiences in NSFNCs as lessons, and believing there's "hard-learned lessons…in all of it".

A major finding in this project was MHPs discovering or strengthening their spirituality due to their work in NSFNCs. All participants described a spiritual transformation as a result of their work, which was largely absent from other research in this area.[2,3,12,17,35] The reasons given by participants included the following: culture and ceremony were part of the community; starting and ending events/meetings with prayer; spirituality was incorporated into counselling sessions; and being witness to unexplainable events, such as the butterfly touching everyone in

the circle at the funeral. Although spirituality was an important part of their work, most MHPs provided few details of their spiritual beliefs.

MHPs also acknowledged being more cautious when going out in the world, e.g., scanning for safety and worrying that the world was not safe, particularly for children. Participants also explained being more aware of racism, and not tolerating it within their families, communities, or more broadly at a structural and political level. Although MHPs wanted to address structural inequalities and systemic racism, most felt a sense of helplessness about influencing change at these levels. Most also felt that focusing on systemic issues were not only overwhelming, but would take away from what they believed they could do. All participants reported that as a result of their work in NSFNCs, they recognized the importance of applying and practicing with an anti-oppressive, decolonized and reconciliatory lens when engaged in trauma work in NSFNCs. Transformation also occurred for participants after having engaged in this project, and they openly discussed their own colonial history and how it related to their work with clients' trauma in First Nations communities. Furthermore, they also explored their own vulnerabilities, with one participant describing how reading other participants' stories helped her acknowledge her own trauma and the need to deal with it. One MHP described her reaction to first reading the compiled summary of participants' stories, as follows:

> "When I first read through it, I cried. I teared up and what my thoughts were, It's so big. This job we do is so big. It's so big emotionally and spiritually and intellectually, and we're all so little and we go into these communities just so vulnerable and so I think that's what got me. And there was a lot of things that I don't think I even talked about that I don't know if I've even just pushed them down, forgotten them. Hopefully I've dealt with them and let them go, but there was a lot of trigger memories coming up as I read … other people's stories".

MHPs experienced a type of tension or strain in their work within northern communities that was exhausting. This strain occurred as MHPs struggled to build trust and find their place in the community within the context of being a social worker, most often Caucasian, trained in Western ways, and approved by a federal government agency - all of which represented historical trauma through colonization and likely triggered strong feelings by Indigenous peoples. This struggle to fit in took place at the same time as MHPs were trying to keep up with

and cope with the job demands, including a high trauma caseload with limited supports. Within this process to fit in, MHPs also recognized that it took time to understand how each community functioned, and their norms. As well, it took time for First Nations community members to understand the ways of each outsider MHP coming to their community. This slow building of relationships was described by one MHP as holding space where both client and provider see resilience and healing. This is in line with the work of First Nations scholar, Willie Ermine[165], who developed the concept of ethical space to describe a place in which two worldviews can be brought together to share conversation and knowledge.

Participants were considered outsiders because they did not reside within the communities in which they worked. Many of the non-Indigenous participants, or those who appeared non-Indigenous, claimed that they experienced racism (racial prejudice) and lateral violence. These issues were rarely discussed in previous studies. As I spoke with participants, they shared their belief that the oppression and the hurt of colonization were the driving forces behind these abusive behaviors. Although they tried not to take the abusive behavior personally, few confronted it directly or reported it to anyone. MHPs felt they needed to be resilient and have a "thick skin" to cope. Those MHPs with clearly-defined boundaries, especially with clients, co-workers and community members, said they could more easily deal with the abuse, as well as confront it. In addition, individuals with strong boundaries reported having more energy and increased capacity to do the work.

Being outsiders, many worried that their every move was being scrutinized by the community, and as such, they were very careful in what they said or did (this was consistent with previous studies).[12,71,72,163] An additional finding highlighted in this project was how being a female MHP had unique challenges in NSFNCs, including feeling unsafe in accommodations due to break-ins, the inability to walk around in the community, especially in the evening, unwanted sexual comments, and an overall feeling of the world not being safe.

Although MHPs indicated that a great deal of effort must go into building relationships in NSFNCs, many felt they would always be viewed as an outsider. As it turns out, even though it takes time to build trust, clients appreciated outsiders not knowing their personal history and respecting confidentiality. On occasion, insider MHPs from the community were viewed by clients as knowing too much about their stories. This overall lack of trust by community

members, and seeing outsiders as the professionals, was a consistent narrative conveyed by participants (Indigenous and non-Indigenous). At the same time, MHPs in this project were taking part in efforts to increase the number of Indigenous MHPs working in northern Saskatchewan, which supports the TRC's Calls to Action.[61] This included mentoring and providing clinical supervision to new Indigenous MHPs; providing practicum placements for Indigenous Social Work students in First Nations communities; and taking the time to talk with Indigenous MHPs who are considering a career in northern trauma work.

MHPs want to provide long-term mental health supports in communities versus short-term crisis supports, which was consistent with other studies.[11] As outsiders, short-term crisis support further undermined MHPs' ability to build crucial trusting relationships to effectively provide trauma-informed care/counselling in NSFNCs. In this project, MHPs believed in the power of relationships, and enjoyed attending events in the community to strengthen these connections and build trust. At the same time, MHPs acknowledged taking on multiple roles in the community in order to fit in, which can be tiring, particularly with the incredible demands of providing trauma-informed care/counselling in northern communities. This was also consistent with previous studies.[2]

Quantitative results from the self-administered ProQOL-5 indicated that compassion satisfaction levels for MHPs were medium to high, and compassion fatigue levels were low to moderate. Although overall rates of compassion fatigue were low to moderate, conflict with management and local politics were identified as key factors in overall feelings of frustration and symptoms of burnout. In this project, the reason most often cited for leaving the job was conflicts with management, whereas in previous studies, an inability to cope and find balance in one's life were the most common reasons.[34,70] Additional negative implications of working in NSFNCs were high trauma caseloads and as a result, feeling that the world was not safe, as corroborated by other studies.[35,40] MHPs reported experiencing increased anxiety, sleep disturbances, decreased desire to connect with others, and increased fatigue. Work barriers for MHPs included the professional Code of Ethics not fitting the work, working in multiple roles, which could lead to boundary challenges, not knowing the community's culture or language, and isolation. All of which were consistent with previous studies.[2,12]

Participants worked in a number of First Nations communities throughout northern Saskatchewan. Although their experiences were similar, there were distinct differences between fly-in NSFNCs, and communities accessible by road. MHPs working in fly-in communities experienced additional layers of isolation including geographical isolation, and the emotional/relational isolation of being away from their family and friends for up to three weeks at a time. This was similar to the findings in other studies in that workers in isolated locations had to deal with high levels of demands because they were also isolated from other professionals.[12]

Although not mentioned in previous studies, MHPs in this project indicated that preparing to go into NSFNCs was demanding, and generated "anticipatory anxiety". Even before they arrived in the community, they had to book their flights, pre-plan their meals, and pack all their food, toiletries, and work supplies. They worried about where they would stay, what crisis they might have to deal with, and started thinking about being away from their family. Furthermore, there was the actual flying time or long drives on poor roads. The majority of MHPs who had stopped working in fly-in NSFNCs said they left because of ongoing frustrations with management. This issue created work environments that were intolerable and in turn, created a sense of being unappreciated, as well as feeling anxious, sad and afraid. The decision to leave was not an easy one because of their deep-rooted relationships with the communities. This finding contributes to previous research as it conveys the importance of the MHPs' relational connection with the community.

Overall, participants identified the following factors as having the strongest impact on their well-being, thereby undermining their capacity to do the work: isolation, ineffective boundaries, insufficient access to resources, lack of safety, experiencing racism (racial prejudice) and lateral violence, and political and management challenges. In addition, systemic issues created many barriers for both participants and the communities to which they provided services. Although there were challenges/barriers, MHPs loved the work, their clients, and the communities in which they worked. There were many positive aspects of the work, including building relationships, being part of a community and seeing positive changes, learning to listen, autonomy, and experiencing the extraordinary beauty of culture and nature. With limited discussion regarding the positive aspects of northern work, this project really highlighted the significance of feeling connected within one's work.[2,3,12,16,17,35,164] Most participants felt very

connected to the working community within which they worked, and wanted the same connections with the community where they lived.

Even though compassion satisfaction rates were moderate to high, all participants recommended that MHPs work with a team. Previous studies found trauma teams with supportive members reported low rates of secondary trauma, and that working collaboratively helped to mitigate burnout stressors.[83,90] Former studies also recommended working in teams that collaborated with professionals and community helpers in northern trauma work in order to retain MHPs (i.e., reduce the number of MHPs leaving their jobs).[2,85] Furthermore, when working in northern Canada, one needs to utilize a trauma-informed framework in addition to the need to build relationships with clients and the community.[2,12]

MHPs working in NSFNCs had experiences that enabled them to provide valuable information for educational programming to prepare individuals who aspire to work in the north.[16] Given the unique circumstances of each community, it has been suggested that training new MHPs include being connected to local families in order to become acquainted with the community, along with its culture and customs.

Participants were committed to the communities in which they worked, and believed that the practices developed in southern Saskatchewan did not fit the needs of northern First Nations communities. All MHPs stated that resources were limited in northern Saskatchewan, and advocated for northern communities to have access to appropriate, sustainable, and high-quality mental health resources. It was clear from the stories told by MHPs that they were very passionate about their work in NSFNCs, and that they recognized the resiliency and strengths of their clients. MHPs are committed and empathetic to the needs of First Nations peoples and believe that reconciliation was an important part of their work. They indicated that they passed these beliefs onto their children so they were educated about the ongoing injustices imposed by mainstream society onto First Nations peoples in Canada. Their strong alliances with First Nations peoples have meant, for some MHPs, choosing not to be in the company of family or friends who do not share the same perspective. Most MHPs report being friends most often with other like-minded social workers who share similar anti-oppressive reconciliatory ways of thinking. MHPs wanted to make a difference in their work, and this included reconciliation efforts being central to these efforts. MHPs want to work collectively to improve the quality of

their work environments, and felt this was now possible as a result of their involvement in this project. Participants in this project also want people to understand that only so much can be taught in a classroom about working in NSFNCs, with one MHP stating “Much of what you learn will be from the people and the community”; and another advising: “You just go in with a kind of … beginner’s mind… Not coming in as the professional who knows it all”.

The conceptual contribution of this project was in regard to individual and community well-being. Participants were able to engage in a collaborative process to define the construct of well-being. This involved participants working with the collective stories, followed by feedback with the goal of reaching agreement as to how well-being would be defined in this project. The narratives and self-reflective processes participants engaged in supported and expanded their own understanding of well-being that was meaningful to them. What emerged from this project specific to well-being was the significance of spirituality, as well as the overwhelming need for safety. All participants discussed the importance of spirituality to their well-being, and the positive impact working in the north had on their life. They also stated that a lack of safety undermined their well-being, as well as their ability to perform their work.

MHPs in this project identified the following well-being supports that are required: access to clinical supervision and consultation; a manager that understood the role of MHPs; healthy boundaries; a balanced, healthy life; grounded nervous system; strong relationships with co-workers; interests outside of work; going into this work healthy and staying healthy; healing your personal traumas; and taking a break from the work when needed.

The group gathering in December of 2019 created the foundation for MHPs working together to hear the stories of others, to generate recommendations, and to begin discussions on building a ‘community of practice’ to carry the recommendations forward and support one another in the work that they do. Although the discussions began and the foundation was laid, COVID-19 emerged in March, 2020, resulting in a State of Emergency being declared in Saskatchewan, which led to people self-isolating in their homes. Participants in this project contacted me and said they needed time to absorb and adjust to the implications of the pandemic for themselves and their families. As such, participants are still not in a position to meet in person, and the only contact to date has been through phone calls, e-mails, and virtually through Zoom meetings. It was the opinion of participants and of the CAC that until the pandemic is

resolved, there will continue to be limitations to building a 'community of practice'. The pandemic was one roadblock in this project that will not likely be resolved in the immediate future. In the next section, I provide an overview of additional limitations or challenges encountered in this project.

5.1 Limitations

I recognized seven limitations or challenges within this project. The first was the complex dynamics of relationships within CBPR.[166] Developing relationships takes time and effort, and the group dynamics were occasionally a source of vulnerability.[95] While it was difficult to facilitate and manage all aspects of these relationship challenges, having strong listening and mediation skills was definitely an asset. The second challenge, which was linked to the nature of the qualitative narrative inquiry, was the lack of generalizability due to the small number of participants and the open-ended interview process.[167] Although the methodology supported generating authentic and meaningful data, it was not meant for comparison. The third limitation was a small sample size and the utilization of a typical case sample. Even though these were conscious choices in consultation with the CAC, it was important to recognize the potential for sampling bias. The fourth was that only women were interviewed in this project, and therefore gender differences would likely exist. The fifth challenge occurred because participant involvement in the data analysis feedback process varied. Although participants were encouraged and given every opportunity to participate in all aspects of the research process, only about half of the participants responding to all feedback requests. The sixth was determining how to weave together both the qualitative findings and the quantitative results into the outcomes. The process of integration in MMR can be challenging, but clearly stating the process allowed the reader to understand how and why it was carried out.[103] The seventh and final limitation was that the self-reflective journals were not utilized by participants for a number of reasons including a lack of time or forgetting about it. As indicated by one of the participants, "calling, texting or e-mailing information" was a more effective process for relaying information rather than using the journals.

Although there were limitations and challenges in the methods used in this project, overall, they were very effective in gathering the in-depth data required to answer the research questions. As well, the participants and I were able to build the trusting relationships needed to

co-create their stories in order to understand the impact of working in NSFNCs, and what was needed to support their well-being. Participants revealed that knowing that other MHPs were experiencing similar events and feelings was both validating and normalizing for them. In essence, the project was also therapeutic for participants because they were able to share and unravel their stories, many of them for the first time, in a safe space conducive to healing. PNI has characteristics similar to narrative therapy as it supported telling as well as reflecting on one's story to create something new. Narrative therapy also supports deconstructing a story to review a problem within the context of its individual and broader social factors to in turn develop a new story.[168]

It was exciting to learn that all participants wanted to work collaboratively with a team and build a 'community of practice' to carry out their work in NSFNCs. The CAC is also committed to undertaking the process of taking participants' recommendations and stories forward. Further discussions will be taking place with participants and the CAC about how best to advocate for the implementation of these recommendations going forward.

Chapter 6
Conclusion/Reflections/Recommendations

The purpose of this project was to hear the stories of MHPs delivering trauma-informed care/counselling in NSFNC, to understand how these experiences have impacted their lives, and to co-create support recommendations such as a 'community of practice'. MHPs' stories were co-created using an embedded MMR design incorporating both qualitative and quantitative methods. A single quantitative method (the ProQOL-5) was self-administered by participants. The qualitative method (PNI) included narrative interviews, a group gathering, e-mails, phone calls, and a self-reflective journal (participants chose not to turn them in). Multiple interviews were required to build rapport and safety with participants so that they could share their in-depth stories to facilitate answering the research questions. This included participants having the opportunity to meet one another, thereby laying the foundation for co-created recommendations including the development of a 'community of practice'.

The methodological contribution of this project was the research processes. The processes have been documented in detail in Chapter 3. As such, a curious and innovative researcher with the desire to engage in participatory research would likely find the process helpful. Utilizing an MMR design with PNI affirmed that developing safe trusting relationships to work with participants is so very important and takes time. PNI supported building these necessary trusting relationships to work collaboratively with participants and the CAC throughout the project. With both PNI and embedded MMR design, the participants and I were able to be innovative and creative in co-creating collaborative research processes. Although at times, I questioned the choice to carry out MMR that was participatory, I know now that it was the right decision for this project. I have learned that working in collaboration with others, although complex and time-consuming, facilitated the co-creation of a collective foundation on which to work together to make recommendations and take them forward in appropriate ways.

The co-created stories were analyzed through an iterative cyclical integrated model using sensemaking, content analysis, narrative contextual analysis, and narrative thematic analysis. Participants were engaged at multiple stages to ensure the accuracy of emerging categories and themes. The stories of MHPs working in NSFNCs contained the following common themes: isolation, lack of safety. very demanding work with high trauma caseloads, and limited access to

supports and resources. MHPs also reported experiencing lateral violence and racial prejudice from co-workers and community members, which further undermined their sense of safety. At the same time, their stories contained the following themes: love of the work and the people, desire to make a difference in their work, spiritual awakening, seeking the beauty and resilience within clients, and believing in the importance of reconciliation. Participants described working in NSFNCs as changing who they are (their identity) and as a result, also changing the people close to them.

Although social workers spend a considerable amount of time supporting, advocating and building capacity in others, they ironically struggle to provide it for themselves. During the interview, participants often tended to talk about the needs of others such as clients and the communities in which they work. I found myself gently guiding them to talk about their own capacity/resiliency, the impact of the work on their well-being, and their own healing. These MHPs appeared to put the needs of others ahead of their own, which has the potential to undermine their own well-being, that of their families, as well as the clients they work with in NSFNCs. All participants felt disconnected from other MHPs working in First Nations communities, and identified wanting to establish these connections. Participants found reading their own stories, and those of others, helped to normalize how they were feeling and provided evidence that their concerns need to be collectively addressed. The gathering on December 13, 2019 was one of the first times these MHPs met as a group to discuss their experiences. They want to continue building on this initial connection, and discussed forming a 'community of practice'.

The participants, along with the CAC and I, have been involved in all aspects of this project, and will continue to be part of the processes moving forward. We have committed as a team to advocate to meet with the agencies and learning institutions that are instrumental in supporting the well-being of MHPs to discuss the recommendations that evolved from this project. These include, but are not limited to, Health Canada, the Saskatchewan Association of Social Workers, the First Nations University of Canada, and the University of Regina. The tasks for this process will take place through collaborative processes that are beyond the scope of this Dissertation.

Exploring MHPs experiences through a gender lens would be important for future studies. A follow-up project for men would be in order, as two male MHPs had indicated their interest in being a part of this project. This would assist in determining what, if any, differences might exist based on gender. Upon completion of such a project that would include men, I would facilitate a larger discussion with participants from both studies being invited to take part in a group gathering with the goal of defining/re-defining the next steps.

This research was meaningful to participants, as it provided an opportunity for MHPs to share their experiences and have their voices heard. As well, MHPs were able to understand how their own thinking, biases and beliefs needed to be examined through a process of sensemaking and critical self-reflection in order to actively move forward with reconciliation efforts. Although they did not use the actual term cultural humility developed by Tervalon and Murray-Garcia,[169] participants described going into NSFNCs with "curiosity" and "a beginner's mind", while striving to "empower clients". This approach is also in line with Nadan[170] who argues that social workers need to critically reflect on the power imbalances as they work with and within communities.[170] This supports a trauma-informed practice approach that moves beyond that of cultural competence[61,77,78] and cultural safety[11] to include ongoing critical self-reflection processes to protect and respect an Indigenous world view.[80] Although this particular process of critical reflection is unique to this project, it is my hope that these findings inspire others to take steps to examine their own colonial history as a way to move towards reconciliation efforts in their practice in NSFNCs.

This project provided the space for MHPs to reflect on their stories and in turn, to make research informed collective recommendations to support their well-being and improve the environments within which they work. These recommendations established how to support MHPs currently delivering trauma-informed care/counselling in NSFNCs, as well as for individuals considering a career in and with northern healing systems (refer to Figure 6.1). This project also provided an opportunity for participants to engage in a project that has the potential to support social workers, both Indigenous and Western-trained, aspiring to work in northern communities. Working with and within NSFNCs requires a collective understanding of a specific approach to working with trauma in northern Saskatchewan. This would include, but would not be limited to, cultural awareness,[15-17] cultural competency,[12,63,77,78] and cultural safety,[11] all of which support the need for self-reflection on our own values [22] to protect an Indigenous world

view.[80] As such, participants were able to contribute to the field of social work under the value of practice competence,

> "Social workers contribute to the ongoing development of the profession and its ability to serve humanity, where possible, by participating in the development of current and future social workers and the development of new professional knowledge".[8]

In conclusion, MHPs working in NSFNCs have been transformed as a result of their lived experiences. This project provided the necessary evidence to bridge the research gap specific to MHPs in northern Saskatchewan, and created an opportunity to address what is needed to support and engage them in this meaningful work.

Policy Brief: Northern Saskatchewan Mental Health Providers

1. It is most important for MHPs to be healthy when entering northern healing systems; more specifically, having healed their own personal traumas. It is understood that helping professionals may also have their own healing to do. Therefore, we encourage MHPs entering northern healing systems to prioritize their own healing and to work from a position of wellness.
2. MHPs need increased resources including formal and informal supports to stay healthy in order to continue providing long-term relationship-driven client services in NSFNCs.
3. Health Canada (Government MHP-approval Agency) needs to review/improve the screening process for new MHP applicants, and to provide all approved MHPs with access to supports. These include clinical supports, access to debriefing, and group gatherings.
4. MHPs recognize that additional supports are needed within NSFNCs to improve the environments within which they work, namely job security and access to safe, predictable and private accommodations.
5. A necessary step in preparing MHPs who want to work in northern healing systems is to provide training. Therefore, specialized training should be developed at the University level, specifically for social workers wanting to work in NSFNCs. As well, this course should be developed with input from experienced MHPs.

a. MHP training should include trauma-informed care/counselling course work.
b. Students should have access to mentorship programs with experienced MHPs who have worked in NSFNCs.

6. MHPs believe interdisciplinary NSFNC teams are needed to encourage community supports/agencies and relevant outside supports to work cohesively and collaboratively.
7. MHPs recognize the need for professional supports and want to co-create (work together) to coordinate the development of a 'community of practice' for MHPs working in NSFNCs.

Figure 6.1: Mental Health Provider Project Participants' Recommendations

References

1. Kiawenniserathe Benedict A. Dying to get away: suicide among First Nations, Métis and Inuit Peoples. In: Kandhai K, editor. Inviting hope: an exposé on suicide among First Nations, Inuit and Métis peoples. Winnipeg (MB): Aboriginal Issues Press; 2015.1-24 p.
2. O'Neill L. Northern helping practitioners and the phenomenon of secondary trauma. Can J Couns. 2010;44(1):130-49.
3. O'Neill L, George S, Sebok S. Survey of northern informal and formal mental health practitioners. Int J Circumpolar Health. 2013;72:[7 p.].
4. Government of Canada. Guide to mental health counselling services.[Internet] 2018; Available from: https://www.canada.ca/en/indigenous-services-canada/services/first-nations-inuit-health/non-insured-health-benefits/benefits-information/mental-health-counselling-benefits/guide-mental-health-counselling-services-first-nations-inuit-health.html#a21
5. Health Canada [Internet]. First Nations and Inuit Health Branch: Brighter futures and building healthy communities. 2013 [updated 2013 Oct 2; cited 2016 Feb 26].Available from: http://www.hc-sc.gc.ca/fniah-spnia/promotion/mental/brighter_grandir-eng.php
6. Hopper E, Bassuk E, Olivet J. Shelter from the storm: trauma-informed care in homelessness services settings. Open Health Serv Policy J.2010;3:80-100.
7. Government of Canada. Who is eligible for the non-insured health benefits program. [Internet]. 2019; Available from: https://www.sac-isc.gc.ca/eng/1574187596083/1576511384063
8. Canadian Association of Social Workers. CASW Code of Ethics [Internet]. 2005. Available from: https://www.casw-acts.ca/en
9. Canadian Institutes of Health Research. Strategy for patient-oriented research: patient engagement framework [Internet]. 2014. Available from: https://cihr-irsc.gc.ca/e/48413.html
10. Wenger-Trayner E, Wenger-Trayner B. Communities of practice a brief introduction. [Internet]. [2015 Apr 15]. Available from: https://wenger-trayner.com/wp-content/uploads/2015/04/07-Brief-introduction-to-communities-of-practice.pdf

11. Assembly of First Nations. First Nations mental wellness and the non-insured benefits (NIHB) short term crisis intervention mental health counselling (STCIMHC) benefit [Internet] Ottawa (ON):2015. Available from: http://www.afn.ca/uploads/files/2015_usb_documents/afn_document_review_stcimhc_nov 2015.pdf.
12. O'Neill L, Koehn C, George S, Shepard B. Mental health provision in northern Canada: practitioners' views on negotiations and opportunities in remote practice. Int J Advancement Couns. 2016;38(2):123-43.
13. Figley CR. Compassion fatigue as secondary traumatic stress disorder: an overview. In: Figley CR, editor. Compassion fatigue: coping with secondary traumatic stress disorder in those who treat the traumatized. New York (NY): Routledge; 1995.1-20 p.
14. Elwood L, Mott J, Lohr J, Galovski T. Secondary trauma symptoms in clinicians: a critical review of the construct, specificity, and implications for trauma-focused treatment. Clin Psychol Rev. 2011;31(1),25-36.
15. Vukic A, Rudderham S, Misener RM. A community partnership to explore mental health services in First Nations communities in Nova Scotia. Can J Public Health / Revue Canadienne de Sante' Publique. 2009;100(6):432-5.
16. Graham J, Brownlee K, Shier, M, Doucette E. Localization of social work knowledge through practitioner adaptations in northern Ontario and the Northwest Territories, Canada. Arctic.2008;61(4):399-406.
17. Coholic D, Blackford K. Exploring secondary trauma in sexual assault workers in northern Ontario locations - the challenges of working in the northern Ontario context. Can Soc Work. 2003;5(1);43-58.
18. Saskatchewan College of Psychologists [Internet].Professional practice guidelines 3rd version [Internet] 2019 [Oct 5] Available from: http://www.skcp.ca/wp-content/uploads/PROFESSIONAL-PRACTICE-GUIDELINES-20193.pdf
19. Saskatchewan Association of Social Workers. Becoming a Member [Internet] 2018. Available from: https://sasw.ca/site/become_member
20. Hill M, Bruyere T, Mushquash C. It takes a whole community: an evaluation of Saskatchewan mental wellness teams. [Internet]. Centre for Rural and Northern Health Research, Lakehead University. Thunder Bay (ON). Available from:

https://www.lakeheadu.ca/sites/default/files/uploads/36/Evaluation%20of%20Saskatchewan%20Mental%20Wellness%20Teams%20%28Dec%2012%202016%29%20%28Final%20Report%29%20%281%29.pdf

21. Statistics Canada. Census Profile [Internet]. 2016. Available from: https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/details/page.cfm?Lang=E&Geo1=PR&Code1=47&Geo2=PR&Code2=01&Data=Count&SearchText=47&SearchType=Begins&SearchPR=01&B1=All&Custom=&TABID=3
22. Moss A, Racer F, Jeffery B, Hamilton C, Burles M, Annis, R. Transcending boundaries: collaborating to improve access to health services in northern Manitoba and Saskatchewan. In: Kulig J, Williams A, editors. Health in rural Canada. Vancouver (BC): UBC Press; 2012. p.159-177.
23. Irvin J, Quinn B, Stockdale D. Northern Saskatchewan Health Indicators Report. Athabasca Health Authority and Keewatin Yatthe and Mamawetan Churchill River Regional Health Authorities. Population Health Unit, La Ronge (SK). 2011.
24. Global News Report. Fallen Fond-du-Lac firefighter shows more help needed to stop suicide: FSIN. [Internet][Updated 2018 Aug 14]; Available from: https://globalnews.ca/news/4388032/fond-du-lac-firefighter-suicide-mental-health-fsin/
25. Federation of Sovereign Indigenous Nations. Discussion paper regarding a Saskatchewan First Nations suicide prevention strategy [Internet] [2017 Sept 22]. Available from: http://caid.ca/SasFNSuiDisPap2017.pdf
26. LaVallie C. Onisitootumowin Kehte-Ayak (The understanding of the old ones) healing from addiction [dissertation]. [Regina (SK)]: University of Regina; 2019. 357 p.
27. World Health Organization. Mental health strengthening our response [Internet]. [2018 Mar 30]. Available from: https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response
28. Mental Health Foundation of New Zealand. Fact sheet: mental health and wellbeing definitions [Internet]. Available from: https://www.mentalhealth.org.nz/assets/Working-Well/FINAL-Working-Well-FS-Mental-health-and-wellbeing-definitions-approved.pdf

29. Health Canada. First Nations mental health wellness continuum framework [Internet]. [2015 Jan]. Available from: https://thunderbirdpf.org/wp-content/uploads/2015/01/24-14-1273-FN-Mental-Wellness-Framework-EN05_low.pdf
30. Adelson N. The embodiment of inequity: health disparities in Aboriginal Canada. Can J Public. 2005; 96:S45-61.
31. Hackett C, Feeny D, Tompa E. Canada's residential school system: measuring the intergenerational impact of familial attendance on health and mental health outcomes. J Epidemiol Community Health. 2016;70(11):1096-1105.
32. Health Canada. First Nations and Inuit Health Branch. A statistical profile on the health of First Nations in Canada vital statistics for Atlantic and western Canada, 2001/2002. Ottawa (ON): 2011.
33. Lavoie J, Gervais L. Access to primary health care in rural and remote Aboriginal communities: progress, challenges and policy directions. In: Kulig J, Williams A, editors. Health in rural Canada. Vancouver, BC: UBC Press. 2012. p. 390-408.
34. Harrison R, Westwood M. Preventing vicarious traumatization of mental health therapists: identifying protective practices. Psychotherapy: Theory, Research, Practice, Training. 2009; 46(2):203-19.
35. Bishop S, Schmidt G. Vicarious traumatization and transition house workers in remote, northern British Columbia communities. Rural Society. 2011;21(1):65-73.
36. Hensel J, Ruiz C, Finney C, Dewa C. Meta-analysis of risk factors for secondary traumatic stress in therapeutic work with trauma victims. J Trauma Stress. 2015;28(2):83-91.
37. Pearlman L, Saakvitne K. Treating therapists with vicarious traumatization and secondary traumatic stress disorder. In: Figley C, editor. Compassion fatigue: coping with secondary traumatic stress disorder in those who treat the traumatized New York (NY): Routledge; 1995.p.150-77.
38. Harinarain E. Compassion fatigue, level of exposure, empathy and affect intensity amongst employee assistance programme counsellors [dissertation]. [Johannesburge (ZA)]: University of Witwaterstrand; 2007. 125 p.
39. Adams SA, Riggs S.A. An exploratory study of vicarious trauma among therapist trainees. Train Educ in Prof Psychol. 2008;2(1):26-34. doi:10.1037/1931-3918.2.1.26

40. Collins S, Long A. Working with the psychological effects of trauma: consequences for mental health- care workers – a literature review. J Psychiatr Ment Health Nurs. 2003b;10:417-424.doi:10.1046/j.1365-2850.2003.00620.x
41. McCann L, Pearlman L. Vicarious traumatization: A framework for understanding the psychological effects of working with victims. J Trauma Stress. 1990;3(1):131-49.
42. Newell J, McNeil G. Professional burnout, vicarious trauma, secondary traumatic stress, and compassion fatigue: A review of theoretical terms, risk factors, and preventive methods for clinicians and researchers. Best Practices in Mental Health. 2010;6(2): 57-68.
43. Stamm BH. The Concise ProQOL Manual, 2nd ed. Pocatello, ID: ProQOL.org. [Internet]. 2010 Available from: https://proqol.org/uploads/ProQOLManual.pdf
44. Figley CR. Compassion fatigue: Psychotherapists' chronic lack of self-care. J Clin Psychol. 2002;58(11):1433-41. doi:10.1002/jclp.10090
45. Rzeszutek M, Partyka M, Gołąb A. Temperament traits, social support, and secondary traumatic stress disorder symptoms in a sample of trauma therapists. Prof Psychol Res Pr. 2015;46(4):213-20.
46. Westman M, Bakker, A. Crossover of burnout among health care professionals. In: Halbesleben J, editor. Handbook of stress and burnout in health care. New York (NY): Nova Science Publishers, Inc; 2008. p. 111-25.
47. Breaux D, Meurs J, Zellars K, Perrewe P. Burnout in health care: when helping hurts. In: Halbesleben J, editor, Handbook of stress and burnout in health care. New York (NY): Nova Science Publishers, Inc; 2008. 39-50 p.
48. Stone S. A phenomenological study of the work experiences of foster care caseworkers with indications of secondary traumatic stress disorder [dissertation]. [Ann Arbor MI] Capella University; UMI Dissertation Pub. 2011. 110 p.
49. Bride B. Prevalence of secondary traumatic stress among social workers. Soc Work. 2007;52(1):63-70.
50. Pearlman L, Mac Ian P. Vicarious traumatization: an empirical study of the effects of trauma work on trauma therapists. Prof Psychol Res Pr. 1995;26(6):558-565.

51. Health Canada. Mental health providers list - Saskatchewan [31 Aug]. Received via e-mail, from: Mental Health Counselling Benefit, First Nations and Inuit Health Branch, Department of Indigenous Services / Government of Canada
52. Sprang G, Whitt-Woosley A, Clark, JJ. Compassion fatigue, compassion satisfaction, and burnout: factors impacting a professional's quality of life. J Loss and Trauma. 2007;12(3): 259-280. doi:10.1080/15325020701238093
53. Carnigi J, Hardiman E, Weldon P, Fletcher S, Devlin M, Stanick C. Secondary traumatic stress and liscensed clinical social workers. Traumatol. 2016;23(2):186-95.
54. Dahle R. Social work: a history of gender and class in the profession. Ephemera articles: theory and politics in organizations. 2012;12(3):309-26.
55. Dehlin M, Lundh L. Compassion fatigue and compassion satisfaction among psychologists: Can supervision and a reflective stance be of help? J Person-Oriented Res. 2018;4(2),95-107. doi:10.17505/jpor.2018.09
56. Thormav S, Gersos B, Juen B, Djakababa M, Karlsson T, Olff M. The impact of disaster work on community volunteers: the role of per-traumatic distress, level of personal affectedness, sleep quality and resource loss on post-traumatic stress disorder symptoms and subjective health. J Anxiety Disord. 2014;28:971-977.
57. Devilly G J., Wright R., Varker T. Vicarious trauma, secondary traumatic stress or simply burnout? Effect of trauma therapy on mental health professionals. Aus N Z J Psychiatry. 2009;43(4):373-85. doi:10.1080/00048670902721079
58. Ludick M, Figley CR. Toward a mechanism for secondary trauma induction and reduction: reimagining a theory of secondary traumatic stress. Traumatol. 2016 doi:10.1037/trm0000096. [12 p.].
59. Morrissette P, Naden M. An interactional view of traumatic stress among First Nations counselors. J Fam Psychother.1998;9(3):43-60.
60. Stewart S. Family counselling as decolonization: exploring an Indigenous social-constructivist approach in clinical practice. First Peoples Child Fam Rev. 2009;4(1):62-70.
61. Truth and Reconciliation Commission of Canada [Internet]. 2015. Truth and Reconciliation Commission of Canada: calls to action. Available from: http://trc.ca/assets/pdf/Calls_to_Action_English2.pdf

62. Thompson S, Kopperrud C, Mehl-Madrona L. Healing intergenerational trauma among Aboriginal communities. In: Kalayjian A, Eugene E, editors. Mass trauma and emotional healing around the world: rituals and practices for resilience and meaning making. Vol. 2: human made disasters. Santa Barbara (CA): ABC-CLIO; 2010.
63. The Truth and Reconciliation Commission of Canada [Internet]. Canada, Aboriginal Peoples, and residential schools: they came for the children. Winnipeg (MB): 2012. Available from: http://www.myrobust.com/websites/trcinstitution/File/2039_T&R_eng_web%5B1%5D.pdf
64. Ray A. An illustrated history of Canada's Native people: I have lived here since the world began. Toronto (ON): McGill-Queen's University Press; 2010. 432 p.
65. Ross R. Indigenous healing: exploring traditional paths. Toronto (ON): Penguin Canada Books Inc; 2014. 322 p.
66. Jacklin K, Warry W. Decolonizing First Nations health. In: Kulig J, Williams A, editors. Health in rural Canada. Vancouver (BC): UBC Press; 2012. p. 373-389.
67. Global News Report.Stats Canada: Indigenous youth overrepresented in Saskatchewan prisons.[Internet] [Updated 2018 Jun 25]; Available from: https://globalnews.ca/news/4296481/stats-canada-indigenous-youth-overrepresented-in-saskatchewan-prisons/
68. Edwards, K. Life after foster care in Canada. The stunning number of First Nations kids in care is a new touchstone for activists—and for rebel parents [Internet]. In: McLean's 2017 Available from: https://www.macleans.ca/first-nations-fighting-foster-care/
69. Allan B, Smylie J. First peoples, second class treatment. The role of racism in the health and well-being of Indigenous peoples in Canada. Toronto (ON):Wellesley Institute; 2015. Available from: http://www.wellesleyinstitute.com/wp-content/uploads/2015/02/Summary-First-Peoples-Second-Class-Treatment-Final.pdf
70. Kanno, H. Supporting indirectly traumatized populations: the need to assess secondary traumatic stress for helping professionals in DSM-V. Health Soc Work. 2010;35(3):225-7.

71. Cruikshank J. The outsider: an uneasy role in community development. Can Soc Work Rev/Revue Canadienne De Service Social. 1990;7(2):245-259.
72. Zapf M. Remote practice and culture shock: social workers moving to isolated northern regions. Soc Work. 1993;38(6):694-704.
73. Galambos C, Watt J, Anderson K, Danis F. Ethics forum: Rural social work practice: Maintaining confidentiality in the face of dual relationships. [Internet]. J Soc Work Values and Ethics. 2006; Available from: https://pdfs.semanticscholar.org/89bf/a7d2556037d20c85a847a56c39af0b5fbc14.pdf?_ga=2.22134654.433364155.1595818026-1147409347.1595818026
74. Substance Abuse and Mental Health Services Administration [Internet]. Trauma informed approach and trauma specific interventions. 2011. Available from: http://www.bharp.org/wp-content/uploads/2016/10/Trauma-Informed-Approach-and-Trauma-Specific-Interventions-_-SAMHSA.pdf
75. Goodman P. Rural Health Training Institute. In: Kulig J, Williams A, editors. Health in rural Canada. Vancouver (BC): UBC Press; 2012. p. 101-17.
76. Wieman C. Six Nations Mental Health Services: A model of care for Aboriginal communities. In: Kirmayer L, Valaskakis G, editors. Healing traditions: the mental health of Aboriginal people in Canada. Vancouver (BC): UBC Press; 2009. p. 401-18.
77. Klinic Community Health Centre. Trauma informed: the trauma toolkit 2nd ed. 2013. Available from: http://trauma-informed.ca/wp-content/uploads/2013/10/Trauma-informed_Toolkit.pdf
78. Sinclair,S, Cochrae C, Meawasige A, Star L, Modupalli K, Kinew K, All of the Assembly of Manitoba Chiefs . Connecting with the strengths of our people: suicide prevention in First Nations in Manitoba. In: Kandhai, K, editor. Inviting hope: An exposé on suicide among First Nations, Inuit and Métis Peoples. Winnipeg (MB): Aboriginal Issues Press. 2015. p. 1-24.
79. Shepard B, O'Neill L, Guenette F. Counselling with First Nations women: Considerations of oppression and renewal. Int J Adv Couns. 2006;28(3):227-40.
80. McCormick R. Aboriginal approaches to counselling. In: Kirmayer L, Valaskakis G, editors. Healing traditions: the mental health of Aboriginal people in Canada. Vancouver (BC): UBC Press; 2009. 337-354 p.

81. Mental Health Commission of Canada. Changing directions, changing lives: The mental health strategy for Canada. 2012, Available from: https://www.mentalhealthcommission.ca/sites/default/files/MHStrategy_Strategy_ENG.pdf
82. Stebnicki M. Empathy fatigue: healing the mind, body, and spirit or professional counselors. Am J Psychiatr Rehabil. 2007;10:317-338.
83. Collins S, Long A. Too tired to care? The psychological effects of working with trauma. J Psychiatr Ment Health Nur. 2003a;10(1):17-27.
84. Mcswain K. Assessing the training needs of First Nations mental health workers in Manitoba. Winnipeg (MN): University of Manitoba; 1997.171 p.
85. Goodwin S, MacNaughton-Doucet L, Allan J. Call to action: interprofessional mental health collaborative practice in rural and northern Canada. Can Psychol. 2016;57(3):181-7.
86. Wenger E, Snyder W. Communities of practice: The organizational frontier. Harvard Business Review. 2000. Jan - Feb. p. 39-45.
87. Nelson-McEvers J. Measurement of self-care agency in a noninstitutionalized elderly population" (1995). [Masters Theses], [Holland, (MI)]: Ground Valley State University; 1995. 53 p. [Internet]. Available from: https://scholarworks.gvsu.edu/theses/223/
88. Salston M, Figley C. Secondary traumatic stress effects of working with survivors of criminal victimization. J Trauma Stress. 2003;16(2):167-174.
89. Ludick M. Analyses of experiences of vicarious traumatisation in short-term insurance claims workers [dissertation]. [Johannesburge (ZA)]: University of Witwaterstrand; 2013. 281 p.
90. Bercier M, Maynard B. Interventions for secondary traumatic stress with mental health workers: A systematic review. Res on Soc Work Pract. 2014;1-9. doi: 10.1177/1049731513517142
91. Ortlepp K, Friedman M. Prevalence and correlates of secondary traumatic stress in workplace lay trauma counselors. J Trauma Stress. 2002;15(3):213-22.
92. Le Blanc P, Schaufeli W. Burnout interventions: an overview and illustration. In: Halbesleben J, editor. Handbook of stress and burnout in health care. New York (NY): Nova Science Publishers Inc; 2008. p. 201-15.

93. Mental Health Commission of Canada [Internet]. Psychological health and safety in the workplace: prevention, promotion, and guidance to staged implementation. National Standards of Canada. 2013. Available from: https://www.csagroup.org/documents/codes-and-standards/publications/CAN_CSA-Z1003-13_BNQ_9700-803_2013_EN.pdf
94. Creswell JW, Poth C. Qualitative inquiry & research design: Choosing among five approaches.4th ed. Los Angeles (CA): SAGE Publications Inc; 2018. 459 p.
95. Kurtz C. Working with stories in your community or organization: participatory narrative inquiry. 3rd ed. New York (NY): Kurtz-Fernhout Publishing; 2014. 674 p.
96. Hacker K. Community-based participatory research. Los Angeles (CA). SAGE; 2013. 137 p.
97. Creswell JW. Qualitative inquiry & research design: Choosing among five approaches 3rd ed. Los Angeles (CA): SAGE Publications Inc; 2013. 448 p.
98. Wilson S. Research is ceremony: Indigenous research methods. Halifax (NS): Fernwood Publishing; 2008. 144 p.
99. Clandinin D, Rosiek J. Mapping a landscape of narrative inquiry: borderland spaces and tensions In: Clandinin D, editor, Handbook of narrative inquiry: mapping and methodology. Thousand Oaks (CA): Sage Publications; 2007. p. 25-75.
100. Burr V. Introduction to social constructionism. New York (NY) Routledge; 1995.198 p.
101. Gehart D, Tarragona M, Bava S. A collaborative approach to research and inquiry. In: Anderson H, Gehart D. editors. Collaborative therapy relationships make a difference. New York (NY): Routlouge Taylor & Francis Group; 2007. p. 367-90.
102. Creswell JW, Plano Clark V. Designing and conducting mixed methods research. 2nd ed. Los Angeles (CA): SAGE Publications Inc; 2011. 457 p.
103. Pitard J. A journey to the centre of self: positioning the researcher in autoethnography. Forum: Qual Soc Res [Internet]. 2017; 18(3). Available from: https://www.qualitative-research.net/index.php/fqs/article/view/2764/4132
104. Senge P, Scharmer, O. Community action research: learning as a community of practitioners, consultants and researchers. In: Reason P, Bradbury H, editors. Handbook of action research: participative inquiry and practice. Thousand Oaks (CA): SAGE Publications; 2001. p. 238-49.

105. Plano Clark VL, Ivankova NV. Mixed methods research: a guide to the field. Los Angeles (CA): SAGE. 368 p.
106. Creswell JW. A concise introduction to mixed methods research. Los Angeles (CA): Sage Publications, Inc; 2015. 132 p.
107. Tashakkori A, Creswell J. The new era of mixed methods (Editorial). J Mix Methods Res. 2007;1(1),3-7.
108. Teddlie C, Tashakkori A. Major issues and controversies in the use of mixed methods in the social and behavioral sciences, In: Tashakkori A, Teddlie C, editors. Handbook of mixed methods in social & behavioral research. Thousand Oaks (CA): SAGE Publications Inc; 2003. p. 3-50.
109. Cameron R. Mixed Methods Research: The Five Ps Framework. Electronic J of Business Res Methods.2011; 9(2):96-108.
110. Fetters MD, Molina-Azorin HF. The journal of mixed methods research starts a new decade. Editorial. J Mix Methods Res. 2017;11(1):3-10. doi:10.1177/1558689816682092
111. Morse J, Niehaus L. Mixed Method Design. Principles and Procedures. Walnut Creek (CA): Left Coast Press; 2009. 193 p.
112. Bazeley P. Editorial: integrating data analyses in mixed methods research. J Mix Methods Res.2009;3(3):203-207. doi:10.1177/1558689809334443
113. Yin R. Mixed methods research: are the methods genuinely integrated or merely parallel? Res Sch. 2006;13(1),41-47.
114. Lucero J, Wallerstein N, Duran B, Alegria M, Greene-Moton E, Israel B, Kastelic S, Magarati M, Oetzel J, Pearson C, et al. Development of a mixed methods investigation or process and outcomes of community-based participatory research. J Mix Methods Res. 2016:1-20. doi: 10.1177/1558689816633309
115. Caruth G. Demystifying missed methods research design: a review of the literature. Mevlana Int J of Edu. 2013;3(2):112-22.
116. Venkatesh V, Brown S, Bala H. Bridging the qualitative – quantitative divide: guidelines for conducting mixed methods research in information systems. MIS Q. 2013;7(1):21-54.
117. Bevan A. Creating communicative space in an action research study. Nurse Res. 2013;21(2):14-7.

118. Josselson R. The ethical attitude in narrative research: principles and practicalities. In: Clandindin J, editor. Handbook of narrative inquiry: mapping a methodology. Thousand Oaks (CA): SAGE Publications; 2007. p. 537-566.
119. Moustakas C. Phenomenological research methods. Thousand Oaks (CA): SAGE Publications; 1994. 192 p.
120. Wells K. Narrative Inquiry. New York (NY): Oxford University Press; 2011. 162 p.
121. Clandinin D, Connelly M. Narrative inquiry: experience and story in qualitative research. San Francisco (CA): Jossey-Bass; 2000. 211 p.
122. Trahar S. Preface. In: Trahar S, editor. Contextualising narrative inquiry. New York (NY): Routledge; 2013. i-xxi p.
123. Polkinghorne D. Narrative configuration in qualitative analysis. Qual Studies in Educ. 1995;8(1):5-23.
124. Wang C, Geale S. The power of story: Narrative inquiry as a methodology in nursing research. Inter J Nurs Sci. 2015,2:195-8.
125. Clandinin D. Engaging in narrative inquiry. Walnut Creek (CA): Left Coast Press, Inc; 2013. 232 p.
126. Israel B, Schulz A, Parker E, Becker A. Review of community-based research:Assessing partnership approaches to improve public health. Annu. Rev. Public Health. 1998;19:173-202.
127. Lasker R., Weiss E, Miller R. Partnership synergy: a practical framework for studying and strengthening the collaborative advantage. Milbank Q. 2001;79(2):179-205.
128. Parker P. Knowledge and participatory research. In: Reason P, Bradbury H, editors. Handbook of action research: participative inquiry and practice. Thousand Oaks (CA): SAGE Publications Ltd; 2001. p. 81-90.
129. Hesse-Biber SN. Qualitative approaches to mixed methods practice. Qual Inq. 2010;16(6):455-468.
130. Elwood Martin R, Chan R, Torikka L, Granger-Brown A, Ramsden V. Healing fostered by research. Can Fam Physician. 2008;54:244-5.
131. Kesby M, Kindon S, Pain R. Participation as a form of power: retheorising empowerment and spatialising participatory action research. In: Kindon S; Pain R, Kesby M,

editors.Participatory action research approaches and methods: connecting people participation and place. 2007. p. 19-25. Available from http://ebookcenral.proquest.com

132. Ramsden V, McKay S, Crowe J. The pursuit of excellence: engaging the community in participatory health research. Glob Health Promot. 2010;17(4):32-42.

133. White G, Suchowierska M, Campbell M. Developing and systematically implementing participatory action research. Arch Phys Med Rehabil. 2004;85: S3-12.

134. Patton M. Qualitative research and evaluation methods.4th ed. Thousand Oaks (CA): SAGE; 2015. 832 p.

135. Patton M. Qualitative evaluation and research methods (pp. 169-186). Beverly Hills (CA): Sage; 1990. 532 p.

136. Rossman G, Rallis S. Learning in the field: an introduction to qualitative research 3rd ed. Los Angeles (CA): SAGE; 2012. 365 p.

137. Smith J, Osborn M. Interpretative phenomenological analysis. In Smith JA, editor. Qualitative psychology. London (UK) Sage; 2003. p. 51-80.

138. Bergold J, Thomas S. Participatory research methods: a methodological approach in motion. Historical Social Research. 2012;37(4):191-222.

139. Tetui M, Zulu J, Hurtig A, Ekirapa-Kiracho E, Kiwanuka S. Elements for harnessing participatory action research to strengthen health managers' capacity: a critical interpretative synthesis. Health Res Policy and Syst. 2018;16(33).

140. Billes M, Francisco, V, Krueger P, Linville D. Participatory action research: Our methodological roots. Int Rev of Qual Res. 2010;3(3):277-286.

141. Guest G, Namey E, Mitchell M. (2013). Collecting qualitative data: A field manual for applied research. Lost Angeles (CA): SAGE; 2013. 376 p.

142. Knibb J. Private lives, public property: narrating the lives of mothers whose children have significant special needs. In: Trahar S, editor Contextualising narrative inquiry. New York (NY): Routledge; 2013. p.20-43

143. Riessman C. Narrative analysis. In: Narrative memory and everyday life [Internet]. 2003 p. 1-7. Available from: http://www.mmcri.org/deptPages/core/downloads/Riessman_Narrative_Analysis.pdf

144. Mitchell M, Egudo M. Published by DSTO Systems Sciences Laboratory Edinburgh (AU) [Internet]. Submitted: January 2003 Published: November 2003 Available from:

https://www.webpages.uidaho.edu/css506/506%20readings/review%20of%20narritive%20methodology%20australian%20gov.pdf

145. Jovchelovitch S, Bauer M. Narrative interviewing. [Internet]. London: LSE Research. 2000. Available from: http://eprints.lse.ac.uk/2633/.

146. Ortlipp M. Keeping and using reflective journals in the qualitative research process. The Qual Report [internet]. 2008;13(4):695-705. Available from: http://www.nova.edu/ssss/QR/QR13-4/ortlipp.pdf

147. Kvale S. Interviews: An introduction to qualitative research interviewing. Thousand Oaks (CA): SAGE Publications; 1996. 326 p.

148. Riessman C. Narrative methods for the human sciences. Los Angeles (CA): Sage Publications; 2008. 244 p.

149. Flick U. An introduction to qualitative research. Thousand Oaks, (CA): SAGE Publications. Ltd; 1998. 293 p.

150. Lieblich A, Tuval-Mashiach R, Zilber, T. Narrative research: reading, analysis, and interpretation: applied social research methods series Vol. 47. Thousand Oaks (CA): SAGE Publications, Inc; 1998.187 p.

151. Erlingsson C, Brysiewicz P. A hands-on guide to doing content analysis. Afr J Emerg Med. 2017;7:93-9.

152. Braun V, Clarke V. Successful qualitative research: a practical guide for beginners. Los Angeles (CA): SAGE; 2013. 382 p.

153. Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol. 2006;3, 77-101.

154. Javadi M, Zarea K. Understanding thematic analysis and its pitfall. J Client Care 2016;1(1):34-40.

155. Lemke J. Textual politics discourse and social dynamics. Bristol (PA): Taylor & Francis Publishing; 1995. 169 p.

156. Riessman C. Narrative analysis: qualitative research methods series 30. New York (NY): SAGE Publications; 1993. 79 p.

157. Sandelowski M. Using qualitative research. Qual Health Res.2004;14(10):1366-86.

158. Davies D, Dodds J. Qualitative research and the question of rigor. Qual Health Res. 1998;12(2):279-89.

159. Creswell JW, Creswell JD. Research design: qualitative, quantitative, and mixed methods approaches. 5th ed. Los Angeles (CA): SAGE Publications Inc; 2018. 275 p.
160. Beeman S. Maximizing credibility and accountability in qualitative data collection and data analysis: a social work research case example. J of Sociol Soc Welf.1995: 99-114.
161. De Fina A, Georgakopoulou A. Analyzing narrative: discourse and sociolinguistic perspectives. New York (NY): Cambridge University Press; 2012. 223 p.
162. Wenger E. Communities of practice: learning meaning, and identity.New York (NY): Cambridge University Press; 1998. 318 p.
163. Schmidt G. Remote, northern communities, implications for social work practice. Int Soc Work. 2000;43(3):337-49.
164. Riebschleger J. Social workers' suggestions for effective rural practice. Soc Work Prac. 2007;88(2):203-13.
165. Ermine W. Indigenous Law Journal. 2007; 6 (1):193-203.
166. Mayan M, Daum C. Worth the risk? muddled relationships in community-based participatory research. Qual Health Res. 2016;26(1):69-76.
167. Pinnegar S, Daynes G. Locating narrative inquiry historically: thematics in the turn to narrative. In: Clandinin D, editor, Handbook of narrative inquiry: mapping and methodology. Thousand Oaks (CA): Sage Publications; 2007. p. 3-34.
168. Morgan A. What is narrative therapy. Adelaide (AUS): Dulweich Centre Publications; 2000. 136 p.
169. Tervalon M, Murray-Garcia J. Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. J Health Care for the Poor and Undeserved. 1998;9(2):117-25.
170. Nadan Y. Rethinking 'cultural competence' in international social work. Int Soc Work. (2017);60(1):74-83.

Appendix A: Ethics Approval

UNIVERSITY OF SASKATCHEWAN

Behavioural Research Ethics Board (Beh-REB) 08-Mar-2019

Certificate of Approval

Application ID: 851

Principal Investigator: Vivian Ramsden

Department: Department of Academic Family Medicine

Locations Where Research Activities are Conducted: Graduate Student Office Space located at the University of Saskatchewan in Saskatoon; Offices located at Suite #205- 20 14th Street West, Medical Building, Prince Albert, SK and 201 b 115 2nd Ave N, Macro Building, Saskatoon, SK, Canada

Student(s): Wanda Seidlikoski Yurach

Funder(s): Saskatchewan Centre for Patient-Oriented Research

Sponsor:

Title: Community-Based Participatory Research: Developing a Community of Practice to Support the Wellbeing of Mental Health Providers Working in Remote Northern Saskatchewan First Nations Communities

Approved On: 07/03/2019

Expiry Date: 06/03/2020

Approval Of: Behavioural Ethics Application; Recruitment Script; Participant Consent Form; ProQOL- 5 Questionnaire; Open-Ended Interview Questionnaire; Counselling/Debriefing Services List; Transcript Release Form

Acknowledgment Of:

Review Type: Delegated Review

CERTIFICATION

The University of Saskatchewan Behavioural Research Ethics Board (Beh-REB) is constituted and operates in accordance with the current version of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS 2 2014). The University of Saskatchewan Behavioural Research Ethics Board has reviewed the above-named project. The proposal was found to be acceptable on ethical grounds. The principal investigator has the responsibility for any other administrative or regulatory approvals that may pertain to this project, and for ensuring that the authorized project is carried out according to the conditions outlined in the original protocol submitted for ethics review. This Certificate of Approval is valid for the above time period provided there is no change in experimental protocol or consent process or documents.

Any significant changes to your proposed method, or your consent and recruitment procedures should be reported to the Chair for Research Ethics Board consideration in advance of its implementation.

ONGOING REVIEW REQUIREMENTS

In order to receive annual renewal, a status report must be submitted to the REB Chair for Board consideration within one month prior to the current expiry date each year the project remains open, and upon project completion. Please refer to the following website for further instructions: https://vpresearch.usask.ca/researchers/forms.php.

Digitally Approved by Patricia Simonson, Vice-Chair
Behavioural Research Ethics Board
University of Saskatchewan

UNIVERSITY OF SASKATCHEWAN

Behavioural Research Ethics Board (Beh-REB) 01-May-2019

Certificate of Approval Amendment

Application ID: 851

Principal Investigator: Vivian Ramsden

Department: Department of Academic Family Medicine

Locations Where Research Activities are Conducted: Graduate Student Office Space located at the University of Saskatchewan in Saskatoon; Offices located at Suite #205- 20 14th Street West, Medical Building, Prince Albert, SK and 201 b 115 2nd Ave N, Macro Building, Saskatoon, SK, Canada
Locations may need to change to meet the needs of individuals wishing to participate., Canada

Student(s): Wanda Seidlikoski Yurach

Funder(s): Saskatchewan Centre for Patient-Oriented Research

Sponsor:

Title: Community-Based Participatory Research: Developing a Community of Practice to Support the Wellbeing of Mental Health Providers Working in Remote Northern Saskatchewan First Nations Communities

Approved On: 01/05/2019

Expiry Date: 06/03/2020

Approval Of: Flexible interview locations to meet participant needs.

Acknowledgment Of:

Review Type: Delegated Review

CERTIFICATION

The University of Saskatchewan Behavioural Research Ethics Board (Beh-REB) is constituted and operates in accordance with the current version of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS 2 2014). The University of Saskatchewan Behavioural Research Ethics Board has reviewed the above-named project. The proposal was found to be acceptable on ethical grounds. The principal investigator has the responsibility for any other administrative or regulatory approvals that may pertain to this project, and for ensuring that the authorized project is carried out according to the conditions outlined in the original protocol submitted for ethics review. This Certificate of Approval is valid for the above time period provided there is no change in experimental protocol or consent process or documents.

Any significant changes to your proposed method, or your consent and recruitment procedures should be reported to the Chair for Research Ethics Board consideration in advance of its implementation.

ONGOING REVIEW REQUIREMENTS

In order to receive annual renewal, a status report must be submitted to the REB Chair for Board consideration within one month prior to the current expiry date each year the project remains open, and upon project completion. Please refer to the following website for further instructions: https://vpresearch.usask.ca/researchers/forms.php.

Digitally Approved by Stephanie Martin, Vice-Chair
Behavioural Research Ethics Board
University of Saskatchewan

UNIVERSITY OF SASKATCHEWAN

Behavioural Research Ethics Board (Beh-REB) 29-Jan-2020

Certificate of Re-Approval

Application ID: 851

Principal Investigator: Vivian Ramsden

Department: Department of Academic Family Medicine

Locations Where Research Activities are Conducted: Graduate Student Office Space located at the University of Saskatchewan in Saskatoon; and, Offices located at Suite #205- 20 14th Street West, Medical Building, Prince Albert, SK and at 201 b 115 2nd Ave N, Macro Building, Saskatoon, SK, Canada
Locations may need to change to meet the needs of individuals wishing to participate., Canada

Student(s): Wanda Seidlikoski Yurach

Funder(s): Saskatchewan Centre for Patient-Oriented Research

Sponsor:

Title: Community-Based Participatory Research: Developing a Community of Practice to Support the Wellbeing of Mental Health Providers Working in Remote Northern Saskatchewan First Nations Communities

Approved On: 22/01/2020

Expiry Date: 21/01/2021

Acknowledgment Of: n/a

Review Type: Delegated Review

* This study, inclusive of all previously approved documents, has been re-approved until the expiry date noted above

CERTIFICATION

The University of Saskatchewan Behavioural Research Ethics Board (Beh-REB) is constituted and operates in accordance with the current version of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS 2 2018). The University of Saskatchewan Behavioural Research Ethics Board has reviewed the above-named project. The proposal was found to be acceptable on ethical grounds. The principal investigator has the responsibility for any other administrative or regulatory approvals that may pertain to this project, and for ensuring that the authorized project is carried out according to the conditions outlined in the original protocol submitted for ethics review. This Certificate of Approval is valid for the above time period provided there is no change in experimental protocol or consent process or documents.

ONGOING REVIEW REQUIREMENTS

In order to receive annual renewal, a status report must be submitted to the REB Chair for Board consideration within one month prior to the current expiry date each year the project remains open, and upon project completion. Please refer to the following website for further instructions: https://vpresearch.usask.ca/researchers/forms.php.

Digitally Approved by Diane Martz, Chair
Behavioural Research Ethics Board
University of Saskatchewan

Appendix B: Participant Consent Form

UNIVERSITY OF SASKATCHEWAN

Participant Consent Form

You are invited to participate in a research study entitled: Community-based participatory research: Developing a community of practice to support the well-being of mental health providers working in remote northern Saskatchewan First Nations communities

Researcher(s):
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Purpose(s) and Objective(s) of the Research:

Purpose: To explore the experiences of outsider mental health providers that have delivered trauma-informed care/counselling in remote northern Saskatchewan First Nations communities (RNSFNCs) to understand the impact of this work (e.g. rates of secondary trauma) and to co-create meaningful support strategies and build a community of practice.

Objectives: The results/findings generated from this study will provide crucial information from mental health providers regarding their experiences to inform direct trauma-informed care/counselling; agencies that approve and contract their services (First Nations communities, Health Canada); professional legislated regulatory associations; and universities which provide training to mental health providers. The information generated in this study is needed to make evidence-informed decisions to co-create sustainable supports to protect the well-being of mental health providers; improve the quality of their work environment; and, in turn improve the quality of services for clients.

Procedures:

This study will employ an exploratory, embedded mixed methods research design to understand the impact of providing trauma support from the view point of mental health providers working in RNSFNCs. A purposeful sample of female mental health providers will be drawn from those approved with First Nations Inuit Health Branch of Health Canada and registered as a Social Worker with the Saskatchewan Association of Social Workers. This study will take place in three phases, incorporating a narrative approach as well as interpretative phenomenological analysis guided through a transformative framework using community-based participatory research to answer the research questions. Community-based participatory research will support partnerships with participants throughout the research process.

In the ***First Phase*** participants will be asked to take part in an in-person, interview that will take approximately 1-1.5 hours and will be audio-recorded and later transcribed. The ***Second Phase*** will take place approximately four weeks after the initial interview. Participants will be asked to take part in a follow up in-person interview that will take approximately 1-1.5 hours and will be audio recorded. Prior to the second interview, participants will have been e-mailed a copy of their first interview transcription to review and edit as deemed appropriate. In the ***Third Phase*** of this study, all participants will be invited to take part in the interpretation of the data which will take approximately 3 hours. Those unable to participate will be given the opportunity to provide their input on an individual basis. Prior to the interpretation, participants will be e-mailed a copy of their second interview transcription to review and edit as deemed appropriate. This phase will focus on co-

creating strategies that will support the well-being of mental health providers including the co-development of a community of practice.

Please feel free to ask any questions regarding the procedures and goals of the study and/or about my role.

Funded by:
WSY received a Graduate Student Scholarship from the Saskatchewan Centre for Patient-Oriented Research – January, 2018 to August, 2020.

Potential Risks:
Risks expected are no greater than would be experienced in your role as a mental health provider. If you experience any level of distress, you may contact the following resources for follow up counselling and debriefing services. In Saskatoon, you can contact the Community Adult Mental Health programs by contacting centralized intake at 306-655-7777. In Prince Albert, Adult Mental Health referrals can be accessed through the Toll-Free #1-888-765-6055 or by calling 306-765-6055, with Walk-In Services located at 2345 10th Ave W, Prince Albert.

The confidentiality of participants will need to be protected to prevent negative implications for independent contracts with communities. Information regarding your well-being relating to secondary trauma will be gathered which may bring forward emotional responses.

Potential Benefits:
Benefits include but are not to limited to giving voice to mental health providers so as to understand the impact of providing trauma informed care/counselling including rates of secondary trauma in remote northern Saskatchewan First Nations communities. As well as, co-creating supports including a community of practice to improve the work environment for mental health providers. This information is important to mental health providers; First Nations communities; health and policy agencies such as Health Canada; learning institutions and regulatory bodies. This information can assist in transforming how mental health providers are expected to provide trauma services in northern healing systems; as well as, the environment expected within the systems.

Compensation:
Participants will be provided with a $50 gift card as an honorarium each time they are interviewed, as well as, payment for mileage and meals if needed. Even if participants withdraw at any time during the each of the interviews, they will still receive the honorarium. A meal or light snack/refreshments will also be available during the interviews.

Confidentiality:
Participant confidentiality will be secured as no identifiable information about your participation will be reported or disseminated in the findings of this study.

In the Third Phase of the project the researcher will undertake to safeguard the confidentiality of the discussion, but cannot guarantee that other members of the group will do so. Please respect the confidentiality of the other members of the group by not disclosing the contents of this discussion outside the group, and be aware that others may not respect your confidentiality.

Although the data from this research project will be published and presented at conferences, the data will be reported in an aggregate form, so that it will not be possible to identify individuals. Moreover, the Consent Forms will be stored separately from the (materials used), so that it will not be possible to associate a name with any given set of responses and the Master List destroyed when data collection is completed.

Please do not put your name or other identifying information on the (materials used). Audio tapes and survey information will be stored securely at the University and will be safeguarded in storage for five years post-

publication. After data is gathered from interviews, you will be given an opportunity to review the transcript of your interview, and add to, alter, or delete information as you may choose.

- **Storage of Data:**
  - The data will be stored at the University of Saskatchewan for a minimum of five years by my Supervisor, Dr. Vivian R Ramsden.
  - When the data is no longer required, the data will be appropriately destroyed and erased.

Right to Withdraw:

- Your participation is voluntary and you can answer only those questions that you are comfortable with. In addition, should you desire, you may ask to have the audio-recording device turned off. If you do, the information that you provide will be captured using a pencil and paper. Your participation in the Third Phase of the project is voluntary and you can participate in only those discussions that you are comfortable with. Should you wish to withdraw, you may leave the group meeting at any time; however, data that have already been collected cannot be withdrawn as it forms part of the context for information provided by other participants.

- You may withdraw from the research project for any reason, at any time without explanation or penalty of any sort. **Your right to withdraw data from the project will apply until June 30, 2019. If you choose to withdraw, all identifiable data will be deleted and appropriately destroyed at your request. After this date, it is possible that some form of research dissemination will have already occurred and it may not be possible to withdraw your data.**

Follow up:

- To obtain results from the study, please contact Wanda Seidlikoski Yurach at was933@mail.usask.ca.
- A meeting will be arranged for all participants to attend so as to share project results/findings.

Questions or Concerns:

- Contact the researcher(s) using the information at the top of page 1;
- This research project has been approved on ethical grounds by the University of Saskatchewan Behavioural Research Ethics Board on (date to be inserted). Any questions regarding your rights as a participant may be addressed to that committee through the Research Ethics Office ethics.office@usask.ca (306) 966-2975. Out of town participants may call toll free (888) 966-2975.

Consent

Your signature below indicates that you have read and understand the description provided; you have had an opportunity to ask questions and your questions have been answered.

I consent to participate in the research project. A copy of this Consent Form has been given to me for my records.

_____ _____

Name of Participant Signature

_____ _____

Researcher's Signature Date

A copy of this consent will be left with you, and a copy will be taken by the researcher.

ORAL CONSENT: (Telephone/video conference)

I read and explained this Consent Form to the participant before receiving the participant's consent, and the participant had knowledge of its contents and appeared to understand it.

_____ _____ _____

Name of Participant *Researcher's Signature* *Date*

Appendix C: Transcript Release Form

Research Ethics Boards (Behavioural and Biomedical)

TRANSCRIPT RELEASE FORM

Title: Community-based participatory research: Developing a community of practice to support the well-being of mental health providers working in remote northern Saskatchewan First Nations communities.

I,_____, have reviewed the complete transcript of my personal interview in this study, and have been provided with the opportunity to add, alter, and delete information from the transcript as appropriate. I acknowledge that the transcript accurately reflects what I stated in my personal interview with Wanda Seidlikoski Yurach. I hereby authorize the release of this transcript to Wanda Seidlikoski Yurach to be used in the manner described in the Consent Form. I have received a copy of this Data/Transcript Release Form for my own records.

Name of Participant	Date
Signature of Participant	Signature of Researcher

Appendix D: Interview Questions

Phase 1: Interview Questions

1. Tell me about yourself.
2. Tell me about your background and how you became interested in providing trauma-informed care/counselling in remote northern Saskatchewan First Nations communities (RNSFNCs).
3. Tell me about your role as a mental health provider.
4. Tell me what it is like to be an outsider mental health provider travelling into RNSFNCs.
5. What has been the positive aspects of this work?
6. What are some of the challenges of this work?
7. Is there anything that you wish you had been asked in this interview that was not covered?

Phase 2: Interview Questions:

1. Tell me if the transcribed information provided to you in advance of this interview accurately reflects your story as a mental health provider working in RNSFNCs.
2. As you reflect on your story as a mental health provider, please describe what this work means to you and how you make sense of it?
3. How would you describe listening to trauma-related stories of your clients as you reflect on your own history of colonization (if applicable)?
4. How have the trauma-related stories of your clients impacted you (emotionally, psychologically, physically and spiritually)?
5. How has this work impacted those who are close to you such as family and friends?

6. Would you be willing to complete a self-administered Professional Quality of Life Scale questionnaire?
7. What do the results of this questionnaire mean to you in relation to compassion fatigue (burnout/secondary trauma) and compassion satisfaction?
8. How do you remain psychologically available to yourself, your family and your clients?
9. Describe your supports, both formal and informal?
10. Is there anything that you wish you had been asked in this interview that was not covered?

Phase 3: Interview Questions

1. How do you see your future in working as a mental health provider in this setting?
2. What advice would you give to individuals thinking of entering this field of work?
3. What recommendations or changes would you like to see in the way mental health providers carry out this work and how they are supported to sustain this work?
4. What do you feel is needed to build a sustainable community of practice for mental health providers?

Just a reminder that if you feel any level of distress as a result of this interview, please contact the following supports: In Saskatoon, participants can contact Community Adult Mental Health programs by contacting centralized intake at 306-655-7777. In Prince Albert, Adult Mental Health referrals are accessed Toll-Free at 1-888-765-6055 or by calling 306-765-6055, with walk in services located at 2345 Tenth Avenue W., Prince Albert.

Appendix E: Counselling Supports Information

Prince Albert Counselling and Debriefing Services

Prince Albert Adult Mental Health Services	1-888-765-6055 or 306-765-6055
Prince Albert Mental Health and Addictions	306-765-6550
Prince Albert Mobile Crisis (24 Hrs)	306-764-1011
Victoria Hospital	306-765-6000
Prince Albert and Area Critical Incident Stress Debriefing Team	
Canadian Mental Health Association	306-763-7737
Catholic Family Services	306-922-3202

Counselling and Debriefing Services

Saskatoon Adult Mental Health Services	306-655-6777
Saskatoon Mental Health Crisis Response	306-655-7950
Saskatoon Mobile Crisis	306-933-6200
Mental Health Outreach Clinic	306-655-7950
Mental Health and Addictions Central Intake	306-655-4100
Canadian Mental Health Association	306-384-9333
Catholic Family Services	306-244-7773

Appendix F: Professional Quality of Life Scale

Professional Quality of Life Scale (ProQOL)

Compassion Satisfaction and Compassion Fatigue
(ProQOL) Version 5 (2009)

When you *[help]* people you have direct contact with their lives. As you may have found, your compassion for those you *[help]* can affect you in positive and negative ways. Below are some-questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days*.

1=Never	2=Rarely	3=Sometimes	4=Often	5=Very Often

_____ 1. I am happy.
_____ 2. I am preoccupied with more than one person I *[help]*.
_____ 3. I get satisfaction from being able to *[help]* people.
_____ 4. I feel connected to others.
_____ 5. I jump or am startled by unexpected sounds.
_____ 6. I feel invigorated after working with those I *[help]*.
_____ 7. I find it difficult to separate my personal life from my life as a *[helper]*.
_____ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I *[help]*.
_____ 9. I think that I might have been affected by the traumatic stress of those I *[help]*.
_____ 10. I feel trapped by my job as a *[helper]*.
_____ 11. Because of my *[helping]*, I have felt "on edge" about various things.
_____ 12. I like my work as a *[helper]*.
_____ 13. I feel depressed because of the traumatic experiences of the people I *[help]*.
_____ 14. I feel as though I am experiencing the trauma of someone I have *[helped]*.
_____ 15. I have beliefs that sustain me.
_____ 16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
_____ 17. I am the person I always wanted to be.
_____ 18. My work makes me feel satisfied.
_____ 19. I feel worn out because of my work as a *[helper]*.
_____ 20. I have happy thoughts and feelings about those I *[help]* and how I could help them.
_____ 21. I feel overwhelmed because my case [work] load seems endless.
_____ 22. I believe I can make a difference through my work.
_____ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
_____ 24. I am proud of what I can do to *[help]*.
_____ 25. As a result of my *[helping]*, I have intrusive, frightening thoughts.
_____ 26. I feel "bogged down" by the system.
_____ 27. I have thoughts that I am a "success" as a *[helper]*.
_____ 28. I can't recall important parts of my work with trauma victims.
_____ 29. I am a very caring person.
_____ 30. I am happy that I chose to do this work.

Appendix G: Permission to Use the Professional Quality of Life Scale

Permission for Use of the ProQOL (Professional Quality of Life Scale: Compassion Satisfaction and Compassion Fatigue) www.proqol.org

Accompanied by the email to you, this document grants you permission to use for your study or project

> ***The ProQOL (Professional Quality of Life Scale: Compassion Satisfaction and Compassion Fatigue) www.ProQOL.org***

Prior to beginning your project and at the time of any publications, please verify that you are using the latest version by checking the website. All revisions are posted there. If you began project with an earlier version, please reference both to avoid confusion for readers of your work.

This permission covers non-profit, non-commercial uses and includes permission to reformat the questions into a version that is appropriate for your use. This may include computerizing the measure.

Please print the following reference or credit line in all documents that include results gathered from the use of the ProQOL.

Stamm, B. H. (2010). The ProQOL (*Professional Quality of Life Scale: Compassion Satisfaction and Compassion Fatigue*). Pocatello, ID: ProQOL.org. retrieved [date] www.proqol.org

Permission granted by
Beth Hudnall Stamm, PhD
Author, ProQOL
ProQOL.org
info@proqol.org

Help us help all of us. Please consider donating a copy of your raw data to the data bank. You can find more about the data bank and how you can donate at www.proqol.org and www.proqol.org/Donate_Data.html. Data donated to the ProQOL Data Bank allow us to advance the theory of compassion satisfaction and compassion fatigue and to improve and norm the measure itself.

Appendix H: Documentation Sheet

Documentation Sheet

A documentation sheet was developed for use after the first two interviews. It is based on an information checklist set out by Flick (1996) as referenced in Flick (1998). The information checklist I developed is outlined in Figure 2.

1. Checklist of Interview
    - Consent reviewed, signed and copy provided to participant
    - Support/counsellor list provided to participant
    - Information card
2. Questions
    - What went well with the interview?
    - What could be improved?
3. Feedback from the participant
    - What went well?
    - What would they change?
4. Broad themes that emerged
5. Other observations
6. Duration of the interview
7. Interview has been transcribed
8. Transcribed interview has been de-identified
9. De-identified transcribed interview e-mailed to participant
10. Feedback received
11. Signed Transcript Release Form received