

Using Two Eyed Seeing to Explore Practice Level Perspectives and Experiences
of Collaboration across Diverse Health Services
with Cancer Control as an Exemplar

A Thesis Submitted to the College of Graduate Studies and Research
In Partial Fulfillment of the Requirements
For the Degree of Master of Nursing
College of Nursing, University of Saskatchewan
Saskatoon, Saskatchewan

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ABSTRACT

Background: Health inequalities have resulted in higher chronic disease rates in Indigenous populations and access to culturally appropriate services has been an ongoing effort of the health system in addressing these needs (Reading & Wien, 2013). Throughout the cancer control continuum, the importance of collaborative partnerships with Indigenous populations has been recognized in Saskatchewan and Canada to improve health outcomes (Canadian Partnership Against Cancer [CPAC], 2011). Culturally competent wholistic care requires effective interprofessional collaboration (Lomax & White, 2015) when bridging the traditional Indigenous and mainstream health services. Some health practitioners have experienced difficulty when collaborating across the two services. Although there has been considerable research on collaboration, its definition, enablers and barriers, the concept remains misunderstood (Bedwell et al., 2012) with limited information of how these partnerships could be more effective from the perceptions of the traditional Indigenous health services (Taylor & Thompson, 2011). For this study, cancer services was used as an example of a healthcare setting through which a better understanding of collaboration when working with Indigenous populations could help to strengthen these partnerships and improve health outcomes.

Study Purpose: To explore the perspectives and experiences of collaboration of select Saskatchewan health professionals practicing across the traditional Indigenous and mainstream health/cancer services, to further understand the concept of collaboration from their perspectives.

Methodology: Using interpretive description and purposive sampling (Thorne, 2008), this qualitative study explored collaboration through observation and individual interviews to elicit the considerations of professionals working across these two services. Overlapping of perspectives or two-eyed seeing (Iwama, Marshall, Marshall, Bartlett, 2009) provided insight of both services to help understand collaboration. Individual transcripts were coded, combined and organized to reflect thematic similarities.

Results/Conclusions: Study participants described collaboration as challenging and difficult to achieve, requiring considerable time and effort for improving health outcomes for Indigenous clients and communities. The idea of collaboration, between these services, was more common than actual collaboration and not always a system priority. Findings supported a need for a shared definition of collaboration that was guided by the virtues of Indigenous and values of

mainstream health services, with more inclusive language and valuing of Indigenous cultures and client and community voices, wholistic approaches, and sustainable outcomes. For participants, collaboration was considered an ongoing commitment similar to offering sacred tobacco. The themes constructed that participants described as enablers of collaboration recognized the importance of embedding virtues/values; valuing difference; building and maintaining relationships; supportive environments, wholistic approaches; having the right people at the table; and making a change for impactful outcomes. These results demonstrate the significance of systemic and organizational support for effective interprofessional collaborative, culturally competent, wholistic service approaches when working across diverse services. The experiences shared by study participants have shown that certain individual behaviors and system supports help to improve relationships thereby enabling effective collaboration. Given the significance of collaboration for effective health outcomes, a more focused provincial effort toward the development and further integration of collaborative practice in Saskatchewan would be beneficial. The findings from this study have provided only a glimpse of the enablers and challenges of collaboration when working together with the traditional Indigenous and mainstream health and cancer services. A comprehensive list of all the enablers of collaboration could be useful at the practice level. For study participants, two-eyed seeing has provided the ability to see the tremendous value and strengths of both worlds and how these diverse services complement each other. These kinds of professionals have become a gateway between these two worlds thereby making accessible the best support available from both services to meet the diverse needs of clients and communities (Hatcher et al.; Iwama et al., 2009).

ACKNOWLEDGMENTS

First and foremost, I would like to sincerely thank the Eagle Moon Health Office Director and Team of the Regina Qu'Appelle Health Region, the Elder advisors, and external partners for their unwavering support and guidance throughout the research process. Thank you so much for participating in this study and sharing your perspectives, experiences, and stories so other health professionals may benefit. Your continuous encouragement and advice challenged me to think more broadly and holistically, and helped me to grow both personally and professionally. Without your genuine interest in collaboration, your sincere devotion to the clients and communities, your knowledge of holistic health approaches, and ongoing efforts to improve health outcomes for Indigenous populations, this research would not have taken place. Your ability to see the strengths and value of both traditional Indigenous and mainstream health services, and apply the best of both services to improve the lives of your patients and communities, is an inspiration to all of us in health service delivery. I am also grateful to the Elders and Eagle Moon Team for their permission, support, and guidance in developing and using a star blanket to illustrate the study findings and Mitch Whiting for the computer graphics. I would also like to sincerely thank my thesis Advisory Committee, my supervisor Dr. Pammla Petrucka, Dr. Lorna Butler, Dr. Marie Dietrich Leurer, Dr. Sandra Bassendowski, and committee chair, Dr. Lynn Jansen, for your expertise, constructive feedback, and the lively discussions to test my understanding and advance my thinking. Dr. Petrucka, my heartfelt thanks for your wisdom, solid support, patience, and guidance that allowed me to discover qualitative research in a way that motivated me to probe further, challenge my thinking, and push me to a greater understanding and appreciation of research and its application in practice. Your approach as a teacher and mentor has made this an enjoyable journey. I also extend my thanks to Ms. Carolyn Hoffman, my external examiner, for your support in this process. Also thank you to Bob Whiting, Brittany Whiting (Donauer), Mitch Whiting, and Latasha Luchsinger for being my sounding board, answering endless questions, and for your immediate responses to my random computer dilemmas. I would also like to acknowledge and thank my employer, the Saskatchewan Cancer Agency, for funding my research. Also, Dr. Jon Tonita, the executive and senior leadership team, and the Prevention Department team, of the Agency, for your support and encouragement that allowed me to continue working while pursuing my educational goals.

DEDICATION

This thesis is dedicated with appreciation to my late-father Nick Vetter and my mother, Margaret Vetter (Trautmann), for your unconditional love, for valuing education, for always encouraging me to accomplish my goals, and for teaching me, by example, about gender equality before I even knew what it was or that it mattered. I owe my deepest gratitude to my husband, Bob Whiting, who has always encouraged me to be the best person I can be, and to go after my dreams. I would not have been able to do any of this work without your love, patience, firm support, and additional effort in taking on more of a workload to ensure I had quiet and dedicated study time; thank you for listening endlessly to my ideas, frustrations, and doubts throughout this process. Also, thank you to my precious children (Ariane, Brittany, and Mitch), your partners (Nilesh, Adam, and Latasha), and my most adored grandchildren (Rykert, Huxley, Thorin, and Jameson). Our family-time is what kept me balanced throughout this process; the fun and laughter you bring into my life always lightened the load for me and reminded me of life's most precious gifts. To each of you, attaining this degree would not have been possible without your unconditional love, encouragement, and confidence in me. I am so grateful; each of you in your own special way helps me to continue to grow as a person.

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1 INTRODUCTION

The complexities of health care have required nurses to demonstrate interprofessional collaborative practice (Orchard, 2010) along with other disciplines within and outside of the health sector (Bedwell et al., 2012). Integration of services in cancer control and other health care settings has required diverse knowledges and expertise to collaborate effectively for meaningful progress in meeting the health needs of Indigenous populations in Canada (CPAC, 2009). Although there has been considerable research on collaboration and its definition and enablers or barriers to its success, the concept remains misunderstood (Bedwell et al., 2012) with limited information of how these partnerships could be more effective from the perspectives and experiences of the traditional Indigenous health services (Taylor & Thompson, 2011). A better understanding of collaboration when working between the traditional Indigenous and mainstream health services could help to strengthen these partnerships and improve Indigenous health outcomes (Taylor & Thompson, 2011).

Some health practitioners have experienced difficulty when collaborating across the two services. Research shows that nurses and other health disciplines are in the process of transitioning from working independently to working more effectively within interprofessional collaborative teams (Lomax & White, 2015, p.59). However, health care environments can influence service delivery and need to be more flexible, welcoming, and culturally competent if cancer outcomes are to improve for Indigenous clients (Thompson, Shahid, Bessarab, Durey, & Davidson, 2011). According to Gagliardi, Dobrow, and Wright (2011, p. 153), cancer services could benefit from further development, implementation, and evaluation of a more collaborative cancer management approach given its multimodal service requirements across many settings. Culturally competent wholistic care requires effective interprofessional collaboration (Lomax & White, 2015) when bridging the traditional Indigenous and mainstream health services. Partnerships between Indigenous and mainstream health services are interactions between people within organizations and depend on trusting relationships to be successful (Haynes, Taylor, Durey, Bessarab, & Thompson, 2014). System-level examination and client participation to better understand the inequalities created within the structure of cancer services could improve survival rates for Indigenous populations (Hill, Sarfati, Robson, & Blakely, 2013). A standard definition of collaboration within the health system (Bedwell et al., 2012) and further

understanding its enablers and barriers could help to strengthen interprofessional collaboration (Gardner, 2005; Morgan, Pullon, & McKinlay, 2015) and the ongoing development of effective strategies and models to support collaboration (Gagliardi et al., 2011) across the two diverse services.

1.1 Challenges in Cancer Control Services for Indigenous Populations

Over a million people call Saskatchewan home with more than 15 per cent of the total population self-identifying as First Nation, Métis, and Inuit (see Appendix A for terminology), collectively known as Aboriginal or Indigenous peoples (Statistics Canada, 2011). For this paper, the term Indigenous was used when referring to First Nations, Métis, and Inuit populations as a group, to reflect the similarities of experiences and the immense universal knowledge system of the original peoples worldwide (Wilson, 2008). This sub-population has been the fastest growing segment of the population in Saskatchewan and Canada. Between 2006 and 2011, the Indigenous population in Canada increased by 20 per cent compared with five per cent for the non-Indigenous population (Statistics Canada, 2013a). Demographic projections of the Saskatchewan population indicate that the Indigenous proportion will grow beyond 32 per cent by 2045 (Government of Saskatchewan, n.d.).

Health inequalities and social determinants have resulted in higher chronic disease rates in Indigenous than non-Indigenous Canadians and access to culturally appropriate services has been an ongoing effort of the mainstream health system in addressing these needs (Reading & Wien, 2013). Cancer and chronic diseases account for about 89 per cent of all deaths in Canada (CPAC, 2011a), with economic impact costs of over 90 billion dollars annually (Mirolla, 2004). Indigenous populations report poorer health outcomes (Statistics Canada, 2013b) and the life expectancy of Canadian First Nations males is about five years shorter than other Canadian men (Statistics Canada, 2013b). Results from the 2008/10 First Nations Regional Health Survey (2012) revealed that 63 per cent of First Nations adults reported having at least one chronic health condition. By age 60, approximately half of the First Nations adult population reported having four or more chronic health conditions (First Nations Information Governance Center, 2012). Risk factors related to cancer and chronic diseases are higher in the Indigenous population than the national average, for example, over 43 per cent of First Nations adults in First Nations communities reported smoking daily, more than double the daily Canadian rate (Health Canada,

2014). The incidence of cancer has been increasing at a faster rate amongst Indigenous peoples compared to other Canadians (Assembly of First Nations, 2011). In the three most northern health regions of Saskatchewan, populated by mainly Indigenous peoples, lung cancer rates are higher than the rest of the province and the leading cause of cancer deaths for both males and females (Irvine, Quinn, & Stockdale, 2011).

The historical reality of colonization and its resulting intergenerational trauma has negatively affected the health status of Indigenous Canadians. Additionally, numerous challenges for cancer services were identified at a National Forum on First Nations, Inuit and Métis Cancer Control (CPAC, 2009) that have created access issues for Indigenous Canadians leading to poorer health outcomes. Some of the priorities for cancer services generally highlighted by participants included: (a) increased awareness of cancer and its risk factors, (b) enhanced prevention and screening interventions, (c) access to culturally appropriate materials and services across the cancer continuum, (d) transportation support in remote and rural locations, (e) affordable drugs and other treatment related costs, (f) access to specialists, diagnostic tests, and health care providers, and (h) additional research and surveillance in cancer control for Indigenous Canadians (CPAC, 2009). Given that at least one-third of all cancer cases globally are preventable (World Health Organization, 2012) and to address these service challenges, there needs to be a better understanding of collaborative partnerships between the traditional Indigenous and mainstream health services (Taylor & Thompson, 2011). The Saskatchewan Cancer Agency (2010) has also identified the need for provincial collaboration around health promotion and cancer prevention that includes partnerships with Indigenous leaders along with identifying and monitoring cancer risk to inform decision making for effective prevention strategies. Considering the service needs and the growth rate of Indigenous populations (Reading, 2009), and that culturally competent wholistic services would require effective interprofessional collaboration (Lomax & White, 2015); a better understanding of collaboration could enhance partnerships and better meet the needs of Indigenous populations (Taylor & Thompson, 2011).

1.2 Collaboration across Diverse Health Services

The meaning of health and illness to Indigenous peoples and their longstanding traditional healing approaches are very different than mainstream health services. The beliefs of

Indigenous medical traditions have served social, religious, and medical purposes within Indigenous societies (Waldram, Herring & Young, 2007). For many Indigenous cultures, approaches to wellness are often wholistic with an emphasis on the interconnectedness of individuals, families, culture and communities (Health Canada, 2014, p.4). In the Indigenous health approach, the spiritual, emotional, mental and physical dimensions are all interrelated with a more wholistic way of addressing ill-health and its prevention (Martin Hill, 2009). On the other hand, Canada's health system has been built on a Western biomedical model of health beliefs and delivery approaches, very different than the wholistic health beliefs and practices of the traditional Indigenous health services (Srivastava, 2007). A study of Saskatchewan Indigenous women's experiences with breast cancer reported issues of racism, power, and socioeconomic inequality as systemic barriers within the mainstream health system that need to be addressed (Poudrier & Mac-Lean, 2009, p. 311). In Australia, Thompson et al. (2011) found that health environments need to become more flexible and respectful of Indigenous cultural needs and practices if cancer outcomes are to improve. Hill et al. (2013) in New Zealand also showed that "the [health] system as a whole is delivering unequal care" and may "inadvertently neglect the needs of Indigenous and ethnic minority groups" (p.39). A study of Indigenous people of Australia, Canada, New Zealand, and United States revealed a need for a more wholistic approach, and a greater effort to understand and make changes to health services that better accommodate the different perspectives of Indigenous people for effective cancer services (Shahid & Thompson, 2009).

A more client centered approach has been evolving in mainstream health services given the complexities of a variety of health issues (Reading & Wien, 2013). This evolution also includes cancer control with its aim to reduce the incidence, morbidity, and mortality of cancer by addressing the whole population through evidence-based interventions that span a continuum of services from prevention to palliation (World Health Organization [WHO], 2008). There are many opportunities for collaboration in cancer control, even though the approaches to health and wellness of traditional Indigenous and mainstream cancer services are very different. Medical pluralism, a more diverse approach to healthcare, has been evolving in Canada and Saskatchewan, with people increasingly accessing a variety of services to meet their needs (Waldram et al., 2007). Bridging services between traditional Indigenous and mainstream health

systems could strengthen services. Saskatchewan people have an expectation of culturally responsive health services and the health system approach has been changing to a more patient- and family-centered care in support of the diverse needs of its clients (Saskatchewan Ministry of Health [SMH], 2011). Also, throughout the cancer control continuum more culturally appropriate wholistic strategies are being incorporated to improve care for Indigenous peoples (CPAC, 2011). The request for traditional healing has been increasing as both Indigenous and non-Indigenous Canadians are accessing these services and recognizing the benefits (Waldram et al., 2007) requiring effective collaboration across these diverse systems.

1.3 Statement of the Problem

A diagnosis of cancer can adversely impact many individuals, families, communities, and workplaces (CPAC, Canadian Strategy for Cancer Control, 2017-2022, p. 3). Therefore, health practitioners need to respect traditional knowledge and recognize its advanced understanding of wholistic health and plant medicines (Stephens, Porter, Nettleton, & Willis, 2006) and build programs and services suitable to the cultural and social environments of all clients (Waldram et al., 2007). Throughout the cancer control continuum, the importance of collaborative partnerships with Indigenous populations has been recognized in Saskatchewan and Canada to improve health outcomes (CPAC, 2011). Nurses have a significant role in helping diverse cultures to navigate the health system to ensure individuals and communities receive the services needed (Srivastava, 2007). Bechtel and Ness (2010) also suggested “whole person care” (p. 916) that includes a better understanding of the clients circumstances, preferences, and values as well as coordination support with the client, family, and health providers to help clients navigate the system. Effective collaboration enables Indigenous peoples to navigate diverse systems in order to receive the support needed to stay healthy or journey to wellness (CPAC, 2011). Cuesta-Briand, Bessarab, Shahid, and Thompson (2015) suggested that building stronger and more effective partnerships between mainstream health service providers and Indigenous communities requires more openness to different perspectives and that “two-way learning and working based on trust and respect could offer a way forward” (p. 130). However, while effective partnerships between mainstream health services and traditional Indigenous health services are necessary for improved client outcomes, many of these partnerships have been strained and unproductive (Taylor & Thompson, 2011). There continues to be some uncertainty about how to collaborate

effectively between the traditional Indigenous and mainstream health services (S. Cavers & D. Lloyd, Eagle Moon Health Office, personal communication, January 17, 2013).

In addition, there has been limited information available about how to effectively collaborate between the traditional Indigenous and mainstream health services (Taylor & Thompson, 2011). More information about the concept of collaboration from the perspectives and experiences of the Indigenous health ways could help to advance these partnerships. Ermine (2007) has encouraged more progression from a singular worldview to the inclusion of other ways of knowing. Ermine (2007) provided the idea of ethical space; a theoretical space between cultures and worldviews where two different worldviews can engage with each other and explore fields of thought (Ermine, 2007, p. 202). Some Indigenous scholars have referred to this common ground and respect of different worldviews as two-eyed seeing, an overlapping of perspectives or perspectives complementing each other (Hatcher, Bartlett, Marshall, & Marshall, 2009). Two-eyed seeing was described by Iwama et al. (2009) as a way to respectfully bring together two equal but different ways of knowing. One eye Indigenous and the other eye non-Indigenous; an overlapping of perspectives, seeing through both eyes, for a sharing of strengths to resolve complicated health related problems. Hatcher (2012) also discussed the need to honor the wholistic view of Indigenous knowledge in its own right rather than viewing it through the Western lens.

2 BACKGROUND

2.1 Literature Review

A review of the literature related to collaboration provided a basis for developing the research questions and initial interview guide and was obtained by accessing three electronic databases, the Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medline, and Google Scholar. Discussions between the researcher and the thesis supervisor in relation to collaboration of health professionals, both within the mainstream health systems and between the mainstream and traditional Indigenous health systems, helped to determine the initial keywords or phrases searched. In CINAHL, the keywords searched were “collaboration” and “diverse health care systems” and a CINAHL suggested heading of “healthcare delivery integrated”. These keywords were searched separately and in combination with “collaboration”. The abstracts of 58 relevant studies about collaboration were reviewed for significance, 27 articles were selected to review full texts. Keywords searched separately and in combination in Medline were “collaboration” and a Medline suggested heading of “cooperative behavior”. Other keywords searched separately and in combination were “diverse healthcare systems” and Medline suggested headings of “delivery of healthcare” and “cultural diversity” with 35 relevant articles. Google Scholar was searched for articles related to “collaboration”, “cultural diversity”, “diverse healthcare systems”, with ten abstracts reviewed for relevance. A later search for articles related to “two-eyed seeing” was conducted, following a discussion about this concept with thesis supervisor, with three relevant articles selected and reviewed. An additional search was completed in consultation with the University of Saskatchewan librarian; key words searched in CINAHL in combination with “collaboration” and “Canada”, were “Aborigines”, “Indigenous health services”, “Indigenous peoples”, “Native Americans”, “medicine Native Americans”, four relevant articles were found and reviewed. Also, key words searched in CINAHL and Google Scholar in combination with “partnerships” and “cancer services” were “Indigenous health services” and “mainstream health services”, nine articles were selected and reviewed.

The search in all three databases was refined to include only peer reviewed academic journal articles (2003 to 2013) and a later brief search for more recent articles to 2015, reported in English, and that met the following selection criteria: addresses the concept of collaboration; and/or the definitions of collaboration; and/or identifies the core components (factors) and/or

influencers/enablers of successful collaboration; and/or provides descriptions of collaboration in nursing and/or health care practice settings; and/or collaboration across culturally diverse groups. Applicable articles prior to 2003 were reviewed after searching references of selected articles.

The benefits of collaboration in healthcare have been frequently discussed in the literature; nurses are expected to collaborate along with other health professionals, both within and across organizations (Bethea, Holland, & Reddick, 2014). Culturally competent wholistic care requires effective interprofessional collaboration (Lomax & White, 2015). Therefore, nurses have been moving away from a service-delivery model of care to a more patient-centered collaborative practice approach (Orchard, 2010); however, many professionals experience difficulty working interprofessionally (Suter et al., 2009). Many studies have stressed the importance of interprofessional collaboration for improved health outcomes. However, the health system environment could benefit from a standard definition of collaboration and an increased understanding of ways to strengthen partnerships between diverse services (Taylor & Thompson, 2011) along with the system support required for its success (Bedwell et al, 2012; Gardner, 2005).

Definitions of collaboration. There are many descriptions of collaboration provided in the literature. Collaboration has been defined across disciplines as an interactive process, structure, outcome or problem-solving activity. The absence of agreement amongst scholars and uncertainty around a standard definition has impeded progression at the practice level (Bedwell et al., 2012). There are also many other terms used interchangeably to describe collaborative work between professionals for example interprofessional, interdisciplinary or multidisciplinary collaboration, teamwork, or partnerships, creating further confusion about its meaning and implications for practice and client outcomes (Xyrichis & Lowton, 2008). Furthermore, “teamwork, collaboration, and communication are sometimes used synonymously but may be understood differently” (Lomax & White, 2015, p. 61). These different concepts could be better understood, given that each of these components is an important contributor to effective patient-centered practice (Lomax & White, 2015, p. 61). Lack of clarification about collaboration as a central component of interprofessional team service delivery can make it difficult to measure the outcomes (Suter et al., 2009).

There are many definitions in the literature; Oxford Dictionaries (2013) has defined collaboration as “the action of working with someone to produce or create something.” The concept of collaboration as it relates to healthcare has been defined as a process of joint communication and decision-making, a partnership around mutual goals and commitment that is based on shared power and authority (Henneman, Lee, & Cohen, 1995, p. 104). Gardner (2005) defined collaboration as “both a process and an outcome” that required combined perspectives to understand and solve complicated problems “that could not be accomplished by an individual or a single organization” (p. 63). Similarly, interdisciplinary collaboration was defined by Bronstein (2003) as “an effective interpersonal process” that helps to achieve goals generally unattainable “when individual professionals act on their own” (p. 299). Orchard, Curran, and Kabene (2005) and Orchard (2010) defined interprofessional collaborative practice as “a partnership between a team of health professionals and a client in a participatory, collaborative, and coordinated approach to share decision-making around health and social issues” (p. 251). Collaboration has been defined by the Public Health Agency of Canada (2010, Glossary of Terms) as “a recognized relationship among various groups or organizations to take action on a particular issue more effectively and sustainably than could be achieved if acting alone for example shared service delivery and accountability of outcomes.” Bedwell et al. (2012) have defined collaboration as “an ongoing process of joint activities and reciprocity between people or organizations to achieve a shared goal” (p. 130). The World Health Organization (2010) has defined collaborative practice as being “the different health disciplines working with clients, families and communities across settings in the provision of comprehensive services and quality care” (p. 13).

Benefits of collaboration. The benefits of collaborative practice have been established in the literature for years. A concept analysis of collaboration by Henneman et al. (1995) found collaboration to be important to nursing practice as a way to improve working relationships and patient outcomes. In a mixed methods study, using a survey and interviews to examine collaborative nursing practice, Negley, Ness, Fee-Schroeder, Kokal, and Voll (2009) identified many benefits of collaboration related to nursing and other health professionals such as interprofessional cohesiveness, improved communication, productivity, and patient outcomes. In a comparative descriptive study to explore the variance in successful collaboration in a hospice

setting, Parker-Oliver, Bronstein, and Kurzejeski (2005) showed that collaborative interdisciplinary teamwork enhanced understanding of clients' needs and improved complex problem solving. Hosley, Gensheimer, and Yang (2003) used a questionnaire to evaluate two collaborative mental health and substance abuse prevention program models in the United States to look at the features that create and maintain successful partnerships between service providers and Southeast Asian communities. Services and programming improved when strong cross-cultural collaborative teams were established. Accreditation Canada (2015, p. 6) standards for population health and wellness, included the importance of collaboration across various jurisdictions throughout the care continuum to support community action for health promotion and disease prevention. Overall, health organizations can benefit from effective interprofessional collaboration through work efficiencies, provider satisfaction, cost reductions and more responsiveness to client needs for improved outcomes (Bethea et al., 2014).

Enablers and barriers to collaboration. Collaboration has been discussed throughout many disciplines with numerous researchers and practitioners using this concept from a variety of perspectives (Bedwell et al., 2012). A review of the literature was conducted to identify the components that enable collaboration and any barriers that have limited its success within health care settings. Some studies examined enablers and barriers amongst a variety of health disciplines as they collaborated with clients and communities of diverse cultures. For example, a literature review by Taylor and Thompson (2011) of the influences of successful collaboration between Aboriginal and mainstream health service partnerships included factors related to the environment such as the political and social climate, membership characteristics of respect, process and structural flexibility and adaptability, open communication, shared purpose, skilled leadership, and sufficient resources. Similarly, Nickson, Dunstan, Esperanza, and Barker (2011) used a strengths-based theory to describe a successful community development collaborative between Indigenous women and social workers, regarding family violence and healing in rural Australia. Elements of effective collaboration revealed a formalized partnership, shared input, and resources (Nickson et al., 2011). Cuesta-Briand et al. (2015) explored the operation of a cancer support network in Australia and reported the need for a more flexible approach based on trust and respect to improve relationships between mainstream service providers and Indigenous clients. Woodroffe and Spencer (2003) highlighted cultural competence as essential in building

working relationships across cultures. In a descriptive study, they showed the importance of collaborative alliances between culturally diverse communities and social workers, specifically child welfare workers, identifying some of the essential building blocks for effective working relationships as mutual goals, formalized partnerships, and shared authority for outcomes (Woodroffe & Spencer, 2003). Hosley et al. (2003) used a survey tool to assess research-based elements of collaboration between culturally diverse groups and found that many of the components that created collaboration were also the strategies necessary for effective teamwork, for example, building trust, respecting differences, and shared decision-making.

Nelson et al. (2011) surveyed occupational therapists using a seven-point scale and found participants rated their confidence and competence to manage cross-cultural partnerships with First Australians as low to moderate recognizing the need for more education, cultural guidance, competency standards, and supportive practice environments. The competency tool for culturally responsive interprofessional collaborative practice developed by Banfield and Lackie (2009) included core components of collaboration to be shared planning and decision making, non-hierarchical relationships, patient-centered practice, cultural competence, and reflective practice. The Regina Qu'Appelle Health Region (RQHR, 2002) in Saskatchewan, Canada developed a framework for collaborative action toward improving the health outcomes of First Nations and Métis populations; the key components of collaboration included joint planning, decision-making, and action (RQHR, 2002). Nelson et al. (2011) studied effective partnerships between occupational therapists and First Australians and identified the need for more inclusion of diverse opinions from First Australians and communities to close the service gap. Nickson et al. (2011) also pointed out the domination of Western models related to women and domestic violence and the limited understanding and support of traditional systems reinforcing inclusiveness of Indigenous people's perspectives as receivers of the services.

Other studies from the literature examined enablers and barriers amongst a variety of health disciplines as they collaborated with clients and communities across a variety of health care settings. Bedwell et al. (2012) following a multidisciplinary review of the literature identified some common themes of collaboration as interdependence, reciprocity, joint activities and decision-making with common goals and outcomes. A literature review by Morgan et al. (2015) of studies that used direct "real time" (p. 1222) observation methods to examine the

process of interprofessional collaboration of primary care teams in New Zealand identified frequent and varied communication methods as a requirement for the facilitation of shared knowledge, goals, and decision-making for effective interprofessional collaborative practice. In a descriptive study, using a five-point scale, Parker-Oliver et al. (2005) found high levels of interdisciplinary collaboration of social workers and other health care disciplines in a hospice setting, highlighting some of the core elements of success as being flexibility, joint goals, and shared responsibility. Negley et al. (2009) used a mixed methods approach to examine the successful elements of a collaborative oncology nursing practice in the Midwestern United States between inpatient and outpatient practice settings; key elements included common goals, and mutual sharing of nursing knowledge, expertise, and resources. Brock and Doucette (2004) used a mixed methods design, personal interviews, and a mailed survey to identify variables important for effective collaboration and the degree of collaboration between pharmacists and physicians in Iowa. Effective communications, joint decision-making, trust in each other's competencies, and increased interdependence, were some important variables for improving collaboration between the two groups (Brock & Doucette, 2004).

Additional studies that looked at enablers and barriers to collaboration were a descriptive study by Gardner (2005) reveal some key elements needed by nurses to put collaboration into practice included valuing diversity, common vision, shared power, and systems thinking. Orchard (2010) in a descriptive study to evaluate enablers and barriers for a patient-centered collaborative nursing practice showed some enablers to be shared power, joint decision-making, and institutional support for collaborative team development. Orchard, Curran, and Kabene (2005) identified enablers of interdisciplinary collaborative practice such as role valuing, role clarification, building trusting relationships, and power sharing. A grounded theory study by Modin, Tornkvist, Furhoff, and Hylander (2010) used semi-structured interviews to develop a model to show the process and factors that impact collaboration between family physicians and district home care nurses. Factors such as trust, positive attitudes towards collaboration, and role clarification enabled collaboration while organizational boundaries, power imbalances, lack of interprofessional knowledge of each other's expectations and strategies, and insufficient time negatively influenced collaboration.

In a descriptive study to better understand interprofessional collaborative patient-centered practice, Orchard (2010) emphasized the importance of nurses clearly articulating their roles, and health professionals understanding each other's roles, and the challenge of maintaining one's professional identity while practicing collaboratively. However, in order to foster a client-centered approach to care, organizational structures needed to change (Sicotte, D'Amour, & Moreault, 2002). Sicotte et al. (2002) surveyed primary health care interdisciplinary teams in Quebec Community Health Care Centers and found that conflicting values and beliefs could undermine collaboration while alignment of interdisciplinary beliefs and values enhanced workplace collaboration. Bronstein's (2003) interdisciplinary collaboration model identified some of the enablers of collaboration to be interdependence (professionals depending on each other to achieve goals), flexibility, shared goals, role clarity, respect for other professional roles, a supportive organizational culture, and a client-centered approach to care.

There are many components of effective collaboration consistently identified in the literature. However, a standard checklist or consensus of all the required elements for collaborative interprofessional practice has not been developed and sometimes there are inconsistencies in the research findings. For example, Suter et al., (2009) found when studying the core competencies of collaborative practice that the blurring of roles could lead to conflict and burnout amongst team members and suggested clear boundaries around individual contributions. On the other hand, MacDonald et al. (2010) when studying key competencies of interprofessional collaborative practice found that some commonalities or overlapping of skills seemed to occur naturally. Parker-Oliver et al. (2005) also proposed that interdependence required the blurring of roles of team members, even though some social workers conveyed frustration when they perceived nurses were taking on their responsibilities. Bronstein (2003) looked at interdisciplinary collaboration between social workers and other health professionals and found role blurring and flexibility to be a necessary element of collaborative practice. Sicotte et al. (2002) studied interdisciplinary collaboration of primary health care models in Quebec and found only modest results after twenty-five years; health professionals tended to work parallel to each other rather than collaboratively, with professional autonomy seen as a barrier to collaboration. Similarly, a review of the literature of conceptual models of collaboration in cancer care and a subsequent evaluation across several countries including

Canada by Gagliardi, et al. (2011) found many professionals working parallel or consultatively rather than collaboratively. Haynes et al. (2014) suggested that partnerships between Indigenous and mainstream health services rely on effective relationships between people that require self-reflection, shared power, trust, time, resources, and accepting difference as some approaches to working together.

In summary, the literature review has provided an overview of the benefits of collaboration, some of its definitions, as well as barriers and enablers that could determine its success as summarized in Appendix B. Collaborative relationships have been examined within and across a variety of health settings and within and between various health disciplines, as well as between different health disciplines and culturally diverse clients and communities. Having a variety of definitions of collaboration and the usage of other terms interchangeably has created confusion about this concept. The identification of some of the enablers of effective collaboration or its barriers to success while seemingly similar across disciplines and settings remain unclear without a comprehensive list of all of these elements. Furthermore, there has been limited information made available about collaboration from the perspectives of the traditional Indigenous health services or information to better understand ways to strengthen partnerships between diverse services to improve health outcomes (Taylor & Thompson, 2011).

2.2 Future Research

The literature on collaboration in addition to its outcomes could examine further the many skills that help to facilitate the process of collaboration (Gardner, 2005). Interdisciplinary collaborative service delivery could be better understood (Sicotte et al., 2002) with more inquiry around the methods of promoting collaboration in a variety of health care settings, including cancer services, and evaluating its effectiveness on patient outcomes (Gagliardi et al., 2011). More research focused on a better understanding of individual attitudes toward collaboration, the effects of organizational culture, the perceptions of power and authority, and how educational preparation has influenced collaboration (Hughes & Fitzpatrick, 2010). Also, more investigation to understand how different cultures might define collaboration or their experiences of collaboration from the perspectives of the traditional Indigenous health services or information to better understand ways to strengthen partnerships between diverse services to improve health outcomes (Taylor & Thompson, 2011).

Also, this researcher's practice experience of more than 20 years as an oncology nurse and over 30 years within the mainstream health system, collaboration between mainstream cancer service and traditional Indigenous health service could be strengthened across the cancer continuum from prevention to palliation. At the practice level, the researcher has experienced the confusion about the concept of collaboration that has been described in the literature, as well as many of the enablers of collaboration, mainly, the importance of building trusting relationships, shared goals, and joint decision-making for effective collaboration between Indigenous and mainstream services. Health practitioners have a willingness to collaborate from both services and there are many opportunities in cancer control to work collaboratively with Indigenous populations concerning health promotion, early detection, and treatment services. Effective partnerships between mainstream and Indigenous health services are needed to improve health outcomes; however, more information is needed on how to make these partnerships productive (Taylor & Thompson, 2011). Also, many health professionals experience difficulty working interprofessionally at the practice level (Suter et al., 2009) and require more system support for its success (Bedwell et al., 2012; Gardner, 2005).

2.3 Research Questions and Objectives

A more collaborative approach to health care and cancer control services has been developing across the country. Increasingly, decision makers and health practitioners from both worldviews are working in partnership (Waldram et al., 2007). However, many professionals experience difficulty working interprofessionally (Suter et al., 2009) including those in cancer services (Gagliardi et al., 2011) and there has been limited information available about the concept of collaboration and the factors that contribute to successful partnerships between the traditional Indigenous and mainstream health services (Taylor & Thompson, 2011). For this study, cancer services was used as an example of a healthcare setting through which a better understanding of collaboration when working with Indigenous populations could help to strengthen these partnerships and improve health outcomes.

The purpose of this study was to explore the experiences of collaboration of select Saskatchewan health professionals practicing across the traditional Indigenous and the mainstream health services to understand further the concept of collaboration from their perspectives. The objectives of this study were (a) to explore their definitions of collaboration;

(b) to explore and describe their perceptions and practice experiences of collaboration, particularly the core components/enablers (both individual and system elements) that make collaboration work and the barriers that make it difficult across the two different health services; (c) to find ways to move forward to catalyze enablers and mitigate the barriers to collaboration; and (d) to identify any unique aspects about participant perceptions of collaboration related to cancer control services specifically.

2.4 Saskatchewan Context

For this study, the significance of collaboration has been positioned within the context of the Saskatchewan health system. Collaboration requires systems thinking and depends upon the context to be effective (Gardner, 2005). The health system in Saskatchewan has been transitioning from a service-delivery model to a framework of patient- and family-centered care (Dagnone, 2009) that has required systems thinking and a new way of provincial strategic planning that was significantly different than its previous models. Particularly within the health sector, the Hoshin Kanri, a systemic approach to strategic planning has been adopted with an underlying expectation of provincial partnerships to achieve shared goals for better health outcomes (SMH, n.d.). This type of foundational support for systemic planning and evaluation could provide the infrastructure for advancing collaborative practice goals. To support interdisciplinary collaborative practice across a diversity of health services would require this sort of health system reform (Bronstein, 2003) and organizational change (Orchard et al., 2005).

The strategic priorities of the Saskatchewan health sector are to cost-effectively improve population health, client care, and system teamwork (SMH, n.d.). Work environments that foster patient- and family-centered care and collaborative practice including collaborating with communities have been deemed essential to achieve success within this new model of healthcare (SMH, 2011). Additionally, supportive relationships between diverse groups would require a practice standard of cultural competency within the health system. It has been well documented in the literature for a number of years that cultural competence was a requirement of effective collaboration (Banfield & Lackie, 2009; Kalyanpur & Harry, 1997; Nelson et al., 2011; Woodroffe & Spencer, 2003). Considerable planning has been done in Saskatchewan in an effort to improve the health and social outcomes of Indigenous people. The *Working Together Towards Excellence Project* provided a model of how the health regions and province could

collaborate across sectors and jurisdictions (RQHR, 2002). The collaboration framework within this model portrayed a wholistic view of health, affirmed support for traditional healing, and outlined the prerequisites for effective collaboration. The *Eagle Moon Health Office Project Charter* (RQHR, 2011) has continued to build upon the 2002 model advancing service delivery in support of traditional healing to improve the health status of Indigenous people. Within this context and climate of change in Saskatchewan, the concept of collaboration needs to be elevated, collectively defined, and its enablers for success examined and better understood to advance collaboration across the traditional and mainstream methods of health services.

3 METHODOLOGY

3.1 Research Design

This qualitative exploratory study used an interpretive descriptive approach to describe how collaboration has been experienced and understood by select Saskatchewan health professionals working across the traditional Indigenous and mainstream health services. There has been limited information made available about collaboration from the perspectives of the traditional Indigenous health services, more specifically the insights and experiences of health professionals working between these two services. Therefore, a qualitative exploratory approach is appropriate for this study. This approach provided a way to describe common realities as well as the unique individual life experiences from the viewpoints of those involved (Grove et al., 2013a). Qualitative research provides a way to develop comprehensive and contextual knowledge about human phenomena; patterns and themes can be examined, described, and documented to better understand the subjective or experiential elements of a phenomenon or different human experiences. Qualitative research offers a method of reasoning within a naturalistic and wholistic framework which allows in-depth exploration and substantive understanding of the subjective human experience (Grove, Burns & Gray, 2013a). The approach of interpretive description, according to Thorne, Reimer Kirkham, and O'Flynn-Magee (2004) can be a way to take raw data and change it into a structure of constructed truths about aspects of a phenomenon that creates new meaning in a useful way to apply in clinical practice. Interpretive description was used for this study because of its reasoned approach to developing knowledge for application in practice. Particularly, aspects of the human experience within its natural context could enhance nursing's ability to better understand the implications of collaboration in practice, more specifically in this case across diverse health services. The researcher used a reflexive position throughout the research process, in an effort to acknowledge and understand the influence of one's own knowledge, attitudes, and beliefs about collaboration (Thorne, 2008).

According to Thorne (2008) interpretive description can be used when other more common qualitative health research methods of the social sciences such as ethnography, grounded theory, and phenomenology, may not fit a particular research question and whose main objective was not to theorize. Grounded theory supports theory development. Ethnography can

provide a logical explanation of how individuals structure their world, and phenomenology helps to describe the essentials of subjective human experience (Grove et al., 2013a). Thorne (2008) has found that some of these methods can be prescriptive and may be problematic for the practical demands of the applied disciplines, such as nursing, where action needs to be taken at the practice level before a problem might be fully understood. The nature of nursing practice questions can involve knowing more about a specific lived experience or about a shared health phenomenon from the perspective of those who are living it. Interpretive description has gained utility in nursing research and was suitable for this study because it offered a framework for data collection and analytic strategies that utilized various qualitative methodologies to better understand practice level issues (Thorne, Reimer Kirkham, & MacDonald-Emes, 1997). For example, Cioffi (2006) in a qualitative descriptive study interviewed eight culturally diverse family members who made the decision to stay with their hospitalized relatives, and used interpretive description to capture their experiences in acute care hospital wards.

Interpretive description is based on the philosophical perspective that reality has been socially constructed through subjective and inter-subjective experiences and shaped by social, cultural, and political influences, rather than an external objective reality to be discovered outside of the human experience. This method of an inductively derived description of a phenomenon also requires an interpretive lens to examine associations, relationships, patterns, and themes related to the phenomenon of interest. Interpretive description helps to look beyond the obvious and provides a logic model for generating descriptive knowledge related to the individual and experiential aspects of the human health experience providing contextual understanding and evidence-based decisions for application in nursing practice. Careful and systematic analysis of a phenomenon and the process of reflective clinical reasoning, through qualitative methodology, can help to integrate what we have learned from studying specific cases and guides us toward a more general knowledge and its application in practice (Thorne, 2008). As well, Hartrick Doan and Varcoe (2008) consider nursing ontology and epistemology to be interconnected; the knowledge translation process seems effective if it reshapes nursing ontology to enhance practice level actions that improve patient outcomes. Essentially, knowledge to action can be demonstrated by nurse's responses in their practices to patient encounters.

Petrucka, Bassendowski, and Bourassa (2007) found qualitative methodology to be consistent with the Indigenous tradition of oral communication, and invited community members to share their stories and experiences of culturally respectful care which highlighted the importance of applying practical knowledge in resolving local level enquiries. A qualitative methodology also aligned with traditional Indigenous research approaches of learning by “watching and doing” to become at ease with a particular group (Wilson, 2008, p. 40). The Indigenous research paradigm asserts “knowledge is relational”; Indigenous ontology and epistemology are indistinguishable and actioned by way of our relationships with the entire universe (Wilson, 2008, p. 56). According to Hatcher et al. (2009) Indigenous science describes knowledge as a “spirit that transforms the holder” and two-eyed seeing merges Indigenous and Western sciences “teaching us to awaken the spirit within” (p. 146). Hatcher et al. (2009) highlighted respectful relationships as a prerequisite for effective learning and connected Indigenous knowledge to the “knowers or learners” (p. 143) as a way of life. Brewer, Harwood, McCann, Crengle, and Worrall (2014) combined an Indigenous research approach and interpretive description in New Zealand, to investigate Indigenous people’s experiences with aphagia; the two approaches were compatible because of the focus on relationship building and “making a difference in people’s lives” (p. 295).

When using interpretive description, there are some philosophical assumptions that are foundational to the human experience and its relation to the development of knowledge for practice level inquiry which includes (a) a naturalistic context and an ethical approach that is respectful of all participants; (b) a valuing of subjective experiential knowledge as a way to understand practice level issues and the importance of comparing and contrasting commonalities and unique experiences; (c) a consideration for the time and context within which the issue was explored as well as the social construction component of human experience and the potential for contradictions; and (d) acknowledgment of the close relationship between the researcher and the study participants and the influences of this interaction on one another (Thorne, 2008).

Interpretive research draws upon practice experience providing an inter-subjective and a socially constructed process of knowledge translation between researcher and participants (McWilliam et al., 2009). For this study, it was important to gain a better understanding of collaboration across diverse systems, specifically its definition, enablers and barriers, identified,

described, and explained by those who have practice experience of collaboration across diverse services and thereby could offer possible solutions for advancing collaborative practice.

3.2 Population and Setting

The population of interest for this study was the team at Eagle Moon Health Office, Regina Qu'Appelle Health Region (RQHR, 2015a) located in a large urban center in southern Saskatchewan, Canada. The Eagle Moon Health Office was established in response to the health challenges and inequities faced by Indigenous populations within the region and its ongoing efforts to improve outcomes (RQHR, 2002). The major goals of Eagle Moon are to assist health region departments to provide more culturally appropriate services for Indigenous populations; support access to the traditional pathway and its wholistic understanding of health; build relationships and strategize on how to collaborate; and facilitate the process between the traditional and mainstream health services (RQHR, 2011). Team members at Eagle Moon are both Indigenous and non-Indigenous health practitioners/consultants including healers, knowledge keepers/elders, and an administrator. This team has an informed perspective because of their understanding of both worldviews; traditional Indigenous and mainstream health services. This team was selected for this study because of their knowledge of traditional Indigenous health ways and their experience collaborating with a variety of tribal groups and departments within the health region in an effort to work collaboratively between these two services (RQHR, 2015a).

Eagle Moon's mandate to support the traditional pathway of wholistic health and the facilitation of collaboration between these distinct services in the region has included 17 First Nations communities and several Métis families. Many First Nations dialects are spoken within these communities such as Cree, Saulteaux, and the Sioux languages of Dakota, Lakota, and Nakota. For over ten years, Eagle Moon Health Office has been working within the health region to bridge these two distinct practices and knowledges to enhance service delivery and improve health outcomes for Indigenous peoples. The team has developed relationships with communities and across sectors by working closely with knowledge keepers/elders, and health directors, to learn more about their health concerns. The team collaborates with community members and health practitioners with an understanding that complete health encompasses mental, physical, emotional, and spiritual well-being. Eagle Moon Health Office has the

guidance of traditional knowledge keepers/elders and their teachings of the spiritual, cultural, and traditional ways in meeting the wholistic health needs of Indigenous populations in the region (RQHR, 2015a).

The Eagle Moon Health Office team and the researcher (Director Cancer Prevention, Saskatchewan Cancer Agency) are known to each other and have a shared interest in exploring, understanding, and improving collaboration between these two health services. Common ground for this study was found in an integrative science approach that practiced co-learning, a mutual commitment to shared goals and methods, and was equally respectful of Indigenous and Western perspectives (Iwama et al., 2009). Integrative science avoids knowledge dominations by using the “guiding principle of two-eyed seeing that recognizes the best of both worlds” (Hatcher et al., 2009, p. 141), “respectfully bringing together different ways of knowing, Indigenous and Western, to motivate people to use all of [their] gifts” (Hatcher et al., 2009, p. 146). Moreover, qualitative researchers acknowledge that people who are living the experience can offer the best source of expert knowledge about it (Thorne et al., 1997). Therefore, the participants selected for this study were a heterogeneous sample of both men and women of different ages and roles within the team at the Eagle Moon Health Office. The sample population involved a nonrandom, purposive sampling technique based upon predetermined criterion in which the setting and participants were selected and reflect a particular perspective (Thorne, 2008), that of having had sufficient knowledge and experience to provide valued opinions about collaboration across diverse health services. An interpretive descriptive approach helped to explore the important elements of collaboration that are shared by the team and distinguish irregularities from commonalities within this process.

3.3 Eligibility Criteria and Sampling

Sampling criteria for this study included (a) a member of the team at Eagle Moon Health Office; (b) the ability to speak and read English; (c) a health professional or health consultant (knowledge keeper/elder, healer, nurse, mental health and addictions counselor), or manager (administrator or director) practicing across the traditional Indigenous and mainstream health services; (d) knowledge of the traditional Indigenous health services and knowledge of the mainstream health services; and (e) experience collaborating between these two diverse health services; or f) an Elder that acts as an advisor to the team at the Eagle Moon Health Office; or g)

a client (community member, leader, or patient) that has accessed the team's services or worked in partnership with the Eagle Moon Health Office team across the two services in relation to an initiative.

A purposive sampling method was used for this study in the selection of specific participants to obtain the rich data needed for a better understanding of the concept of interest. For interpretive description, there was no predetermined sample size. However, many studies that have used this approach have generally been small with sample sizes that have ranged between five to 30 participants (Thorne, 2008). The sample size for qualitative research can be determined by the amount of quality data required to obtain the necessary insight into the phenomenon being studied (Grove et al., 2013c). The sample size for this study was eight participants, including six members of the Eagle Moon Health Office team (seven of nine team members were eligible and six participated) and two external partners of the team that have worked collaboratively for several years to improve health services. To enhance the trustworthiness of this study, the elders that were invited to participate have developed strong linkages with communities and have acted as advisors or have partnered with the team for many years which has been invaluable in gaining a better understanding of collaboration from their perspectives and experiences (Petrucka, Bassendowski, Bickford, & Elder Goodfeather, 2012). The workload and availability of team members and what might be a reasonable interruption of their daily work were given consideration during the study period (Thorne, 2008).

3.4 Procedure

Following ethical approval from the University of Saskatchewan's Behavioural Research Ethics Board, the required regional and organizational Internal Review Board approvals, and Eagle Moon Health Office Elders approvals, data collection using semi-structured interviews and researcher observations of the study participants took place over a nine month period in 2015, from a selected purposeful sample population of health professionals of the Eagle Moon Health Office and two of their partners. A demographic data collection form (Appendix C) and a semi-structured interview guide (Appendix D) was developed, based on the literature review, and used for all participant interviews. For the researcher to elicit and explore participant experiences and perspectives of collaboration, the interview guide consisted of a few open-ended questions for example, "What enables or helps collaboration? What makes collaboration difficult? All

interviews were conducted by the researcher; each face-to-face audio-recorded interview ranged from approximately 90 to 200 minutes in duration and was scheduled at a time and location convenient for participants as recommended by Cioffi (2006). Digitally recorded interviews were transcribed verbatim by the researcher following each interview as suggested by Grove et al. (2013b).

Prior to study implementation, the researcher, a registered nurse, arranged in-person meetings with the Director and team at the Eagle Moon Health Office to inform them about the study and obtain permission about the approach and recruitment process. The Director of the Eagle Moon Health Office played a substantial intermediary role to ensure the appropriate cultural practices and protocols were honoured throughout the research process and also assisted with the identification of potential study participants who met the eligibility criteria for interviewing and for the external partnership interviews. Potential participants were asked to contact the researcher if they were interested in participating in the study. Interested participants were recruited for periods of observation and interviews including two external partners to provide further clarification of the topic. After recruiting the study participants, the researcher provided in-person information sessions to the participants and described the study and obtained a signed written consent from those who were interested in participation. To help the participants in understanding the study, both verbal and written information was provided. The researcher outlined the purpose of the study, its processes, potential risks and benefits, confidentiality considerations, data storage plan, and participant's right to withdraw. Following the in-person meetings, the researcher scheduled with participants the appropriate times for the semi-structured face-to-face interviews and observation periods, and provided the researcher's contact information for participant questions or concerns throughout the study period.

To offer further credibility to the findings, two partners experienced in working over several years in partnership with the study participants of the Eagle Moon Health Office team, were also interviewed to learn about their experiences of collaboration with the team. A similar interview guide (Appendix E) was developed and used to help focus the discussion for these external partner interviews. The researcher shared with each participant their interview transcript and asked for clarification and feedback. All participants reviewed their individual transcript, four provided changes, before signing the Transcript Release Form (Appendix F); the

researcher incorporated these changes prior to data analysis. The researcher also met with the Eagle Moon Health Office team members that had participated in the study and shared the preliminary findings. Participants were asked to verify through group discussion if the interpretations and understandings formulated in the findings provided an accurate reflection of the team's experiences of collaboration (Thorne, Con, McGuinness, McPherson, & Harris, 2004).

Four, unstructured, observation periods were arranged with study participants, for about three to five hours at a time, and totaled over fifteen hours of study. During these opportunities, the researcher freely observed and recorded interactions, activities, and non-verbal communication of the study participants, in their practice setting (Grove et al., 2013b), as they interacted and worked with each other, with their clients, and external partners across the two health services. The researcher observed the participants on two separate occasions as participants collaborated with each other for team meetings and strategic planning and also another two separate events, a First Nations community horse dance ceremony, and a provincial elders sharing circle. In some circumstances, the researcher took brief notes when observing the internal team meetings; however, notes were not taken during the horse dance or elders sharing circle. The researcher made notes immediately following these two events to remain respectful of participants and the traditional and ceremonial protocols. Also, the study participants made the researcher feel welcome and comfortable about participating in these events by sharing the anticipated processes and protocols in advance of each occasion and provided ongoing guidance to the researcher throughout these events.

Member checks were conducted to share a synthesis of the findings with participants to help validate the initial insights of the in-person interviews. Participants were asked and willingly made themselves available to be contacted for further clarification of their transcripts, more in-depth questions or to expand on issues for clarification of ongoing interpretations and elaboration of any developing themes (Cioffi, 2006). Follow up clarifications to the transcripts were documented and revisions were made and approved by participants. Applicable grey literature, such as partnership agreements, strategic planning documents, and work plans were examined for additional background information and to verify or refute emerging insights throughout the data collection period (Thorne et al., 1997).

3.5 Data Analysis

The demographic information collected from each participant prior to the interview consisted mainly of categorical data (i.e., age, gender, ancestry, and practice experience) and was descriptively analyzed to describe participants as a group. Data analysis was an inductive and iterative process, which required immersion in the raw data and exploration by grouping, sorting, and transcribing the data pieces into patterns and themes and considering relationships between groupings and patterns to develop a cohesive description of the themes that helped to understand collaboration (Thorne, 2008). The audiotaped participant interviews were transcribed verbatim by the researcher and analyzed following the interviews. Being involved in the transcription process helped the researcher to become immersed in the data, and allowed a deeper focus on the words, phrases, and nuances of what was shared by the study participants, for example, intonations, pauses, emphasis of subject matter, and some of the nonverbal communication that was recorded.

Prior to the interviews, the researcher documented and reflected upon personal beliefs and experiences of collaboration to enhance awareness of how this might influence what was observed and heard from the study participants and consequently the research process and findings (Grove et al., 2013a). Prior to coding the transcripts, and to better understand individual participant experiences and researcher bias, the researcher wrote a synopsis of each interview. The researcher highlighted words and phrases within the text of these narratives to illuminate the researcher's own perspectives, biases, and assumptions regarding the topic. The narratives also provided ongoing reflection during the process of comparative analysis to remain cognizant of individual experiences while identifying inductively the commonalities and variations among these experiences (Hunt, 2009).

After the narratives had been developed, each transcript was reviewed line-by-line, similar words and phrases were color coded electronically and then copied and pasted into a chart; common words, phrases, and patterns were coded according to interview questions and grouped and sorted by color. Following the development of charts of the data pieces from the individual interviews, the charts were combined of all participant quotes and further organized to develop the data set as a whole. When combining the charts, very broad-based coding schemes and marginal memos were used rather than rigid codes in alignment with the work of Thorne,

(2008). Similar ideas were grouped and compared with similar or dissimilar ideas allowing ongoing review and reflection of the data set to determine which ideas and common themes provided an understanding and possibly new information about collaboration (Thorne, 2008), (see Appendix G for an example of codes to themes). Throughout the organizing and conceptualizing phase of data analysis, the researcher kept notes within the chart of key elements, developing themes or patterns, outliers of relevant variations to capture evolving thought and inquiry. Member checks were used to confirm and clarify important relationships within the data set. Also, field notes were made of the researcher's observation periods of the study participants within their practice environment and reflected upon during the data analysis period. Main themes were identified, and findings were written of the participants' perceptions and experiences that have enabled or limited effective collaboration across diverse health services.

Seven of nine members of the Eagle Moon Health Office team were eligible to participate in the study and agreed to participate. The data collection process was considered to be sufficient when additional information did not change the patterns of the results (Grove et al., 2013c); therefore, six of seven members of the Eagle Moon team that were eligible to participate were interviewed. Word processing software was used to create electronic files with descriptive titles to manage the data and assist with data analysis (Thorne, 2008). The novice researcher consulted with an experienced researcher (thesis supervisor) and thesis committee with expertise in qualitative research methodology.

3.6 Ethical Considerations

Ethics approval was obtained from the University of Saskatchewan's Behavioural Research Ethics Board (BREB), Eagle Moon Health Office Elders, and participating organizational Internal Review Boards for the necessary approvals prior to commencing the study. This study involved the participation of Indigenous groups and followed the codes of research practice established by the Indigenous communities according to the guidelines of the Canadian Institutes of Health Research (CIHR, 2011) as outlined in the Tri-Council Policy Statement. This approach included adherence to the OCAP principles (ownership, control, access, possession) concerning the data collection, ownership, and assertion of self-determination related to research (Schnarch, 2004). The researcher, Director, and team at Eagle

Moon Health Office made a concerted effort and created a meeting place or a “neutral zone” as described by Ermine (2007, p. 202) that provided the space for open dialogue and for the exploration and further understanding of other ways of knowing which helped to achieve a partnership and a convergence of different worldviews concerning the study topic. For this study, it was determined that the Eagle Moon Health Office would have ownership of the information collected (audio-recorded interviews), the raw data was in the possession of the researcher throughout the study period, and the study participants had full access to their individual transcripts.

Also there were ethical implications surrounding the relationships developed between researcher and participants pertaining to the researcher’s influence upon the participants and therefore the data being gathered. It would be difficult to claim the neutrality of talking and acknowledge that sharing experiences with an interviewer can have an impact on the participants. Therefore the consenting process was ongoing and participant’s commitment was continually reassessed by the researcher (Robinson & Thorne, 1988).

The consenting process was an ongoing ethical responsibility of the researcher and participants were provided an explanation of the continuous consenting process and were asked to share only what they were comfortable with disclosing (Thorne, 2008). The researcher explained the study in detail and answered questions before participants were asked to provide their consent for participation. Information about the study and the consenting process followed the guidelines from the University of Saskatchewan BREB (Appendix H); all participants received a copy of their signed consent form. The consent form provided participants with written information related to the study purpose and processes, eligibility criteria, what their participation involved, the risks and benefits of participating, ethics approvals, usage and storage of the data collected, the voluntary nature of the study and rights to withdraw, assurance of confidentiality, and consenting process to participate. The researcher provided a culturally suitable gift to participants and an appropriate honorarium to Elders for their time and involvement in the study.

To preserve participant confidentiality and anonymity, all data collected was de-identified, all names and personal information was eliminated from the data transcripts (Grove et al., 2013b) and replaced with pseudonyms, and identifiers recorded on a master list and stored

electronically and separately to the research data, and was made available only to the research team. The master list will be deleted after five years. Data files were password-protected. To ensure confidentiality and auditability, the audiotapes of the interviews have been stored in a locked drawer at the Eagle Moon Health Office and will be deleted after five years by the researcher and the Director of the Eagle Moon Health Office. Transcripts of the interviews, and the researcher's reflective narratives and field notes were stored electronically and password protected. Study findings will be presented and published using pseudonyms. Participants were invited to review their individual transcripts and were provided an opportunity to withdraw any of their raw data prior to its analysis and release for presentation or publication purposes.

There may or may not be any direct benefits to the Eagle Moon Health Office team for their participation in this study. It was anticipated that the information gained from the study could be used in the future to benefit other people that work with Indigenous populations. One benefit of participation might be of having the work of the Eagle Moon Health Office team documented in a way that contributes to a better understanding of collaboration across these two diverse services within the health system in Saskatchewan. Potential risks of the study may have included mental fatigue due to the in-depth conversations and ongoing discussions about collaboration resulting in some participant discomfort. Also, participants may have felt uncomfortable about being observed in their practice setting and sharing their views and opinions about collaboration.

4 FINDINGS

4.1 Demographic Information

The findings from this study were based on semi-structured, audio recorded interviews and observation periods of some of the team members at the Eagle Moon Health Office with further concept clarification from two of their partners. Demographic information requested of the participants prior to individual interviews provided an overview of participant demographic characteristics such as age, gender, ancestry, as well as knowledge and practice experience working across traditional Indigenous and mainstream health services. Eight participants took part in the study, 6 were members of the Eagle Moon Health Office team, and 2 participants were partners of the team from joint initiatives. Seventy-five per cent of the participants were female, all participants were 50 years of age or older with over 60 per cent of participants of Indigenous ancestry. More than 85 per cent of the participants have had 5 or more years practice experience of traditional Indigenous health services, and 75 per cent of participants have had 5 or more years practice experience within the mainstream health services. Half of the participants have had sixteen or more years of experience in either the traditional Indigenous health ways or the mainstream health services. All the participants have had at least ten years' experience working across the traditional Indigenous and mainstream health services with half of the participants having more than 20 years. The demographic characteristics are summarized and illustrated in Appendix I.

The educational backgrounds of participants were not collected because of the inability of the researcher to adequately and appropriately demonstrate the level of knowledge gained by way of the oral Indigenous teachings. The Director of the Eagle Moon Health Office shared that the educational backgrounds of the team are very diverse. Some team members have gained knowledge in the mainstream academic system and may have one or more undergraduate degrees or graduate level degrees, while others have both mainstream and traditional Indigenous teachings and knowledges. For example, the knowledge of a healer might be gained over many years through the oral traditional Indigenous teachings and training or may consist of both mainstream academic preparation and traditional Indigenous teachings. Also, the advanced knowledge acquired in the traditional Indigenous way has generally not been shared openly with others and would be seen as inappropriate. As well, the process of traditional knowledge

development has not been described or defined in the same way as mainstream academia. Therefore, to capture both kinds and levels of knowledge and educational backgrounds from both worldviews may not be an accurate reflection of the actual knowledge of some of the participants and, therefore, the researcher, out of respect for the team, did not include educational background on the demographic data collection form. However, the team at Eagle Moon Health Office includes such disciplines as nursing, education, human justice, social work, and psychology.

4.2 Collaboration Overview

The concept of collaboration was described by participants as being complicated and difficult to achieve. Participants described collaboration as challenging and often considerable time, and effort was needed to achieve meaningful outcomes. Participants spoke about both successful and unsuccessful collaboration with more examples of difficult collaboration circumstances when working across the traditional Indigenous and mainstream health services. However, when meaningful and effective collaboration does happen it was described encouragingly and excitedly by participants as something special using words such as “incredible”, “remarkable”, “amazing”, and an “unforgettable” experiences. As one participant shared, “it was a beautiful experience” and another participant stated, “It’s an experience that I hold to this day.” Participants shared that collaboration seems to be less of a system priority but does occasionally happen on a smaller scale and would like to see more significant collaboration across the two distinct services. One participant stated, “it does happen, people do, do it” and another participant said, “It’s just not something that is at the forefront” or “as a system we have not made the progress that we should’ve made over all the years.” However, participants offered significant insights into defining collaboration, its enablers, barriers and possible ways to move forward to advance collaborative efforts between the traditional Indigenous and the mainstream health services.

4.3 Defining Collaboration

During the interviews, the researcher asked the participants how they would define collaboration and if they have used other terms besides collaboration in their practice. The researcher also shared a few examples of definitions of collaboration from the literature to help participants understand the concept being explored and were asked to provide their reactions to

some of these definitions. The following insights were summarized to capture the general perspectives of the participants.

Collaboration terminology. The word collaboration was not a common term used by the study participants and may not be well understood. One participant expressed that collaboration was a term that was used “loosely” and that its meaning was not implicit. Similarly, another participant suggested that some people were using the idea of collaboration rather than actually doing the collaboration. For example, having a meeting with a group of individuals, hearing their opinions or getting input on something might seem like collaboration. However, this participant felt that until you develop a partnership and walk the road together with an understanding that helps you to change your thinking or internalize some of the learnings to approach the work differently, you have not really collaborated. One participant preferred the word collaboration to “working together” and wondered “about the ones over here” recognizing that sometimes in the process of bringing groups together not everyone was included. Participants spoke a lot about the virtues of trust and respect as being inherent in a successful collaborative process, as stated by a participant, “you have to walk the virtues, I can’t think I’m more important than you.” One participant suggested that, while the concept of collaboration seems very simple, it can be difficult to achieve saying, “...it’s a simple concept but it’s difficult to action.” Another participant said, “There’s so many ways to collaborate, there’s ways of how you speak, there’s ways of how you look, your body language, the words that come out of your mouth...”

Participants generally preferred using other words and phrases in the place of the word collaboration when working in partnership with others. However, there was not a common word or phrase used consistently amongst the participants or their partners, and not all participants were in agreement that collaboration was a misunderstood term. For example, some participants commonly used terms such as “working group”, “working together” or “working as a team” rather than collaboration while other participants preferred “brainstorming”, “the meeting of the minds” or “the joining of the minds.” One participant uses the term “partnership” instead of collaboration because it describes a more equal or balanced relationship whereas another participant preferred using the term “working together” rather than “partnership” because of it

being too “formal.” On the other hand, one participant preferred the word collaboration to working together, and felt that the term collaboration was understood overall.

Participant’s definitions of collaboration. Participants were asked how they would define collaboration, yielding a variety of definitions. Even though different definitions were put forward, participants consistently spoke about similar elements of collaboration that were important to them. For participants, collaboration was about shared goals, ownership and accountability with an emphasis on equality. For example, participants defined collaboration as “two or more people, working together for a common goal”; or “a willingness to walk a journey together, and be responsible together for the outcomes...” However, participants were concerned about who might be naming the problem or defining the goal and if the goal was shared by partners. Participants emphasized equality and the importance of working together as equal partners. As one participant explained, “one partner is not better than the other partner...” and questioned if it seemed that way sometimes in part because the mainstream health services have more resources than the traditional Indigenous health services, requiring one to rely on the other thereby creating an inequality in some cases.

Participants also talked about inclusiveness and valuing each partners’ contribution toward a common goal; particularly, the importance of having the respective knowledges coming together to work on behalf of an individual or an organization with each one contributing towards the outcome. For participants, each partner has to make a contribution, and each has to be equally valued for what they can contribute within the partnership. For example, one of the participants defined collaboration as “an equal effort...inputting from a different background...and everybody coming together.” Emphasis was placed on equality around power and authority as well as trust and respect concerning each other’s contributions within the collaborative. One participant stated, “Work together...leave each to his own...stay out of each other’s boats.” When distinct knowledges come together to achieve a common goal, everybody comes in with a different mandate to contribute towards that common goal of wellness. According to one of the participants, in real collaboration, it doesn’t matter if you come into the partnership as a traditional medicine man, healer, doctor, nurse, or administrator; each partner has an equally important contribution towards the success of the client’s wellness. Collaboration

defined by this participant was about “working together and sharing responsibility to offer the best for whoever it is we’re trying to serve...and that’s done by walking all those virtues.”

Participant’s responses to definitions from the literature. The researcher shared a few examples of definitions from the literature and asked the participants to provide comments to help determine if these definitions resonated with participants or if there were any components of the definitions that they might be in agreement or disagreement with in relation to collaboration. Participants while acknowledging that the definitions were developed by mainstream, responded more positively and were in agreement more often when the definitions included words about joint decision-making, mutual goals, equal power and authority, or shared outcomes. However, participants consistently questioned the equality of many partnerships saying “it can’t be one way...but I don’t know if that will ever happen, I’m hoping that it will someday” reaffirming “that joint has to be equal...but one has always dominated.” Rather than equality of partners at collaborative tables, participants have had experiences of Indigenous people being brought into a group at times, to make it appear outwardly as though it was a joint collaborative, and referred to this practice as tokenism. One participant said, “we are put on things as tokens...just because there needs to be an Aboriginal person there...so you’re sitting there, you’re not really participating because you’re not feeling that you can...but you’re there...without any power to do anything.” In addition, another participant suggested including the virtues in the definitions from the literature. This participant shared that if a definition was to be put forward by Indigenous people they might add “guided by those virtues or values” because inherent in the collaborative process needed to be the virtues and values of the Indigenous people and organizations. Without the virtues to guide the collaborative process, equality of the partnership would seem unlikely. The following quote from a participant described the importance of the virtues in how collaborative work could be approached,

Collaboration is a beautiful word, its great definitions, but it’s the operations of collaboration that are actually what lends to the success of the organizations, not the ideologies. The values are very beautiful, but unless they’re operational, unless you act respectfully, you can write it all you like.

Participants stressed the importance of making a change, difference, or shared positive outcome for successful collaboration. One participant pointed out that along with these various definitions are assumptions that everybody understands their meaning and interpretation saying

“it doesn’t usually happen that way. They already have their own preconceived processes in their mind.” Within the traditional wholistic approach, the spiritual, emotional, and mental aspects are attended to before the physical. However, the mainstream health system focus has been primarily on the physical component. One participant expressed the differences in approaches by saying “basically on the Western side...you go right to the physical part and start addressing that part” while the traditional Indigenous way would initially bring people to the ceremony to address the spiritual part before the physical component can be addressed. Concern was expressed that the current health system resources the physical aspects of care while fewer resources are allotted for the spiritual, emotional, and mental components of wholistic health. The traditional health way values all four components of health equally and therefore may not always feel included in the mainstream health system. As one participant shared about the collaborative effort “...so we’re just ...supposed to fit in wherever we fit in and...kind of show up when we’re supposed to show up...and kindly move to the back of the bus when it’s convenient.” Another participant reflected on the definitions that are about mutual goals or shared power and authority and indicated that this idea might be an assumption rather than a reality saying “there’s usually one dominant side...the collective goal is either tilted in favor of one of the partners and less of the other.” Participants also commented on the difficulties of communicating with people that come from a different understanding or worldview because you may have to do some work to get on the same page. As one participant said, “communication might be something you have to work on to get versus something that you might think you already have.”

Definitions that described collaboration as a partnership between a team of health professionals and the patient was for some participants a concern because of the power imbalance often experienced between the patient and the health care providers, as one participant commented “all of these professionals versus the one little wee client.” Another participant said, “I don’t think it’s up to the professionals to decide on everything.” Participants talked about the importance of the team of health professionals including the client’s family and a larger support network, for example, somebody that would understand the language to help balance the “power over” dynamic in some way. Another participant questioned whether as health care providers we really listen to the patient and reaffirmed the importance of equality in a partnership; a shared

power and accountability saying that “in a true collaboration one person cannot be perceived to have more power because ultimately they can trump.” Another participant questioned definitions about professional disciplines working together negating the wholistic approach because a group of professionals may not include the grassroots community people or the elders as advisors, saying “we don’t usually term an elder as a professional.” Therefore, this type of language in the definitions might seem less inclusive and more applicable to mainstream health services. Participants acknowledged that more partnerships are starting to include Indigenous participants but frequently there may be only one Indigenous person within a collaborative. As one participant said, “a lot of times I’m sitting at a table all by myself...I’m only one small voice.”

When reacting to the definitions from the literature, participants stressed the significance of spirituality. One participant said, “The part that helped was the spiritual part.” Spirituality was seen as foundational; a part of all aspects of one’s life including work. For some participants, it was, however, a component that has not been well recognized or well received at times within the mainstream system. One participant explained that there are varied approaches because of cultural differences, and the whole idea of knowledge and what is shared could be quite different between diverse groups. For example, a medicine man may not be permitted to tell you everything. However, some definitions that expect everything to be put on the table may be culturally inappropriate, for spiritual reasons, because of what can be properly shared or explained in certain circumstances. With diversity, the element of trust was identified as a major component of collaboration and differences need to be respected rather than perceived as being secretive or resistant. Another participant talked about the importance of getting people to the ceremony within the traditional Indigenous culture and its positive outcomes. This participant expressed concern around too much talk and not enough action, saying “we can’t talk and talk...about it...and not do...As traditional people we always try to ensure that we don’t stop halfway...We go all the way to the ceremony from something that we ask initially.” Another comment from the same participant was “how much can you safely say if you’re not going to actually do anything.”

Participants asked about the sustainability component of collaboration pointing out its absence in the definitions saying “they don’t provide the sustainability picture on it.” On the

contrary, collaboration within the traditional Indigenous health way was equated by participants to a client providing and an elder accepting the gift of sacred tobacco; collaboration was equated with the exchange of tobacco by participants as a commitment that does not come to an end. As one participant described, “a successful collaboration is where those efforts are still there today.”

4.4 Describing and Experiencing Collaboration

Participants shared their experiences of collaboration by describing a situation or significant event in which collaboration was successful followed by an example of unsuccessful collaboration. The researcher probed further by asking participants to describe what that experience was like, their role within this collaborative process and how others might have been involved. To explore the concept of collaboration in more detail, the researcher asked participants to describe from their practice experiences, both at an individual and system level, what they considered to be the core components/enablers that helped collaboration to work and any barriers that made it difficult. Participants were also asked for their advice on how to move forward to advance collaboration between the traditional Indigenous and mainstream health services.

The collation of responses from the participants’ perspectives provided a rich description of collaboration. Even though participants had varying stories and practice experiences, their combined insights were consistent across all the interviews including their partners and revealed a compelling and detailed description of collaboration that could be arranged within specific themes. Also, as participants shared many examples of what enables and inhibits collaboration it appeared that if an action or behavior was to enable collaboration, then the opposing action or behavior seemed to create barriers to collaboration. For example, trust and respect within a partnership was shown to enable collaboration whereas mistrust and disrespect were considered barriers. These themes will be described further in the following pages.

Collectively, all participants acknowledged that effective collaboration required a willingness to walk a journey together. Participants described collaboration as purposeful, with shared and clearly defined goals, and a shared power and joint responsibility of outcomes. Participants believed that a combination of talent and points of view could result in something better than individual effort. The shared insights of participants were constructed into seven major themes when grouping their perspectives and experiences of actions and behaviors, both

individual and system level, that could conceivably influence collaboration between the two services by: Embedding the Virtues/Values; Making a Change; Valuing Difference; Building and Maintaining Relationships; Supporting Environments; Approaching Wholistically; and Having the Right People at the Table. Descriptions of these major themes helped to elicit some of the main components that have enabled collaboration based upon the participant's detailed perspectives and experiences.

Embedding the virtues/values. The virtues of traditional Indigenous people and the values of organizations were frequently described by participants as the “ingredients” that are “inherent” in how the process of successful collaboration could be carried out effectively. Participants shared that the virtues/values help individuals within a collaborative to feel safe and move together in an equitable way. Many virtues were important to participants for example trust, respect, openness, patience, forgiveness, hope, compassion, kindness, humility, courage, humor, and self-reflection. One participant referred to the virtues as “those principles and rules I give myself.”

Trust, respect, humility, humor, self-reflection. Specifically, trust, respect, and humility were identified by participants as vital to effective collaboration; participants shared, “trust has to be there right away and a lot of times it really isn't” and “you have to feel that you're respected.” Humility “to not feel that you have all the answers” can be helpful when collaborating, according to participants as one might then be more open to the input of others. Also, humor was seen as important within collaborative arrangements to help lighten the burden of the effort by making it fun along the way. Awareness of others and the conduct of oneself, when working in partnership, were important to the study participants. The ongoing need of thoughtful reflection or some sort of introspection was considered necessary to ensure one is striving to live the virtues rather than merely talking or writing about them. As one participant shared, “you have the job of yourself, which is, you have to make sure that you keep yourself on track all the time and that you do those self-examinations.”

On the other hand, self-centeredness and judgmental behaviors were seen to cause conflict and get in the way of collaboration. As one participant put it, “sometimes we have to get over ourselves” and another participant said, “my judgment was impeding things.” Hesitantly, some of the participants talked about racism and intimidation as ongoing barriers to effective

partnerships by saying, “do you know how it feels to be called brownie in front of you, many people have experienced that...they continue to be put down” and another participant said, “you know it’s systemic racism we have to go through, we encounter that.” Feeling safe within groups was seen as a necessary component of working together productively and was believed to be accomplished by living those virtues. The following statement of a participant expressed the significance of living the virtues/values, “it’s easy to collaborate if we walk the values of the contemporary system and the virtues of the Indigenous system, and those are not inanimate words, those are actions.”

Transparency. Associated with the virtue of trust was transparency in promoting collaboration and the subsequent impact of hidden agendas and assumptions that could weaken collaboration. Participants provided several examples of superficial arrangements and personal or political agendas that were experienced to hinder collaboration while behaviors of transparency and clarity of expectations could advance collaboration. One participant explained, “We can’t come there with our own agenda, and that’s what happens in a lot of cases...” and another participant said, “that person at that side of the table will sometimes put their own beliefs ahead of the joint collaborative picture...” Participants explained further about the importance of clarifying assumptions when working together. One participant said, “what is it going to look like, how are we going to make decisions, who’s doing this, why are we working together” and another participant shared, “make sure you understand and not assume one understanding” or “you don’t have to say anything, but they assume it, you know, and then they carry it on that way.”

Uncertainty. Within the idea of clearing up assumptions participants shared further that effective collaboration could be advanced when all partners come to the table with some uncertainty rather than preconceived ideas of the objectives and outcomes. One participant said about impeding collaboration, “they already have their own preconceived processes in their mind.” Participants shared that feelings of uncertainty could bring with them the benefits of open-mindedness of partners when approaching a collaborative table and the value of being supportive of a collection of ideas for the progression of shared goals and outcomes. One participant expressed, “you have to have some vision about what the project is going to look like. I didn’t have a clue, which was upsetting right up to the time we started. As it turned out, it was

amazing.” Another participant concurred by saying, “you can move along and move forward without being comfortable with how it’s going to look.” One participant summed it up in this way,

Knowing nothing is most important...in a world where collaboration’s to succeed, that’s what you have to be, and that should be a great comfort. So when I hear that, hallelujah, we have a chance. When I hear somebody...and this is who you should bring in to...lead that meeting because they will advise you, then I think, you’re not ready to be here yet.

Courage. Courage was another virtue described in more detail by participants as essential to collaboration. Participants talked about the fear of the unknown that comes with working across the two diverse services and courage in taking risks and thinking outside the box when traversing unknown territory. Participants expressed the need at times to bend the rules and do things differently in order to help collaboration and ensure meaningful outcomes. As one participant described, “If this is going to move [you] must be prepared to take risks” and another participant shared, “always did her nursing outside the box because it didn’t really fit with the clientele she was working with so she had to do it on the sly a little bit.” Also, the partners interviewed talked about the Eagle Moon team and their tremendous effort of going above and beyond their jurisdictions, working around barriers, and continuously advocating for clients and communities. As one participant shared, “they did whatever they had to do to make it work for the client” and another partner shared, “really fought for the system to recognize and support their clients in whatever the client circumstances were” and “they stretched themselves out into the community into the places where they weren’t exactly welcome sometimes.” One participant summed it up by saying, “To take risks with those you know nothing about, you must be pretty respectful and trusting and have confidence in yourself but be humble enough to accept what others can bring as well.”

Equality. Participants also shared numerous experiences of dominance as opposed to equality within collaborative arrangements. Equality within partnerships was experienced to advance collaboration while dominance and hierarchical approaches created barriers. Participants described that collaborative partnerships required equal voices, shared power and authority, and the valuing of each member’s contributions. As one participant stated, “everybody was kind of shoulder to shoulder, there was no hierarchy in there” and another participant said, “being person to person, not I’m up here you’re down here.” In opposition to

equality, behaviors of dominance, control, coercion, and manipulation by any partner within a collaborative were described as major barriers to collaboration. Participants have experienced “power over” situations when collaborating across the diverse systems, one participant said, “that equality, so that’s the part that could be difficult in bringing our two systems together” and another participant shared, “I think that is important, it includes equality one part is not better than the other part or higher than the other although it seems that way sometimes” while another participant explained the benefits of equality saying, “...it can’t be true collaboration or the best collaboration if you have people that all have a similar voice coming together, to come up with the same thing” and another participant stated, “[the] ones at the bottom don’t often feel that they can influence much at the top.” One participant summarized inequity by saying, “[it] seems organizations need to dominate what they do, until the systems work on it...looks within and sees it’s their power issue that is inhibiting them from advantaging from all ways of helping, determinants will never be addressed.”

Making a change. Making a significant change or making a difference seemed to be a required outcome if collaboration was to be considered productive. Participants expressed a need for movement from discussions and ideologies to actions and mutual outcomes reiterating that we cannot just talk about collaboration we have to do it. As one participant stated, “there’s got to be something tangible.” Conversely, participants have experienced nonproductive collaboration when goals and objectives have not been met or a benefit has not realized, as one participant stated, “once a strategy is developed, let’s hope it doesn’t sit” and another participant said, “For us it’s the outcome of the people is what keeps us going.” Additionally, participants expressed that partners within real collaboratives have to be willing to participate in a change or adaptation that will make a significant impact on the wellbeing of Indigenous people. As one participant indicated, “it’s a collective coming together of individuals who really want to make a difference” and another participant said, “a desire of the system to really make a change” and another participant saying, “I have to do something completely different.” While participants deemed positive change as necessary to effective collaboration, they also recognized both the individual and system level resistance that can come with making a change. One participant stated, “I tried to get people to understand the importance of the change.”

Other participants felt that for partners to make a change the purpose of the collaborative had to be valued and prioritized within the system, as one participant said, “Constantly putting it on the agenda and bringing it forward.” Another participant took this idea further by saying that within effective collaboratives it is necessary to make a shift in our thinking or internalize the change or the approach to something. Participants felt that collaboration was more than an expectation within a job description and that if collaboration was to be effective, each partner has to really think differently about the issue or the problem. A fundamental shift comes about, an enhanced understanding, that changes our thinking, as one participant described,

We have projects we have to do and we collaborate with people and we get it done and we do a better job because we did it as a system, interacting, but unless we change our thinking, to begin to apply that in other things that we’re doing, it’s collaborating but I think it has to be more than that.

Valuing difference. Embracing diversity and inclusiveness was an ongoing theme of participants to improve collaboration and shared decision-making between the traditional Indigenous and mainstream health services. Participants spoke about valuing and accepting the Indigenous teachings and processes rather than its ongoing validation, “the Western side they want to validate that...more, when it already has the traditional [approvals].” Participants spoke continuously about valuing diverse voices versus a one-sided voice, fitting the services into client’s needs versus fitting the client into the system’s needs stating “you really need to have a variety of voices. It can’t be a one-sided voice and that’s where I think sometimes our system gets a little bit rocky, it’s a one-sided voice.” Participants talked about the uniqueness of the many tribal groups with very diverse histories and backgrounds and their ongoing struggles within the mainstream health system for the inclusion of the traditional Indigenous health ways and the acknowledgment of other ways of knowing and doing. One participant shared, “I’m not going to fit into the Western [system]. We don’t work that way. It’s just how it is.”

The diversity of partnerships and, therefore, their distinctive contributions were experienced by participants as strengthening collaboration. Everyone needs to contribute and has a role to play at the collaborative table. As one participant said, “everybody had a role, and that’s the best way to work” and another participant said, “you each have a contribution towards the success of that happening” and “we all come in with only what we’re there to offer and do.” Participants spoke appreciatively about the varied perspectives and influences of the many tribal

groups, patients, and their communities when developing wellness plans. One participant stated, “well that’s from that lens, maybe this other wellness way has a lens of expertise.” Alongside each partner’s unique contribution to the collaborative, participants expressed the importance of ensuring that individual roles and responsibilities are clearly identified and that partners do not interfere with each other’s work. As one participant explained, “not imposing either knowledge” or contrastingly, “the professional boundaries are just all over the place.”

Participants expressed a need for broader perspectives within the mainstream health system that could come from patients and the community as was stated, “getting stuck in a ditch with thinking but have a different perspective and they need to get that from the community, that they serve, and we don’t do that enough from what I see at tables.” Another participant said, “You walk together, it’s never a doing to, it’s doing with.” According to the participants, within effective collaboratives, each partner is valued. Collaboration would not work if it has been decided that one way was better than another. One participant summarized these ideas by saying, “We wouldn’t even be talking about this if one alone could do all. We’d already just be doing it.”

Participants recognized how difficult it can be when two very distinct knowledges try to work together and that both the traditional Indigenous and mainstream health services would need to be more open to other ways of doing things. One participant described it in this way, “both sides have to be open to other ways of learning or teachings and sometimes that could be difficult in achieving” and “why don’t we look to other ways of helping and maybe there are answers outside of what I can offer you here” and “we need to be open to other ideas, thoughts, cultures, that’s part of collaboration.” Participants shared many examples of exclusion of the traditional Indigenous health ways. One participant said, “I’m talking about that call to action, where I wasn’t even called” or “you’re a First Nations person, so you’re not really a part of, but you’re sitting there as a person.” Even though there are many services being provided to patients and communities by traditional medicine and knowledge keepers, and healers, it seems to be unacknowledged, “kept hidden” and “not out there in the open” according to the participants. As one participant stated, “today we’re kind of...we’re in the system but not really” or “we’re service providers, but we provide an underground service.” A participant summed it up by

saying, “accept us because we all have the same goal, we all want to help the people...not to be sick. That’s why we’re in the health system.”

Participants have experienced the benefits of working across the two systems and have seen how the different knowledges and practices of healing and wellness can complement each other; seeing one as not less than the other. Participants expressed hopefulness for more collaboration between the two services and the importance of being “willing to be inclusive of those that know something different.”

Building and maintaining relationships. Building cohesive relationships was seen as essential and as an initial step of a collaborative arrangement before impactful work could occur. Participants stressed many times that before a group can work together to accomplish something they need to take the time to develop an understanding of each other’s perspectives and cultures to really appreciate the contributions of each member of the collaborative including the patient and/or community perspective because of living the experience every day. As one participant said we need to have a better understanding “outside our boundaries and boxes.” Another participant said, “You look at other people in a different way, when you have a little better understanding of who they are” and “relationship phases, that has to come first before you can even begin.” Participants have experienced that collaboratives seem to work more effectively when interpersonal relationships are strengthened and partners have created a bond or friendships saying, “sometimes when you have to share the personal side of you, so people get to know you, and not to be afraid to do that” and “people were actually friends at that table.”

Participants also conveyed the tremendous value in ongoing teaching, observation, and listening as being vital among partners at collaborative tables for members to gain an understanding of each other’s “talents and gifts” given the numerous and distinctive tribal groups. Open communication and actively listening to people was frequently mentioned as qualities that seemed difficult to achieve within partnerships. Some Indigenous people have not felt their voices were heard at collaborative tables, as one participant explained, “it’s going to take a while before these people are going to say, [yes] you’re going to actually listen to me” and another participant shared, “if we truly listen to the patient” and “really hear their perspective” or as another participant said “sometimes we don’t use enough of observation and listening.” Participants felt that really listening was necessary in order to learn about others before being

able to develop an understanding amongst partners. Participants frequently mentioned the steep learning curve within diverse collaboratives and the importance of creating an environment conducive to learning, as one participant said, “constant learning” and another participant said, “understand both worlds have to learn.” Participants spoke about the willingness of partners in wanting to better understand Indigenous ways saying “there’s so many professional people out there that have no idea about First Nations people and some of them want to learn, some of them want to know more.”

Participants described some challenges of understanding the complexities of other diverse backgrounds, perspectives, and community issues, for example, beliefs, languages, and education. One participant stated “sometimes things had to be brought down to...a grassroots level, not a professional level” and another participant said if you “don’t have that level of understanding...you can’t support it in a way that needs to be supported.” Equally acknowledged by participants, when working together, was the importance of understanding the intergenerational trauma that comes from the histories of Indigenous peoples. Recognizing the difficult experiences of the colonization process as an ongoing part of the culture was described as essential when building these relationships. As one participant said, “in everything that we do, we have to take a look at colonization processes because it’s evident today” and “When you work with the First Nations...you have to be aware that we’re definitely still in the process of colonization, there are still results, we all have that.” One of the participants summarized the importance of developing relationships by saying, “if you want something big to come out of it, you take the time to develop the relationships...it’s an investment, in the long run,...it’ll tear down a lot of the barriers...taking extra time at the front end.”

Supporting environments. The combination of several enabling elements became the subject of supportive environments deemed necessary by participants to create and sustain collaboration. Effective and sustainable collaborative efforts appeared to be supported by the physical atmosphere, flexible structures, strong leadership, navigation support, and adequate resources.

Physical atmosphere. The physical atmosphere was put forward by participants as an important component of enabling collaboration. For example, a partnership with a community would involve holding meetings in the community rather than a boardroom to “get to know them

a little bit more in their own home environment.” Also mentioned by participants was the need to develop an atmosphere that was inviting, for example, sharing food and socializing to help partners feel comfortable. One participant shared, “...we ate a wonderful meal, and we had lots of sunlight, it was a perfect atmosphere...and that made friends.” Also, ensuring that the elders were respected and their needs were met was a priority of participants, “they were very catered to and looked after.”

Flexible structures. Participants spoke at length about the kind of system that both supports and hinders collaboration. Overall, collaborative partnerships seem to require organization within a framework or structure. However, participants cautioned about being too restrictive or prescriptive. In some cases defined processes, policies, protocols, and signed agreements were described as enabling to collaboration while in other circumstances, were deemed prohibitive. For example, some participants said “It’ll stop, if you don’t adhere to all those rules and policies and procedures” while conversely “existing policies that we know have inhibited us.” or “it won’t work as long as we structure things.” Within the traditional Indigenous health services there are many protocols that are respectfully adhered to for ceremonial purposes; one participant stated that “...essentially you have to utilize a process, the process on the traditional side there’s a wide variance of diversity, but I find the Western side uses that as a barrier a lot of times.” Participants concluded that while some protocols and structure seemed necessary to effectively work across diverse systems, the frameworks, structures, or agreements that we operate within need to promote collaboration rather than obstruct its progress.

Strong leadership. Strong leadership from both worlds was frequently named by participants as significant if collaboration was to succeed. Specifically, open minded, senior leaders with willingness to make decisions and take action to generate change were believed essential to fruitful collaboration. Participants had all experienced collaboratives both successful and unsuccessful that pointed to leadership. Participants expressed that the presence of decision-makers at collaborative tables with the authority to move things forward was necessary saying “people that we had on board were people that could make decisions and change, and that was key” and “if your leadership doesn’t give your people permission then it will not happen” or “I don’t think that I could have done that without that level of support.” Participants described the

impact of leadership both within the contemporary and Indigenous services. The guidance and advisory roles of elders were seen to be equally as significant as senior leaders within the mainstream system. Participants shared “it has to come from the top in your organization...to make it happen, leadership was key” and “under the guidance of the elders” or “elders were leading that.” Specifically within the traditional Indigenous health services, participants talked at length about consulting their advisors behind the scenes, those that are knowledgeable about community needs and help to guide and support the representatives at collaborative tables. As one participant explained, “you have to have a team behind you supporting your direction and your guidance” and “people that will be sitting behind the scenes that are kind of guiding you on what you can bring forth to the table.”

Navigation support. Collaboration across diverse systems was perceived by participants, to be complicated, and in their experience requires navigation or facilitation support. Facilitators and coordinators were described as key to effective collaborative action and creating and maintaining supportive linkages between the two distinct services. Participants provided several examples of the role of coordination and facilitation to assist, guide, advise, and advocate for clients, community members and health professionals surrounding access and movement across the two systems. More specifically, participants talked about the role of a “gatekeeper” as one who has knowledge about both worlds of service and can provide some bridging and can help navigate areas within these systems. As one participant shared, “circling around and helping to facilitate discussions with the elders” and another participant said, “she knows how to navigate certain areas that nobody else does.” Participants talked about the need to feel safe and some of the uncertainties for clients and care providers when accessing diverse services and the benefits of having the support of a navigator. As one partner explained, “you walk with the person” and another participant said, “There was an opportunity to sit down and talk to somebody who could help navigate through some of those feelings or some of those uncertainties” and “trying to navigate a road and not offend people when there are so many divergent views.” Someone that could advocate on behalf of a patient, client, community member or health care provider was frequently stated by participants saying, “you must act on behalf of that family” or “they invite you to do this on their behalf” or “it comes all the time you know, people are asking for guidance.” Effective navigation, according to participants was enabled by someone who has

experience and an understanding of both the traditional Indigenous and mainstream health services. As one participant described it, “you have to have one of those collaborators being one of those in between people...and has relations with both worlds.”

Adequate resources. Adequate resources to develop and maintain collaboration was described by all of the participants. A variety of resources were mentioned by participants such as human, financial, materials, time, and system support. Concern was expressed about collaboration occurring off the sides of people’s desks or support required of the elders/traditional knowledge keepers without adequately resourcing these contributions. One participant said, “resource accordingly” and another participant said, “the only reason it ended, sadly, is that they ran out of funding.” Participants expressed many times the tremendous amount of time and effort required for successful collaboration particularly when developing and maintaining relationships and orientating partners to an initiative or project. As one participant stated, “when I think of barriers in particular, time...can be a huge one” and “do whatever we needed to do to make this work.”

Approaching wholistically. Identifying the problems and the needs of patients, clients, and communities and consequently approaching collaboration more wholistically to find solutions was a common theme articulated by participants. A broader perspective of what constitutes the health and wellbeing of clients and communities according to the traditional Indigenous way was shared by participants. Specifically, the First Nations beliefs about the interconnectedness of the spiritual, emotional, mental, and physical aspects that make up the whole person and the challenge to address these components in isolation of each other. The idea of patient-centered care and more wholistic approaches within the mainstream health services were perceived to be in need of further development. As one participant stated, “our wholistic approach...should be part of the system, as an option for individuals...” and “I do wish that they [the system] would...think a little bit more wholistically.”

Spirituality was a major component of the wholistic approach that was identified frequently and consistently by all participants. Spirituality was described as foundational, an essential component of successful collaboration. Spirituality was notably the first step when bringing individuals and groups together and inherent in the collaborative process. As one participant stated, “a wholistic approach centers on the spiritual, that’s a foundation” and another

participants said, “the first thing that we would attend to...on a traditional side is the spirituality.” Participants also shared their experiences regarding the limited understanding within mainstream health services about the integral focus of spirituality within traditional Indigenous health services. As one participant powerfully stated, “people that don’t understand the spirituality, don’t understand First Nations people.” Furthermore, participants saw the spiritual connection as a common ground that could help to bring people together. One participant said, “That spiritual piece is a common ground. When we talk...I can relate a lot more with that piece.” Another participant shared an experience of finding that common ground through spirituality by saying, “she was talking from that space too...so we actually had a communication of hearts, even though I didn’t follow the traditional way, and even though she didn’t follow my way. We had a very peaceful interaction.”

Accepting and respecting diverse cultural practices, protocols and processes required to fulfill spiritual and cultural obligations were major components of a wholistic approach to collaboration. Participants consistently spoke about the many diverse tribal groups, the variety of protocols and ceremonies, and the significance of these cultural practices for individuals and communities. Participants described several traditional helping and healing ceremonies and protocols in support of collaboration. One participant said, “When you say any successes, it’ll be the ceremonies.” Another participant shared, “The ones that can move things forward on the traditional side, are the ones that participate in those ceremonial ways” and “they’re all going to go and have a ceremony to help each other or whoever came for help.” Another participant stated, “In the traditional way, that circle is probably your healthiest ground to be able to do collaboration from very strong, sometimes opposing views.” Participants also shared that there is limited understanding about Indigenous cultural practices within the mainstream health system and also among some of the different tribal groups. This recognition brought forward the importance of retaining and protecting these practices for future generations saying, “There’s things we can’t talk about, about that ceremony” and another participant said, “I was just totally amazed at how many professional people have no idea about First Nations traditions.”

Having the right people at the table. Regularly, participants spoke about the importance of carefully selecting representatives, knowledgeable and experienced, to constructively input at collaborative tables. Selecting the “right people”, whether Indigenous or non-Indigenous

representatives, was so important to the success of collaboration that participants spoke of a selection process and hand-picking specific individuals most suited for collaboration. In addition, choosing individuals with the right attitude and willingness to collaborate was deemed essential, as one participant explained, “recruit staff to that team that really wanted to be there.” Another participant explained how an individual can be a barrier to collaboration by saying, “not everyone...is suited for collaboration, they know everything, they’re right all the time, they have all the answers.” Individuals with the right attitude were described by participants as those who could follow the principles or virtues of the traditional Indigenous way or adhere to mainstream organizational values as described previously.

Also, according to participants, it is important that individuals collaborating are content experts about the topic surrounding the collaborative effort, especially those most closely affected by a particular initiative and its outcome. In addition to professional expertise within collaboratives, participants spoke at length about the prominence of patients, clients, elders/knowledge keepers, and community member representatives if collaboration was to work effectively. As one participant stated, “by no means can we become the voice for the community people.” Another participant said, “I don’t think it’s up to the professionals to decide on everything, I think it’s important that the grassroots people get involved and participate.” Moreover, representatives of the traditional Indigenous health way would need to be the traditional knowledge keepers/elders, healers, and medicine people that are trained and have practiced within the traditional way and are recognized as “genuine” by communities. Participants spoke of the challenges of misrepresentation by some individuals, who may have limited knowledge and experience, attempting to teach other people about traditional practices and ceremonies. As one participant stated, “there’s a lot of people out there that are...taking bits and pieces of the Native culture, Native ceremony, Native ways and teaching it as something they know about to someone that has no clue...they’re teaching them these things that are not right...” Another participant stated, “That individual has to be very knowledgeable in their own field and have a good basis there if you’re going to bring that in and share it with somebody.”

Taking ownership and responsibility individually, professionally, and organizationally was perceived to be a necessity of effective collaboration according to participants. Joint accountability among partners was required for the success of collaboration and its outcomes. As

one participant stated, “you have a responsibility for your part too, to do the best you can to make whatever it is work.” Another participant said collaboration required taking “...one-hundred percent responsibility for ourselves.” The right people were thought to be champions who would take initiative and never quit. As one participant stated, “true collaborators take the initiative to do it.”

For example, the role of one of the study participants, as a health consultant, was to bring community and mainstream health service managers together to find solutions for more “user friendly” programs supportive of clients and community members who follow a traditional pathway. This participant, when reflecting on the study findings, emphasized how challenging it can be to work in harmony, and the immense learning curve in “seeing and appreciating” when collaborating with a different way of knowing and understanding that is out of one’s own comfort zone; “trying to see and understand from a different world lens cannot be underestimated or assumed to be a simple formula.” This participant, of Indigenous ancestry, acknowledged an upbringing and academic preparation in health and education, which was entirely understood within the mainstream systems; “I had no knowledge or experience with the traditional Indigenous world, and at times felt exasperated when traditional Indigenous understanding conflicted with my very ingrained mainstream system worldview.” According to this participant, “a glimmer of understanding” took several years of community involvement, and “listening, asking, and learning, from co-workers at Eagle Moon Health Office with extensive knowledge and personal experience of traditional practices.” For this participant, “a critical first step was taking the time to develop solid relationships; building the trust and respect with co-workers, communities, and mainstream health professionals, which allowed me the freedom to check my understanding, without concern of being offensive.” This participant learned that both services needed preparation before collaborating to be able to openly contribute and spirituality provided a common ground.

The researcher offered sacred tobacco, and with the permission and guidance of elder advisors and Eagle Moon Health Office team, explored using a star blanket to illustrate the study findings. The elders explained that a star blanket is considered a very special gift that is an honour to receive. The symbol of a star blanket was thought to be suitable because the learnings from this study could be shared as a gift to others interested in working collaboratively with

Indigenous populations. The centre of the star blanket reflects the understanding that offering and acceptance of the gift of sacred tobacco represents an ongoing commitment to the process of collaboration. The peaks of the star signify the seven themes or actions, from the study findings, that are important for effective collaboration. The eighth star peak represents future knowledge, the continuing need for more knowledge and understanding of collaboration. The colors of a sunrise were chosen for the star blanket (yellow, orange, red) to symbolize the welcoming of a new day; a day when there will be more effective collaboration between the traditional Indigenous and mainstream health services in order to achieve better health outcomes for clients and communities (see Figure 4.1).

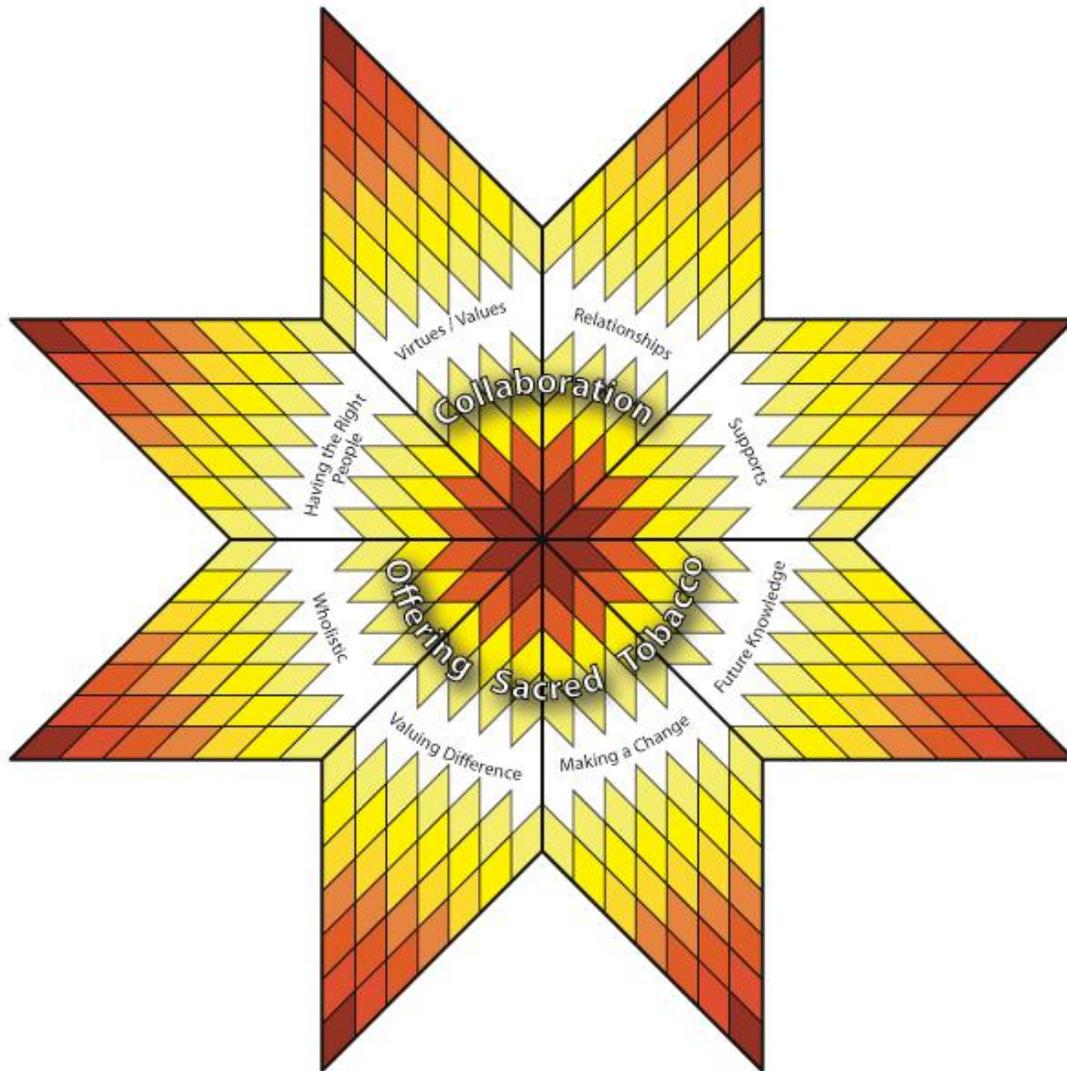


Figure 4.1: Star Blanket Illustration

4.5 Concerning Cancer Control

Before concluding the interview with each participant, the researcher asked for specific advice based on their experiences with cancer services that might be unique aspects for this service specialty, about collaboration. Participants reaffirmed previously identified elements that could enable collaboration, as requirements for collaboration with cancer services and the traditional Indigenous health services. Participants described the cancer problem as becoming more severe for Indigenous populations; thereby prompting more of an urgency to enhance collaboration to more effectively address the needs and improve the outcomes for Indigenous populations. Participants spoke about building upon the momentum that has already been developed with further clarification of its direction and priorities. Some participants expressed the need to move forward more rapidly than has been experienced concerning the collaborative efforts between cancer services and the traditional Indigenous health services. As one participant expressed, “The momentum, we should be able to continue to advance on that and maybe advance on it a little quicker...”

Participants talked about a more wholistic approach to cancer care and described situations where more collaboration within the mainstream health services across specialties could be beneficial. For example, one participant’s experiences with cancer services and palliative care saying,

Palliative care is maybe admitting we weren’t successful...so we don’t get the level of collaboration and the interaction or the support that might happen for clients at a stage earlier, if you put the client at the center of it...I don’t think we’ve done as good a job as we can...

The wholistic approach to care included addressing the spiritual needs of clients. Participants expressed the importance of cancer services understanding and accommodating the needs of Indigenous clients that practice their traditional ways. One participant indicated that no matter what level of care a patient may require, “it still involves a person, so eventually...they actually inquire about traditional spiritual care...you have to prepare the organization for that, what are the current practices.” Participants expressed the valuable contributions of the knowledge keepers/elders of the traditional health way for the support of clients, families and communities. Currently however, this resource has been underutilized and under-resourced.

One participant talked about the fear of cancer saying, "...to a lot of First Nations people cancer's a death sentence." This participant would like to see more collaboration with communities to raise awareness and increase understanding about cancer saying "I don't think there's enough being done to advocate for these people that are newly diagnosed...these people are not going; they're not participating." Furthermore, some services constructed within the mainstream health system, with the intention of supporting Indigenous clients, can be ineffective if unfamiliar with traditional Indigenous practices. One participant stated, "using Aboriginal departments that operate the same way as the mainstream health system...[is not] the way to support traditional health ways." Another participant talked about respecting the traditional health ways and ensuring that only those knowledgeable in the traditional ways are supported to practice in this way saying, "What we do is respect the ways we've been told they will be handled and kept and managed...because if you don't...you create risks in both ways." Participants suggested that working with the authentic traditional Indigenous knowledge keepers/elders would help to safeguard and not intrude upon these practices. One participant conveyed, "There's a whole very different way of doing that in the traditional way than this contemporary, specifically to cancer...there's so much that cancer care does that violates traditional care ways."

4.6 Observing the Eagle Moon Health Office Team Study Participants

The researcher observed that the study participants' interactions and behaviors, were similar, regardless of whether they were interacting and collaborating with each other internally, or surrounded by their partners and community members. The study participants' communications with each other and their partners were very friendly exchanges of hugs and greetings; the respect partners had for the study participants and their close ties with the community people were apparent. The Eagle Moon team study participants appeared to have a close bond with each other that might resemble a friendship more than a working relationship. The study participants created an atmosphere that was relaxed and welcoming; participants laughed and had fun together and seemed to genuinely enjoy each other's company. The openness and caring nature of the study participants toward each other were also transferred to their partners and community members. Socializing, sharing food, conversation, and laughter were regularly observed between study participants and their partners. Participants seemed to

have fun together and frequently used humor during their interactions with some bantering and playfulness that also included the researcher who was made to feel welcome and part of the team.

Relationships amongst the participants appeared to be appreciated; they acknowledged at various times verbally how much they needed each other to advance their work. Study participants seemed open to the contributions of each team member and their partners and spoke positively about the efforts of others. Participants seemed to be very aware of what each member brings to the team, for example, the diversity of their backgrounds and specific roles within the group. Participants frequently thanked each other for the work they were doing; acknowledgments seemed genuine and heartfelt. Participants seemed to be very committed to each other and helped each other out whenever they could to solve problems or address challenges. Appreciativeness, welcoming and friendly gestures were similarly conveyed to their clients, patients, and community members; hugs were shared, and sincere inquiries were made about their needs and interests. The events that the researcher observed appeared to be more like a family gathering than a work environment, and study participants made an effort to ensure everyone was included and comfortable. For example, they would place themselves at different points in the sharing circle and were very attentive to the needs of all of the participants such as refreshments and comfortable chairs. Throughout these events the environment seemed to be very inclusive, the circle was respectful, friendly, open, honest, and humor was used on occasion to help lighten the mood and make everyone feel more comfortable when conversations or problems were of a serious nature. Participants comforted their partners when they were overwhelmed with emotion as they shared very personal stories and challenges. Clients that came to meet with the participants during the time of the sharing circle were accommodated and were then also welcomed into the circle to contribute. Commonly partners thanked and praised the study participants for their friendship and ongoing support including the traditional teachings they provided when working across mainstream and traditional services.

Participants appeared to be comfortable with each other, their clients, patients, community members and partners. During the team meetings, the study participants shared in the planning of their work and seemed to speak out freely and offer opinions and suggestions. Conversations appeared open, honest, and feedback was encouraged. Also, participants seemed

at ease when challenging each other when new ideas were presented or viewpoints differed. Similarly, participants shared freely during the elders sharing circle about their ideas and experiences; everyone was given an opportunity to speak, and participants respectfully listened. When observing the study participants within the sharing circle, any prominence of roles was indistinguishable; for example, a director or elder from a client or community member; all participants were given similar respect and consideration for their input and feedback. Study participants made an effort to consider other perspectives and other ways of knowing that were outside of their team, for example, the guidance from traditional medicine and knowledge keepers/elders, and healers in other jurisdictions and health region partners. Participants welcomed the many different teachings of the elders and made a great deal of effort during these events to accommodate the many protocols of various tribal groups. Participants were not always in agreement about the issues or the approach to their work which led to more discussion and frank conversations for further clarification of the situation or problem. However, participants remained calm, respectful, and continued to share their point of view in a straightforward manner.

Study participants during one team meeting were provided with praise in relation to their work and, also, in one case negative feedback from an internal source. While the study participants were appreciative of the compliment about their work they did not appear to be overly proud about this feedback but rather acknowledged the many contributions of others concerning their successes. Participants also received the negative feedback in a very respectful, non-judgmental manner. Interestingly, the team did not become inflated or over confident when praised by others for their successes and were also very forgiving of individuals that criticized their work. The team seemed open to negative feedback and made every effort to understand opposing perspectives and considered ways to enhance a better understanding of their work.

Spirituality and cultural traditions were an integral component of each event. Participants worked to link the spiritual aspects into every part of their work. In all of the events observed, participants aligned and accommodated the traditional ceremonies and protocols, traditional medicine practices, as well as linkages with the medicine keepers and clients as guided by the elders. The researcher was also informed of the considerable work, many protocols and processes, that takes place “behind the scenes” to prepare for these events. Traditional

Indigenous teachings and ceremonies were respectfully incorporated into the ongoing processes of the team and their work; prayers, comradery, and friendship, gifts, and an outward recognition of the strengths and contributions each member brings to the team.

Study participants at these team meetings discussed their workload along with the issues and challenges of their work and planned their next steps. Their approach to the work was across sectors with consideration to health equity and community support services. Participants looked for the strengths and abilities of their clients and communities and took advantage of opportunities in a way that moved efforts forward to help the patient/client. Participants had challenges with some jurisdictional issues that they had to overcome to meet the needs of their clients. The participants shared that they can be more creative in their work when they are not restricted or “boxed into” a predetermined way.

4.7 Summary of the Findings

Participant’s insights and understandings of collaboration showed both its significance and the complexities of working across different systems. Collaboration seems to require considerable effort to ensure meaningful outcomes. When collaboration does happen, participants found it to be special and impactful for addressing the needs of clients and communities. Participants reflected upon definitions from the literature and offered a few of their own ideas to further describe collaboration. Essentially, collaboration was considered an ongoing commitment similar to offering and accepting the gift of sacred tobacco. Participants provided many examples of ways to enable and move collaboration forward while reducing its barriers. A compilation of participant stories was constructed into themes for advancing collaboration by Embedding the Virtues/Values; Making a Change; Valuing Difference; Building and Maintaining Relationships; Supporting Environments; Approaching Wholistically; and Having the Right People at the Table (see Table 4.1 Findings Summarized). Specifically, participants emphasized within these themes the importance of striving to live the virtues of the Indigenous ways and the values of the mainstream health services especially trust, respect, humility, humor, equality, transparency (no hidden agendas and assumptions), along with the need for courage to take risks and accept uncertainty in order to do things differently and make significant changes to benefit clients and communities. For participants, the effort of collaboration means action with concrete results by including the diverse and unique

contributions of a variety of perspectives. Paramount to the success of collaboration was developing relationships, really listening to understand other perspectives, cultures, and specific roles within the collaborative, with an approach to continuous learning. According to participants, collaboration required strong leadership within supportive environments that are welcoming, flexible, and adequately resourced with guidance to navigate the complexities of both systems. Approaching collaboration more holistically to address the needs of patients and communities was articulated by participants with spirituality as its foundation. Essential was accepting and respecting diverse cultural practices required for spiritual and cultural responsibilities. Additionally, participants spoke about carefully selecting representatives with a willingness to collaborate and with the knowledge and experience required to contribute collaboratively. Especially important were individuals that would take ownership and responsibility of the collective priorities; a champion for sustainable outcomes.

While collaborative efforts are improving, participant experiences have demonstrated that more could be done to strengthen partnerships and linkages between services, including cancer services, for better patient and community outcomes. The critical need for improving collaboration was articulated by a participant,

...millions and millions and millions of dollars being paid out...another child dies another person goes to jail another person develops diabetes, another one has cancer...if people would just open up their eyes and have that availability; we're not asking for a lot we're not asking for you to change everything...

Another participant acknowledged some progress of collaboration by saying, "maybe as long as you're still working at it maybe that's a success in itself."

Table 4.1: Findings Summarized – Definition, Themes, Enablers, Barriers to Collaboration

<p>Definition: important components - shared goals, ownership and accountability with an emphasis on equality; inclusive language - valuing cultural diversity and the contribution of different perspectives, including patient and community voices; includes the virtues; wholistic approach; spirituality significant; making a change or shared positive outcome; sustainability component equated with the exchange of sacred tobacco, a commitment that does not come to an end</p>
<p>Major Themes to Collaboration:</p> <ul style="list-style-type: none"> • <i>Embedding the Virtues/Values:</i> trust, respect, openness, patience, forgiveness, hope, compassion, kindness, humility, humor, courage, self-reflection, transparency, clarify assumptions, uncertainty rather than preconceived ideas, willingness in taking risks, thinking outside the box, equality, equal voices, shared power and authority • <i>Making a Change:</i> movement from discussions and ideologies to actions and mutual outcomes; a change or adaptation that will make a significant impact on the wellbeing of Indigenous people; purpose of the collaborative valued and prioritized within the system; a shift in our thinking; internalize the change • <i>Valuing Difference:</i> embracing diversity; valuing and accepting the Indigenous teachings and processes; inclusion of the traditional Indigenous health ways; acknowledgement of other ways of knowing and doing; valuing each other’s distinctive contributions; individual roles and responsibilities are clearly identified; includes broader perspectives from patients and communities • <i>Building and Maintaining Relationships:</i> cohesive relationships essential; take the time to develop an understanding of each other’s diverse perspectives, beliefs, backgrounds, histories, cultures; appreciate the contributions of each other; value ongoing teaching, observation, and listening; open communication; create a learning environment • <i>Supporting Environments:</i> physical atmosphere; flexible structures; strong leadership; navigation support; adequate resources • <i>Approaching Wholistically:</i> broader perspective of health and wellbeing; interconnectedness of the spiritual, emotional, mental and physical aspects that make up the whole person; spirituality foundational; accepting and respecting diverse cultural practices, protocols, and processes required to fulfill spiritual and cultural obligations; importance of retaining and protecting these practices for future generations • <i>Having the Right People at the Table:</i> selecting representatives carefully with the knowledge and experience to constructively input - those most closely affected by a particular initiative (client/community voice) and its outcome; take ownership and responsibility individually, professionally, and organizationally; choosing individuals with the right attitude and willingness to collaborate; individuals who follow the virtues of the traditional Indigenous way or mainstream organizational values; representatives of the traditional Indigenous health way that are trained and have practiced within the traditional way and recognized as genuine by communities; joint accountability; champions who take initiative and never quit
<p>Enablers to Collaboration: acceptance, accountability, action, adaptability, adequate resources, advocacy, apply the virtues, bring in different lenses, bring your best, change, client/community voice, common purpose/goal, contribute, courage, dedication, diversity, elder advisors, embrace cultural diversity, empathy, equality, facilitation, flexible structures, flexibility, gatekeeper role, go above and beyond, help, hope, humility, humor, impactful outcomes, inclusiveness, integrity, joint effort, kindness, knowledgeable/expertise, leadership, navigation, ongoing effort, open-minded, perseverance, really listen/hear what I’m saying, recognize it’s special, reflection, relationships/get to know each other, respect, respect traditional ceremonies/protocols, risk taking, role clarity, safety, self-care, shared agenda, shared outcomes, skillset, spirituality foundational, sustainability/stay the course, take initiative, take responsibility, take the time, teach/keep learning, think outside the box, transparent, trust, uncertainty, value difference, wholistic approach, willingness</p>
<p>Barriers to Collaboration: assumptions, bullied, conformity, disapproval, disorganized, disregard of traditional ceremonial obligations, disrespect, distrust, domination/power over, ego, fear, feeling threatened, gossip, helplessness, hidden agendas, hierarchy, hopelessness, imbalance, imposing, inaction, interfering, intergenerational trauma, intimidation, jealousy, judgment, lack of time, mistrust, non-productive, policies that inhibit, politics, power structures, prejudice, prescriptive, racism, resistance, rigid structures, selfishness, shortcuts, silos, stereotyping, talking not doing, tokenism, tug of war process, unkind, violated protocols</p>

5 DISCUSSION

5.1 Interpretation of the Findings

Consistent with interpretive description, the findings from this study were compared with previously reviewed and re-examined literature and relevant grey literature in relation to the definitions, enablers, and barriers of collaboration along with the observation periods of participants within their practice environment. An important notation about these study results is that the researcher's observations of the study participant's behaviors and interactions amongst themselves and their partners were consistent with their transcripts of how they described and experienced collaboration within their work environment. Therefore, the researcher's observations have not been discussed in further detail within these findings.

Examining the similarities and differences between the literature and the findings from this study and highlighting the additional components of collaboration that participants found to be beneficial can be aligned with the existing system and organizational frameworks and competencies that could be further developed and implemented to advance practice level collaboration between these distinct services. Also, while the study results are consistent with the current body of knowledge, there are some important components of collaboration that were emphasized by participants that may further inform nursing practice and research, and perhaps other disciplines when working between these services. The themes that have been constructed were examined further in the context of the Saskatchewan health system, specifically the significance of system and organizational support for collaboration along with cultural competent wholistic patient- and family-centered care models that if better integrated might serve as building blocks to improve interprofessional collaborative relationships and client and community outcomes across these diverse services.

System and organizational level support. Supportive practice environments are a requirement to help individuals working within these systems to know how to action collaboration effectively (Nelson et al., 2011). There has been considerable research about effective models and frameworks that could support interprofessional collaboration. Additionally, interprofessional collaboration appears to be a foundational component of effective culturally competent care and wholistic/patient-centered care models. Moreover, the main themes created from the study findings of the actions and behaviors both individual and system

level that could strengthen collaboration across diverse systems, can also be aligned with these supportive system models. Essentially, the advancement of very broad and diverse collaboratives aimed at driving real change for the wellbeing of patients and communities, need to be supported by environments that are directed by strong leadership, guided by systemic codes of conduct across services, and interprofessional collaboration and cultural competency as standard practice, in order to advance the delivery of wholistic/patient- and family-centered care.

Interprofessional collaboration within the practice environment can be challenging and requires supportive environments and collaborative frameworks to be achieved. The lack of a shared definition and limited understanding of how collaboration works makes it difficult to operationalize (Bedwel et al., 2012). Support for collaboration has to be both at a system and organizational level. A better understanding of the meaning of collaboration and accepting a common definition for it could be a starting point for developing system support for collaboration (Bedwell et al., 2012). There are many definitions put forward in the literature that helps to explain collaboration. However, the definitions that were shared with participants were reflected upon with mixed feedback. While some participants have used the word collaboration within their practice, a majority of the participants have not and felt that collaboration was complicated and its meaning unclear or used too “loosely” for some participants. Participants described examples of the idea of collaboration that often happens when large groups work together as opposed to actual collaboration for impactful outcomes. A variety of other terminology was preferable to the word collaboration and used by participants. However, collectively they did not share a common definition of collaboration but could easily relate to it as being similar to the obligation of offering and accepting the gift of sacred tobacco. The lack of clarity of collaboration and its inconsistent use has been described in the literature including a need for a standard definition and a comprehensive multidisciplinary approach to clarifying the concept (Bedwell et al., 2012; Gardner, 2005) which seems comparable to the situation within the Saskatchewan health system. Collaboration could be clarified further as it relates to individuals, teams, organizations and multi-team systems as well as the fundamental processes inherent in collaboration (Bedwell et al., 2012). Additionally, the term collaboration has been used in many ways and often interchangeably with other terms that may not be clearly defined (i.e., coordination, cooperation) (Bedwell et al., 2012) as well as teamwork, multidisciplinary

teams, and interdisciplinary teams (Martin-Rodriguez, Beaulieu, D'Amour, & Ferrada-Videla, 2005).

Furthermore, particular words and phrases within the definitions of collaboration shared from the literature received positive responses from participants for example, joint decision-making, mutual goals, equal authority, and shared accountability for outcomes. Participants, although in agreement with these equality statements, expressed that these elements were not necessarily being experienced within some collaboratives and in some circumstances there was considerable inequality, tokenism, and even racism. Participants put forward additional information to expand upon existing definitions of more inclusive language about valuing cultural diversity and the contribution of different perspectives, including patient and community voices, that might resonate more within the traditional Indigenous health service. D'Amour, Ferrada-Videla, Martin-Rodriguez and Beaulieu (2005) found there to be an absence of the patient's side within proposed definitions and the need to better integrate the client within the care team. Some study participants suggested entrenching the virtues/values within the process of collaboration and to further articulate its importance by adding "guided by those virtues" to these definitions, as a way to increase the action of collaboration. For participants, inherent in "how we work together," needs to be the virtues of Indigenous people and the values of mainstream organizations. Cuesta-Briand et al. (2015) in a study of an Indigenous cancer support network, suggested relationships based on "trust and respect offers a way forward" (p. 130) to work effectively between Indigenous and mainstream health service providers. Thompson et al. (2011) also found building trusting relationships, and respecting cultural needs, to be major considerations when planning cancer services for Indigenous people.

Also apparent, and as important as defining collaboration, are the many components, both individual and system level, that researchers have described as requirements of successful collaboration. However, an exhaustive list has not been developed of all known enablers and barriers to collaboration which could benefit the health system and other sectors and jurisdictions wanting to collaborate. Many priority elements that enabled or limited collaboration were described by participants and were consistent with those in the literature. As well, participants offered a few more elements, for example, the virtues/values of humility and humor, and approaching collaboration more wholistically that could also be taken into consideration when

examining systemic and organizational supports for collaboration and will be discussed further in this section.

System level support, even though outside of organizations, would be necessary if a change was to occur at the practice level. Substantial system change to support collaborative partnerships within and across sectors including between mainstream and Indigenous services can only occur within a supportive socio-political climate (Taylor & Thompson, 2011). Hill et al. (2013) reported system-level problems in New Zealand, such as “location, resourcing, and cultural norms of services” (p. 37) that have created inequalities for Indigenous populations in the provision of cancer services. Similarly, Shahid, Finn, Bessarab, and Thompson (2011) found many challenges were experienced by Indigenous clients in Australia when accessing cancer services that would require system-level changes to improve service coordination, social support, and cultural safety. The authors suggested these issues could be “addressed if care was truly patient-centered and respectful of culture and circumstances” (Shahid et al., 2011, p. 240). Additionally, Jansen (2008) puts forward a variety of systemic concerns that would require attention in order to advance collaborative practice. Some examples included system changes in relation to its authoritative and power structures, equitable funding models that support collaborative team development, and professional educational models to develop collaborative interdisciplinary practice teams. Similarly, Martin-Rodriguez et al. (2005) cited that collaborative team successes would depend upon the educational and professional systems that help to promote an understanding and valuing of other professional roles in the facilitation of interprofessional collaboration. System and organizational support for collaboration included education, training, and development of employees to be more flexible and adaptable. Behaviors that embrace collaboration would need to be further identified and included in performance evaluation processes and rewards tied to team successes. Further understanding of the personnel requirements associated with collaboration could benefit the recruitment, selection and placement decisions within organizations (Bedwell et al., 2012). System-level support for collaborative practice has been an expectation of Accreditation Canada (2015); for example, population health and wellness standards recognize the importance of collaboration across various sectors and jurisdictions and throughout the continuum of care to support community action for health promotion and disease prevention. Additionally, measurable and,

comprehensive interprofessional competencies have been developed in support of effective team building and patient-centered practice that could be further incorporated into practice models for enhanced collaboration (Canadian Interprofessional Health Collaborative [CIHC], 2010).

Understanding these professional competencies as they relate to practice settings could also help to determine the professional development needs of staff to improve standards of practice (Suter et al., 2009).

Collaborative practice at an organizational level can be influenced by work environments that are flexible, less hierarchical, and supportive of teams and shared decision-making. Cuesta-Briand et al. (2015) found opposing views between Indigenous and non-Indigenous health providers; the former wanting more flexibility and less formality, than the latter, within a cancer support group. Supportive organizations have effective leadership and a willingness to collaborate which includes the elements of trust, respect, active listening, also mentioned by participants and supported by research. Team development processes to facilitate communication and interaction are needed for effective team performance (Bethea et al., 2014). Organizational support means the implementation of standards, policies, and processes in support of collaborative practice including adequate time and resources to develop interpersonal relationships and the valuing of openness and risk-taking (Martin-Rodriguez et al., 2005). These organizational attributes of strong leadership, living the virtues/values, risk taking, dedicated time, and resources were also identified by study participants as enablers of collaboration. Taylor and Thompson (2011) examined partnerships between Aboriginal and mainstream services and also found relationships, senior level leadership, champions, adequate resources, and shared power to be some enablers of sustained partnerships. According to Bethea et al., (2014) when collaboratives are supported and maintained, these strengthened relationships become a catalyst for continued collaboration on other important issues. Study participants described several enablers and barriers of collaboration and ways individuals and systems could work to improve collaborative efforts that have been supported by research.

Supportive environments and selecting “the right people” to collaborate were of major significance to study participants to moving collaboration forward and included physical atmosphere, flexible structures, strong leadership, navigation, and adequate resources. These influential components have been supported by research, for example flexibility (Bronstein,

2003; Parker-Oliver et al., 2005), formalized partnerships, (Nickson et al., 2011; Woodroffe & Spencer, 2003), and shared resources (Negley et al., 2009; Nickson et al., 2011). Other scholars point to system support for skill development, education and training (Orchard, 2010) and more systems thinking (Gardner, 2005) for collaboration to succeed. Participants saw a need for selecting the “right people”, those that are willing to collaborate and Modin et al. (2010) also stressed a need for positive attitudes towards collaboration for its effectiveness. It is well described in the literature that the success of collaboration would require supportive organizational cultures (Bronstein, 2003) and structures (Sicotte et al., 2002) that can enable collaboration rather than organizational boundaries and insufficient time (Modin et al., 2010) that limits progress. The inordinate amount of time and effort for managing the challenges of collaboration were recognized by participants. Nelson et al., (2011) summarized system enhancements to better manage cross-cultural partnerships as being educational, cultural guidance, competency standards, and supportive practice environments.

However, for study participants, selecting the “right people” went beyond having a positive attitude and willingness to that of taking initiative, being content experts, and champions of the collaborative effort, and taking responsibility for its progress and outcomes. Individual and organizational accountability for the success of collaboratives was a requirement and, according to participants, could not happen without strong leadership. Leadership has been described as critical to influence and provide direction, and remove barriers. Leadership creates the culture that fosters collaboration across disciplines and sectors along with the frameworks to make it happen (Bethea et al., 2014). Therefore, system support included supportive leaders, in both systems, for decision making and managing substantial changes required to move the work forward productively and effectively. For participants this was senior leaders within mainstream and elders/knowledge keepers within the traditional Indigenous health services to provide guidance and advice for worthwhile outcomes.

Participants shared that collaboratives require adequate resources if there was going to be impactful outcomes. Researchers have described shared resources (Negley et al., 2009; Nickson et al., 2011) as a key component of successful collaboratives. However, beyond shared resources, participants spoke about adequately resourcing, both human and financial, for collaborative action. Especially important to participants was the need to resource “accordingly”

specifically the considerable contributions of elders/knowledge keepers and healers within the traditional Indigenous health services to achieve success. Described by study participants and substantiated within the research, system support for collaboration by way of its leadership, structures/models, codes of conduct, practice standards, and competencies could provide extensive backing for productive and impactful collaboration between services (Martin-Rodriguez et al., 2005). Bedwell et al. (2012) agreed that staff selection of individuals with a willingness for teamwork, and the selection of employees whose skills and knowledge overlap with outside groups enables collaboration, particularly when diverse expertise or skill was required. One participant described the importance of understanding organizational level collaboration before attempting broader collaborative efforts saying,

We should be collaborating as teams internally that's safe to start with, like-minded then expand circle with our teams externally...and that's often what I hear, well, we work in the same department but we don't even talk to each other. Well then how do you expect to work collaboratively outside of that department ...start with yourselves, look within, you're going to find your own answers.

According to participants, the need to action the virtues/values of both systems was essential to moving collaboration forward, especially the principles of trust, respect, and equality as well as the need for a better understanding and valuing of all roles and contributions of different partners. Participants consistently shared the significance of striving to live the virtues/values as the “how” of collaboration.

Also, ongoing racism within the health system was described by study participants as a barrier to collaboration. According to the 2008/10 First Nations Regional Health Survey, about one-third of First Nations people in First Nations communities had personally experienced racism in the past 12 months (First Nations Information Governance Center, 2012). Racism and social exclusion that has resulted from the impacts of colonialism can create barriers to health care access (Health Canada, 2014, p. 43). Peiris et al. (2012), when assessing health system support for Aboriginal clients in Australia, found considerable discrimination requiring improved systemic measures to address this complex issue. Poudrier and Mac-Lean (2009, p. 311), in a study of Indigenous women's experiences with breast cancer in Saskatchewan Canada, reported concerns of racism, power, and socioeconomic inequality that needed to be addressed. Developing and implementing system and organizational codes of conduct and incorporating

them within performance management processes to ensure these virtues/values are upheld within and across organizations and systems were deemed necessary for collaboration.

Equality was also valued; study participants regularly explained the need for purposeful collaboration with shared and clearly defined goals, and joint power and responsibility of outcomes. These enablers of collaboration have been described consistently by scholars; for example, as joint goals and shared responsibility by Parker-Oliver et al. (2005); as role valuing, role clarity, trusting relationships, and power sharing by Orchard et al. (2005); as trust, respecting differences, and shared decision-making by Hosley et al. (2003); and as shared planning and decision making of Banfield and Lackie (2009). Entrenching the virtues within the collaborative process was for study participants, key to advancing collaboration. Similarly, Sicotte et al. (2002) found conflicting values and beliefs as barriers to collaboration and the need for alignment of interdisciplinary values. Within services, making clear the organizational values and ensuring they are actioned versus only documented, as one participant stated, could strengthen inter-system support for collaboration.

Other virtues found advantageous to study participants were those of humility and humor. Humility was important to participants and was described as having the ability to recognize one's limitations and openly look for other ways of knowing and doing. Individuals that possess humility are able to value the knowledges and contributions of a variety of perspectives. Also, important to participants was using humor to build relationships and to help relieve some of the tension within a collaborative effort by having fun along the way. Courage was also important to participants for risk taking, thinking creatively, and accepting the uncertainties that come when working with diverse partners. Uncertainty for study participants was thought to be positive; seen as more open to new ideas rather than having preconceived views. Uncertainty has also been recognized within the CIHC (2010) competency standards as an expectation of interprofessional collaboration given the system complexities within which teams needed to function. Bedwell et al. (2012) described how collaboration can be influenced by environmental characteristics such as the degree of risk and stressors such as uncertainty. Potentially the element of uncertainty may be an enabler or a barrier to collaboration depending upon the circumstances. When considering the values, specifically trust helps to foster an appreciation of the roles of others; Brock and Doucette (2004) suggested both a need to trust and also

interdependence of each other's capabilities. Other scholars have also discussed increased interdependence of partners for advancing collaboration (Brock & Doucette, 2004; Bronstein, 2003; Parker-Oliver et al., 2005). Mutual dependency of partners rather than autonomous team members supports collective action (D'Amour et al., 2005). Effective communication, valuing the contributions of others, and respecting other skillsets helps to achieve interprofessional collaboration (Lomax & White, 2015). According to Bethea et al. (2014) interdependence, shared partnerships and power are key components of collaboration. Also valued by study participants to advance collaboration was transparency of goals and clarity of expectations without assumptions or hidden agendas. Transparency has been identified as important within the competency standards of the CIHC (2010) for enhancing communication, and building trusting and respectful interprofessional relationships.

Key to successful collaboratives and consistently described by study participants and researchers, was the importance of valuing differences (Gardner, 2005) and being inclusive of other voices (including the patient/client), roles, contributions, knowledges, and practices of many tribal groups. A study that included Australia, Canada, New Zealand, and United States, by Shahid and Thompson (2009), suggested the biomedical model of cancer care needed to be more accommodating of the diverse perspectives of Indigenous people for effective services. Lomax and White (2015) found open-mindedness and valuing differences a requirement for team building in addition to clear purpose, active listening, honesty, compassion, and flexibility. Bilodeau, Dubois, and Pepin (2015) observed that interprofessional oncology teams needed to be more inclusive of the "opinions and experiences" (p. 33) of their patients' for improving patient-centered practice. Participants spoke of valuing rather than validating the cultural practices in some collaborative arrangements. Valuing to the participants meant accepting each partner's contributions toward the outcomes while being clear about the role of others and not interfering, "staying out of each other's boats" requiring role clarification and building understanding and knowledge amongst all partners. This is consistent with Orchard's (2010) encouragement of health professionals to better articulate their unique roles, knowledges, and skills when collaborating. Similarly, Modin et al. (2010) reported the absence of interprofessional knowledge of each other's roles, expectations, and strategies as barriers to collaboration. Mutual

sharing of knowledge and expertise was also cited by Negley et al. (2009) to support collaboration.

To understand what each partner can contribute and move forward together, developing relationships and open communication (Brock & Doucette, 2004) was seen by participants as a major first step of collaboration when working across distinct services. Meaningful outcomes of collaborative effort occur when the people within the systems of both services, mainstream and traditional Indigenous health services, work together effectively. Taylor and Thompson (2011) explored partnerships between Aboriginal and mainstream health services in Australia; open, trusting relationships with linkages to the community were vital for productive partnerships. To address maternal health inequities in the United Kingdom, Aquino, Edge, & Smith, (2015) suggested more collaboration with clients and other health providers, and improving cultural competence.

Culturally competent wholistic patient-and family-centered care. Strengthening relationships between diverse groups requires collaboration and cultural competency as standards of practice within and across systems and organizations. Well documented in the literature and made apparent by study participants was a requirement of cultural competence for effective collaboration (Banfield & Lackie, 2009; Nelson et al., 2011; Woodroffe & Spencer, 2003). Nelson et al. (2011) also pointed to cultural competency standards and supportive practice environments as a way to manage cross-cultural partnerships. Culturally competent care has been linked closely to effective partnerships and communication (Kersey-Matusiak, 2012) making collaborative practice important for achieving cultural competence. Similarly to collaborative practice challenges, there are many culturally competent care models available. However, many practice settings have difficulty with implementation of standards and policies given some of the confusion around definitions and, in some cases, limited evidence to support their use. This may also be the situation within the Saskatchewan health system as well. The researcher was made aware of the development of a provincial cultural responsiveness framework drafted in partnership with Indigenous leaders, government, health regions, and cancer agency in an effort to transform the mainstream health services to be more culturally responsive and supportive of Indigenous health and wellness practices, education, strengthened relationships, policies, and programs. Unfortunately, to the researcher's knowledge there has not

been further development of this important initiative. Noe, Kaufman, Kaufmann, Brooks, and Shore (2014) determined organizational characteristics supportive of culturally competent services would include senior leadership practices, support for new programs, and open communication. From a public health perspective, Ogbolu and Fitzpatrick (2015) offered the development of implementation teams and interprofessional collaboration as a way to move standards into practice for culturally appropriate services. Collaboration was seen as an essential component of the implementation process and organizational commitment to use the required standards, policies, procedures and ensure ongoing training.

Cultural guidance (Nelson et al., 2011) and navigation support was emphasized by study participants as a way to advance cultural competence at the practice level. Navigation support could enhance collaboration by steering partners through the unknown territory of different ways of knowing and doing. Study participants and their external partners shared about the benefits of navigation by those that have knowledge and experience in both systems. Navigation support has been described by some scholars as an overlapping of perspectives or two-eyed seeing (Hatcher et al.; Iwama et al., 2009). Navigating with partners and helping them to see through both eyes has been invaluable in bringing together the different knowledges and practices of both services and helps partners to find ways to complement each other and share strengths to better serve patients and communities (Iwama et al., 2009). In a Saskatchewan study, Indigenous women with breast cancer proposed a navigator role and relevant information especially upon diagnosis, as supportive approaches in meeting their needs (Poudrier & Mac-Lean, 2009, p. 316). Bechtel and Ness (2010) also suggested coordination support; someone to help clients navigate the system. This approach has also been beneficial in Saskatchewan through the team at the Eagle Moon Health Office and their work in bridging the traditional Indigenous and mainstream health services (RQHR, 2015a).

Paramount within the study findings, in addition to valuing differences and inclusion of the cultural practices and ceremonies, was the need to approach collaboration more holistically. A common theme of study participants was ensuring that the significance and understanding of spirituality and cultural obligations were made apparent when describing this concept and actually collaborating. For participants, spirituality was foundational within this process and a common ground to help bring people together. Also accepting and respecting the many diverse

cultural practices required for spiritual and cultural obligations, was described by participants, as essential throughout the collaborative process. For participants, more understanding within mainstream health services of Indigenous perspectives of wholistic health and cultural practices as well as further development of wholistic approaches within mainstream health services could strengthen collaboration between the two services. According to Bechtel and Ness (2010) caring for the “whole person” (p. 916) was valued by clients and collaborative practice was an expectation. At times, the system can fall short on delivery which causes care providers to work around the barriers to achieve wholistic care, a shortcoming that was described by study participants and their partners. Organizational and system support were considered essential for effective collaboratives. Xyrichis and Lowton (2008) found that team structure and processes as well as lack of clarity around leadership impacted team effectiveness and interprofessional collaboration. These foundations extended to organizational support for innovation, implementing change, and evaluation of team effectiveness. Study participants and partners described experiences of risk taking, doing things “under the table” or “outside the box” as ways of working around prohibitive organizational rules and policies in order to meet the needs of clients and communities. Organizational support for innovation or improving ways of doing things was shown to enhance team collaboration, along with incentives, ongoing evaluation of teams, and financial investment in collaborative practice (Xyrichis & Lowton, 2008).

Bergman and Connaughton (2013) found significant variation concerning patient-centered care models and would like to see more culturally diverse models. Bethea et al. (2014) found that disciplines exhibiting more commitment to collaboration have a more wholistic view of healthcare delivery because of their experiences working across boundaries, sharing knowledge, and learning with others. Collaboration was seen as essential for quality health care and teamwork to provide patient-centered care (D’Amour, Ferrada-Videla, Martin-Rodriguez & Beaulieu, 2005). Health care has been evolving from autonomous decision-making by specific health providers to more collaborative decision-making by a broader group of health practitioners to address wholistic health (Gagliardi et al., 2011). Aligned with cultural competence comes valuing a wholistic approach to collaboration and the tremendous significance of spirituality within this process. This was described at length by study participants and reinforced by Hatcher (2012) to honour the wholistic view of Indigenous knowledge without

looking at it through the Western lens. The idea of patient-centered care and a more wholistic approach within the mainstream health system in the province was perceived to be in need of further development according to participants. Within the traditional Indigenous health services, spiritual and cultural aspects are intrinsic and paramount when collaborating. All participants spoke of the limited understanding within the local mainstream health system and inter-tribally, about Indigenous cultural practices, protocols, and significance of spirituality. These practices are fundamental to successful collaboration for many individuals and communities. Therefore, acceptance and respect for diverse cultural knowledges, practices, ceremonies, and processes required to fulfill spiritual and cultural commitments implants a wholistic approach as a fundamental component of collaboration. In support of what the study participants have described and associated with cultural competence, researchers refer to patient-centered practice and cultural competence (Banfield & Lackie, 2009) and supportive organizational cultures (Bronstein, 2003) as influencers of collaboration. Lomax and White (2015) found strong collaborative relationships to be the basis of safe patient-centered care that included team values such as respect, trust, and the embracing of cultural diversity. MacDonald et al. (2010) found that more wholistic client care can be accomplished with interprofessional collaborative practice particularly knowledge of the role of others and openness to their contributions.

A more wholistic and collaborative approach to cancer services was also proposed by study participants and was considered a priority. Shahid and Thompson (2009) also determined that a wholistic approach to cancer services could impact participation of Indigenous clients. However, developing and implementing interprofessional collaborative practice to advance wholistic service delivery would have to include substantial systemic and organizational support for its evolution. For example, the complexities of cancer care with its multi-model services requires both systemic and organizational support for effective teamwork, interprofessional collaboration, and integrated care delivery within and across organizations for continuity of care and case management. However, Gagliardi et al. (2011) found in Canada and other countries many health professionals working in cancer care have continued to work in parallel as opposed to integrated collaborative models of care and that interdisciplinary care models are needed that more fully engaged practitioners. A Canadian study, of oncology patients and families experiences of interprofessional patient-centered practice, found “sporadic” sharing of

information and collaboration between professionals (Bilodeau, Dubois, & Pepin, 2015, p. 34). Cancer care requires substantial collaboration and a better understanding of collaborative practice models and how to operationalize and evaluate them. Along with organizational support, team effectiveness models would be beneficial to improve collaboration and patient outcomes (Gagliardi et al., 2011).

Difficulties implementing collaborative practice within complicated and forever changing health care environments (Jansen, 2008) has been a reality in Saskatchewan even though substantial evidence supports the need for collaborative interdisciplinary teams as a requirement for addressing complex patient needs and improved outcomes. The ultimate goal and purpose of collaboration for study participants were meaningful outcomes that are impactful for Indigenous clients and communities. Within the literature (Woodroffe & Spencer, 2003), and for study participants, shared outcomes advance collaboration. Though for study participants this engagement in the research went beyond agreeing about a joint outcome to a requirement of making a significant change/difference or adaptation that would considerably impact the wellbeing of Indigenous people. One participant further explained that within effective collaboratives we need to think and do things differently, internalizing the change. The study participants had an expectation for real change through collaborative strength across services given all the effort that goes into collaboration with this being an important priority for cancer services. Bedwell et al. (2012) also found that the collaborative process resulted in a tangible product, idea, shared understanding, personal growth or satisfaction. Similarly, study participants recalled collaboration as being special and meaningful when outcomes were of significance for Indigenous clients and communities.

While the literature and study participants have described many enablers of collaboration as well as its barriers, what seems to be known about collaboration may not have translated as easily into some practice environments. For example, many enablers of collaboration known to be effective and also important to study participants have been outlined within the CIHC (2010) interprofessional competency framework; for example, leadership, listening, trust, respect, inclusiveness, valuing the contributions of others, transparency, and the expectation of uncertainty, just to name a few. Support within the system for further incorporation of these competency standards would be an important step forward. Saskatchewan's health system could

benefit from the further adoption and implementation of these competencies as requirements within a provincial framework for collaboration along with the necessary training to develop and implement interprofessional collaborative practice to support wholistic culturally competent service delivery. Particularly within the health system, the Hoshin Kanri systemic approach to strategic planning has been adopted with an underlying expectation of provincial partnerships to achieve shared goals for better health outcomes (SMH, 2015-16). This type of foundational support could provide invaluable support for advancing collaborative practice goals for more effective wholistic patient- and family-centered care. Implementing a provincial culturally competent interprofessional collaborative framework could be informed by, and could build upon, current efforts within the province. For example, Pasqua Hospital's Accountable Care Unit, a pilot program in the Regina Qu'Appelle Health Region, has a team-based approach to care, inclusive of patients and families, and a signed agreement to maintain its values (RQHR, 2015b). Real collaboration across disciplines and even sectors could be advanced with further development and integration of existing culturally competent wholistic/patient- and family-centered care models to meet the needs of diverse clients and communities. In this way, the enablers of collaboration experienced by the study participants could be addressed in a meaningful way and possibly become a catalyst for further assessment of current collaborative wholistic practice models for significant advancement of cross-cultural relationships and initiatives. The priorities of study participants, embedding the virtues/values, valuing difference, building and maintaining relationships, supportive environments with the right people and wholistic approaches could be addressed within these models and processes to advance wholistic culturally competent collaborative practice. The resultant meaningful change, as anticipated by participants, could come about to better meet the needs of clients and communities.

In summary, collaboration can be complicated and collaborative interprofessional practice requires significant system and organizational support to be effective (Martin-Rodriguez et al., 2005). Additional complexities become apparent when attempting to collaborate outside of our comfort zones and across jurisdictions and sectors with other knowledges, practices, and professionals including patients and communities. To increase collaboration across a variety of disciplines, services, and cultural health care paradigms, the concept has to be clearly defined with more inclusive language of cultural diversity including discerning the differences between

collaboration and other related concepts such as teamwork and partnerships (Bedwell et al., 2012). Also, the elements that influence/enable and the barriers of collaboration need to be better defined, understood, and measured at the practice level. The significance of collaboration for impactful patient and community outcomes has been well described and supported by the research (Gagliardi et al., 2011). For improving services and outcomes, collaboration across diverse health services would require a more focused provincial effort toward the development and further incorporation of a strengthened interprofessional collaborative practice in order to advance the goals of culturally competent wholistic/patient-centered care.

5.2 Study Trustworthiness and Limitations

Interpretive description methodology values practice level experience as the starting point to explore research questions (Hunt, 2009). Before conducting the interviews, the researcher documented personal beliefs and experiences currently held (Grove et al., 2013a) about collaboration that might influence the research process and findings. Throughout the data construction and interpretation phase of the research process, the researcher's assumptions, biases, and professional perspective and experiences were reflected upon (Robinson & Thorne, 1988) by developing a narrative of each interview and identifying within the text the researchers own beliefs and understanding of collaboration to uncover any predeterminations of the topic of interest. To remain immersed in the data and enhance its trustworthiness, the researcher conducted and transcribed all of the audiotaped interviews verbatim. Interpretive description also helped to draw out the biases of the researcher about the topic through member checks of ongoing discussion and reflection with the study participants (Hunt, 2009). Member checks were conducted throughout the study period which helped to challenge conceptualizations and verify the findings (Thorne et al., 1997). However, there could be limitations concerning member checks and verifying the overall results with participants. According to Morse, Barrett, Mayan, Olson, and Spiers (2002), member checks may not be a useful verification strategy because the data has been synthesized, decontextualized, and abstracted from and across unique participant experiences making it unrecognizable to individual participant experiences. In this way, member checks might invalidate the findings of the researcher and could limit the analytical process. Conversely, Wilson (2008) sees data synthesis as a way to build relationships and enhance credibility through continuous participant feedback helping to confirm the accuracy of analysis,

elaborate upon ideas, and learn from other participants. For this study, data analysis was an iterative and flexible process of checking and rechecking to confirm congruence among the research questions, design, data collection, analysis, and what has been described in the literature. The novice researcher consulted with a thesis supervisor and supervisory committee of experienced researchers in qualitative methodology throughout the study. To enhance the credibility of the findings, a detailed decision trail was developed during the analytical process, and some of the data were independently reviewed and analyzed by the thesis supervisor for consistency and increased rigor (Morse et al., 2002).

The purposive sampling approach used for this study helped to obtain rich information from experienced practitioners. However, this type of sample can also be a limitation, as the findings are limited to a specific time and one small geographic region of the province (Bernhardson, Tishelman, & Erik Rutqvist, 2007) and are only the perspectives of a few practitioners and not a representation of the immense diversity of all Indigenous peoples, therefore limiting the generalizability of the findings. However, trustworthiness of the findings can be supported by its integration of and reference to the practice setting and the available relevant literature (Davison & Simpson, 2006). To enhance fittingness of the data collected, the researcher compared and contrasted the behaviors, observations, and participant responses to the related literature (Sandelowski, 1986).

There are also limitations to interviewing participants as a data collection method, particularly the relationship between subjective and objective knowledge as well as the difficulties of clearly expressing complex human subjective experiences (Thorne, 2008). Also, this study was conducted in English, which might be a limitation, as there are many traditional languages that could offer further meaning and insights to the concept of interest (Petrucka et al., 2007). There are possibly many experiences of Indigenous and non-Indigenous partnerships that may not have been documented and could have provided invaluable information to this study (Taylor & Thompson, 2011). Additionally, digitally recording interviews may be problematic because of discomfort levels with the technique by some participants or environmental distractions. Interviews were conducted in a suitable location that was agreeable to the participants with all agreeing, to be audio-taped (Easton, Fry McComish, & Greenberg, 2000).

Another limitation of this study might be that the researcher was known to the team at Eagle Moon Health Office. Sandelowski (1986) suggested that a close relationship between investigator and participant may both enhance and threaten the truth value of qualitative inquiry and advised to maintain an appropriate distance for meaningful description and interpretation. However, other scholars, with community based participatory research experience, recognized that knowing its people and its context was foundational and can be imperative prior to entering a community (Petrucka et al., 2012). Similarly, Hatcher et al. (2009) reasoned, that in contrast to Western sciences, the Indigenous worldview requires an intimate connection between knowledge, the knowers, and the learners. Participant observations can also be another limitation of qualitative methodology because the researcher's presence can influence the setting (Thorne, 2008). Also, the study was conducted by a Caucasian researcher from a mainstream health/cancer service employer which may have influenced what the study participants were comfortable in sharing about their experiences of collaboration.

Given the limitations of these various data collection methods, the researcher used triangulation of multiple data collection methodologies for this study. Interviewing study participants, member checks, observations of study participants within their practice environment, and comparing and reviewing the literature to determine any commonalities and differences in relation to collaboration which has provided multiple perspectives, meaning and context about the concept of collaboration (Thorne et al., 1997). The researcher also acknowledges that even though a review of the literature was comprehensive, it was not necessarily exhaustive and may have lacked breadth depending on key words outside of the review process. With the concept of collaboration, there have been definitional challenges, which may have precluded finding papers that have used different terms to describe it (Morgan et al., 2015).

5.3 Implications for Nursing Practice and Research

Findings from this study have provided descriptions and perspectives of practitioners that have significant practice experience collaborating between the traditional Indigenous health ways and mainstream health services. Participants shared their unique experiences and perspectives openly and honestly in an effort to inform other health care providers in gaining a better understanding of the concept of collaboration, its enablers and barriers, as well as ideas that

could potentially enhance interprofessional collaborative practice when invoking different knowledges and practice ways. The suggestions for nursing practice, administration, education, and research are based on the findings from this study. Particularly at the practice level, the main themes that were constructed from the study findings might encourage nurses and other disciplines within the health sector to reflect upon their own practice experiences and further examine how they are currently approaching collaborative practice within and across settings. Individual nurses could consider how they are living their organizational values each day and whether they themselves value the differences and contributions of each of their clients, families and other health care providers for optimal benefits of their clients and communities. Nurses can also consider how clearly they are describing their specific roles and contributions to other team members and whether their relationships are unifying and productive within their unit, organization, and across sectors, in support of meeting client needs, and improving patient outcomes and community wellbeing. Individual nurses can also be advocates for changing the culture within their own practice environments and can be that “right person at the table”, someone respectful, open-minded, and willing to advance collaborative and culturally competent holistic practices.

Nurse managers and administrators may find this information useful when examining unit or organizational codes of conduct, policies, and practice standards concerning interprofessional collaboration or when assessing culturally competent holistic/patient- and family-centered care models given the associations between collaborative practice and effective holistic care (Ogbolu & Fitzpatrick, 2015). Research shows the complexities of implementing collaborative practice. Nurses are major influencers within the health system and organizations, and can be the main catalyst for the kind of system and cultural changes that would be necessary for further development and integration of interprofessional collaborative, culturally competent, holistic practices for improving patient outcomes (Bethea et al., 2014). Perhaps managers could regularly initiate discussions about the organizational values and required team effectiveness behaviors at department meetings and ask nurses to share examples of how they are living the values or maybe noticing other nurses and coworkers demonstrating these values may help to further implant these actions within the daily work of departments. Managers might also consider incorporating the organizational codes of conduct, team effectiveness behaviors, and competency

standards for collaboration, into practice models and employee performance evaluation processes. The performance review process could be an opportunity for nurses and other team members to identify specific values and team-effectiveness behaviors that they are demonstrating effectively and possibly those that need strengthening within the team as a way of embedding the organizational values and teamwork into practice. Ongoing education of clinical teams on effective, collaborative, and wholistic care models could be beneficial to enhance awareness and understanding of the need for practice level change. With the input of the team, components of these models could be gradually incorporated over time, in order to manage this necessary evolution within very busy practice environments.

Apparent within the research and the study results was also the need for more education and knowledge translation activities about collaborative practice models, and team effectiveness strategies (Gagliardi et al., 2011) for implementation, as well as system and organizational support for such a major change within provincial practice environments. Practice environments are complicated and always evolving; continued work within professional education programs to help prepare nurses and other health disciplines to think and behave more collaboratively with a more wholistic view of health would be beneficial for entry into practice (Bethea et al., 2014). Organizational values or codes of conduct could be reviewed by students prior to entering a unit. While on the unit, students could look for examples of other students and staff members living these values including themselves. These kinds of observations could be shared with the unit manager and discussed at team meetings to elevate the values as an organizational priority. When students are assigned to teams for projects and coursework, an expectation and initial step of the group, might be to develop a set of values, behavioral norms, or a code of conduct for the team. Team effectiveness behaviors could be identified by students and incorporated into their evaluation process. Possibly, health practitioners from diverse cultures, knowledges, and practices could be invited into the classroom to share their unique perspectives on health and wellness with students. Also, clinical placement of students for their practical experiences might include a variety of diverse practice settings and communities, for example, working with a traditional healer, medicine keeper, or elder. As well, ongoing education about collaborative, wholistic practice approaches and skill development needs to be offered across organizations and included in the professional performance and development goals of organizations. For example,

nurse educators at the practice level could be advocates and help to create more awareness about the need for, as well as the challenges and potential solutions regarding collaborative practice, to continue the ongoing shift away from siloed thinking and practices to a more systemic and wholistic approach to health services (Lomax & White, 2015).

Nurse researchers could also make a significant contribution to advancing interprofessional collaborative practice. More research concerning a standard definition of collaboration would be beneficial especially one that covers a broader range of processes and interactions between individuals, teams, departments, organizations, systems, and alliances. Also, greater distinction needs to be made between the concepts of collaboration, teamwork, partnerships, and other terminology utilized in the health sector as well as a better understanding of the human dynamics within the collaborative processes. Further development of process (i.e., adaptability) and outcome measures (i.e., shared goals) for desired behaviors, would be useful to appropriately advise practitioners on required behaviors for effective collaboration (Bedwell et al., 2012). More research, concerning empirical evidence on how organizational structures could foster collaboration, especially given the ongoing restructuring within organizations and the redesigning of care models including a better understanding of the relationships between systemic, organizational, and the interpersonal processes of collaboration (Martin-Rodriguez et al., 2005). Also, there are several models of collaboration proposed in the literature; however there are inconsistencies in how the process of collaboration has been conceptualized or its outcomes. More testing and empirical data would be useful. Collaboration needs to be understood not only as professionals but also as a human process (D'Amour et al., 2005). Additionally, collaborative cancer care requires further development, implementation, and evaluation. More research would be useful for the application of interventions and strategies to promote models that support collaborative interdisciplinary, integrative cancer care management (Gagliardi et al., 2011). Also further research on collaboration, its definition and enablers, from the perspectives and experiences of health professionals that practice across the traditional Indigenous and mainstream health services. More objective methodology might help to advance the knowledge of collaboration, direct observation versus self-reported techniques about the essential elements of interprofessional collaboration (Morgan et al., 2015) and perhaps a reference list of all of the enablers or necessary components of collaboration. Future research

may also help to determine additional competencies that could be necessary to ensure successful interprofessional collaboratives and would require a shared understanding of collaboration (Suter et al., 2009). Also, additional research about the approach of two-eyed seeing and how this capability could be further developed, supported, and evaluated in practice to advance cross cultural collaboration.

6 CONCLUSION

Collaboration is complicated, difficult to achieve, and often misunderstood at the practice level, and requires considerable time and effort to improve health outcomes for Indigenous clients and communities. Collaboration was not a term generally used by study participants; “working together” and “partnership” were more preferable. The idea of collaboration, and at times tokenism, within mainstream health services seems more commonplace than actual collaboration. Even though collaboration is essential for wholistic care and improved health outcomes, it is not always perceived as a system priority. However, when collaboration is effective and outcomes are sustainable, participants found it to be a gratifying and valuable experience.

More research to develop a standard definition and clarify the differences between other similar concepts such as partnership and teamwork could help to advance real collaborative action (Bedwell et al., 2012). Findings from this study support a need for a shared definition of collaboration that is guided by the virtues of the Indigenous health services and the values of mainstream health services, with more inclusive language and valuing of the diversity of Indigenous cultures and client/community voices, wholistic approaches, and sustainability of outcomes. The themes constructed that participants described as enablers of collaboration between the two services recognized the importance of embedding the virtues and values (especially trust, respect, humility, humor, equality, transparency, courage, self-reflection, and accepting uncertainty) to help individuals within a collaborative to feel safe and move forward together in an equitable and productive way. Valuing difference meant embracing diversity and including the unique contributions from a variety of perspectives. Building and maintaining relationships was the first step and essential for impactful work which included continuous learning, open communication, and really listening to understand and appreciate other viewpoints, cultures, and a variety of roles and contributions within a collaborative. Supportive environments included such enabling elements as an inviting, sociable, physical atmosphere; flexible and supportive structures, policies, and processes; open-minded senior leaders with a willingness for change; navigation support to guide, advise, and advocate for clients, community members, and health professionals to successfully access and work between the two services; and adequate resources to support sustainable outcomes. Collaboration needs to be approached

more holistically; spirituality was seen as foundational and a common ground to bring people together. Throughout the collaborative process the diverse cultural practices required for spiritual and cultural obligations needs to be respected. Also, a more holistic approach to health and a further understanding within mainstream health services of the traditional Indigenous approach to health and cultural practices could help to strengthen collaborative efforts. Additionally, having the right people at the table was so imperative that participants suggested hand picking the representatives for collaboration to ensure these are individuals with the right attitude that follow the virtues and values, and are willing collaborators. For participants, these are individuals that are knowledgeable and experienced to constructively input at a collaborative table, would take ownership and responsibility of the collective priorities, champion the initiative, and never quit for sustainable outcomes. According to participants, productive collaboration changes our thinking and approach to the way we work together and requires making a significant change, adaptation, or impactful health outcomes for clients and communities. Specific to cancer control services, more holistic approaches to cancer services and an increased understanding and accommodating of traditional Indigenous health ways within these services, inclusive of the valuable contributions of knowledge keepers/elders and healers, could enhance support to clients and communities.

Given the significance of collaboration for effective holistic care and better health outcomes, a more focused provincial effort toward the development and further integration of collaborative practice in Saskatchewan would be beneficial. Health service environments could benefit from further awareness, development, implementation, and evaluation of collaborative practice models. Also the enablers of collaboration need to be better defined, understood, and measured in practice (Bedwell et al., 2012). A comprehensive list of all the enablers of collaboration has not been developed and could be useful at the practice level. Within the mainstream health system, there needs to be more action around working collaboratively between these two diverse services rather than mainly writing and talking about it. These results demonstrate the significance of systemic and organizational support for effective collaborative and holistic practice approaches when working across diverse services. The experiences shared by the study participants have shown that certain individual behaviors and system supports help to improve relationships thereby enabling more meaningful collaboration. The

themes created from this study could become a talking point for generating more awareness and discussion on the topic of collaboration between the two services. The themes could also be used when assessing current systemic and organizational cultures and supportive structures for more collaborative, team effective, wholistic practice models and professional education models that incorporate the competency standards for collaboration; cultural competence and collaboration as standard practice; codes of conduct that are actioned; employee recruitment, training and skill development, and performance evaluation processes; and resource allocation for collaboration (Bethea et al., 2014; Martin-Rodriguez et al., 2005; & Nelson et al., 2011). These suggestions for going forward could help to strengthen relationships between both services that result in real collaborative action and improved outcomes for clients and communities. This approach would be a positive way forward given that collaborative relationships are the basis for effective wholistic care and optimal health outcomes (Lomax & White, 2015). Nurses can influence system change (Bethea et al., 2014) and can play a major role in advancing collaboration. Nurses at all levels and in all areas of practice, education, and research are leaders in the health sector and collectively could bring a sharper focus to this important topic. With a shared emphasis on collaboration, nurses could help to generate the individual, organizational, and system level changes that would be necessary to advance effective collaborative practice that could bring about more meaningful progress toward culturally competent wholistic care in the province.

The findings from this study have provided only a glimpse of the enablers and challenges of collaboration when working together with the traditional Indigenous and mainstream health and cancer services. For the study participants, two-eyed seeing has provided them with the ability to see the tremendous value and strengths of both worlds and how to utilize each service to complement the other. These kinds of practitioners have become a “gateway” (Bechtel & Ness, 2010, p. 917) between these two distinct worlds of practice thereby making accessible the best support available from each service to meet the needs of diverse clients and communities (Hatcher et al.; Iwama et al., 2009). Collaboration although seemingly very complex has also been simplified within the traditional Indigenous health way. For study participants, collaboration was compared to the humble, yet revered gesture, of a client offering, and an elder accepting sacred tobacco. Within this transaction, all of the enablers of collaboration described

by the participants are understood and accepted along with a commitment to work together in a trusting, respectful, and equitable manner to achieve the optimal client outcome. One participant provided a poignant reminder of why we are all working in health care, “it’s not what the traditional people do, it’s not what the Western people do, it’s the outcome of a person...that’s very important.”

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Appendix A: Terminology

DEFINITIONS		REFERENCES
Aboriginal peoples	A collective name for the original peoples of North America and their descendants. The Canadian constitution recognizes three groups of Aboriginal people: Indians (commonly referred to as First Nations), Métis and Inuit. These are three distinct peoples with unique histories, languages, cultural practices and spiritual beliefs	Health Canada, 2011 & Government of Canada, Aboriginal Affairs and Northern Development Canada, 2013a
First Nations people	A term that came into common usage in the 1970s to replace the word 'Indian' which many people found offensive. Although the term 'First Nation' is widely used, no legal definition of it exists. Many Indian people have also adopted the term 'First Nation' to replace the word 'Band' in the name of their community. Both Status and non-Status Indians in Canada are referred to as 'First Nations people(s)'. In the Canadian Census of Population, 'North American Indian' is the term used for both Status and non-Status Indians	Health Canada, 2011 & Government of Canada, Aboriginal Affairs and Northern Development Canada, 2013b
Indigenous peoples	An official definition of "indigenous" has not been adopted by the United Nations system due to the diversity of the world's indigenous peoples. Instead, a modern and inclusive understanding of "indigenous" has been developed and includes peoples who: <ul style="list-style-type: none"> • Identify themselves and are recognized and accepted by their community as indigenous. • Demonstrate historical continuity with pre-colonial and/or pre-settler societies. • Have strong links to territories and surrounding natural resources. • Have distinct social, economic or political systems. • Maintain distinct languages, cultures and beliefs. • Form non-dominant groups of society. • Resolve to maintain and reproduce their ancestral environments and systems as distinctive peoples and communities 	World Health Organization, 2007
Inuit people	The Aboriginal people of Arctic Canada. The word "Inuit" means "the people" in the Inuit language called, Inuktitut and is the term by which Inuit refer to themselves. The term "Eskimo," applied to Inuit by European explorers, is no longer used in Canada	Government of Canada, Aboriginal Affairs and Northern Development Canada, 2010
Métis people	Métis means a person who self-identifies as a Métis, is distinct from other aboriginal peoples, is of historic Métis Nation ancestry, and is accepted by the Métis Nation	Métis Nation of Alberta, 2007, Health Canada, 2011, & Métis National Council, n.d.

Appendix B: Summary Literature Review

Definitions of Collaboration:
The action of working with someone to create something (Oxford Dictionaries, 2013)
As an ongoing process of joint activities and reciprocity between people or organizations to achieve a shared goal (Bedwell et al. 2012, p.130)
The different health disciplines working with clients, families and communities across settings in the provision of quality care (World Health Organization, 2010)
A partnership between a team of health professionals and the patient with joint decision-making around health and social concerns (Orchard, 2010, p. 251)
A recognized relationship among various groups or organizations to take action on a particular issue more effectively and sustainably than could be achieved if acting alone, for example shared service delivery and accountability of outcomes (Public Health Agency of Canada, 2010)
A process and an outcome that requires combined perspectives to understand and solve complicated problems that could not be accomplished by an individual or a single organization (Gardner, 2005)
An effective interpersonal process that helps to achieve goals that could not be attained when individual professionals act alone (Bronstein, 2003, p.299)
A process of joint communication and decision-making, a partnership around mutual goals and commitment that is based on shared power and authority (Henneman et al., 1995)
Benefits of Collaboration:
Canadian population health and wellness standards recognize the importance of collaboration across various sectors and jurisdictions and throughout the continuum of care to support community action for health promotion and disease prevention (Accreditation Canada, 2015)
Health organizations can benefit from effective interprofessional collaboration through work efficiencies, provider satisfaction, cost reductions and more responsiveness to client needs for improved outcomes (Bethea et al., 2014)
Improves interprofessional cohesiveness, communication, productivity, and patient outcomes (Negley et al., 2009)
Enhances understanding of clients' needs and improves complex problem solving with collaborative interdisciplinary teamwork (Parker-Oliver et al., 2005)
Improves service delivery and programming when strong cross-cultural collaborative teams are established (Hosley et al., 2003)
Improves working relationships and patient outcomes in nursing practice (Henneman et al., 1995)
Core Components / Enablers of Collaboration:
Frequent and varied communication methods a requirement for the facilitation of shared knowledge, goals and decision-making (Morgan et al., 2015)
Reported the need for a more flexible approach based on trust and respect if relationships between mainstream service providers and Indigenous clients are to improve (Cuesta-Briand et al., 2015)

Effective relationships between people that require self-reflection, shared power, trust, time, resources, and accepting difference as some approaches to working together (Haynes et al., 2014)
Interdependence, reciprocity, joint activities and decision-making with common goals and outcomes (Bedwell et al., 2012)
Formalized partnerships, shared input and resources (Nickson et al., 2011)
Environment factors such as political and social climate, membership characteristics of respect, process and structural flexibility and adaptability, open communication, shared purpose, skilled leadership and sufficient resources (Taylor & Thompson, 2011)
Some commonalities or overlapping of skills seemed to occur naturally (MacDonald et al., 2010)
Trust, positive attitudes towards collaboration, and role clarity (Modin et al., 2010)
Shared power, joint decision-making, institutional support for collaborative team development, clarity of roles, and health professionals understanding each other's roles (Orchard, 2010)
Shared planning and decision making, non-hierarchical relationships, patient-centered practice, cultural competence, and reflective practice (Banfield & Lackie, 2009)
Common goals, and mutual sharing of knowledge, expertise, and resources (Negley et al., 2009)
Valuing diversity, common vision, shared power, and systems thinking (Gardner, 2005)
Role valuing, role clarification, trusting relationships, and power sharing (Orchard, Curran, & Kabene, 2005)
Flexibility, joint goals, shared responsibility, interdependence and blurring of roles (Parker-Oliver et al., 2005)
Effective communication, joint decision making, trust in each other's competence, increased interdependence (Brock & Doucette, 2004)
Interdependence, flexibility, role blurring, shared goals, role clarity, respect, a supportive organizational culture, and a client-centered approach to care (Bronstein, 2003)
Building trust, respecting differences, and shared decision-making (Hosley et al., 2003)
Cultural competence, mutual goals, formalized partnerships, and shared authority for outcomes (Woodroffe & Spencer, 2003)
Joint planning, decision-making, and action (RQHR, 2002)
Alignment of the work group beliefs with interdisciplinary values (Sicotte et al., 2002)
Barriers of Collaboration:
Professionals working parallel or consultatively rather than collaboratively (Gagliardi, et al., 2011)
Limited education, cultural guidance, competency standards, and supportive practice environments to manage cross-cultural partnerships (Nelson et al., 2011)
Domination of Western models/limited understanding and support of traditional systems (Nickson et al., 2011)
Organizational boundaries, working conditions, power imbalance, lack of interprofessional knowledge of each other's expectations and strategies, and insufficient time (Modin et al., 2010)
Nurses socialized into the profession with a profession-only focus; nurses and other health professionals need to better articulate

their unique roles, knowledges and skills to each other in order to clearly identify opportunities for collaboration (Orchard, 2010)
Blurring of roles could lead to conflict and burnout amongst team members and suggested clear boundaries around individual contributions (Suter et al., 2009)
Conflicting values and beliefs; health professionals working parallel to each other rather than collaboratively, professional autonomy may be a barrier to collaboration (Sicotte et al., 2002)
Organizational structures (Sicotte et al., 2002)

Appendix C: Demographic Data Collection Form

DEMOGRAPHICS

Demographics: (collect for each study participant)

Check

(✓)

Age Range (years): 20-29, 30-39, 40-49, 50-59, 60-69, 70 or more	
Gender: Male or Female	
Cultural Background/Ancestry:	
I work in a First Nations Community	
I work at the Eagle Moon Health Office	
I have practice experience of traditional Indigenous ways of health service for:	
Less than 5 years	
5-10 years	
11-15 years	
16-20 years	
More than 20 years	
I have practice experience of the Western/non-traditional health service for:	
Less than 5 years	
5-10 years	
11-15 years	
16-20 years	
More than 20 years	
I have knowledge of traditional Indigenous ways of health care	
I have knowledge of the Western/non-traditional health service	
I have experience practicing traditional Indigenous ways of health care	
I have experience practicing as a health care professional or administrator within the Western / non-traditional health system	
I have experience collaborating across the traditional Indigenous and Western/non-traditional health services	

Appendix D: Study Participant Interview Guide

Question #1	The researcher will start with: I would like to learn as much as possible about your experience of collaboration. The researcher will ask the participant to describe a situation or significant event where collaboration went well – not so well. The researcher will ask probing questions about: what was it like, what was your role, what was the involvement of others etc...)
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Comments:

Question #2	How would you define collaboration? Do you use other terms besides the word ‘collaboration’ in your practice?
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Comments:

Note: *Researcher / Interviewer share a few examples of definitions of collaboration described in the literature to help participants understand the topic of interest being explored and provide feedback.*

Question #3	Based on your experience, what are the core elements or components (both individual and system) that make collaboration work?
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Comments:

Question #4	Based on your experience, what enables or helps collaboration (both individual and system)?
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Comments:

Question #5	Based on your experience, what makes collaboration difficult (both individual and system)? What are the barriers to collaboration (both individual and system)?
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Comments:

Question #6	How could we move forward to improve collaboration across these two diverse services?
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Comments:

Note: *Following the questions about collaboration generally – ask if there are any unique aspects about collaboration in relation to cancer control specifically that it would be important for cancer services to know about.*

Thank you for sharing your perspective and experiences about collaboration

Appendix E: Study Participant Interview Guide – Partners

Question #1	The researcher will start with: I would like to learn as much as possible about your experience of collaboration with the Eagle Moon Health Office team. Describe your experience of collaboration with the Eagle Moon Health Office team – describe a situation or an event where you partnered with the Eagle Moon team and it went well – not so well. How would you define collaboration?
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Comments:

Note: *Researcher / Interviewer share a few examples of definitions of collaboration described in the literature to help participants understand the topic of interest being explored and provide feedback*

Question #2	Based on your experience working in partnership with the Eagle Moon Health Office team, what are the core elements or components (both individual and system) that make collaboration work?
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Comments:

Question #3	Based on your experience working in partnership with the Eagle Moon Health Office team, what do they do to enable or help collaboration (both individual and system)?
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Comments:

Question #4	Based on your experience working in partnership with the Eagle Moon Health Office team, what makes collaboration difficult (both individual and system)? What are the barriers to collaboration (both individual and system)?
-------------	---

Comments:

Question #5	How could we move forward to improve collaboration across these two diverse services?
-------------	---

Comments:

Note: *Following the questions about collaboration generally – ask if there are any unique aspects about collaboration in relation to cancer control specifically that it would be important for cancer services to know about.*

Thank you for sharing your perspective and experiences about collaboration

Appendix F: Transcript Release Form

I, _____, have reviewed the complete transcript of my personal interview/s in this study, and have been provided the opportunity to add, alter, and delete information from the transcript as appropriate. I acknowledge that the transcript accurately reflects what I said in my personal interview/s with Cheryl Whiting.

I hereby authorize the release of this transcript to Cheryl Whiting 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.

Participant _____

Date_____

Researcher _____

Date_____

Appendix G: From Codes to Themes (Sample)

Transcripts	Code	Theme
“if we just did what all our beautiful documents say”	move to action	Embedding the virtues/values
“the time developing the respect”	respect	
“when two people aren’t respecting each other’s way of working”	lack of respect	
“it’s a whole building of respect of the team of people that you’re working with before you can do that”	respect	
“Inherent in that process you’re describing are these virtues”	virtues	
“those principles and rules I give myself”	principles/rules	
“come together respectfully but it isn’t easy”	respect	
“follow those virtues”	virtues	
“trust has to be there right away and a lot of times it really isn’t”	trust/lack of trust	
“apply the virtues to that and walk those ways”	apply/walk virtues	
“there’s a big element of trust that’s needed in that”	trust	
“trust is----first thing”	trust	
“to take risks with those you know nothing about, you must be pretty respectful and trusting”	respect/trust	
“it’s easy to collaborate if we walk the values of the contemporary system and the virtues of the Indigenous system. And those are not inanimate words, those are actions”	action values/virtues	



CO-RESEARCHER / PARTICIPANT INFORMATION AND CONSENT FORM

STUDY TITLE: Using Two Eyed Seeing to Explore Practice Level Perspectives and Experiences of Collaboration across Diverse Health Services with Cancer Control as an Exemplar

PRINCIPAL INVESTIGATOR: Dr. Pammla Petrucka and Cheryl Whiting

SPONSOR: University of Saskatchewan, College of Nursing

CONTACT PHONE NUMBERS:

PAMMLA PETRUCKA - 306-337 - 3811

CHERYL WHITING – 306 - 359 - 5602

INTRODUCTION

You are invited to take part in this research study because you have experience collaborating effectively to connect the traditional Indigenous and Western/non-traditional methods of health services. Learning more about how to collaborate across diverse health services could help to bridge these two worlds of knowledge and expertise for meaningful progress in closing the service gaps in cancer control and improving the health of Indigenous populations.

Your participation is voluntary. It is up to you to decide whether or not you wish to take part. If you wish to participate, you will be asked to sign this form. If you do decide to take part in this study, you are still free to withdraw at any time and without giving any reasons for your decision.

If you do not wish to participate, you will not lose the benefit of participation in any other research projects. It will not affect your relationship with Dr. Pammla Petrucka, Cheryl Whiting, or other members of the research team.

Please take time to read the following information carefully. You can ask the researcher to explain any words or information that you do not clearly understand. You may ask as many questions as you need. Please feel free to discuss this with your family, friends or peers before you decide.

WHY IS THIS STUDY BEING DONE?

This study is being done because effective collaboration is often difficult to achieve in practice and has generally been described by the Western or mainstream/non-traditional health system; little is known about the perceptions and experiences of the traditional Indigenous health system.

WHO CAN PARTICIPATE IN THE STUDY?

You are eligible to participate in this study if you (a) are a member of the team at Eagle Moon Health Office; (b) speak and read English; (c) are a health practitioner or health consultant (knowledge keeper, healer, elder, nurse), or manager (administrator or director) practicing across the traditional Indigenous and Western/non-traditional health services; (d) have knowledge of traditional Indigenous health services and knowledge of the Western/non-traditional or mainstream health service; and (e) have experience collaborating between these two diverse health services; or; f) are an Elder that acts as an advisor to the team at the Eagle Moon Health Office; or g) are a client (community member, leader, or patient) that have accessed the team's services or worked in partnership with the Eagle Moon Health Office team across the two services in relation to an initiative.

WHAT DOES THE STUDY INVOLVE?

This study will involve being asked about your opinions and understandings of how collaboration works as a client or partner of the Eagle Moon Health Office team or as a member of the Eagle Moon Health Office team as you practice across the traditional Indigenous and Western/non-traditional health systems. It is estimated that you will meet with the researcher 2 or 3 times for about an hour and a half the first time and about an hour each the following times to clarify the information you provide. The researcher will also spend time at the Eagle Moon Health Office, about three to four visits, for about one hour each visit, to observe and record team member's interactions, activities, and nonverbal communication between co-researchers / study participants, their clients, and external partners as they collaborate across the two methods of health services. It is estimated that the study will last 8 to 12 months.

WHAT ARE THE BENEFITS OF PARTICIPATING IN THIS STUDY?

If you choose to participate in this study, there may or may not be any direct benefits to you. It is hoped that the information gained from this study can be used in the future to benefit other people that work with Indigenous populations. A benefit of participation might be to having the work of the Eagle Moon Health Office team documented in a way that contributes to a better understanding of collaboration within the health system in Saskatchewan.

ARE THERE POSSIBLE RISKS AND DISCOMFORTS?

If you choose to participate in this study, it is possible that you may feel some mental fatigue due to the in-depth conversations and ongoing discussions about collaboration. You may feel uncomfortable about being observed in your practice setting and/or sharing your views and opinions about collaboration. The Eagle Moon Health Office has elders available upon request for study participants who would like emotional or counselling support or who seek direction and healing because of participating in this study. To access this support please contact Stephanie Cavers, Director Eagle Moon Health Office, Regina Qu'Appelle Health Region, Phone Number 306-766-6984.

WHAT IF NEW INFORMATION BECOMES AVAILABLE THAT MAY AFFECT MY DECISION TO PARTICIPATE?

During the course of this study, new information that may affect your willingness to continue to participate will be provided to you by the researcher.

WHAT HAPPENS IF I DECIDE TO WITHDRAW?

Your participation in this research is voluntary. You may withdraw from this study at any time. You do not have to provide a reason. There will be no penalty or loss of benefits if you choose to withdraw.

If you choose to enter the study and then decide to withdraw later, your right to withdraw your specific data from the study will apply until the results have been pooled. After this it is possible that some form of research dissemination will have already occurred and it may not be possible to withdraw your data. Prior to pooling the data, when a participant withdraws, his/her data will be deleted from the research project and destroyed, if desired by the participant.

WILL I BE INFORMED OF THE RESULTS OF THE STUDY?

The results of the study will be available in December 2015 from Cheryl Whiting. You may ask for copies of all reports or information about this study. Participants will be involved in the decisions about how the information will be shared before any presentations or publication of the results.

WHAT WILL THE STUDY COST ME?

You will not be charged for any research-related procedures. You will not be paid for participating in this study. You will not receive any compensation, or financial benefits for being in this study, or as a result of data obtained from research conducted under this study.

WHAT HAPPENS IF SOMETHING GOES WRONG?

By signing this document, you do not waive any of your legal rights.

WILL MY TAKING PART IN THIS STUDY BE KEPT CONFIDENTIAL?

Your confidentiality will be respected. No information that discloses your identity will be released or published without your specific consent to the disclosure. However, research records identifying you may be inspected in the presence of the Investigator or his or her designate by representatives of the University of Saskatchewan, University of Saskatchewan Research Ethics Board for the purpose of monitoring the research. However, no records, which identify you by name or initials, will be allowed to leave the Investigators' offices. The results of this study may be presented in a scientific meeting or published, but your identity will not be disclosed.

WHO DO I CONTACT IF I HAVE QUESTIONS ABOUT THE STUDY?

If you have any questions or desire further information about this study before or during participation, you can contact Cheryl Whiting at 306-359-5602.

This research project has been approved on ethical grounds by the University of Saskatchewan Research Ethics Board and Regina Qu'Appelle Health Region Research Ethics Board. 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 TO PARTICIPATE

Study Title: Using Two Eyed Seeing to Explore Practice Level Perspectives and Experiences of Collaboration across Diverse Health Services with Cancer Control as an Exemplar

- I have read (or someone has read to me) the information in this consent form.
- I understand the purpose and procedures and the possible risks and benefits of the study.
- I was given sufficient time to think about it.
- I had the opportunity to ask questions and have received satisfactory answers.
- I understand that I am free to withdraw from this study at any time for any reason and the decision to stop taking part will not affect my future relationships.
- I give permission to the use and disclosure of my de-identified information collected for the research purposes described in this form.
- I understand that by signing this document I do not waive any of my legal rights.
- I will be given a signed copy of this consent form.

I agree to participate in this study:

Printed name of co-researcher / participant:

Signature

Date

Printed name of person obtaining consent:

Signature

Date

Appendix I: Demographic Characteristics of Participants

Demographic Characteristics of Participants	
Characteristics	Number of Participants
Age Range (years): 50 or more years	8
Gender: Male or Female	M(2)/F(6)
Cultural Background/Ancestry:	Aboriginal(5)
	Non-Aboriginal(3)
I work in a First Nations Community	5
I work at the Eagle Moon Health Office	6
I have practice experience of traditional Indigenous ways of health service for:	
Less than 5 years	
5-10 years	2
11-15 years	1
16-20 years	1
More than 20 years	3
I have practice experience of the Western/non-traditional health service for:	
Less than 5 years	
5-10 years	1
11-15 years	1
16-20 years	1
More than 20 years	3
I have knowledge of traditional Indigenous ways of health care	7
I have knowledge of the Western/non-traditional health service	8
I have experience practicing traditional Indigenous ways of health care	5
I have experience practicing as a health care professional or administrator within the Western/non-traditional health system	5
I have experience collaborating across the traditional Indigenous and Western/non-traditional health services	8