"Lifting Spirits": Supporting the Psychological Resiliency of Urban Aboriginal Service Providers in New Brunswick and Nova Scotia

UAKN Atlantic Regional Research Centre

Research Team

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The Urban Aboriginal Knowledge Network, the UAKN, is a community driven research network focused on the Urban Aboriginal population in Canada. The UAKN establishes a national, interdisciplinary network involving universities, community, and government partners for research, scholarship and knowledge mobilization. For more information visit: www.uakn.org

Acknowledgments

EXECUTIVE SUMMARY

The colonization and forced assimilation of Aboriginal people in Canada are considered to be the root causes of the elevated levels of social and mental distress found in many Aboriginal communities today (Kirmayer, Tait, & Simpson, 2009). The effects of these related traumas tend to ripple outward from the victims to those who surround them, and among residential school survivors, the consequences of emotional, physical and sexual abuse continue to be felt in each subsequent generation. This has important implications for the delivery of mental health services to Indigenous populations.

Aboriginal people have, however, experienced disparities and related inequities regarding the delivery of appropriate mental health care (Royal Commission on Aboriginal People, 1996; Aboriginal Healing Foundation, 2005; 2006). It has been documented that in order for service delivery to be appropriate for Aboriginal people, both cultural safety and cultural competence are necessary (Brascoupé & Waters, 2009). This would require practices that acknowledge, honour and support the cultural identity of individuals, and exclude the use of practices deemed culturally unsafe, viz. "actions that diminish, demean or disempower the cultural identity and well-being of an individual" (Cooney, 1994).

As service provision often entails hearing the stories and witnessing the suffering of survivors of trauma, one could argue that Aboriginal persons face a higher risk of being triggered by a situation, an attitude or expression, or by a certain environmental situation that replicates the dynamic of trauma (MacCann & Pearlman, 1990; Sabin-Farrell & Turpin, 2003). To be effective, the service provider must understand the impacts of trauma, and also understand the fundamentals of trauma-informed practice to be able to support clients in a manner that avoids harm (re-traumatization) to the service provider, while recognizing and acknowledging the impact and meaning that the trauma has to the client (Dunkley & Whelan, 2006; Furlonger & Taylor, 2013; Goodleaf & Gabrielle, 2009).

Purpose

This study was designed to gain insight into the experiences of Aboriginal frontline service providers who report and experience trauma secondary to supporting their clients, as well as their family, friends and communities. Of particular significance is the question whether culturally safe and competent practices are present in outreach mental health supports for frontline service providers working in Aboriginal organizations. The study also seeks to make recommendations for culturally supportive and safe options to respond to trauma, and to advocate for the importance of attentiveness to mental wellness and practices of self-care within Aboriginal organizations.

Methodology

The project obtained ethics approval from the New Brunswick Aboriginal Peoples Council and the University of New Brunswick Research Ethics Board. From there, the research questions were developed in consultation with urban Aboriginal community members and the project Elder. The researcher used a conversational methodology to gather information. The conversational method is a "*method of gathering knowledge based on oral story telling tradition that is congruent with an Indigenous paradigm*" (Kovach, 2010). Thus, frontline service providers were interviewed either in focus groups or individual interviews. Participants were provided with the interview questions prior to meeting with the researcher. All participants signed consent forms with a promise of anonymity, if requested. The researcher used audio recording when the participants consented and were comfortable with being recorded.

Criteria required participants to be employed at an urban Aboriginal organization. They had to interact and directly provide services to members of an urban Aboriginal community. Participants were recruited or referred to the researcher through pre-established partnerships in the context of the Capacity study (UAKN Atlantic, 2018) conducted by the New Brunswick Aboriginal Peoples Council in May of 2017. These partnerships included organizations such as Under One Sky Friendship Centre (UOSFC), New Brunswick Aboriginal Peoples Council (NBAPC), HanMartin Associates, Gignoo Transition House, and the Native Council of Nova Scotia. Additionally, Skigin-

Elnoog Housing Corporation and Turning Leaf Foundation were also invited to participate in the study.

Findings

The data derived from this research is broken down under three main headings: stress in the workplace, barriers and gaps of current mental health supports, and relevant mental health interventions that current frontline service providers consider supportive.

I) Stress in the workplace

- Participants felt that they were underqualified for their job despite having high qualifications for the position. The majority expressed that their educational experience did not prepare them to deal with the high acuity needs of the clients.

- Many participants felt that their clients had put a lot of trust and responsibility in their ability to successfully support their needs. This inability to successfully support the needs of their clients was met with guilt. Service providers then felt the need to perform tasks that were outside their job description in order to successfully support their clients.

- Participants identified that dealing with outreach services was often a negative experience resulting in frustrations and stress. Outreach services seemed to be culturally insensitive to the history of Aboriginal people.

- Participants felt that there were insufficient mechanisms in the workplace to support their mental health needs. Participants identified that employer benefits were difficult to navigate.

- Participants stated that there were no formal debriefing protocols in their workplaces.

II) Gaps and barriers in mental health supports available for Aboriginal service providers

- The cost of employee benefit plans available for not-for-profit organizations were unaffordable for employers.

- The absence of in-house policies in organizations surrounding mental health needs and supports.

- The lack of cultural awareness when accessing mainstream mental health supports.

- The absence of culturally sensitive interventions within mainstream mental health interventions.

III) Mental health interventions considered to be supportive

- Having open dialogues about mental wellness throughout the workplace.

- Learning and incorporating effective debriefing mechanisms in the workplace.

- Integrate all forms of mental health support with Aboriginal culture.

Recommendations

Aboriginal organizations are providing invaluable services to a growing population of Aboriginal people within Atlantic Canada. Barriers to appropriate mental health care must be addressed using holistic and long-term approaches in order to support their dedication and unwavering efforts. Without a meaningful and adequate commitment to addressing these barriers, programs designed to respond to the mental health needs of Indigenous people will be underused and less effective. It is the hope of the author that frontline service providers, Aboriginal organizations and policy makers will act on the following recommendations:

RECOMMENDATIONS

The research team recommends

1. THAT Aboriginal organizations build infrastructure to support frontline service providers becoming trauma-informed practitioners;

2. THAT Aboriginal organizations acknowledge that providing service is work that involves trauma-related risks, and thus the risks of vicarious trauma and re-traumatization become high;

3. THAT Aboriginal organizations invest in coordinated systems that are client-centered, trauma-informed, and culturally sensitive to minimize the dual risks of vicarious trauma and re-traumatization;

4. THAT Aboriginal organizations develop sustainable modes of providing staff and volunteer mental health supports as part of the organizational mandate. These supports

may include the provision of employee mental support benefits and the creation of in-house policies and practices;

5. THAT mental health care providers become aware of and educated in Aboriginal history and culture, including the systemic effects of colonization. Western models of mental health should not be treated as the only mode of interventions for Aboriginal people;

6. THAT mainstream health services work more closely with Aboriginal organizations, community members and Elders to ensure the integration of Indigenous concepts of wellness into the mainstream healing process and the development of culturally appropriate methods of care.

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INDIGENOUS MENTAL HEALTH – SYSTEMIC AND CONCEPTUAL CONTEXT

The colonization and forced assimilation of Aboriginal people in Canada are considered to be the root causes of the elevated levels of social and mental distress found in many Aboriginal communities today (Kirmayer, Tait, & Simpson, 2009). Due to the intergenerational impacts of residential schools as well as the experience of racist attitudes that continue to permeate Canadian society, Aboriginal people in Canada are four times more likely to experience severe trauma and re-traumatization than the non-Aboriginal population (Haskell & Randall, 2009; Aboriginal Healing Foundation 2005; Bride, 2004). Trauma can be defined as an event that involves a single experience, or enduring or repeated events, that completely overwhelm an individual's ability to cope or integrate the ideas and emotions involved in that experience (Hensel, Ruiz, Caitlin, Dewa & Carolyn, 2015). These events can cause some emotional responses such as terror, fear, horror, helplessness and in some cases physical stress reactions (MacCann & Pearlman, 1990).

The effects of trauma tend to ripple outward from the victims to those who surround them, and among residential school survivors, the consequences of emotional, physical and sexual abuse continue to be felt in each subsequent generation. Deep, traumatic wounds exist in the lives of many Aboriginal people who were taught to be ashamed, just because they were Aboriginal (Royal Commission on Aboriginal People, 1996). Trauma and the risk of re-traumatization have important implications for the delivery of mental health services to Indigenous populations.

Aboriginal people continue to experience disparities and related inequities regarding the accessibility to appropriate mental health care (Royal Commission on Aboriginal People, 1996; Aboriginal Healing Foundation, 2005; 2006). Colonization brought with it a persistent disregard of rich systems of Indigenous knowledge, including those regarding mental health. Instead, settler society almost exclusively privileged its own knowledge systems (Waldram, Herring & Young, 2007; Aboriginal Healing Foundation, 2006). In the context of mental health, traditional Western perspectives generally define mental health as the absence of mental illness (Restoule, Hopkins, Robinson & Wiebe, 2015; Thomlison & Thomlison, 2011). Western biomedical models

of mental illness became the standard practice of intervention for Indigenous people seeking mental health support. While these Western concepts of mental health and treatment have benefitted some Aboriginal people, research generally indicated low rates of long-term success and consistency (Wesley-Esquimaux & Snowball, 2010; Thomlison & Thomlison, 2011).

By contrast, Indigenous perspectives conceptualize mental health more holistically and acknowledge that mental wellness is associated with a person's connection to language, land, beings of creation, ancestry, and community support (Fiedeldey-Van, Rowan, Dell, Mushquash, Hopkins, Fornssler, Hall & Shea, 2017). Mental wellness is achieved through individual efforts toward the attainment of balance and harmony in life and the fulfilment of personal potential. Therefore, in contrast to Western perspectives, Indigenous concepts of mental health imply more than an understanding of mental illness. They depend instead on an understanding of the inter-relatedness of various aspects of life and relationships (National Aboriginal Health Foundation, 2008). Sickness is thought to arise from disruption, or imbalance in these inter-related spheres (Aboriginal Healing Foundation, 2005; 2006; Waldram, Herring & Young, 2007; Cooke, 2005).

Scholars and Indigenous leaders have been advocating for the elimination of these destructive colonial and abusive patterns in public health. Researchers and governments have acknowledged that the poor state of Aboriginal mental health cannot be simply improved by Western interventions alone (Mental Health Commission of Canada, 2012). Instead, Indigenous concepts of wellness should be integrated into dominant biomedical models (National Aboriginal Health Organization, 2008; Smye & Browne, 2002; Wesley-Esquimaux & Snowball, 2010; Brascoupé & Waters, 2009).

Responding to this advocacy in the past decade, governments have acknowledged this history and the intergenerational impacts of colonization on the mental state of Aboriginal people in Canada (Mental Health Commission of Canada, 2012; Maar, 2004, Rice, 2005). Canada has made it a key priority in its mental health strategy to "establish a coordinated continuum of wellness services for and by Indigenous people, which includes traditional, cultural, and mainstream approaches" (Mental Health Commission of Canada, 2012).

Consistent with this federal priority, provincial and federal governments have actively endorsed the creation of new Aboriginal participatory structures and mechanisms within health authorities. Many Canadian mental health systems have reformed to work alongside government and *with* Aboriginal people in improving the health status of Aboriginal people (Smye & Browne, 2002; Marr, Marion, Shawnde & Marjory, 2010). The premise is the involvement of Aboriginal peoples and communities in health policy and programming will foster the development of a holistic wellness system that is responsive to the mental health needs of diverse Aboriginal communities across Canada (Mental Health Commission of Canada, 2012). These initiatives envision the reintegration of Aboriginal perspectives, worldviews and principles into a framework that addresses mental health.

Despite this conceptual progress, systemic barriers to improved mental health systems for Indigenous people remain. After centuries of colonial suppression of Aboriginal cultures, traditions and spirituality, traditional healing and wellness went underground. Assimilation practices such as the residential school system made it difficult for Aboriginal people to pass traditional knowledge on to subsequent generations and disrupted the education of traditional practitioners in many communities (Aboriginal Healing Foundation, 2005; 2006; Waldram, Herring & Young, 2007; Cooke, 2005). Knowledge of traditional healing became dormant in many communities. Thus, the revitalization of traditional practice in Aboriginal communities and organizations is a key element of any successful Indigenous mental health strategy.

At the same time, mainstream mental health services will continue to play an important role in the delivery of mental health care for Indigenous people. In order to achieve better outcomes for Aboriginal people, services have to become culturally competent and culturally safe. Research demonstrates that both cultural safety and cultural competence are necessary to successful service delivery (Brascoupé & Waters, 2009). In the context of mental health supports, this would require practices that acknowledge, honour and support the cultural identity of individuals and exclude the use of practices deemed culturally unsafe, viz. "actions that diminish, demean or disempower the cultural identity and well-being of an individual" (Cooney, 1994). In addition, mainstream services providers need to be aware of their own cultural perspectives and biases. Therefore, culturally safe mental health systems require providers to have an awareness

and knowledge of Aboriginal culture and history, cultural self-knowledge by non-Aboriginal service providers, and a mutual and respectful relationship that focuses not only on service delivery but also on the aspirations and broader well-being of a client (Boher & Regehr, 2006; Brascoupé & Waters, 2009; Smye & Browne, 2002).

Aboriginal service providers are key potential contributors to an improved mental health system. They may be knowledge holders with respect to traditional Indigenous practice; they may act as trainers in culturally safe and competent practice for mainstream providers; and they may be culturally competent and safe providers of services. However, Aboriginal service providers are also at significant risk of re-traumatization. As service provision often entails hearing the stories and witnessing the suffering of survivors of trauma, one could argue that Aboriginal persons face a higher risk of being triggered by a situation, an attitude or expression, or by a certain environmental situation that replicates the dynamic of trauma (MacCann & Pearlman, 1990; Sabin-Farrell & Turpin, 2003). To be effective, the service provider must understand the impacts of trauma, and also understand the fundamentals of trauma-informed practice to be able to support clients in a manner that avoids harm (re-traumatization) to the service provider while recognizing and acknowledging the impact and meaning that the trauma has to the client (Dunkley & Whelan, 2006; Furlonger & Taylor, 2013; Goodleaf & Gabrielle, 2009).

A concern for the mental wellness of Aboriginal service providers should therefore inform policy and practices of Aboriginal organizations with respect to both volunteers and staff; it also implicates mainstream service providers, who should be prepared to provide support to Aboriginal service providers in a manner that is culturally safe and competent.

PROJECT BACKGROUND

To deal with the ongoing crisis of missing and murdered Indigenous women, the New Brunswick Aboriginal Peoples Council (NBAPC) is spearheading a research and community action project titled *Looking Out For Each Other* (LOFEO) to enhance the collective understanding of cases involving missing and murdered Indigenous women, girls, and sexual and gender minorities in Eastern Canada. Under the leadership of President & Chief Wendy Wetteland and in

collaboration with Principal Investigator Dr. Jula Hughes (UNB Law), the project goal is to provide concrete and effective assistance to families and friends when an Indigenous person goes missing. The project intends for communities and organizations to have the resources to empower them to collaborate, access services, improve outcomes, and to address victimization and loss. In May of 2017, the Urban Aboriginal Knowledge Network Atlantic Research Centre funded the preliminary stages of the LOFEO project by providing the resources to conduct a capacity study (Urban Aboriginal Knowledge Network Atlantic Research Centre, 2018) at all participating urban Aboriginal Organizations. The objective of the capacity study was to determine how urban Aboriginal organizations can support families and friends of missing persons in practical ways, to identify what resources they require from the LOFEO project to do so, and to begin capacity building within Aboriginal partner organizations.

Findings from this research demonstrated there is an evident need for research and tool development at the community level to better enable Indigenous organizations to respond to the #MMIW crisis. Although not directly related to assisting families of missing Indigenous persons, many organizations expressed the need for mental health supports for service staff. Staff in Aboriginal organizations noted that there is a lack of culturally safe and appropriate mental health services for frontline service providers. More generally, many participants expressed that their jobs require a great deal of compassion. Without mental health supports and self-care strategies, their daily tasks present challenges. For instance, many voiced that they had experienced emotional distress resulting from assisting their members and clients.

> *… We don't have a big staff, so we are constantly involved in everything. We don't get a break, at times it can get hard. Our jobs put a lot of emotional stress on us… Our community really depends on us, so we need to have the best mindset we can have*. (Capacity study, 2018, pg.16)

> *… We need mental health support for our staff because we don't have the time or resources to know how to debrief effectively. We often run from one crisis to the next and we don't take time in between to self-care. We need the skills to know how to do it and be able to tell our staff why it's important. This is a work place, but the community sees us as a home. We need to have good mental health to do our jobs effectively.* (Capacity study, 2018, pg.17)

These employees also noted that there are mainstream services that are accessible in their areas. However, the services are not always appropriate and helpful.

> *Sometimes when we access mainstream services, professionals get lost in trying to understand the historic and systematic discrimination that Aboriginal people have faced. I think if there was a service that was already immersed in these facets and integrated within our understandings, accessing mental health services would be less of a nuisance and would be more valuable.* (Capacity study, 2018, pg.17)

Participants recommended that "*services that engage any forms of mental health support for Aboriginal populations should involve healing mechanism that are within Indigenous ways of knowing*". They stated culturally appropriate mental health services are "*greatly missing from our mental health services*".

The next step was then to develop a detailed research plan that would allow the LOFEO project researchers to advance the agenda set out for us by our community partners. The *Lifting Spirits* project was thus initiated to further explore the experiences of urban Aboriginal frontline service providers. As asserted by the Mental Health Commission of Canada (2012, pg. 15), in order to support healing from the intergenerational impacts of colonization, First Nations, Inuit, and Métis, need access to a full continuum of culturally safe mental health services, treatments and supports, delivered through a collaboration of mainstream and First Nations, Inuit, and Métis organizations. Cultural safety is grounded in Indigenous knowledge and experience. It is based on the recognition of cultural diversity among Aboriginal communities and individuals, and it recognizes the influence that social inequalities and imbalances of power have on relationships between the service provider and service user. Thus, by collaborating with frontline service providers who work within Aboriginal organizations, this project seeks to make grounded and specific recommendations for culturally supportive and safe options to respond to trauma, and to advocate for the importance of attentiveness to mental wellness and practices of self-care within Aboriginal organizations.

TERMS AND DEFINITIONS

For the purposes of this research study, the term *Aboriginal* is used to describe anyone who identifies as an Aboriginal person regardless of status, including people who are First

Nations, Innu, Inuit, and Métis. *Indigenous* is used synonymously with Aboriginal[1]. The term *urban Aboriginal community* is used to describe any local community of status and non-status Aboriginal people who reside off-reserve. The term *urban Aboriginal organization* is used to describe an Aboriginal-run organization that provides services to urban, off-reserve, and non-status Aboriginal Peoples including non-profits. The term *frontline service provider* is used to describe an employee of an urban Aboriginal organization who interacts directly and provides a service to an individual of the urban Aboriginal community.

METHODOLOGY

Participants

The participants consisted of 12 female and 3 male frontline service providers. The selection criteria required participants to be employed at an urban Aboriginal organization. They had to interact, and directly provide services to members of an urban Aboriginal community. Participants ranged in professional experience between 6 months to 13 years. Participants were recruited or referred to the researcher through pre-established partnerships in the context of the LOFEO project, and the Capacity study (UAKN Atlantic) conducted by the New Brunswick Aboriginal Peoples Council in May of 2017. These partnerships included organizations such as Under One Sky Friendship Centre (UOSFC), New Brunswick Aboriginal Peoples Council (NBAPC), HanMartin Associates, Gignoo Transition House, and the Native Council of Nova Scotia.

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[1] In this application, we use the terms "Indigenous" and "Aboriginal" interchangeably to collectively describe populations who assert Aboriginal rights under s. 35 of the Constitution Act, 1982 and the United Nations Declaration on the Rights of Indigenous Peoples, acknowledging that neither term may be the chosen terminology of the Wolastoqiyik (Maliseet), Mi'kmaq, Passamaquoddy, Inuit, Innu, Métis, Cree, Kanien:keha'ka (Mohawk), Anishinaabeg, Atikamekw, Wendat or non-territorial Indigenous Peoples living in Eastern Canada. In a similar vein, we use the term "sexual and gender minorities" to describe populations who may face discrimination based on grounds of gender, sexual orientation and/or gender identity, again acknowledging that this terminology may not coincide with how LGTBQ2S individuals may self-identify. We also note in particular that in Eastern Canada, Indigenous communities on and off reserve have varying traditional or current interpretations of two-spiritedness or may have no relationship to this notion at all.

Additionally, Skigin-Elnoog Housing Corporation and Turning Leaf Foundation were also invited to participate in the current study.

Data collection and Analysis

The project obtained ethics approval from the New Brunswick Aboriginal Peoples Council and the University of New Brunswick Research Ethics Board. From there, the research questions were developed in consultation with urban Aboriginal community members and the project Elder. The researcher used a conversational methodology to gather the information. The conversational method is a "*method of gathering knowledge based on oral story telling tradition that is congruent with an Indigenous paradigm*" (Kovach, 2010). Thus, frontline service providers were interviewed either in focus groups or individual interviews. Participants were provided with the interview questions prior to meeting with the researcher. All participants signed consent forms with a promise of anonymity, if requested. The researcher used audio recording when the participants consented and were comfortable with being recorded.

Participants were asked questions about their educational background and their role in the organization. They were asked a series of questions relating to clients who access their services. These questions pertained to whether they consider certain situations or referrals more stressful than others, whether or not these situations preoccupy their thoughts after work hours, whether or not the organizations have any strategies/resources to help their employees debrief, and whether they find current existing strategies/resources helpful. Finally, participants were asked to provide suggestions to promote and improve self-care in their organization and what resources they would like to have available to do so. (See appendix A for all questions).

Interviews underwent basic qualitative data analyses that included a thematic analysis. The thematic analysis included an examination of both the written notes taken during the interview and the transcriptions. All standards for data security were ensured through maintenance of files in secure filing cabinets and/or password protected file storage.

FINDINGS

The data gathered during the focus groups and individual interviews indicated a significant need for mental health supports for frontline service providers. The data derived from this research is broken down under three main headings: stress in the workplace, barriers and gaps of current mental health supports, and relevant mental health interventions that current frontline service providers consider supportive.

STRESS IN THE WORKPLACE

Many participants voiced an experience of distress as a result of supporting clients. *"I am an emotional person and I get very attached, so I have problems with separating from work. I try to make myself unavailable because I need to, so I try not to take my laptop home. I'm trying to recognize that I'm burning out. Some of my anxiety has come back in full force and I have not been dealing with it."* It was indicated that mental distress can affect work environments. *"We recently had a co-worker that struggled with burnout and it was difficult for everyone to watch. We know that burnout can happen, we have probably watched it happen many times and maybe not have known what it was. But recently, we saw it for sure and it was hard for everyone in the environment."*

Many of the participants had commonalities in what were considered stressors in the workplaces. They identified several areas of stress in the workplace related to: a) a feeling of being underqualified despite having high qualification, b) having an overbearing feeling of responsibility, c) frustrations with outreach services, and d) feeling unsupported by workplace mental health supports.

The Feeling of Being Underqualified Despite Having High Qualifications

Numerous participants identified a sense of stress with having to support clients who were low income, single parents, had addictions to drugs and alcohol, offenders with high-risk of re-offending, and were illiterate. *"A lot of our clients are dealing with addictions, which often stems from mental illness. These issues often go unnoticed because we are not trained to know if*

they are using narcotics or are having deeper mental health issues". Although 11 participants had received a college diploma or a university degree, the majority expressed that their educational experience did not prepare them to deal with the high acuity needs of the clients. *"I do not have any training on addictions, domestic violence, and mental health and unfortunately I learn a lot through my experiences with clients. Although my background is in business and that can directly assist my job, I find myself dealing more and more with addictions and domestic abuse. When clients come in to access our service, it's hard to initially to gauge where they are in terms what they really need. They may need housing, but we are also dealing with their addictions and mental health in the larger picture. It's very stressful to be in that kind of position when you don't really know how to fully help them with ALL their needs".*

Having an Overbearing Feeling of Responsibility

Many participants felt that their clients had put a lot of trust and responsibility in their ability to successful support their needs. This was often met with an overbearing feeling of responsibility and stress. *"I think the amount of trust that our clients put on us is stressful. We are supposed to be referring these clients to people and if the client comes back to us, you know the referral wasn't successful. You take that on. I have a lot of fear that my referrals won't be successful, and at the end of the day that is not my fault, but it's extremely hard because you want the best for your clients."* For some participants, the inability to successfully support the needs of their clients was also met with guilt. *"I often have a hard time calling in for work because I feel like I need to be here. My clients put so much trust in me. If I am not there, I feel like I am letting them down."* As a result, participants indicated that they often felt the need to perform tasks that were outside their job description in order to successfully support their clients. *"There is only so much you can do and sometimes you feel like a client's needs are not being met. You almost feel like you need to take on a larger role. At the end of the day you can't always go above and beyond because you are just the referral. That is stressful."*

Frustrations with Outreach Services

Participants identified that dealing with outreach services was often a negative experience resulting in frustrations and stress. Participants felt many outreach services were not culturally sensitive to the history of Aboriginal people. *"I am constantly running into road blocks with government departments while trying to find housing for my clients. For instance, I always have jurisdictional battles when it comes to getting support for Aboriginal people who live off-reserve. You know a lot of people are ignorant towards our clients because they don't understand what it means to live off-reserve and have to support 3 children. There is still a lot of discrimination. They get $536 a month and they are told to find an apartment. Obviously, that's just not going to happen in this urban city, so they go back or a rooming house or they become homeless. It's an endless cycle."*

Feeling Unsupported by Workplace Metal Health Supports

Participants felt that there were insufficient mechanisms in the workplace to support their mental health needs. *"Sometimes you only have enough mental energy to get through your day at work and the crises that you face there. We don't feel like there is really any time to debrief, we just go from one thing to the next. There are no breaks and I think we need mental breaks"*

Participants who had existing employer benefits that would support their mental health needs identified that these benefits were difficult to navigate. *"I know we have employer assistance programs, but I have no idea what it does for me. No one came to explain to us how it works. We don't know how or where to access it or how many times we can use it. It's confusing and it would be nice if someone came and explained those details to us."*

One of the most concerning findings was that all 15 participants stated that there were no formal debriefing protocols in their workplaces. *"When it comes to debriefing, we are left to that by ourselves. It is no one's job to check in with staff when things get stressful. We voice when we need to debrief when something happens or when we need it. We mostly just stick to our office friends, or family to debrief with."*

Participants voiced that it should be a priority for employers to support their staff's mental health needs. These participants felt that there was a stigma associated with needing mental health supports and engaging in self-care. *"I don't think people are really comfortable talking about mental health in this workplace. We don't have those discussions and to me it seems like those conversations are wanted to be left out of this workplace. I think I would feel uncomfortable leaving my work during regular hours to access a professional mental health service… I feel like these things are important and I shouldn't feel like it is such a burden to have a positive relationship with my mental health. Especially if it stems from my job."*

On a more positive note, it was common across all workplaces involved in this study that participants sought the help of their co-workers for support when high-stress situations arose. *"We are all very close. That's one thing about working in a small office. I consider my co-workers to be my sisters and my brothers and I always have them to pick me up when I am down… We have some staff who have been in this line of work for a long time, so they are wise, I guess. They help us a lot and teach us some valuable lessons. That's another benefit of having a small staff, you always know when someone is off, and you can pick them up when they need it."*

GAPS AND BARRIERS IN MENTAL HEALTH SUPPORTS AVAILABLE FOR ABORIGINAL SERVICE PROVIDERS

Participants indicated that there were gaps and barriers in current mental health supports. These gaps were: a) the unavailability of employer-sponsored benefit supports, b) the absence of in-house policies surrounding mental health, and c) a lack of cultural awareness in mainstream supports.

No Employer Benefit Supports

Participants indicated that there were limited options that would support their mental health needs provided by their employer. This was mainly expressed by participants who were employed by not-for-profit organizations. *"I work for a non-profit and it seems there are limited options for employer benefit assistance programs or counseling programs. Our employer does not offer any benefit packages at all. It's unfortunate because we get traumatized on a daily basis*

and we have no way to deal with this. It's inevitable that we burn out." Participants acknowledged that the majority of benefit plans available for not-for-profit organizations were unaffordable for their employer. *"The benefit plans that are available for us are too expensive… Whether it be a small business or not-for-profit, there should be some benefit where the government can cover the costs, or at least a portion of it to make it affordable. You shouldn't have to be a large successful company or make a lot of money to have access to professional mental health support."*

Absence of In-House Policies Surrounding Mental Health

Participants indicated that there were no in-house policies surrounding mental health in their employer organization. *"I feel like there should be in-house policies surrounding mental health and wellness. It should be mandatory. We keep telling our clients the importance of accessing their culture and the importance of wellness, but we never practice what we preach. We smudge but that is the only piece of wellness we get on a weekly basis. I would like to do more such as have the opportunity to do a sharing circle, go to a sweat, do community stuff together. We are a community in this office and we should be doing things that bring us all together and heal each other when we are down."*

Lack of Cultural Awareness in Mainstream Supports

Participants were unanimously concerned with the lack of cultural awareness they experienced when accessing mainstream mental health supports. Specifically, participants spoke about their experiences with professionals who lacked knowledge of Aboriginal culture and history. *"There is just no cultural awareness in our mental health system. And that is both stressful and depressing. At this point you are up against a system, so it doesn't really matter what these professionals think about our mental health problems, ultimately, they are governed by a structure, a settler one. When we try to talk something in the program that might not work for Aboriginal people, we are left to educate the professional why. This is not the reason why we are seeking help from a professional. It shouldn't be my job to do that."*

Additionally, participants voiced the need to include culturally sensitive interventions within mainstream mental health interventions. Participant indicated that if the professional had

known about their Aboriginal culture and history, that it would have removed a level of stress. *"Having a professional know and understand my background would instantly remove one level of stress. I feel like I always have to justify why I'm feeling a certain way. It would just be nice to have someone understand how being Aboriginal could relate to a certain stressor without having to explain my background. For instance, being able to understand my choices based on the choices of my ancestors. I wish I could talk about these things with a professional as easy as it is to talk to my Elder. I just feel like they don't want to focus on these things because they are scared to offend me or say the wrong thing culturally. But these are the things I want to be focusing on, they are important to me, my wellness and my culture."*

Participants voiced that they would have felt more comfortable seeking support if the professional was Indigenous. *"Ideally, I think that in order for us and other Aboriginal people to talk about their issues it would makes more sense for us to talk to people like us. It saves a lot of explaining time. We know our degrees of awareness and we can provide a safe and sensitive environment for one another to talk about our mental health needs. It's hard to feel comfortable talking about those things to someone who can't relate at all."*

MENTAL HEALTH INTERVENTIONS CONSIDERED TO BE SUPPORTIVE

Participants identified resources and supports, they considered useful and supportive when they experienced stress in the workplace. There were: a) starting open and supportive dialogues about mental wellness; b) creating in-house debriefing mechanisms; and c) connecting mental wellness with culture.

Starting Open and Supportive Dialogues About Mental Wellness

Participants indicated that they wanted to start open dialogues, where mental wellness could be freely and positively discussed throughout the workplace. *"I think we need more mental health resources in our establishment. Specifically, ones that are related to burnout and vicarious*

trauma. They should be Aboriginal friendly of course." Participants were very optimistic about ways that they could integrate these conversations throughout the workplace. *"I think it needs to be a frequent agenda item of staff meetings and we could even have a self-care day, even having one day a year dedicated to wellness."*

Creating and Using Debriefing Mechanisms

Participants were willing to learn about effective debriefing mechanisms that could be practiced and incorporated in the workplace. *"I think could all use some training on how to debrief or at least assign a designate to be the person to check in. If any sort of incident would occur, we have no trauma training. How do we help people and how should we help ourselves should be questions we know the answers too? People get triggered so easily in this line of work and we should be able to help one another."*

Connecting Mental Wellness with Culture

Participants felt that it was deeply important to integrate all forms of mental health support with Aboriginal culture. *"We need to be connecting self-care with some kind of cultural activity. Basket making for example could be a way to turn an extremely stressful situation into a cultural teaching which could make a sensitive topic a little less daunting. I would also want to get out on the land. That's who we are. I don't think these things are valued within mainstream supports but are extremely important to our healing process.". "It's important to be open about what we know about our culture and what we don't know. Some people don't know much because they never had the opportunity to learn. We are all at different stages in our learning journey and I think it's important to not be ashamed of that. Knowledge is not competition and we need to be open to sharing everything."*

DISCUSSION AND IMPLICATIONS

The current mandate of health care related sectors is to strategically and profoundly change the way healthcare is delivered to Aboriginal people by growing cultural safety and competence in services. It has been suggested that this reversal of current practices that create

cultural danger or peril, where individuals and communities are put at risk or in crisis, would extend political power to Aboriginal people (Smye & Browne, 2002; Wesley-Esquimaux & Snowball, 2010; Brascoupé & Waters, 2009). In turn, this would result in more successful and effective interventions that would support the wellness of Aboriginal people. However, the results of the present research suggest that Aboriginal people are still experiencing disparities and inequities relating to the accessibility of culturally safe and competent mental health care. Destructive and colonial patterns still appear to be present in systems of care.

It is clear from the findings of this study that appropriate mental health supports are needed to support service providers in Aboriginal organizations. Current Aboriginal service providers are working in and for a community where they have personal relationships with family and friends whose life patterns are often similar to their own. Participants in this study voiced that this often resulted in experiences of anxiety, stress, depression and trauma. This phenomenon is well documented in the literature as vicarious trauma. The same literature indicates that the effects of vicarious trauma are serious, cumulative and permanent. They contribute to a lack of mental wellbeing and to burnout. It is therefore important that service providers avoid vicarious trauma or manage its effects in order to be well and to avoid burnout (Sabin-Farrell & Turpin, 2003; Goodleaf & Gabrielle, 2009).

To support the needs of staff working on the frontlines, it is recommended that organizations consider incorporating mental health supports into their policies and procedures. The majority of stressors identified by participants tended to relate to the feeling of being unsupported in workplace environments. For instance, a common concern in this study was a sense of stress related to being unable to adequately support the complex and varied needs of clients. Relevant literature to service provision indicates, when staff lack a basic understanding of certain approaches to service delivery, this may exacerbate vulnerabilities and triggers of trauma survivors. It can foster an environment where there are increased risks of traumatization (Dunkley & Whelan, 2006; Furlonger & Taylor, 2013). Organizations should acknowledge the fact that providing service is work that involves trauma-related risks, and thus the risk of vicarious trauma and re-traumatization becomes high. Despite the related costs, it is important for organizations to invest in coordinated systems that are client-centered, trauma-informed, and

culturally competent to minimize this risk. It is important for organizations to account for the human and economic cost of failing to provide these supports, including high staff turnover rates. Sustainable modes of providing staff and volunteers with mental health supports, needs to be identified as part of the organization's mandate. This may include the provision of employee mental health support benefits and the creation of in-house policies and practices.

On a larger scale and responding to the systemic context, it would be important that current mental health care providers become aware of and educated in Aboriginal history and culture, including the systemic effects of colonization. It was clear from the experiences of participants, there is a lack of cultural competence and safety currently integrated into interventions in the mainstream system. Our findings confirm that of previous studies, the inability to recognize the contemporary conditions of Aboriginal people resulting from their post-contact history may result in poor care outcomes. Non-Aboriginal service providers continue to have less than ideal outcomes for their clients because they lack the cultural competency to strengthen the capacity of Aboriginal communities to resist stressors and build resilience (Restoule, Hopkins, Robinson & Wiebe, 2015; Thomlison & Thomlison, 2011). This suggests there is more work to be done and that Western models of mental health are still being treated as the dominant practice of interventions for Aboriginal people.

The failure to consider the history and long-term impacts of domination and cultural genocide is of grave concern. Without a developed sense of Aboriginal worldviews, the attempt to create appropriate mental health interventions will only continue to enforce destructive patterns of colonization. Participants in this study had common experiences where their mental health problems, such as stress, anxiety, trauma, and depression, were thought of as individual issues rather than responses to the historic and intergenerational trauma consequent to systematic racism, policies of assimilation, and cultural genocide. These experiences of care are reflective of Western biomedical medical models (Thomlison & Thomlison, 2011). It would, therefore, seem that mental <u>illness</u> is still being thought to arise from individual pathology, dysfunction, and life-style choices; rather than focusing on mental <u>wellness</u>, which is a holistic term that involves the recognition of the social determinants of health as key components (Reime, Kirkham & Anderson, 2002; Wesley-Esquimaux & Snowball, 2010; Waldram, Herring &

Young, 2007). Gains in mental wellness can only be made by going beyond classification-based care focused of an individualized understanding of pathology and must include an understanding the pathology in society. Aboriginal people may differ in what they consider an appropriate approach to attain wellness. As indicated by participants, mainstream services should actively seek out cultural expertise when developing psychosocial programs to assist Indigenous populations.

It is recommended that mainstream services work more closely with Indigenous organizations, community members and Elders to ensure the integration of Indigenous concepts of wellness into the mainstream healing process and the development of culturally appropriate methods of care. In essence, the challenge for governments and health care systems is to understand the systemic origins of crisis situations and to develop responses that resist superficial and individualizing models of care in favor of deeper engagement with Aboriginal history and culture. In order to bring concepts of safety and competence into service delivery to Aboriginal people, one must consider how these concepts affects relationships, power structures and trust (Brascoupé & Waters, 2009). In any event, a developed sensitivity to the culturally appropriate needs for ceremony, for privacy, and personal needs in responding to distress and trauma, should always be paramount.

CONCLUSION

In conclusion, this research sought to shed light on the challenges faced by Aboriginal front line service providers and document their experiences in the hopes of providing grounded and specific recommendations for improved support structures with the ultimate goal of restoring a sense balance and wellbeing for these workers. This research gives a voice to workers facing extremely difficult working conditions resulting from the realities of serving clients with complex and varied needs on the frontline. We seek to honour them for their extraordinary service in our communities and to encourage policy makers and government to build a compassionate support system for frontline workers. Our work confirms that there is a great need to better support these workers. Research has shown the benefits and effectiveness of

incorporating traditional concepts of wellness into interventions for Aboriginal people. The reasons for these better outcomes remain imperfectly understood and more research on this is urgently needed. Yet, we do not need to wait for the outcomes of this research to begin carefully integrating holistic concepts of mental wellness into mainstream systems of care. We need to act now and provide culturally safe supports for the mental wellness of frontline workers, to realize the potential for profound positive impacts on the mental health of Aboriginal people, families and communities.

RECOMMENDATIONS

Aboriginal organizations are providing invaluable services to a growing population of Aboriginal people within Atlantic Canada. Barriers to appropriate mental health care must be addressed using holistic and long-term approaches in order to support their dedication and unwavering efforts. Without a meaningful and adequate commitment to addressing these barriers, programs designed to respond to the mental health needs of Indigenous people will be underused and less effective. It is the hope of the authors that Aboriginal organizations and policy makers will act on the following recommendations.

RECOMMENDATIONS

The author recommends

1. THAT Aboriginal organizations build infrastructure to support frontline service providers becoming trauma-informed practitioners;
2. THAT Aboriginal organizations acknowledge that providing service is work that involves trauma-related risks, and thus the risks of vicarious trauma and re-traumatization become high;
3. THAT Aboriginal organizations invest in coordinated systems that are client-centered, trauma-informed, and culturally sensitive to minimize the dual risks of vicarious trauma and re-traumatization;
4. THAT Aboriginal organizations develop sustainable modes of providing staff and volunteer mental health supports as part of the organizational mandate. These supports

may include the provision of employee mental support benefits and the creation of in-house policies and practices;

5. THAT mental health care providers become aware of and educated in Aboriginal history and culture, including the systemic effects of colonization. Western models of mental health should not be treated as the only mode of interventions for Aboriginal people;

6. THAT mainstream health services work more closely with Aboriginal organizations, community members and Elders to ensure the integration of Indigenous concepts of wellness into the mainstream healing process and the development of culturally appropriate methods of care.

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APPENDIX A.

Guiding Interview Questions

Part 1

1. Tell me about what brought you to the work you are doing in this organization?
2. Can you tell me about your background and your role in the organization?
3. How many years have you been working here?
4. Are you part or a larger team or do you work individually?

Part 2

1. Can you tell me a bit about your clients?
2. What kinds of needs do you see in the clients that you serve?
3. Would you consider your job stressful?
4. Are there particular situations or issues that are above average stressful?
5. Do you think that stress can affect your day at work? How?
6. Do you feel like you take your work home with you?
7. What do you do to transition from work to home?
8. Do you have any strategies to self-care or to debrief?
9. Is there anything the organization does in informal or formal ways to promote self-care?
10. Is it anyone's job to check in with staff when high stress situations arise?
11. Are you finding these support/strategies are helpful?
12. Does your employer have an Employee Assistance Plan or extended health plan that covers counselling or similar services?
13. Do you think that there are any cultural barriers within the available services to you?
14. When accessing these services have you ever felt that factors such as identity, class, sexual orientation, religion or any other dimensions have affected your experience?

Part 3

1. What do you think could be added for this organization to promote self-care?
2. What would you like to see in this organization to promote self-care?
3. Are there any kinds of information you need that you would like to have access to?
4. How do you envision self-care within this organization?