THE WELLBEING OF FIRST NATIONS CHILDREN: AN EXPLORATION OF INDICATORS AND EVALUATION OF A NEW MEASURE

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Abstract

The purpose of this project was to create, implement, and evaluate a tool designed to measure the wellbeing of First Nations children in the Robinson Superior Treaty Area. This project followed a community-based participatory research approach and was overseen by a research advisory made up of employees from the partner organization. Interviews were conducted with community members in the Robinson Superior Treaty Area and analyzed to identify indicators of wellbeing for children. This analysis was utilized to generate items for a pilot version of the measure. This pilot version was administered by two mental health intake workers to the parents and caregivers of 91 children who were seen through intake for service at Dilico Anishinabek Family Care, along with the Child and Adolescent Needs and Strengths measure (Lyons et al. 2003). Following piloting, interview with the mental health intake workers, and measure refinement, a principal component analysis was conducted and three factors emerged: General Wellbeing, Traditional Activities, and Social Engagement. This measure represents one of few created and validated for use specifically with a First Nations population and aligns with the literature regarding the importance of engagement in traditional activities and understanding of culture for the wellbeing of Indigenous people.

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CHAPTER 1. INTRODUCTION

"Wellbeing" is a term that appears often in psychological literature and, while definitions often include a combination of objective and subjective indicators, the term remains ambiguous and lacks an operational definition (Exenberger & Juen, 2014a). "Wellbeing" is also a culturally-bound notion as certain attributes aid an individual in succeeding within their culture and context, while other attributes are less helpful (Exenberger & Juen, 2014b). For this reason, definitions of wellbeing that exist within majority culture may not correspond to definitions in other cultures or contexts.

Conceptualizations of wellbeing within Indigenous cultures are often more holistic and incorporate relationships with nature and the spiritual in addition to what might be considered majority culture indicators such as education and access to healthcare (Canadian Institute for Health Information, 2009). The wellbeing of children is also a unique construct and many current measures of wellbeing do not accurately capture this notion as they are focused on family dynamics or outcomes in adolescence and adulthood as opposed to the child's current functioning (Amerijckx & Humblet, 2014; Ben-Arieh, 2007). Few researchers have examined the unique factors that contribute to the wellbeing of Indigenous children from the perspective of Aboriginal peoples. Thus, the current methods by which Indigenous child wellbeing is measured is, at best, inaccurate and, at worst, limited and unhelpful.

Aboriginal People in Canada

Aboriginal people represent 4.9% of the total population of Canada (1 673 785 people) and this proportion is growing; between 2006 and 2016, the Aboriginal population of Canada increased by 42.5%, compared to less than 10% in the non-Aboriginal population (Statistics Canada, 2018). First Nations people are the largest group of Aboriginal people in Canada,

accounting for 58% of the total Aboriginal population, followed by Métis people (35%) and Inuit people (3.9%; Statistics Canada, 2017a). These three groups represent significant diversity of histories, traditions, cultures, and contexts.

The Aboriginal population of Canada is also relatively young. A higher fertility rate in this population compared to the non-Aboriginal population, has resulted in 29.2% of the total Aboriginal population being age 14 and under (Statistics Canada, 2017a). Aboriginal children between 0 and 4 compose 8.7% of the total Aboriginal population, compared to 3.5% of majority culture children, while adults over the age of 65 account for only 7.3% of the Aboriginal population, compared to 16.3%% of the non-Aboriginal population of the country (Statistics Canada, 2017b). Given these statistics and the growing number of Aboriginal children living in Canada, it is important to ensure that the health and wellbeing of this group is well understood.

Children in Aboriginal Cultures

The structure of the Aboriginal family often extends farther to other family and community members than in majority culture where the term "family" usually refers to a mother, a father, and their children (Mandell, Clouston, Carlson, Fine, & Blackstock, 2006; McShane & Hastings, 2004). In Aboriginal communities, the term "family" can include all those who are involved in the care of the child (McShane & Hastings, 2004). In many Aboriginal cultures, children are considered to be gifts from the spirit world and, therefore, their development is dictated by the Creator; parents and other adults are not to control a child's development, but instead support that development and provide the context for the child to grow into the person they are destined to be (Neckoway, Brownlee, & Castellan, 2007). Many Aboriginal individuals believe that all people, including children, "have the right to travel their independent paths with a sense of security to discover that path without interference" (Greenwood, 2005, p. 554). This

perspective may lead to a parenting style in which fewer expectations are placed upon the child and there is less intrusion in the child's life. Aboriginal children are encouraged to learn by making their own mistakes, as well as regulating their own sleeping and feeding schedules from a younger age than in majority culture; from a Western perspective, this style of parenting may appear neglectful (Mandell et al., 2006).

Mental Health of Aboriginal People in Canada

The World Health Organization (2014) defines mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (para. 1). Rates of mental health difficulties in First Nations communities are significantly higher than the general population, which can be partially attributed to historical factors such as colonialism and assimilation policies (King, Smith, & Gracey, 2009). The suicide rate in First Nations communities is also, on average, approximately 5 to 7 times greater than the general population, however this rate varies greatly from community to community (Kielland & Simeone, 2014). While one-third of the Canadian population reports moderate to high levels of psychological distress, the rate increases to nearly half of First Nations peoples living on-reserve (First Nations Information Governance Centre [FNIGC], 2012). There is also a high rate of addiction amongst Aboriginal peoples in Canada, which has been ascribed to a heightened level of social stressors such as poverty, racism, unemployment, and insecurity regarding family and residence, as well as other adverse childhood experiences (King et al., 2009). Unfortunately, these mental health challenges are present across the lifespan; for example, First Nations youth are at an increased risk of experiencing mental health difficulties compared to youth of majority Canadian culture (Snowshoe, Crooks, Tremblay, Craig, & Hinson, 2015).

The mental health care system in Canada is situated within a Western paradigm, which can create issues for First Nations peoples. If clinicians approach mental health care in First Nations communities from a solely Western perspective, care likely does not fully capture the local definitions and conceptualizations of health or wellbeing and is therefore conceptually and epistemologically incongruent. A flexible approach to mental health care that can accommodate each client's unique worldview, while maintaining evidence-based practice, is generally recommended, but often not utilized by clinicians (Vukic, Gregory, Martin-Misener, & Etowa, 2011). This effort to incorporate a client's worldview and provide access to Indigenous methods of healing can be viewed as a decolonizing process in and of itself (Nelson & Wilson, 2017).

Social Determinants of Health

Health disparities are multi-determined, but can result from the individual-level manifestations of inequities in social, political, and economic domains (Adelson, 2005). The origins of these inequities are sometimes misattributed to Aboriginal peoples themselves, but lie in the relationship between Aboriginal communities and the broader Canadian government and society, the autonomy the government has denied these communities, and colonialism evident through forced relocations and placement of children in residential schools and with foster families (Adelson, 2005). Many of the inequalities that First Nations individuals experience, including health inequalities, originate in childhood and approximately one in three First Nations children have been identified as having one or more illnesses by a professional (FNIGC, 2012; Greenwood & de Leeuw, 2012). The unique factors that influence the health of Aboriginal children and contribute to inequity include the ongoing impacts of colonization and discrimination, cultural disruption that has contributed to a weakened sense of identity and

belonging, as well as exposure to adverse childhood experiences (Kielland & Simeone, 2014; Williamson et al., 2014).

Social determinants of health refer to a broad range of systems, environments, and structures that individuals experience that shape health and wellbeing (Reading & Wien, 2013). They are typically organized into distal (e.g., contextual factors), intermediate (e.g., resources, systems), and proximal (e.g., individual behaviours; Reading & Wien, 2013). Proximal determinants exert a direct influence on the individual and include factors, such as overcrowding, family violence, and health behaviours (Reading & Wien, 2013). Intermediate determinants of health are often the source of the proximal determinants, for example, lack of access to health care and public health education resulting in negative health behaviours such as smoking and substance use (Reading & Wien, 2013). Distal determinants exert the greatest influence on health and are the constructs that create both proximal and intermediate determinants (Reading & Wien, 2013). Colonialism, racism, and lack of self-determination are all distal determinants that contribute to the poor health individuals in many Aboriginal communities experience (Reading & Wien, 2013).

Since contact, the settlers and Canadian government have been attempting to assimilate the Aboriginal peoples of Canada. This has resulted in a loss of autonomy, damage to the crucial relationship between Aboriginal peoples and the land, and sudden marginalization (King et al., 2009; Reading & Wien, 2013). Colonialism and the associated consequences, including racism, are fixed in Canadian society and can be considered Aboriginal-specific determinants of health (Greenwood & de Leeuw, 2012). Despite the fact that these are considered to be shared experiences amongst Aboriginal people in Canada, these determinants of health exert differing effects within communities (Reading & Wien, 2013). Nelson and Wilson (2017) provided a

critical review of the research on the mental health of Indigenous peoples in Canada thus far and concluded that colonialism is often conceptualized at the individual level instead of being understood as a factor that interacts with class, race, and gender to lead to a variety of outcomes. Thus, it is important to acknowledge that while colonialism impacts all Indigenous peoples, the way in which this framework does so can vary considerably within communities and individuals (Nelson & Wilson, 2017). There are several social determinants that have been shown to impact the health of Indigenous peoples in Canada: racism and social exclusion, education, employment and income, housing, language, and residential schools.

Racism and social exclusion. Aboriginal individuals in Canada have experienced racism and social exclusion since the time of first contact, which has a negative influence on health and wellbeing. Social exclusion bars Aboriginal people from fully participating in and benefiting from national social policies and the economy, resulting in disproportionate exposure to harmful determinants of health and increased negative health outcomes (Reading & Wien, 2013). At an individual level, racism and social exclusion may deter or prevent Aboriginal people from pursuing higher education, which limits employment opportunities and income, increasing an individual's likelihood of experiencing poverty (Reading & Wien, 2013). Nearly 40% of Aboriginal adults report experiencing racism within the last 12 months and 27% of those perceive these experiences as having at least some effect on their self-esteem (Reading & Wien, 2013). The negative effect of social exclusion on mental health is not unique to adults; Aboriginal youth report that following an experience of social exclusion, their substance use increases (Mignone & O'Neil, 2005).

Education. First Nations people living on-reserve are less likely to graduate from high school by age 20 (36% vs. 84.6%) and obtain a post-secondary education than the general

population of Canada (22.7% vs. 5.1%; Canadian Institute for Health Information [CIHI], 2009). While 22.5% of the Canadian population does not complete high school, almost half (48.6%) of the First Nations population does not (CIHI, 2009). An increased level of education can enhance employment opportunities, income, and housing available to an individual and improve health and wellbeing as a result (Reading & Wien, 2013).

Employment and income. A high level of employment is an indicator of a healthy economy and society (CIHI, 2009). The rate of First Nations peoples living on-reserve who are unemployed, but looking for employment, is four times higher than the national rate (27.7% vs. 7.3%; CIHI, 2009). For those who are able to obtain employment, the average income is considerably lower than the Canadian average ($10,631 vs. $22,274; CIHI, 2009). This effect is amplified for First Nations women; while the income of employed women in the general population is typically lower than men employed in the same position, women who are employed on-reserve are paid nearly 60% less than the average Canadian woman (CIHI, 2009). Employment and income arguably contribute most directly to an individual's likelihood of experiencing poverty and low socioeconomic status and is related to: food insecurity; obesity and diabetes; criminal activities; and poor mental health outcomes, often manifested as symptoms of anxiety and depression (Galabuzi, 2004; Iwasaki, Bartlett, & O'Neil, 2004; Reading & Wien, 2013).

Housing. The living conditions of Aboriginal peoples in Canada are often described as "Third World" (Adelson et al., 2005). Housing represents a serious issue in First Nations communities and plays a large role in many of the deleterious health outcomes that individuals experience. The number of on-reserve households that rate below adequacy standards set by the Canada Mortgage and Housing Corporation (i.e., not requiring major repairs) is in excess of ten

times that of Canada as a whole (22.4% vs. 2%; CIHI, 2009). Overcrowding is also an issue for First Nations individuals; the amount of on-reserve dwellings that fall below the suitability standards and do not have the appropriate number of bedrooms for residents is five times greater than that of off-reserve dwellings (CIHI, 2009). Overcrowding contributes to a variety of adverse health outcomes including facilitating the spread infectious diseases and general stress across the lifespan (CIHI, 2009; Reading & Wien, 2013). Access to water and sanitation services is also crucial to health, particularly in preventing the transmission of disease, however one-quarter of the Aboriginal people in Canada do not have adequate water service and one-fifth do not have access to adequate sanitation services (CIHI, 2009).

Language. Speaking and/or understanding one's language is an important aspect of Aboriginal identity and has also been suggested as a social determinant of health (Greenwood & de Leeuw, 2012). Despite this, less than 50% of those living on-reserve report an Aboriginal language as their first language (CIHI, 2009). Hallett, Chandler, and Lalonde (2007) demonstrated that the rate of youth suicide was higher in communities where less than 50% of the residents spoke a traditional language. Unfortunately, many First Nations languages do not currently have a population of speakers great enough to ensure transfer, despite language being identified as an important component of culture (CIHI, 2009). Language is also the method by which a shared worldview is constructed and oral traditions are maintained (Battiste, 1998; Hallett et al., 2007). Drawson, Mushquash, and Mushquash (2017a) analyzed publicly available data from Statistics Canada and the Indian and Northern Affairs Canada (INAC) websites to demonstrate difficulties that arise when simple linear models are applied to complex phenomena. While they initially showed that speaking a traditional language was related to lower community wellbeing scores, they further demonstrated that by including a variable called Zone (i.e.,

location in relation to nearest major city) as a covariate, remoteness accounted for the reduction in community wellbeing scores, and not traditional language (Drawson et al., 2017a). The confound lay in the fact that there was a high correlation between Zone and traditional language, such that as a community became more remote, more of its residents spoke a traditional language (Drawson et al., 2017a).

Residential schools. From 1879 to 1986 the Canadian government and several religious institutions operated residential schools across the country. The purpose of these schools was to "kill the Indian in the child" (Royal Commission on Aboriginal Peoples [RCAP], 1996) by isolating children from their families and culture, thereby forcing assimilation. Many of the individuals who spent time at these schools were left unable to speak their traditional languages or participate in cultural activities, but also were not viewed as equal by the non-Aboriginal population, leaving them marginalized (Kielland & Simeone, 2014). The residential schools era was relatively recent and continues to be an important part of the narrative of Aboriginal people living in Canada. Nearly 50% of the respondents to the First Nations Regional and Longitudinal Health Survey who are over 50 years of age are residential school survivors and almost half (47.3%) of these survivors report that their experience negatively affected their health and wellbeing; the majority of survivors reported experiencing isolation from family (81.3%) and loss of cultural identity (76.3%) as a result of their attendance (FNIGC, 2005).

The residential school experience in Canada is intergenerational and continues to exert a negative influence over family members of those who attended (Evans-Campbell, 2008) – 43% of second generation survivors (i.e., children of residential school survivors) report that their parents' attendance had a negative influence on their parenting ability (FNIGC, 2005). Second generation survivors report greater symptoms of depression, which possibly originate from a

heightened sensitivity to trauma and adversity in both childhood and adulthood (Bombay, Matheson, & Anisman, 2011). There is also a cumulative effect of residential school attendance such that third generation survivors (i.e., both a parent and grandparent attended residential school, but the individual did not) have poorer psychological wellbeing than second generation survivors (Bombay, Matheson, & Anisman, 2014).

Wellbeing

The concept of wellbeing evolved from the Greek theories of hedonism and eudaimonia. Hedonism postulates that happiness, which is the sum of one's pleasurable experiences, constitutes wellbeing. This is also known as subjective wellbeing. Eudaimonia refers to achieving the highest possible state of human goodness and falls into the domain of objective wellbeing. Objective wellbeing examines community-level factors such as income, housing, access to health care, and leisure time, while subjective wellbeing centers on internal feelings such as satisfaction (Huebner, 2004). Objective indicators of wellbeing can be observed and measured by an outsider, while subjective indicators of wellbeing require that the individual report on their feelings, attitudes, or preferences in a certain domain (Exenberger & Juen, 2014a). It seems natural that objective and subjective wellbeing would be related, but this is not the case; instead, there is only a small relationship between the two domains, suggesting that objective and subjective wellbeing represent two unique constructs (Huebner, 2004). Despite this, current conceptualizations of wellbeing often incorporate aspects of both these domains (Exenberger & Juen, 2014a).

In modern psychology, wellbeing is often categorized into subjective wellbeing and psychological wellbeing (Linley, Maltby, Wood, Osbourne, & Hurling, 2009). Subjective wellbeing refers to life satisfaction, as well as our experience of positive and negative emotions,

while psychological wellbeing is conceptualized as how well one is able to function in their environment and is measured according to six key domains: self-acceptance, purpose in life, personal growth, environmental mastery, positive relations with others, and autonomy (Linley et al., 2009; Ryff, 1989).

Wellbeing of children. There are several motives for measuring the wellbeing of children that are outlined in the literature: gaining public attention, describing society, creating measurable outcomes, conducting outcome-based measurement, monitoring of children, and program evaluation (Exenberger & Juen, 2014c). Regardless of the motivation, Exenberger and Juen (2014a) argue that the wellbeing of children is a combination of indicators of both objective wellbeing and subjective wellbeing (life satisfaction) and resilience, and how these three domains interact (Exenberger & Juen, 2014a).

Resilience is a term that appears often in the literature regarding children's wellbeing and is defined as "…both the capacity of individuals to navigate their way to the psychological, social, cultural, and physical resources that sustain their well-being, and their capacity individually and collectively to negotiate for these resources to be provided in culturally meaningful ways" within the experience of adversity (Snowshoe et al., 2015; Ungar, 2008, p.225; Ungar, 2012). Contemporary researchers prefer to conceptualize resilience as the ability to access available resources to enhance wellbeing, acknowledging that certain capacities must be present in the individual and also within their community for a child to be considered resilient (Exenberger & Juen, 2014a; Ungar, 2011). Similar to this relationship proposed by Exenberger and Juen (2014a) and Ungar (2011), UNICEF (2007) has suggested six domains that must be considered in the assessment of child wellbeing: material wellbeing, health and safety, education

wellbeing, family and peer relationships, behaviours and risk, and subjective wellbeing (UNICEF, 2007).

The influence of culture on wellbeing. The term *culture* broadly refers to learned meanings and behaviours that are shared by a group, including traditional activities and spirituality; cultures may differ based on geographical location, but not necessarily (Gone & Kirmayer, 2010; Marsella & Yamada, 2000; Whitbeck, Hoyt, Stubben, & LaFromboise, 2001b). The definition of wellbeing is culturally bound and cannot be separated from the context in which it is measured – it is a flexible concept that refers to what a group of people determine to be a good life and can vary from community to community (Amerijckx & Humblet, 2014; Ereaut & Willis, 2008). Wellbeing is not a rigid set of values inherent in a population, but a fluid concept that provides options regarding how to navigate the world (Angel & Williams, 2013). The benefit of certain attributes and abilities varies from culture to culture – if a trait assists an individual in successfully navigating life, then it is valued and the presence of this trait within an individual could be considered indicative of wellbeing (Exenberger & Juen, 2014b).

Culture influences the way in which an individual sees both the world and themselves in society (i.e., self-construal). There are two models that explain how an individual experiences self-construal: independent and interdependent. Independent self-construal is prevalent in individualistic societies (e.g., Western cultures), in which value is placed on autonomy, self-reliance, and uniqueness. Interdependent self-construal is more often seen in collectivistic societies, in which the interest of the individual is seen as auxiliary to the interest of the group. Traits such as conformity, obedience, and respect of elders are valued in these groups (Exenberger & Juen, 2014b). The two self-construals are conceptualized as poles on a spectrum – individuals can fall anywhere along the spectrum, and may experience a combination of self-

models (Exenberger & Juen, 2014b). In a society where many individuals abide by an interdependent self-construal, any trait that promotes the health of the group may be considered an indicator of wellbeing – possession of this trait would enhance an individual's likelihood of successfully navigating their world.

Resilience is also bound by culture and context. The amount that a child's resilience can influence their life is limited by the cultural and contextual relevance in which the trait is being expressed (Ungar, 2008). For example, an affiliation with a positive peer group may be a resilience factor in Western culture, but less important in non-Western cultures in which affiliation with family is highly valued (Ungar, 2008). Thus, conceptualizing constructs such as wellbeing and resilience in a manner that is appropriate to culture and context of Aboriginal cultures necessarily results in better applicability of research.

Cultural continuity. Culture can also be the source of unique factors that promote wellbeing - these factors generally extend beyond the level of the individual and family (i.e., community-wide). For example, First Nations communities in Canada that have self-government and access to cultural facilities generally have lower rates of suicide (Chandler & Lalonde, 2008; Kielland & Simeone, 2014). These factors could be considered indicators of wellbeing as they serve to promote health within this context, despite falling outside the traditional dimensions of the construct. Cultural continuity, defined as "being who we are" (Oster, Grier, Lightning, Mayan, & Toth, 2014, p. 148), has been suggested as a protective factor against mental health difficulties. It is represented by variables that a community may be capable of controlling including self-government, land claims, and access to education, health services, cultural facilities, and emergency services, however there are likely additional factors (Chandler & Lalonde, 1998). Individuals in communities with high levels of cultural continuity generally

report better mental outcomes including higher self-esteem and cultural identity, reduced mental health difficulties amongst youth, increased prosocial behaviours, and lower rates of suicide and substance use issues (Auger, 2016; Chandler & Lalonde, 2008; Kielland & Simeone, 2014; Whitbeck, Hoyt, McMorris, Chen, & Stubben, 2001a; Whitbeck et al., 2001b; Zimmerma, Ramirez-Valles, Washienko, Walter, & Dyer, 1998). In the highly influential paper by Chandler and Lalonde (1998), presence of each independent factor was related to a decrease in youth suicide rates, with even greater protection at the level of the community, such that communities with all six demonstrated lowest rates of youth suicide.

Auger (2016) completed a synthesis of 11 qualitative studies that focused on cultural continuity, specifically in North American Indigenous populations, and found five themes: cultural continuity and wellbeing, conceptualizations of cultural continuity, the role of knowledge transmission, journeys of cultural (dis)continuity, and barriers to cultural continuity. The first theme, related to cultural continuity and wellbeing, links the construct to health outcomes. The second theme is simply differing explanations of what cultural continuity actually represents. These two themes (along with theme five, barriers) are often explored in the literature, including both qualitative and quantitative studies, and generally better understood than the remaining three themes (Chandler & LaLonde, 1998; Chandler & Lalonde, 2008; Kielland & Simeone, 2014; Oster et al., 2014; Whitbeck et al., 2001a; Whitbeck et al., 2001b; Zimmerman, Ramirez-Valles, Washienko, Walter, & Dyer, 1998).

The relationship between cultural continuity and physical health outcomes has also been demonstrated as positive. For example, Oster et al. (2014) found that in communities with higher levels of traditional language, the prevalence of diabetes was lower even when controlling for income, unemployment rate, and high school completion rate. Further, participants in this study

also identified cultural continuity factors - connection to culture, understanding of teachings and language, and involvement in traditional activities - as important protective elements against physical health ailments (Oster et al., 2014). A high level of cultural continuity does not imply a lack of exposure to or integration of Western culture in an individual's life. In the past, the strength of one's cultural identity was measured by the extent to which they had assimilated (or not) into the dominant culture, but it is now understood that one can relate highly to both Indigenous and Western cultures (Snowshoe et al., 2015).

Aboriginal conceptualizations of wellbeing. Aboriginal cultures are generally holistic and promote a worldview that mental health can be enhanced through belonging or connectedness, cleansing, balance, empowerment, and discipline (CIHI, 2009). Belonging or connectedness is akin to maintaining a connection with family, culture, nature, the land, and spirits, while cleansing refers to the communication and expression of emotions in a healthy manner (CIHI, 2009). Balance is often conceptualized within the framework of the medicine wheel and harmony of the mental, physical, emotional, and spiritual dimensions of oneself (Adelson, 2005; CIHI, 2009; King et al., 2009; Reading & Wien, 2013). In this conceptualization, health and illness are not simply a reflection of biological functioning; rather they indicate the stability and coordination of the physical, emotional, mental, and spiritual aspects of oneself whereby one domain of health cannot be removed from another (Vukic et al., 2011). For example, the Anishinabek term "mno bmaadis" and the Cree term "miyupimaatisiiun" both roughly translate to "being alive well", but serve as a representation of health (Adelson, 1998; King et al., 2009). Additionally, the Obijway term "aakozi" has been translated into English as 'sick,' but better understood as "out of balance" (Fortier & Norrgard, 2002; Burgess, 2006). Further, a person can experience "aakozi" within the physical, emotional, mental, and

spiritual domains (Burgess, 2006; Fortier & Norrgard, 2002). Aboriginal definitions of health are often broader than Western definitions and incorporate several aspects of wellbeing; as a result, many Aboriginal theories of wellness do not fit into a Western framework (Adelson et al., 2005).

An examination of the definitions of "health" in a First Nations community in Manitoba demonstrated that the conceptualization of the Medicine Wheel as a framework for health is important – individuals described health as leading a healthy lifestyle within the spiritual, physical, mental, and emotional domains (Isaak & Marchessault, 2008). Participants described that a person with a physical illness may be a healthy person and that a person may be physically healthy, but ill in other areas of their life, rendering them a generally unhealthy person (Isaak & Marchessault, 2008). This group also identified the importance of positive adults role models in maintaining emotional health of youth, utilizing traditional ceremony in maintaining spiritual health, and making good choices as a means to maintain mental health (Isaak & Marchessault, 2008). This conceptualization is more consistent with recent Western models of health that recognize the importance of social determinants in an individual's health status (Reading & Wien, 2013).

Despite numerous health disparities, self-report data indicate that only 13% of Aboriginal people in Canada describe their current health as "poor" or "fair" and 26% describe their health as "excellent" (Adelson, 2005). These reports of subjective health are inconsistent with Western perspectives on health; data also indicate that 30% of participants reported a disability and 73% sought services of a health-care professional, which implies that a significant portion of the individuals surveyed do indeed have substandard physical health (Adelson, 2005). This discrepancy may indicate that the Aboriginal concept of health does indeed extend far beyond the physical domain and absence of disease (King et al., 2009). The term "health" may in fact be

a misnomer for many Aboriginal peoples and perhaps "wellness" is a more appropriate descriptor of the concept.

Kant, Vertinsky, Zheng, and Smith (2014) interviewed and also administered a questionnaire to First Nations adults living on reserve in both Ontario and British Columbia to determine a definition of wellbeing. They categorized their data according to six domains of wellbeing: social, cultural, and land use; income; employment; education; housing; and health (Kant et al., 2014). The researchers also used structural equation modeling to develop a multidimensional model of wellbeing and found that the social, cultural, and land use domain (which included access to cultural sites, participation in ceremony, and eating a traditional diet) was the most important contributor to overall wellbeing (Kant et al., 2014).

Aboriginal healing approaches are increasingly being documented within mainstream peer-reviewed literatures. For example, Dell et al. (2011) presented the story of a young male client in a culture-based residential youth solvent abuse program. This client was struggling with controlling his angry outbursts, so in addition to traditional songs and healing prayers, the Elder also prescribed this client medicine in the form of blueberries and unshelled peanuts. When this client was upset, he was to ask the staff for his medicine. The blueberries were used to give the client strength and the unshelled peanuts provided the client with both an activity to focus on and ample time to calm down and reflect on his emotions (Dell et al., 2011). If this issue were treated from a Western medical perspective, the client may have been prescribed a psychiatric medication to accomplish the same goal of reducing the client's outbursts and risk of harming himself or others. The prescriptions may have resulted in similar levels of success (i.e., client calms down), however the traditional approach provides the client with a culturally-relevant intervention that he is able to draw on outside of the treatment setting. Nelson and Wilson (2017)

reviewed the literature on the mental health of Indigenous peoples in Canada from a critical lens and concluded that when considering an Indigenous approach to healing, services that are managed by the community are the most successful. Therefore, community-based and controlled mental health services should be supported (Nelson & Wilson, 2017; Rowan et al., 2015).

First Nations Mental Wellness Continuum Framework. The First Nations Mental Wellness Continuum Framework is a model that includes the domains that provide the foundation for mental wellness or wellbeing amongst First Nations people in Canada (Assembly of First Nations & Health Canada, 2015). This model is presented as "a shared vision for mental wellness" (p. 8) and was created as a practical tool to provide guidance to communities and agencies in their development of programs, as opposed to a theory of wellness for First Nations peoples (Assembly of First Nations & Health Canada, 2015). It features nine layers of factors that contribute to wellness (i.e., community, populations, specific population needs, continuum of essential services, supporting elements, partners in implementation, indigenous social determinants of health, key themes for mental wellness, and culture as foundation) centered around the outcomes that are seen when a First Nations person is experiencing balance in these domains: hope, meaning, belonging, and purpose (Assembly of First Nations & Health Canada, 2015). According to the First Nations Mental Wellness Continuum Framework:

> connection to spirit (identity, values, and belief) promotes hope; a connection to family, community, land, and ancestry promotes a strong sense of belonging; knowing who one is and where one comes from allows one to think and feel and understand life from an Indigenous perspective and promotes a sense of meaning; and an understanding of the unique First Nations way of being and doing in the world promotes purpose (Assembly of First Nations & Health Canada, 2015, p. 13).

In this model, wellness and the outcomes of hope, meaning, belonging, and purpose are "facilitated through relationships, having an attitude of living life to the fullest, and having connections to family and community" (Assembly of First Nations & Health Canada, 2015, p. 4).

The conceptualization of wellbeing proposed by the First Nations Mental Wellness Continuum Framework is distinct from Westerns models of wellbeing that emphasize quality of life or mastery across a variety of domains (Linley et al., 2009; Ryff, 1989). Researchers, clinicians, and administrators in Canada can now utilize the First Nations Mental Wellness Continuum Framework in developing and evaluating appropriate programs, services, and tools to enhance the wellbeing of First Nations people.

Cultural Bias in Assessment

Due to a unique connection to the environment and land, as well as cultural views of health and wellbeing, it is possible that objective indicators of wellbeing that are employed for use in majority culture may not be entirely relevant or effective in measuring the wellbeing of Aboriginal peoples in Canada (Kant et al., 2014; Le Grande et al., 2017). Just as an individual's daily life is influenced by culture, their behaviours and thoughts, which psychological assessment instruments aim to measure, are also influenced by culture (Canadian Psychological Association [CPA], 2018; Mushquash & Bova, 2007). There are also cultural biases inherent in items on assessment measures, as well as problematic language (McShane & Hastings, 2004; Oesterheld & Haber, 1997). Even self-described "culture-free" tests can have components that require some understanding of the culture in which they were created and have a foundation in Western constructions of mental health. As clinicians must answer the referral question they are presented with, and this often requires the use of a psychological measure, current best practices would be to utilize a test with excellent psychometric properties when validated in the majority

culture. Interpretation of the results of any assessment should be made while keeping in mind the influence culture likely has on the test and construct in question, however this is not always ideal when implementing across cultures.

Several researchers have undertaken the task of validating common measures with Aboriginal populations. An attempt to validate the Connors Parent Rating Scale (Connors, 1989) and Child Behaviour Checklist (Verhulst & Achenbach, 1995) with Dakotan/Lakotan parents in the United States yielded three concerns: words or idioms were difficult to understand, phrases have alternate meanings in the Dakotan/Lakotan culture, and respondents believed the answers would be misinterpreted by members of majority culture who did not understand the Dakotan/Lakotan culture. Generally, parents reported that they could understand the questions, but they were concerned about their responses being misunderstood by the dominant culture clinicians who interpret the data (Oesterheld & Haber, 1997).

Measures must be both valid and reliable to warrant use; results must accurately reflect the construct purported to be evaluated and be consistent when the measure is administered repeatedly (Oesterheld & Haber, 1997). When an instrument is utilized with a group that it has not been validated for, these assumptions may be violated (Mushquash & Bova, 2007). Many researchers who have investigated the mental health of Aboriginal children and youth modified existing measures in an attempt to render the tool more culturally appropriate. This is problematic as the modified versions of the tools have not been validated with any population and the process of modification may eliminate or alter key items in the scale (Williamson et al., 2014). Authors of a 2007 meta-analysis that examined mental health research conducted with Aboriginal youth from North America, Australia, and New Zealand found that only 14% of the instruments (11 of 79) utilized in the studies were validated for use with this population. While

some measures had adequate reliability or validity, none had both good reliability and validity (Williamson et al., 2014). The lack of proper measurement tools likely contributes to the scarcity of research in the area of Aboriginal children's mental health and wellbeing (Williamson et al., 2014). The majority of wellbeing and quality of life measures that currently exist have not been validated for use in a Canadian Aboriginal population.

The current distinction between Aboriginal and non-Aboriginal assumes that those who fall within the Aboriginal population are homogenous; they share the same culture, beliefs, and identity, and therefore, mental health and wellbeing concepts (Vukic et al., 2011; Waldrum, 2009). Differences between different groups of Aboriginal peoples are equally pronounced as differences between groups of Aboriginal and Non-Aboriginal peoples, suggesting that understandings of mental health and wellbeing also differ between Aboriginal cultures. Therefore, tools validated for one nation may not be appropriate for another (Williamson et al., 2014; Vukic et al., 2011). The Anishinabek people of Northwestern Ontario represent a unique culture. Amongst this group, there is variation between communities and individual members, but also shared beliefs. The Anishinabek people practice traditional ways, including smudging, drumming, healing with the four sacred medicines and observing the medicine wheel and its teachings (Anishinabek Culture, 2018). The primary traditional language spoken among the Anishinabek people is Ojibway, however rates vary considerably from community to community (Anishinabek Culture, 2018).

To date, there has been little research done in the measurement of Aboriginal child wellbeing in Canada. One study was completed with children from Wikwemikong First Nation in Southern Ontario that resulted in a measure of Aboriginal children's wellbeing (Young et al., 2013). The study was qualitative in nature and used a sample of 38 participants aged 8-18. Youth

contributed to both focus groups and a photovoice component and adult community members were involved in both an advisory board and community consultation sessions to generate a total of 60 indicators of wellbeing for children in the community. The researchers also included items from the Pediatric Quality of Life questionnaire (Varni, Seid, & Rode, 1999) and Strong Souls (Thomas, Cairney, Gunthorpe, Paradies, & Sayers, 2010), a measure of wellbeing in Indigenous Australian children, but few of these items were endorsed as indicators of wellbeing or health in Wikwemikong First Nation. This suggests that First Nations child wellbeing is a unique construct and not fully captured by tools designed to measure wellbeing in children of majority culture or other Indigenous cultures.

Le Grande et al. (2017) completed a review of tools that evaluate the social and emotional wellbeing of those who are Indigenous to Australia. They concluded that the researchers should be engaged in the creation of measures specifically designed for use with Indigenous populations, as opposed to attempting to translate and/or modify measures already validated for use with majority culture (Le Grande et al., 2017). The authors also provided a list of recommendations for the future use and development of these measures:

1. Researchers and practitioners should examine [social and emotional wellbeing] within a holistic framework that emphasises positive wellbeing as well as acknowledging the variety of cultural, historical, and environmental determinants that contribute to negative wellbeing.
2. Researchers and practitioners should endeavour to investigate and use Indigenous developed instruments (such as GEM, HANAA, SSI) wherever possible to assess Indigenous wellbeing.

> 3. If Indigenous adapted wellbeing instruments have been used, their applicability should be viewed with caution. Attention should be paid to whether the instrument has undergone a
>
> formal cross-cultural adaptation and psychometric evaluation in an Australian Indigenous population.
>
> 4. If standard wellbeing instruments have been used, it should be acknowledged that they have not been validated for use with Indigenous Australians.
>
> 5. Further development, psychometric testing, and refinement of instruments developed specifically to assess Indigenous [social and emotional wellbeing] is required. The qualitative literature dealing with Indigenous perceptions of health, wellbeing, and dealings with the health system are potential valuable resources that could assist with this refinement.
>
> 6. While it is important to recognise individual communities with their specific colonial histories, many of the concepts and processes involved in the development of national historical trauma and wellbeing assessment instruments (e.g. development of the "Indigenous Peoples of the Americas Survey" [Brave Heart et al., 2011]), could potentially be applied transnationally and prove to be useful in the development of localised [social and emotional wellbeing] instruments (p. 170-171).

Despite publication of this article following the commencement of the current project, the researchers have adhered to similar principles in the creation of the measure at hand.

The Canadian Psychological Association (CPA) recently circulated a response to the Truth and Reconciliation Commission of Canada's Report. This report represents the findings of a task force that was created to develop "guiding principles for psychological practice with

Indigenous Peoples in Canada" (CPA, 2018, p. 6). The task force also evaluated and made recommendations for psychologists regarding "assessment, treatment, research, education, clinical training at the graduate level, continuing education for practicing psychologists, program development and evaluation, and advocacy" (CPA, 2018, p. 6).

The report echoes the sentiments of Williamson et al. (2014) and Vukic et al. (2011) and encourages psychologists in Canada to explore, develop, and implement alternative approaches to assessment, treatment, and program evaluation that are culturally appropriate (CPA, 2018). Of particular relevance are the recommendations concerning assessment, the current state of which they identify as "dire" (CPA, 2018, p. 16). The task force states that psychologists must "recognize and acknowledge that appropriate assessment and treatment of Indigenous Peoples includes understanding people in the context of their family, community, and their history of colonization and resurgence" (CPA, 2018, p. 11). Further, the task force recommends that assessment should utilize a holistic model of mental health and cultural conceptualizations of health that may include relationships with the land and community, while also focusing on strengths the individual possesses as opposed to solely pathology (CPA, 2018).

Measuring the Wellbeing of Children

Just as measures validated in dominant culture are inappropriate for use in minority cultures, measures validated for use with adults should not be utilized with children - children and adults are likely to be affected by events and societal pressures very differently and these discrepancies require distinct measure for assessment (Ben-Arieh et al., 2001a). Despite acknowledgements that the wellbeing of children is a unique construct, standards of wellbeing for children are often based on outcomes in adolescence or the likelihood of a child becoming a contributing member of society, and wellbeing during childhood is generally disregarded (Ben-

Arieh, 2007). There are discrete measures of child health available, but these traditional tools assess survival (such as childhood mortality rates and immunization rates) and are concerned with a child's basic needs being met, but do not consider the quality of their life (Ben-Arieh et al., 2001a; Ben-Arieh, 2007). The measures currently in use also tend to focus on risk factors and deficiencies despite the fact that wellbeing should refer to positive aspects of an individual's functioning; wellbeing represents an area that can be completely strength-based and positive (Ryff, 1989). The majority of measures also focus on children's readiness for adulthood as an outcome, ignoring the fact that children are citizens (Amerijckx & Humblet, 2014; Ben-Arieh, 2007). Measures that are currently used to assess the wellbeing of children include the Adaptive Behavior Assessment System (ABAS-III; Harrison & Oakland, 2015), Behaviour Assessment Scale for Children (BASC-3; Reynolds, Kamphaus, & Vannest, 2015), and the Child and Adolescent Needs and Strengths (CANS; Lyons, 1999).

The ABAS-III (Harrison & Oakland, 2015) is a behaviour rating system that is completed by caregivers or teachers of a child or youth age 0 through 21. There is also an adult version available for individuals ages 16 through 89. The ABAS-III evaluates the level of adaptive skills (i.e., practical skills required to succeed in one's environment) that the child or youth possesses across three domains: conceptual, social, and practical (Harrison & Oakland, 2015). It is often used in the diagnosis of developmental delays, autism spectrum disorder, intellectual disability, learning disabilities, neuropsychological disorders, and sensory or physical impairments (Harrison & Oakland, 2015).

The BASC-3 (Reynolds et al., 2015) is a rating system that can be completed by caregivers and teachers of children and youth ages 0 through 21. There is also a self-report version that can be answered by children themselves (ages 6 through 21). The results of the

BASC-3 detail problems that a child is experiencing with regards to externalizing symptoms (e.g., hyperactivity, aggression, conduct problems), internalizing problems (e.g., anxiety, depression, somatization), behavioural symptoms (e.g., atypicality, withdrawal, attention problems), and adaptive skills (e.g., adaptability, social skills, leadership, activities of daily living, functional communication; Reynolds et al., 2015). The BASC-3 is deficits-based and does not identify strengths that the child may possess, but is useful for diagnosing a variety of mental disorders.

The CANS (Lyons, 1999) is a tool designed to primarily facilitate decision-making in treatment contexts and also track outcomes. It is not diagnostic in nature, but aims to provide concrete treatment targets. The CANS contains a total of 51 items across six subscales. Each item is rated on a scale from 0 to 3, which indicates level of need. For the majority of subscales, a score of 0 indicates "no evidence" of a need, while a score of 3 demonstrates "severe, disabling, dangerous, immediate action needed." The Individual Strengths subscale is reverse coded; a score of 0 represents a "center -piece strength," while a score of 3 indicates "no strength identified." These 51 items are categorized into six subscales: Mental Health Needs, Risk Behaviours, Family/Caregiver Needs and Strengths, Functioning, Care Intensity and Organization, and Individual Strengths (Lyons, 1999).

A recent literature review by Amerijckx and Humblet (2014), found over 200 published articles including the terms "child" and "wellbeing" in the title. Of these publications, only 3% were theoretical, while 82% were empirical. This suggests that the definition of child wellbeing is still largely unstandardized and the majority of researchers in this field are concerned with describing potential indicators of wellbeing without consensus on a definition (Amerijckx & Humblet, 2014). The Organisation for Economic Co-operation and Development (of which

Canada is a member: OECD, 2009) also acknowledges that, "there is no unique, universally accepted way of actually measuring child well-being that emerges from the academic literature" (p. 22).

Due to difficulties in defining "wellbeing", research to date has focused on developing a single construct, such as health or family supports, to represent childhood wellbeing as opposed to developing a multidimensional construct (Amerijckx & Humblet, 2014). The majority of studies focus on "microsystems" (Bronfenbrenner, 1979), which are the environments in which children directly participate. The microsystem with the greatest representation in the literature is the family environment and, unfortunately, most of this research is focused on the negative aspects of a family context such as parental conflict or separation, parental alcohol or drug use, and disability (Amerijckx & Humblet, 2014). Approximately 5% of the literature on child wellbeing involves the examination of community-level indicators of wellbeing and the involvement of the greater community in fostering wellbeing in children (Amerijckx & Humblet, 2014). This literature review concluded that there are five spectrums that definitions of wellbeing can be located on: positive vs. negative, objective vs. subjective, state vs. process, material vs. spiritual, and individual vs. community; the majority of the literature in this field focuses on the negative ends of each of these spectrums (Amerijckx & Humblet, 2014).

UNICEF has produced a list of best practices when selecting indicators of children's wellbeing, including that the child, rather than the family, serve as the focus and that the indicators should apply to children up to age 17 (UNICEF, 2007). Although there is no consensus on aspects that should be included in a multidimensional assessment of child wellbeing, the majority of researchers who examine this construct include a measure of education, health, and material wellbeing (Exenberger & Juen, 2014c; O'Hare & Gutierrez,

2012). Only four of 19 available measures of child wellbeing include emotional or spiritual wellbeing as a domain, while only one examines community engagement or connectedness (O'Hare & Gutierrez, 2012). However, it is recommended that indicators should be specific to the child and not their environment, family, educational opportunities, or desirable conditions and not include indicators of legal rights (e.g., standards of living; Ben-Arieh et al., 2001a). A comprehensive composite domain-driven index of child wellbeing is ideal and measures all facets in a given community or setting, yields a single score, and features indicators of wellbeing that cluster around a variety of domains (O'Hare & Gutierrez, 2012); for a measure of children's wellbeing to truly capture the construct, it must be multidimensional (Ben-Arieh et al., 2001b).

An index is a tool that integrates data from several areas and yields a single number that indicates status on a variable (O'Hare, 2014). This format is useful because it can represent a host of indicators with a single number, making it easier for service providers to understand how the child is functioning (O'Hare & Gutierrez, 2012). Researchers must reconcile the desire to create a thorough, but potentially more complicated measure with the need to provide users with an efficient and easy-to-use tool (O'Hare & Gutierrez, 2012). Indices of child wellbeing measure, on average, 5.5 domains, but many utilize 6 or 7 domains, suggesting that this number of domains may represent a consensus amongst researchers (O'Hare & Gutierrez, 2012).

History and culture both contribute to worldview, so an understanding of personal history and culture is essential for the wellbeing of all people, including children (Greenwood, 2005). As such, attempts to enhance or measure the wellbeing of Aboriginal children must conceptualize health in a holistic framework and address both the historical and modern determinants of health that Aboriginal children live every day (Greenwood & de Leeuw, 2012). Targeting individual behaviour and proximal determinants of health is not sufficient and distal determinants and the

wider context of Aboriginal childrens' lives must be prioritized in these measurement tools (Greenwood & de Leeuw, 2012). Context is often the limiting factor in terms of children accessing services and having opportunities to achieve their highest possible level of wellbeing, so this must also be a consideration when assessing children's wellbeing. Many measures of child wellbeing do not effectively account for the relationships between the child and their community, thereby excluding a component that may account for a large proportion of the variance in wellbeing (Ben-Arieh et al., 2001c).

Dilico Anishinabek Family Care

In partnership with First Nation communities in the Robinson-Superior Treaty Area, Dilico Anishinabek Family Care provides a range of programs and services for Anishinabek people. The organization was incorporated in 1986 in response to the overwhelming number of Ojibway children in foster care in Thunder Bay and the surrounding area. In 1994, District offices were opened in five communities proximal to the Dilico partnering First Nations: Nipigon, Longlac, Armstrong, Marathon, and Fort William First Nation. Children's mental health services were added to the mandate of the organization in 1996.

The mandate of Dilico Anishinabek Family Care is to provide services that enhance wellbeing for Anishinabek people. Dilico approaches these services from a holistic framework and aims to deliver services in a way that appreciates client's strengths and traditions of Anishinabek culture. As such, Dilico has developed cultural programming that includes drumming, medicine wheel teachings, and access to Elders and traditional culture-based healers. Dilico Anishinabek Family Care provides services to 13 communities in the Robinson-Superior Treaty area in Ontario. The communities are: Red Rock Indian Band, Whitesand First Nation, Animbiigoo Zaagi'gan Anishinaabek, Bingwi Neyaashi Anishinaabek (Sandpoint),

Ginoogaming, Long Lake 58 First Nation, Michipicoten First Nation, Ojibways of Pic River, Fort William First Nation, Kiashke Zaaging Anishinaabek, Biinjitiwaabik Zaaging Anishinabek (Rocky Bay), Pays Plat First Nations, and Pic Mobert First Nation.

CHAPTER 2. METHODS AND RESULTS

This project was conceptualized using a holistic approach and incorporated a range of research methods to best determine how to meet the needs of Anishinabek children, families, and communities. Researchers must acknowledge that their way of knowing is not the only way or necessarily the correct way for this context (Greenwood & de Leeuw, 2012). Consistent with ethical and culturally appropriate research protocols, this project was directed by an advisory comprised of senior management that oversaw the work, provided advice, and championed this initiative in the organization and communities. Convening a project advisory was essential in ensuring that the needs of children, families, and communities involved with Dilico Anishinabek Family Care were met.

The purpose of this project was to understand child wellbeing from the perspective of First Nations communities and develop, implement, and evaluate a culturally and contextually appropriate tool designed to measure the indicators of wellbeing for First Nations children.

Study I Method

The objective of Study I was to gather data from general community members and key informants regarding First Nations' definitions of child wellbeing. Ben-Arieh et al. (2001c) suggested that conducting primary research (as opposed to simply using census-level or survey data) is the preferred method when measuring children's wellbeing and that qualitative research is ideal for understanding unique indicators of wellbeing in a given community (Ben-Arieh et al., 2001c).

Community-Based Participatory Research

The approach that the research team pursued in this project truly embodied the spirit of community-based participatory research (CBPR). This approach is recommended by the First Nations Information Governance Centre, which drafted the principles of Ownership, Control, Access, and Possession (OCAP™; FNIGC, 2014). The hallmarks of CBPR are the prioritization of community preferences, community control, and dissemination to relevant parties (Castleden et al., 2008; Drawson, Toombs, & Mushquash, 2017b). Initially, A.D. (the author of this dissertation) expressed interest in exploring a project that contributed to the wellbeing of First Nations people to her supervisor, Dr. Christopher Mushquash, who in turn consulted with Dilico Anishinabek Family Care. The organization responded with the research question, which initially came from concerns expressed by management and frontline workers. They believed that the measures being utilized during the intake process did not accurately capture the construct of wellbeing for their children. Prior to the conceptualization of the project, Dr. Mushquash collaborated with the organization to form a Research Advisory. This Research Advisory was composed of organizational senior management, including staff from child welfare, counseling, health care, and finance. These individuals were deemed to have an exceptional understanding of the organization and relevant policies and procedures, as well as the children in the Robinson-Superior Treaty Area who were being served by Dilico Anishinabek Family Care. Many of the Research Advisory members also identified as First Nations, which provided an additional advantage to their inclusion; not only could they provide guidance to the research team on an organizational level, but also a personal level. Often, in research approached from a Western lens, such enmeshment would be viewed as a deterrent and potential conflict of interest, but

within a CBPR approach, this is not the case. Instead, relevant community-level expertise is necessarily embedded within people belonging to the community.

The research team considered including community members who were not employed by Dilico Anishinabek Family Care on the Research Advisory, but this was ultimately decided against. This was primarily decided for practical reasons; frequent meetings were required with the research advisory to design the research project and methods and it would have been challenging to include these individuals given the distance between their communities and Thunder Bay. Further, as the Research Advisory was composed of senior management and staff, these individuals were privy to sensitive organizational information that was often deemed relevant to the project and shared in meeting and with the research team. Through a CBPR lens, Dilico Anishinabek Family Care can be conceptualized as the community, with individual First Nations communities that they serve nested within.

The CBPR goals of power, trust, and ownership (Castleden, 2008; ownership also being an OCAP [FNIGC, 2014] principle) were paramount and respected throughout the conceptualization and implementation of this project. Balancing power within any research projects is challenging, as there is an inherent inequality between researchers and participants (Castleden, 2008). Researchers are often viewed (and mistakenly view themselves) as the "experts" – that the many years of study in a particular field elevate them above those experiencing the very phenomena that they have built their careers on. Prior to engaging in CBPR, researchers must acknowledge that they are facilitators of the project, and are bringing their experience and skills to communities to aid in the gathering of knowledge. This acknowledgement must be paired with a sense of humility with regards to their community partners' skills and flexibility to accommodate their needs and requests. The research team in

this project studied the concept and tenets of CBPR, both independently and in conjunction, while also conceptualizing this project with the Research Advisory. We were also candid with these individuals about the intention to rebalance power and assist in the creation of research capacity within the organization. Another avenue to rebalance power in a researcher-community relationship is by fostering trust, which is the second goal of CBPR (Castleden, 2008).

Time was also spent developing relationships based on mutual trust between the team and community contacts. The community contacts were individuals identified mainly by the Research Advisory who resided in a community and were considered to be leaders. The two graduate students who were responsible for traveling to the communities and collecting data began and maintained communication with these individuals and placed their concerns and preferences at the forefront of the process. Any recommendations made by the community contacts were prioritized and enacted to ensure that participants were comfortable, but also to demonstrate trust and rebalance power (Castleden, 2008). For example, the research team was instructed by one community contact to provide a meal to a group of elders as a sign of respect for their sharing of time and knowledge. This was a simple request, but it was taken seriously and applied.

While the Research Advisory and the research team collaboratively managed all aspects of the project, it was clearly designated that Dilico Anishinabek Family Care (and, therefore, the leadership from the 13 communities that compose the Board of Directors) possessed control over the direction of the project and also the knowledge gathered as a result. To satisfy the OCAP (FNIGC, 2014) principles of Access and Possession, the data was housed at Dilico Anishinabek Family Care and physical control of the data has been firmly with the organization throughout the project.

Qualitative Question Development

The objective of the Study I was achieved through the gathering of stories of success, proposed strategies, and examples of barriers to child wellbeing in each community. Studies examining the wellbeing of Aboriginal peoples in Canada often utilize a qualitative approach with a combination of semi-structured interviews and focus groups or Sharing Circles (Rothe, Ozegovic, & Carroll, 2009) to gather information about the definitions and indicators of health and wellbeing in the community (Kant et al., 2014; Young et al., 2013). Data were gathered via one-on-one interviews, and a focus group that respected the preferences of the communities and individuals involved.

A set of 11 open-ended questions were developed for use in both the focus group with the general community and one-on-one interviews with key informants. These informants were often identified by the community contact people and often considered to have some expertise or wisdom regarding children. Questions focused broadly on child wellbeing (see Appendix A) and were developed in collaboration with the project advisory group. As the First Nations Mental Wellness Continuum Framework is one of few available models of wellness for First Nations people in Canada, several questions included in Study I originated from this model (Assembly of First Nations & Health Canada, 2015). Currently, many Indigenous language speakers utilize words or phrases related to "balance" when speaking about Western conceptualizations of illness, therefore the notion of balance was also incorporated into these questions (i.e., "How can a child achieve balance/health in…?"). The set of questions was approved by the Dilico Board of Directors (composed of community members representing the 13 First Nations) as well.

Five additional open-ended questions were developed for use in only the one-on-one interviews (see Appendix A). These additional questions addressed topics that may be too sensitive for the general discussion or elicit responses that are critical of the current processes, which was not the goal of this study.

Participants

Participants were adult (18 years old or greater) First Nations individuals who resided in one of the communities where focus group and interviews were held. They did not need to be involved in services with Dilico Anishinabek Family Care. We anticipated a high response rate due to our plan for community engagement, as well as the championing of our initiative by Dilico Anishinabek Family Care senior management and employees in the communities. Studies examining child wellbeing in First Nations communities that utilized a similar process have had a high response rate and attributed this to involvement of the whole community in the research and support from the Chiefs of the communities (Kant et al., 2014).

Data Collection

A qualitative method was employed during two phases of data collection: key informant interviews and a culturally-relevant focus group. Key informants were invited to participate in an interview and all audio was recorded and transcribed. Both researchers also took process notes during the interviews. The focus group was conducted in English (interpreters were offered, but not necessary) in a community setting, according to community norms and customs. Contact persons for each community were identified by the Dilico Anishinabek Family Care staff who served on the Research Advisory and also the Board of Directors. These individuals were well-known and respected in the community and often held employment with a central agency, such as the band office or health centre. The community contacts were essential for the development

of a data collection environment and plan that considered and respected any norms or customs within the community, as well as, for recruiting individuals who have expertise in the domain of child wellbeing. Audio for focus group session was not recorded and transcribed as all participants did not consent to this. In lieu of this, detailed notes were taken by both researchers. Refreshments were also provided the focus group session.

Verification

A second set of meetings with interviewees and focus group participants was held to verify themes that emerged in the data analysis. This was an important step in the process of community-based participatory research; community members must have an opportunity to correct or clarify any misunderstood contributions prior to the creation of the measurement tool. Participants were ensured that refinements would be made to the original themes accordingly.

Study I Results

From fall 2015 through fall 2016, two graduate students traveled within the Robinson Superior Treaty Area to meet with participants and conduct interviews and focus groups. In total, 15 one-on-one interviews and one focus group were facilitated, with twenty-four participants representing seven First Nations across both. Following data collection, audio recordings of interviews (focus group participants did not provide consent for audio recording) were transcribed and transcriptions were entered into QSR NVivo® computer software (NVivo, version 12; Doncaster, Australia: QSR International Pty Ltd, 2018) for analysis. Qualitative data were examined using thematic analysis.

Thematic Analysis

Thematic analysis allows for flexible analysis of the semantic nature of qualitative data, but also encourages researchers to investigate deeper patterns relevant to the research questions

(Braun & Clarke, 2014). While the researcher is initially focused on the content of the qualitative data (e.g., how often a specific term is referenced), the purpose then shifts to exploring patterns and themes to ultimately answer a larger research question (Clarke & Braun, 2014). Thematic analysis was also an advantageous choice as it is atheoretical, allowing for deductive or inductive interpretation of the data (Clarke & Braun, 2014). For this study, a qualitative data analysis approach was required that would allow for efficient and systematic analysis to facilitate the creation of items for the tool as opposed to a method focused on developing comprehensive theories or frameworks for the construct in question.

The method of thematic analysis in relation to qualitative data has been in use for over 40 years (Braun & Clarke, 2014), however, a structured approach to this process was only introduced in 2006 by Braun and Clarke. This approach includes six steps:

1) Familiarizing yourself with the data and identifying items of potential interest
2) Generating initial codes
3) Searching for themes
4) Reviewing potential themes
5) Defining and naming themes
6) Producing the report

Throughout step one, the researcher would read through the transcripts of recordings multiple times, as well as listen to the audio, with the dual purpose of acquainting oneself with the data and also beginning to determine which data points may be significant to the research question (Braun & Clarke, 2006). The second step is to begin generating codes for the analysis, followed by exploring the data for themes, which differ from codes in that they reflect patterns seen across all transcripts (Braun & Clarke, 2006). Step three is more subjective than step two in

that the researchers are using personal judgment to determine what is or is not important in the data (Clarke & Braun, 2014). The next two steps are reviewing the potential themes that have been generated for relevance to the dataset as a whole and then to define and name themes (Braun & Clarke, 2006). Finally, the researcher produces the report (step six; Braun & Clarke, 2006).

Step two was of particular relevance for this project, as the researchers proposed to use a blended approach of thematic analysis and grounded theory for qualitative data analysis. Grounded theory is an inductive approach to the analysis of qualitative data (Charmaz & Belgrave, 2007). In a true grounded theory approach, the researcher does not engage in any literature review prior to beginning the data collection and analysis (Charmaz & Belgrave, 2007). As such, analysis is thought to be procured solely from the data and free of pre-existing biases on the part of the researcher (Charmaz & Belgrave, 2007).

Clarke and Braun (2006) suggest that researchers can choose to identify codes that are semantic (focusing on the face valid content of the data) or descriptive (including an element of interpretation on the part of the researcher and are generally deductive). It was essential that the most inductive approach possible (within the practical constraints of the project) was utilized as to ensure that the tool that was created accurately reflected the participants' contributions. However, the researchers are immersed heavily in research and clinical work with the Anishinabek people of the Robinson-Superior Treaty area and other Indigenous peoples in Canada; therefore, an authentic grounded theory approach in which the researchers are completely free of preconceptions was impossible. After consideration, this combined approach of thematic analysis and grounded theory was chosen; this choice was reflected in the

researchers' decision to generate codes at the semantic level and avoid interpretation of the data, which would violate tenets of grounded theory.

A.D. analyzed the qualitative data according to the steps laid out by Braun and Clarke (2006). She began by reviewing the transcripts and audio recordings for dual purpose: to ensure accuracy of the transcripts and also immerse herself in the data. Within the QSR NVivo® computer software, codes were created for each of the referenced indicators of wellbeing for First Nations children living in the Robinson-Superior Treaty Area, as specified by step two (Braun & Clarke, 2006). Some often-referenced indicators were categorized into sub-codes to provide more specific information regarding the content of the codes. These parent codes served as the themes of the dataset and steps three through five were carried out accordingly.

Indicators of Wellbeing

Participants spoke most often, and elaborately, of the importance of Traditional Activities (n = 45) in relation to the wellbeing of children in their communities. This theme also included specific sub-codes of Teachings, Ceremony, Crafts, and Land-based Activities. Within the code of Teachings, sub-codes of Balance and the Seven Grandfather Teachings were nested. Participants also noted two of the seven grandfather teachings sufficiently often to warrant independent sub-codes: Respect and Humility. Other frequently cited indicators were Physical Activity *(*n = 18), Expression/Communication (n = 17), Social Engagement (n = 17), Self-worth/value/esteem (n = 16), Positive Role Models (n = 12), Healthy Appearance (n = 11), History and Culture (n = 11), Mental Health as All-Encompassing (n = 11), Support (n = 11), Healthy Home Environment (n = 11), Structure and Routine (n = 10), Connection (n = 9), Spirituality (n = 9), Coping Skills (n = 8), Smiling/Laughing (n = 7), Safety (n = 6), Healthy Community (n = 3), Stability (n = 3), Well-Behaved (n = 3), Cooperative (n =2), Creativity (n =

2), Positive Outlook (*n* = 2), Purpose (*n* = 2), Responsibility (*n* = 2), Following Values (*n* = 1), Helpful (*n* = 1), Independence (*n* = 1), Insight (*n* = 1), and Thinking Through Consequences (*n* = 1). Based on the indicators that emerged in analysis and expertise of the research team, the focus of items was limited to eleven themes, which are conceptualized as domains of wellbeing:

Table 1

Domains of Wellbeing

Domain area	Description
Traditional Activities	Has experience with the seven grandfather teachings; respects themselves, others, and others' property; tells the truth; is humble; cares for others; keeps their promises; attends ceremonies; and engages in land-based activities
Physical Activity	Participates in formal and informal physical activity, and enjoys playing outside
Expression and Communication	Expresses their feelings and needs, contemplates before speaking, and listens well
Social Engagement	Has several age-appropriate friends and engages well with children who are around
Self-Worth & Self-Esteem	Takes pride in who they are and their Indigenous identity
Positive Role Models	Has positive adult role models
Healthy Appearance	Takes care of their hygiene and personal appearance
History and Culture	Shows an interest in or understanding of their First Nations history and culture and understands, speaks, or would like to learn their language

Structure and Routine	Has stable and consistent caregivers
Spirituality	Identifies with a religion or is spiritual
Coping Skills	Can identify and manage emotions that they experience

Traditional activities. Many of the participants focused on the importance of *traditional activities* and cultural ways of being and doing across all facets of a child's life:

> It's a traditional aspect, so when I see a child who is able to, say, go to a pow-wow and dance, whether you have regalia or not, there's a reason why you're doing that. Also, they're connected and they have respect for the Creator. They're thankful for what they have, whether it be, you know, having dinner with your family or, um… like, they're humble, also having respect for your animals and, um, the trees, those kind of things.

This code was broken down further into several sub-codes: Teachings (sub-codes Balance and the Seven Grandfather Teachings), Ceremony, Crafts, and Land-based Activities.

Teachings. Participants who spoke about *traditional activities* and *teachings* described these as a way of life or philosophy as opposed to a simple practice. One participant stated that through instruction in teachings and *traditional activities*, the children of the community are "learning who they are as Anishinaabe kids."

A participant spoke about how *teachings* are often not transferred from parents to children in difficult situations:

> Sometimes our basic principles of life aren't taught on a day-to-day basis when you're living in crisis, because it's more important to… to wonder what we're going to eat today, because that's the sad reality is that we don't all have food in our cupboards on a day-to-day basis.

Balance. The concept and teaching of *balance* was often linked to the medicine wheel and the *balance* between the physical, mental, emotional, and spiritual domains of oneself:

> We've done this with our kids where we've printed out blank medicine wheels. OK, how does your wheel look? If… if one of your wheels is… there's not a lot into it that… we look at it like a flat tire where you're stuck in the mud, and it may not feel like a big deal but it is; because if we're unbalanced, physically, mentally, emotionally, spiritually, we… we… we'll always be stuck until your… your circle is balanced, and that circle needs to go all the time because every stage of our life we're learning something and we're not meant to stay idle.

Participants also spoke about *balance* related to First Nations teachings on man and woman: "you have to have a man and a woman. A woman can't do it alone. A man can't do it alone. You have to have that balance all the time." This *balance* is also linked to specific ceremony:

> …always providing that teachings as to the balance of a man and woman in everything, whether it's a pipe ceremony, the balance there, whether it's the drum arm and the actual drum, um, and the… and going off to that interconnectedness.

Seven Grandfather Teachings. Participants specified that the *Seven Grandfather Teachings* are used to assist children in developing the skills necessary to succeed: "Well, there are… our Seven Teachings says it all. Um, that's the ones that I… I use when teaching my kids life skills."

Participants noted several of the *teachings* throughout their interviews:

> We… we try to promote the Seven Grandfather Teachings for… for values. Um, and, uh, we definitely the… the honesty, the, uh… the love, the… the entire thing, the, uh, being able to forgive people for something, uh, to… not to… how do you say that… to let their

> feelings out there, I guess. Um, if something is bothering you, say it; you know, don't try hiding it…

Respect. In much of the discussion around the *Seven Grandfather Teachings*, *respect* emerged as paramount: "Well, it… it all goes to our Seven Teachings, you know, truth, honesty, kindness, they're all things that would be nice. I think respect is the big one."

Participants discussed not only *respect* for others, but *respect* for the self:

> "Um, respect is a big one, but it's not only, um, for other people. I think more importantly it's for yourself, and they need to… they need to know that how important they are and they need to… I guess they need to feel respected, um, in order to give that respect to other people."

An interesting finding that emerged from the analysis was that, despite the importance of *respect*, children in the relevant communities are generally lacking *respect*:

> …and just like a respect, I see it going all over the place because like a lot of the kids don't have respect for nobody. Like again, it's that they don't look at you as an adult, figure just you're some dude.

Humility. The Grandfather Teaching related to *humility* was also specifically referred to by participants:

> You know, those values right there I think should be embodied by… by everyone. You know, to me, I… when I think of the Seven Grandfather Teachings, I just… I think it's like kind of a set of values of how to treat other people; you know, by having that humility.

Ceremony. Many participants spoke about the importance of *ceremony* in the lives of their children from birth onwards:

For me, a healthy child is a child who is following their rites of passage. That… that's going to keep them balanced. Don't skip the important things. Teach their… teach their mothers the importance of keeping that placenta and doing that welcoming ceremony, like what… to be right in your family, but… and it's beautiful. When you see that baby being passed around from individual to say, you know what, I will be there when you want this drum, I… I will teach you your language. And going around, because that's the old ways and… and also remind us that it's not just mom and dad's role to look after this child, it's the community's role and it's the family role. And if mom and dad know that, it… it's easier to ask for help, right…?

Ceremony was viewed by participants as essential to the wellbeing of children, specifically to facilitate personal growth: "And to go out and then do that ceremony and for them to receive their name, and… and then that's their foundation. That's their foundation that's going to build them into these strong men and women."

Crafts. Participants spoke about traditional *crafts* as a simple activity to teach children about their culture and also maintain cultural ways of being and doing: "…so we're trying to get people to come out and share that…with the younger kids because otherwise that's how things get lost…So we'll do that. Um, crafting…teaching… teaching them how to sew, teaching them how to bead…"

Land-based activities. Many participants spoke about the variety of *land-based activities* that children in their communities engage in:

> I find that a lot of the children and kind of the youth around here, because we're surrounded by, you know, the… the bush and the forest, so there's a lot of like nature walks and hiking, you know, um, a lot of kind of just being mindful of our environment; uh, fishing, hunting, like there's a lot of those types of sports, so…

Participants were able to explain that participating in *land-based activities* is not an important cultural practice, but also vital for wellbeing:

> I mean, I find if you're outside, you feel better; you're… you know, there's less stress, there's… I think the bush is a great healing tool, but, uh, there's… you can always go out and find something new and learn something new, and… and that's, uh… it's a place to be, um, open and honest and free and it's a safe place…

They also reported that children are able to succeed when they are connected to the land: "We always know that our children work best when they're… when we bring them into the bush. There's something about the land or there's something about the water, and they don't have enough of that."

Physical activity.

Physical activity, specifically organized sports, was often cited by participants: "Sports in my community is a big one is sports, very, uh, competitive, um, right from baseball, hockey." Participants also explained that *physical activity* is a powerful tool to decrease the amount of time children in their communities spend watching TV or playing video games:

> Like when we ask our children to let us know, like, or give us what a day looks like in their life, it's a lot of walking around, maybe biking. A lot of them are into their game… the gaming.

Expression and communication.

Children who can effectively express and communicate their thoughts and feelings, particularly to adults, are viewed as well by participants:

> That child who can cry; that child that can tell you, you hurt my feelings; that child that said I don't like when you yell at me; that child that says I had a really good day today.

> To have that emotional vocabulary and to be able to communicate… yeah, and to speak of it, right, or to say I think I need… again, like I think I need to smudge; or, Mom, I think I need tea; Mom, can you make me some cedar tea because I'm struggling right now? That's an emotionally healthy child.

Social engagement.

Participants noted that "if you have someone very outgoing and smiling and happy and positive, they're in balance," referring to the coordination of the four domains of physical, mental, emotional, and spiritual wellness. They also spoke of *social engagement* as a simple method for observers determine a child's wellness:

> If they're out there, um, laughing and they're having a good time, you definitely know they're healthy. Uh, and yet kids that sit back and don't want to be involved and just don't have the energy, I guess, to do anything, then you know there's a problem, for sure.

Participants shared that they expect some variation amongst children in terms of comfort level in social situations, but that generally being socially engaged is a positive attribute and signals health in the emotional domain:

> They tend to be a little bit more outgoing or interactive or… or, um, some kids are naturally shy and that's… there's nothing wrong with that; but, um, I find kids that are not as emotionally healthy are… are more shy or they're introverted, they… you know, they don't want to be noticed, they don't want to… they don't want to be involved so…

Self-worth and self-esteem.

Participants explained that a child is well if "he's just going out to play and he carries that confidence, that… and he's not worried about what the rest of the world is going to think" and if

they are "comfortable [with] who they are." This behaviour is indicative of a sense of *self-worth and self-esteem*.

Positive role models.

Many participants explained that *positive role models* (e.g., parents, grandparents, teachers, extended family members, elders) are the vehicle by which children in their communities learn traditional activities:

> It could be parent… parents, whether it's their parents, their grandparents or role models, um, through different things; through school, they learn that at school; they learn that at church; they learn that at pow-wows. There's always like pow-wows, there's always little teachings. Uh, stuff is taught… is taught like that through school. Um, I know for us, we do youth programming, and, uh, the youth programming is done in, uh, my community as well, so you learn from there. You learn from the elders and the traditional resource people.

The concept of a broader definition of family was also connected to the transmission of cultural values:

> Um, it is important to have values, and you learn the values from your family. Um, I would say are, um… a lot of families learn their values from their teachers, right, or… or their family members, extended, um, the elders in the community; they will teach the kids, you know, respect and, um… it all comes from their traditional teachings.

Healthy appearance.

Participants also noted that observers are able to determine a child's wellness by their appearance: "They have energy. You can tell by their skin, their hair, their teeth, just their physical appearance, um, and they're not tired." This construct appears to be related to not only

self-care and hygiene, but also demeanor: "A healthy child would be one that… that would wake up and smile, be happy, sing, um, skip, no worries in the world, um, bright complexion, um, nice shiny teeth, um, just being how that… that at that age is supposed to be…"

History and culture.

When participants spoke about children being interested and engaged in their First Nations culture, they described a lifestyle as opposed to a practice that one can start and stop: "Um, it's one thing to learn your traditional ways, but it's… it's another to be able to incorporate it into everything that you do. If you're going to incorporate it into everything you do, you have to live it every single day and it's a huge, huge commitment"

Structure and routine.

Participants described *structure and routine* as an essential aspect of a child's wellness, which provides a foundation for good habits to grow from:

> I think structure has a lot to do with it. If you don't have those structures, it's like any… anything you look at, if… if you don't have a good foundation, everything else will just not be there. It'll be crooked or it'll be unstable or some way or another. Like if… if you build a house or you build a car or anything that you build, it's got to have a good foundation.

Participants also noted that providing *structure* is often challenging for caregivers in their community because "a lot of families live in…day-to-day crisis is… is a norm for them…so …they don't understand personal boundaries."

This lack of *structure* impacts the children's ability to engage their community and learn important values:

> In my community, like… like they just run free like pretty much. There's no structure, right? So there's no real teaching of volunteer and what it means and, uh… and things like that, because I mean basically these kids are raising themselves... Just like I said, again, structure… structural-wise, right, taking care of yourself, uh, being home on a… at a reasonable time, and like there's nothing there.

Spirituality.

When participants spoke about *spirituality*, they did not refer to a specific belief system, but rather the "sense or that understanding that there is something greater than oneself." This was contrasted with statements regarding specific practices, including those around First Nations beliefs.

Coping skills.

Participants identified that children who are well are "able to handle some sort of crisis on their own and do it independently." When a child has a high level of wellbeing and coping skills they "learn that your… the sad and the losses that you do encounter are… are out there, right? But now you got to find the tools to overcome those… those, uh, losses and… and take the positives from them."

Study II Method

The objective of Study II was to develop, implement, and evaluate a culturally and contextually appropriate tool designed to measure the indicators of wellbeing for Anishinabek children. This tool will assist Dilico Anishinabek Family Care and the 13 communities served in determining when their children are thriving or in need of additional supports.

Generating Items

The first course of action was to create items based on the themes generated from Study I and compile these items into a preliminary questionnaire. Information provided by the participants in Study I was utilized to develop items. For example, data regarding attendance at traditional ceremonies was coded within the theme of Traditional Activities, therefore an item asking about engagement in ceremonies was generated. In this way, the thematic analysis provided a framework to develop items, which were often based on the exact words that participants spoke.

A review of current tools available to assess child wellbeing, including the few tools available to specifically assess Aboriginal child wellbeing was conducted to aid in wording of items. However, this review did not inform item content development; the specificity of qualitative research on children's wellbeing makes it inappropriate to generalize data regarding the wellbeing of children of one culture to another (Ben-Arieh et al., 2001c).

Selecting Items

Items, as defined by the participants in Study I, were written to reflect the reading level of the average 12-year-old (Streiner, Norman & Cairney, 2015). The draft questionnaire was distributed to the Research Advisory for review of content validity utilizing a modified version of the method developed by Snowshoe et al. (2015) to gather qualitative feedback on the relevance of items to the construct of First Nations children's wellbeing. The Research Advisory was also instructed to identify any items that contained ambiguous or judgment-laden language, jargon, and other words that were difficult to comprehend, imply a vague time-frame (e.g., "often" or "lately"), or required the participant to answer two or more questions (i.e., double-barreled; Streiner et al., 2015).

Child and Adolescent Needs and Strengths (CANS; Lyons, 1999). The First Nations service delivery organization partner routinely completes the CANS (Lyons, 1999) to evaluate treatment targets for their clients. The CANS was created to aid in clinical decision-making and treatment recommendations (Lyons, Weiner, & Lyons, 2004). The measure does not abide by an underlying theory and development was guided by the practical needs of service delivery organizations to plan and monitor treatment (Lyons et al., 2004).

The CANS was chosen to establish convergent validity of the First Nations Children's Wellbeing Measure due to its psychometric properties and established reliability in the measurement of children's mental health (Anderson, Lyons, Giles, Price, & Estle, 2003; Lyons, 1999). It has also been validated for use across cultures, including Indigenous Canadian cultures, and also with children who reside in rural communities (Kowatch, 2017; Moore & Walton, 2013).

All six subscales of the CANS were utilized in this study: Mental Health Needs, Risk Behaviours, Family/Caregiver Needs and Strengths, Functioning, Care Intensity and Organization, and Individual Strengths. The Mental Health Needs subscale features eight items indicative of mental health disorders (e.g., psychosis, attention deficit), as well as temporal and situational consistency, and parent-child relational problems. The Risk Behaviours subscale details a child or youth's engagement in problematic behaviours such as self-injury, posing a danger to others, and crime or delinquency. The Family/Caregiver Needs and Strengths subscale includes items related to the availability of resources, a safe environment, and the physical and mental health of parents/caregivers. The Functioning subscale has 12 items that detail a child or youth's current level of performance across personal (e.g., motor, self-care, school achievement, sleep) and interpersonal (e.g., family, peer) domains. The Individual Strengths subscale features

11 domains in which a child or youth may demonstrate strengths (e.g., interpersonal, optimism, talents and interests, and self-expression; Lyons et al., 1999).

Participants

From March 2017 to October 2017, workers administered the First Nations Children's Wellbeing Measure (Pilot Version 1; Appendix B) to the parents or caregivers of 91 children (ages 4 through 18) who were referred for mental health services through the organization. Prior to administration, the workers read aloud a script (see Appendix B, E, or F) to children's parents or caregivers. Following this, verbal consent was obtained. If the child referred for service was 16 years or older, they were provided the option to consent to the study and complete the measure independent of their caregivers. These 91 children formed the convenience sample for the quantitative analysis of this measure.

The average age of children in the sample was 9.7 years (SD = 6.42) and nearly evenly split between genders (50.5% male). The sample overwhelmingly identified as First Nations (as expected), with only 1 child identifying as Caucasian.

The Manual

A simple manual to guide administration of the measure was developed by the author (Appendix D). The content of this manual was based on measures of similar constructs, such as the ABAS-3 (Harrison & Oakland, 2015) and BASC-3 (Reynolds et al., 2015). The manual included an introduction to the measure, a description of the domains the items were expected to evaluate, detailed instructions on administration, and scoring procedures (Appendix D).

Study II Results

These themes and domains found in Study I were used to generate 51 items for the proposed measure. As Traditional Activities were referenced 45 times, compared to 18 times for

the second most cited indicator, Physical Activity, several items related to Traditional Activities were included (see Appendix E).

Feedback from Research Advisory

The 51-item Pilot Measure was circulated to members of the Research Advisory for review. A variety of feedback was provided related to the organization, length, and content of the measure. The advisory expressed that the Pilot Measure (featuring 51 items) was too lengthy, however they were agreeable to the length following the research team's explanation of the process of psychometric validation. One member also suggested that the questions could be grouped into themes such as self-care, culture, etc. Many recommendations were made regarding repetitive items.

Table 2

Feedback Regarding Repetitive Items

Item	Recommendation
2. Respects themselves.	Items 3. Respects others in the community and 4. Respects others' property/shows respect when using others' possessions could be examples for item 2. Respects themselves.
9. Shows love for friends/family/caregivers.	Items 10. Gives hugs and 11. Cares for friends or family are better as examples for item 9. Shows love for friends/family/caregivers.
12. Thinks carefully before acting.	Item 13. Controls their impulses could be an example for item 12. Thinks carefully before acting.
18. Participates in physical activity, through formal or informal means (ex. playing in an organized sports league OR playing outdoors).	Items 19. Is physically active, 20. Likes to play outside, and 21. Has a favourite outdoor activity are captured by item 18. Participates in physical activity, through formal or informal means (ex. playing in an organized sports league OR playing outdoors).
23. Refrains from saying or doing things that will upset others.	Items 24. Talks back and 25. Listens when being talked to are examples of item 23. Refrains from saying or doing things that will upset others.

Items 26. Engages with several appropriately aged friends and 27. Has friends the same age are similar.	These items are repetitive.
Items 28. Plays with friends/cousins/neighbours, 29. Plays with other children at school, and 30. Plays with other children in the community are similar.	These items are repetitive.
33. Has pride in who they are.	Items 34. Knows what community they are from, 35. Knows their spirit name, and 36. Knows their clan are examples of item 33. Has pride in who they are.
Items 39. Dresses themselves, 40. Brushes their teeth regularly on their own, and 41. Bathes regularly on their own could all be captured under a "self-care" item.	These items are repetitive.
42. Shows an interest in learning about their history and culture.	Items 43. Demonstrates an understanding of their First Nations history and culture, 44. Explores their First Nations culture and history, 45. Understands or speaks their First Nations language, and 46. If the child does not speak a First Nations language, is the child interested in learning their language? are examples of item 42. Shows an interest in learning about their history and culture.
Items 50. Has healthy coping skills to manage emotions and 51. Identifies emotions that they are experiencing are similar.	These items are repetitive.

The advisory also recommended that the research team explore alternative forms of response, as opposed to a Likert-type scale. A Likert-type scale response format (e.g., anchors and rating scales) was derived from Western research approaches and, therefore, there may be an alternative response method that better fits the needs of the First Nations participants in this study (McShane & Hastings, 2004). Considering these ideas, the Research Advisory was presented with two options: a Likert-type scale ranging from one to five or a circular answer

format, in which participants would shade in the appropriate amount of the circle to indicate their response (Appendix C). The Research Advisory received the circular answer option positively and noted that it was interesting and innovative. However, this approach presented issues in scoring: the administrator of the measure would have to measure and calculate the coverage area for each of the 51 items. To ameliorate this issue, a member of the Research Advisory suggested that the circle be split up into six sections, using dotted lines to denote each segment (Appendix C). This proposal was not integrated into the final measure as providing six sections for participants to shade-in was viewed as too similar to a Likert-type scale with responses ultimately ranging from one to six. Furthermore, the scoring of this format would still be time consuming, with little empirical evidence to support the implementation. According to recommendations from Streiner et al. (2015), the version of the measure for the pilot featured a Likert-type scale with five response options (numbers one through five) to provide an odd number of options.

The Research Advisory also informally provided feedback regarding content validity, confusing wording, and use of jargon within the pilot version of the measure; this was integrated prior to the pilot commencing. The final version of the measure for the pilot retained 51 items with a 5-point Likert-type scale. Two items were to be reverse-scored.

Piloting of the First Nations Children's Wellbeing Measure

Piloting of the first version of the measure (Appendix B) began in March 2017. Five intake mental health workers, who completed brief intake assessments for the service delivery organization, were trained by A.D. in both theory and administration of the measure. They were also provided with copies of the manual (Appendix D) and encouraged to provide feedback to the research team. One worker provided feedback and suggested that the items be re-ordered to

enhance ease of administration; the research team adjusted the order of items to reflect these recommendations (Appendix E). The numbers that correspond to each item were not changed on this re-ordered version – this was done to avoid confusion during data analysis.

Thematic Analysis

Study II also included qualitative data regarding administration of the pilot measure. Following this period of data collection, two of the mental health intake workers were interviewed to obtain important information regarding administration and content validity. This qualitative data was transcribed by a research assistant and random validity checks were performed by A.D. to ensure accuracy of transcription. Data were analyzed using QSR NVivo® computer software and a thematic analysis approach, again guided by the recommendations proposed by Braun and Clarke (2006).

Three overarching themes emerged: Barriers of the Measure (n = 20), Suggestions for Improvement (n = 15), and Positive Aspects of the Measure (n = 10). These three themes were further classified into sub-codes. Within the Barriers of the Measure theme, sub-codes were Repetitive Questions (n = 9), Confusing Wording (n = 6), Participant Issues (n = 3), Too Long (n = 3), Does not Identify as First Nations (n = 2), and Age Appropriate Questions (n = 1). Sub-codes related to Suggestions for Improvement were Provide Examples (n = 5), Combine Questions (n = 3), Administration (n = 2), Length of Questionnaire (n = 2), and Text Boxes (n = 1). Positive Aspects of the Measure had sub-codes of More Information (n = 5), Complements Other Measures (n = 2), and Simple Questions (n = 1).

Table 3

Themes and Supporting Quotations

Theme	Supporting Quotations
1. Barriers of the Measure	

Repetitive Questions	"…9, 10 and 11, when I would say "shows love, gives hugs, kisses to family"…usually those were…exactly the same [answer]. And again I know there is a reason you are doing this, but at the same time they would be like "Oh yes, the same question three times" it would be like "Yes, yes, yes" you know I got that feeling from it." "some get annoyed with how many questions there are… and how some are similar." "No one could ever give me an answer for 16. And that is the craft one. They wanted to tell me all about it in number 15."
Confusing Wording	"…They were like "well what does that mean?" so I explained that the best that I could."
Too Long	"They would turn the page and be like "Are you serious there's more?" And I'm like "Yeah"." "I don't think they were super excited to do a second assessment after the first one…You know what I mean?"
Participant Issues	"…mothers that had lots of kids around. You know like they are just so busy."
Did Not Identify as First Nations	"Occasionally, and this was rare, probably 1 in 15. I would get a strange feeling when I would say well "do you do any traditional… whatever" especially if it wasn't… you know if they were not really… if they did not obviously identify with First Nations… that was a bit tricky. I never had anyone say "don't ask me that" or " I cant believe you asked me that" and nothing like that…" "It was the very odd time that the client was not involved with their culture at all. And I get to the cultural piece and I asked a few questions and they get a little bit offended but like I tell them it is nothing personal we are not judging you it is just the questions we ask everybody. So that kind of diffuses them. But that is the odd time that like "no why… is that a problem?" and they can get a little bit mad.

	But that was it. It was just that one question."
Age Appropriate Questions	
2. Suggestions for Improvement	
Provide Examples	
Combine Questions	"I realize that those are two different questions [20. Likes to play outside and 17. Likes being on the land], but they are always answered the exact same. I think if you look through they are very very close."
Administration	"…the odd time… 47 [Has stable and consistent, supportive caregivers (e.g., mom, dad, aunty, grandmother) in their life] would make people upset just because they have child welfare involvement… That is the only one people get really mad about when I ask them."
Length of Questionnaire	
Text Boxes	"…a spot where I can make a note because I am sure you saw my little scribbles…there were lots of little spots where I almost wanted to write… because you don't get the full story of what is going on in these kids lives when you do this measure and like sometimes I would be answering, "Never or not applicable" and I would want to write like, "There is a reason for this" there is more to it than just… you know what I mean? I am sure you saw that when you looked at some of them. Some of them were probably more confusing because you only get numbers right. You don't get a full story."
3. Positive Aspects of the Measure	
More Information	"…when we get into the questions about the seven grandfather teachings and stuff like that is where I found there was more discussion. And I really liked that." "…we don't have any of that on the [CANS] so that was kind of cool to find out if they were involved at all. Finding out if they speak the language or they have a spirit name or they know what clan they are from. Or they really do a lot of practicing." "Anything that mentioned the First Nations history and culture like…these ones were easy…they could do that no problem."

Complements Other Measures	"I hate number 37 [on the CANS]. I would take that and I would put your culture questions."
Simple Questions	"I mean the questions were straight forward… they were short enough that when I asked them… probably 75% of them I didn't have to elaborate at all. Like "brushes their teeth regularly on their own, bathes regularly on their own."

Barriers of the measure. Workers were able to identify several *Barriers of the Measure*. Workers reported that *Repetitive Questions* complicated administration and confused the participants and the repetitive nature of some questions agitated participants. Workers provided examples of repetitive questions. Both items 15 and 16 involved engagement in ceremonies or traditional activities. As items 37, 43, and 44 all ask about participation in First Nations history and culture, it was recommended that the three "could just be one question." It was also suggested to the research team that item 27 "Has friends the same age" was captured well in item 26 "Engages with several appropriately aged friends." Workers reported that when asked about items 18, 19, 20, and 21 participants would sometimes share frustration over the repetitive nature, which workers also echoed.

Despite best efforts by the research team and advisory, workers reported that some of the wording in the pilot version of the measure was confusing. The item "Shows humility" required constant defining by workers. The two reverse-scored items on the measure ("Withdraws from social opportunities" and "Does not like playing with others") were administered one after another and also reported to be confusing by the workers. The item "Demonstrates spirituality" was also noted to be confusing and required explanation. The same worker also reported that it

was challenging for her to provide clarification when participants queried about items related to First Nations traditions and practices, as she does not identify as First Nations.

In terms of administration, workers noted that the 51-item measure was often too long for participants. The research team expected to receive this feedback and explained the purpose of including many questions related to psychometrics and that the intention was to eliminate a number of questions following analyses. The workers reported that often it was not the number of questions, but the fact that the participants were asked to complete two measures. Additional challenges in administration were presented when multiple demands were being placed on participant, for example, caring for multiple children who were present at the intake session. Workers also highlighted that a proportion of the participants *Did Not Identify as First Nations* or did not practice traditional activities. When presented with the items that were related to these practices, rapport could be impacted. One worker indicated that the use of the word "play" may be confusing for older children and teens.

Suggestions for improvement. The mental health intake workers also provided valuable feedback regarding Suggestions for Improvement. To ameliorate the issue with *Confusing Wording*, the workers recommended that examples were provided – specific suggestions were coded under the sub-node Provide Examples. It was recommended to add examples (or expand on current examples) for the following items: "Shows humility," "Attends traditional ceremonies (ex. smudging, sweat lodges)," and "Demonstrates spirituality".

Workers also proposed that the research team combine questions to reduce the repetitive questions in the measure and the resulting frustration of participants. They suggested that the items "Feels/demonstrates/reports a connection to their First Nations ancestors," "Demonstrates an understanding of their First Nations history and culture," and "Explores their First Nations

culture and history" could be summarized in one item. The workers noted that certain items asked about similar constructs and were consistently answered with the same response. Workers were also in consensus that the final version of the measure should be approximately 20 to 25 items in length.

The mental health workers reported challenges in administration of the measure. Flexibility in language was recommended such that administrators would be able to choose from multiple ways of phrasing a question or able to modify as they see fit. They also suggested that the language used in one question be altered to reduce negative emotions that would sometimes arise. The worker indicated that she had re-worded the question and this seemed to appease the participant.

The last node that was coded under *Suggestions for Improvement* was *Text Boxes*. One worker suggested that the research team add a section where administrators can provide additional information for each response beyond the 5-point Likert scale.

Positive aspects of the measure. The mental health workers provided qualitative data regarding *Positive Aspects of the Measure*, in addition to perceived issues. The most often cited Positive Aspect was the information about the child's involvement in and affinity for First Nations traditions. Several items in the measure focused on First Nations culture, including the *Seven Grandfather Teachings*, and workers reported that these questions generated discussion that was helpful for the intake process. Not only does the FNCWM provide greater information about the child's interest and involvement in First Nations culture (compared to available measures), but workers have also taken the initiative to creatively use the measure to drive treatment:

> I did like that it had more cultural questions on there. Because I find it helpful now when I am going in [to recommend treatment], like because I know that…it has the cultural questions and if I am opening up a new client, I'll go and take a quick check if the family is in the culture. So I know when I go and work with that client that that is something that they would be open to if I think it is appropriate.

The workers administered the FNCWM along with the CANS as part of the pilot; the CANS had already been approved by organizational management as a tool to assess clients' baseline functioning (as well as 6- and 12-month follow-up). During interviews, the mental health workers expressed that they found the FNCWM and CANS to complement each other and that the FNCWM addressed some of the shortcomings of the CANS. To utilize the measures in conjunction, one worker reported that she would complete the CANS and then the FNCWM and utilize the answers on the FNCWM (particularly those questions related to First Nations culture and traditions) and supplement the CANS items: "I could kind of go back to my CANS after and add [the information on culture] as like a strength-based thing as well. So in that way those two are really good together."

The workers also noted that the simple nature of the questions and ease of administration were benefits of the measure. Participants' also seemed to enjoy answering simpler questions that did not require elaboration.

Measure Revisions

Due to the small sample included in this pilot and recommendations from the mental health intake workers, two senior graduate students with expertise in Indigenous mental health were recruited to review the measure. These two graduate students not involved in the measure development independently provided feedback about redundant items, as well as issues with

content validity and confusing language, and A.D. compiled this feedback. Suggestions from the two graduate students and two mental health workers were then utilized to generate version three of the questionnaire in which 29 items were retained (Appendix F). This version was used in the principal components analysis.

Quantitative Analysis

Data cleaning. The dataset was cleaned and items were transformed to z-scores and descriptive statistics were calculated to examine skewness and kurtosis. Any item that exceeded the standard parameters of -2/+2 was further investigated (Field, 2009). All skewness statistics were within the acceptable range. One item was identified as being high in kurtosis. This item was regarding the child's ability to dress themselves; as all children in the sample were above the age of 6 and dressing oneself is an age-appropriate skill, this kurtosis was expected.

Principal components analysis. To determine the underlying structure of the pilot measure, a principal component analysis was conducted utilizing IBM SPSS Statistics Version 25. Principal component analysis, or the similar exploratory factor analysis, are used to summarize a data set and provide information about the underlying constructs that an assessment measure may be evaluating (Pallant, 2016). When the researcher does not possess sufficient evidence to develop hypotheses regarding the relationships that may exist amongst the items, these methods are appropriate (Pallant, 2016). This represents the first step in validating an assessment measure for use, followed by confirmatory factor analysis (Pallant, 2016).

The dataset was deemed suitable for principal components analysis, according to recommendations by Norman and Streiner (2008), with a minimum ratio of 3:1 (participants to items). Despite varying opinions and recommendations regarding this ratio, a 3:1 ratio was chosen. Values associated with both the Kaiser-Meyer-Olkin and Bartlett's Test of Sphericity

were acceptable (Pallant, 2013). Five components with eigenvalues greater than one were detected, but upon examination of the scree plot, it became evident that a three-factor model was more appropriate. Prior to running additional analyses, one item that did not load onto any of the three factors was removed from analyses. A total of 58.8% of variance was accounted for by the three-factor solution, with each factor contributing 39.9%, 12.4%, and 6.5%, respectively.

Table 4

Factor Loadings of the Principal Components Analysis

Factor 1	Factor 2	Factor 3
2. Respects themselves	1. Abides by/has experience with/has instruction in/has mentorship in the seven grandfather teachings.	33. Has pride in who they are.
3. Respects others in the community	15. Attends traditional ceremonies and activities (ex. smudging, sweat lodges).	38. Has positive adult role models.
5. Is truthful	34. Knows what community they are from.	17. Likes being on the land.
6. Shows humility	35. Knows their spirit name or clan.	18. Participates in physical activity, through formal or informal means (ex. playing in an organized sports league OR playing outdoors).
7. Congratulates and celebrates others' successes	43. Demonstrates an understanding of their First Nations history and culture.	27. Plays appropriately with friends the same age (cousins, at school, in the community).
8. Does what is right, despite consequences	44. Explores their First Nations culture and history.	
9. Shows love for friends/family/caregivers	45. Understands, speaks, or is interested their First Nations language.	

22. Expresses/vocalizes/communicates their feelings and needs (to caregivers)	49. Demonstrates spirituality.	
23. Refrains from saying or doing things that will upset others		
39. Takes care of themselves (physically; e.g., brushes teeth, bathes, dresses themselves)		
25. Listens when being talked to		
50. Has healthy coping skills to manage emotions		
51. Identifies emotions that they are experiencing		
12. Thinks carefully before acting		
14. Keeps promises that they make		

Scale Statistics

Scale statistics for each of the three factors were also examined using the threshold of .700 suggested by Nunnally (1978). For Factor 1 (General Wellbeing), internal consistency was very high (Cronbach's alpha = .950). Inter-item correlations between items were generally satisfactory, however 12 of the correlations were above the acceptable range (.25 to .65), ranging from .653 to .776. Upon further investigation, the majority of these correlations were quite close to the top end of the acceptable range (i.e., within .10 of .65). Additionally, Cronbach's alpha if these items were to be removed were examined and the removal of any of the items yielding high correlations did not improve the Cronbach's alpha of the scale. The internal consistency of Factor 2 (Traditional Activities) was also high (Cronbach's alpha = .884) and included five inter-item correlations to be above the acceptable range. Results showed that Cronbach's alpha could

be slightly improved (by .02) with the removal of one item ("Knows what community they are from"). Based on inspection of the inter-item correlations and corrected item-total correlation for this item (which yielded acceptable results) and the subtle differences that this item may detect compared to similar items such as "Knows their spirit name or clan" or "Demonstrates an understanding of their First Nations history and culture," the decision was made to retain the item. Internal consistency was adequate (Cronbach's alpha = .762) and inter-item correlations for Factor 3 (Social Engagement) were acceptable, with the exception of the correlation between the items "Likes being on the land" and "Has positive adult role models" being slightly low (r = .234). Examination of the corrected item-total correlations yielded acceptable results for all items and it was determined that the removal of any item would not improve internal consistency, therefore all items were kept on the scale.

Convergent Validity

Despite each item providing information regarding areas for improvement, the CANS subscales have also been used in past research (Lyons, Griffin, Quintenz, Jenuwine, & Shasha, 2003). The CANS subscales were chosen to establish convergent validity with the FNCWM scales (Factors 1-3). A scale total for each of the six domains included on the CANS (Mental Health Needs, Risk Behaviours, Family/Caregiver Needs and Strengths, Functioning, Care Intensity and Organization, and Individual Strengths) and the three factors of the FNCWM (General Wellbeing, Traditional Activities, and Social Engagement) was calculated. Following this, Pearson product-moment correlations were calculated (see Table 5). Overall, Factor 1 and 3 were significantly and negatively correlated with the majority of CANS subscales, as anticipated. The exceptions were the relationships between Factor 1 (General Wellbeing) and the CANS Family/Caregiver Needs subscale (r = -.099) and Factor 3 (Social Engagement) and the CANS

Care Intensity and Organization subscale (r = -.133), which were both negative, but not significant. The correlation between Factor 2 (Traditional Activities) and the Individual Strengths subscale was significant and emerged as expected (r = -.380), however the relationships between Factor 2 and all other CANS subscales were not significant.

CHAPTER 3. DISCUSSION

The purpose of this project was to develop, implement, and evaluate a culturally and contextually appropriate tool to measure the indicators of wellbeing for First Nations children in the Robinson Superior Treaty Area. In Study I, members of First Nations in the Robinson Superior Treaty Area were interviewed and provided information regarding indicators of the wellbeing of children in their communities. In Study II, these indicators were utilized to generate items and these items were compiled into the First Nations Children's Wellbeing Measure, which was piloted and validated for use. Feedback regarding the measure was also gathered from the mental health intake workers.

Study I

The qualitative data collected from interviews and focus groups yielded results that reflected our main purpose and hypothesis: traditional activities and engagement in culture are extremely important to the wellbeing of First Nations children. Additionally, this construct appears to be unique and, while certainly related to other aspects and indicators of wellbeing, resulted in an independent factor in the analysis of the measure. The other indicators that emerged in qualitative data analysis were Physical Activity, Expression/Communication, Social Engagement, Self-worth/value/esteem, Positive Role Models, Healthy Appearance, History and Culture, Mental Health as All-Encompassing, Support, Healthy Home Environment, Structure and Routine, Connection, Spirituality, Coping Skills, Smiling/Laughing, Safety, Healthy

Community, Stability, Well-Behaved, Cooperative, Creativity, Positive Outlook, Purpose, Responsibility, Following Values, Helpful, Independence, Insight, and Thinking Through Consequences.

During the conceptualization of this project, many members of the research team and Research Advisory believed that traditional activities would be cited often in interviews and focus groups. The majority of the research team and Research Advisory had experience working directly with First Nations children and families and were able to provide anecdotal reports of the influence that traditional activities had on these individuals. Members of the research team also have experience in evaluating the cultural bias inherent in psychological testing instruments (Mushquash & Bova, 2007) and this provided some evidence for the anecdotal reports. Within the entire qualitative dataset for the current project, the Traditional Activities theme (including sub-codes Teachings, Ceremony, Crafts, Land-based Activities, Balance, the Seven Grandfather Teachings, Respect, and Humility) was referenced 45 times. These references represent approximately 16% of all references in the dataset.

The goal within the interviews and focus groups was to uncover all aspects of wellbeing for children in the Robinson-Superior Treaty Area. This goal was monitored through the iterative qualitative analysis process; it was important to ensure that all themes that were to be used in item development had reached saturation. Because of this process and the observed saturation of the dataset, it can be assumed that the data served as a complete and accurate representation of this construct. According to that logic, Traditional Activities account for approximately 16% of that construct for this group, which supports the notion proposed by the partner organization that measures of wellbeing for majority culture children do not sufficiently capture this construct. Many other measures of child wellbeing or mental health focus on indicators that loaded onto

Factor 1 (General Wellbeing) and Factor 3 (Social Engagement) within the First Nations Children's Wellbeing Measure.

This finding was consistent with emerging literature connecting the wellness of Aboriginal children and engagement in culture and traditional activities. In a study utilizing a similar method, parents of Aboriginal and Torres Strait Islander children were interviewed about elements that are essential for their healthy development; as in the current study, culture was referenced most often (Colquhoun & Dockery, 2012). This included possessing a positive identity in terms of what it means to be an Aboriginal or Torres Strait Islander and also an understanding of their community, language, and stories (Colquhoun & Dockery, 2012). Young et al. (2017) also interviewed parents of Aboriginal children, who were located in New South Wales, Australia, regarding factors that contribute to the resilience of their children. Participants reported that a strong cultural identity and understanding of cultural knowledge and traditions were important for the development of resilient Aboriginal children who could adapt to and withstand adversity throughout their lives (Young et al., 2017). Despite these examples originating from Australia and New Zealand, the results reflect extremely similar messages: to be Aboriginal and well, children must be engaged in their culture and traditions.

There have been several studies evaluating health outcomes and/or the wellbeing of Aboriginal children using instruments normed with samples of majority culture children or demographic data and simple statistics, such as correlation. This is problematic, as it has been demonstrated that these instruments do not adequately capture the construct of wellbeing for Aboriginal people (CPA, 2018; LeGrande, 2017). If it can be assumed that engagement in and understanding of culture is important for the wellbeing of all Indigenous people (Assembly of First Nations & Health Canada, 2015), then using the results of Study I, these instruments were,

at best, evaluating 84% of wellbeing for Indigenous people. When items regarding involvement in cultural activities were included, these were often added by the researcher and were not empirically validated. This practice minimizes the conclusions that can be made following analyses and also has the potential to fail to detect relationships that are present. An example is a study by Mota et al (2012). The researchers in this study utilized data from the 2002–2003 Manitoba First Nations Regional Longitudinal Health Survey of Youth to examine the correlates of suicide. Participants responded to 16 questions about whether or not they engaged in a variety of cultural activities, including attending pow wows and hunting; results showed that none of these activities were related to suicidality (Mota et al., 2012). The authors explained that this lack of relationship was due to "the crudeness of the measure used for cultural practice" (Mota et al., 2012, p. 1359).

LeGrande et al (2017) conducted a scoping review of the current measures designed to assess the social and emotional wellbeing of Indigenous Australians adults. Of the 22 measures they identified, only six were developed specifically for use for Indigenous people (LeGrande et al, 2017). Two of these specifically-designed measures included a factor related to cultural engagement and one of these was only for cancer patients who identified as Indigenous, leaving one measure that was validated for use with Indigenous people and that also evaluated some aspect of culture (LeGrande et al., 2017).

The CPA task force's response to the Truth and Reconciliation Commission of Canada's report has identified a lack of culturally relevant assessment measures as a major issue for psychologists. They state "few psychological assessments recognize or highlight the gift of a person's connection to the spirit world, their relationship to deceased elders, their contribution to an extended family or collectivist society, or a concrete contextualized description of behaviour

observed within the home and community. Instead, assessments generally address Western theories of mental health and illness" (CPA, 2018, p. 15). Despite the publication of this report after the completion of the current project, the FNCWM does acknowledge these unique aspects of Indigenous identity and wellbeing. The qualitative data collected in Study I that resulted in the theme of Traditional Activities was essential in demonstrating the importance of this construct for Indigenous children in the Robinson-Superior Treaty Area.

The second most often cited indicator of wellbeing was Physical Activity. This indicator is well established in the literature for majority culture children and adolescents (Biddle & Asare, 2011; McMahon et al., 2016), and there is an emerging body of literature associating physical activity with wellbeing in Indigenous populations. A systematic review conducted by Bruner et al. (2015) aimed to determine what aspects of Aboriginal youth development were positively influenced by participation in sport and physical activity. They found that involvement in physical activity can reduce self-harm and substance use in Aboriginal youth, as well as provide an opportunity to engage in traditional activities (Bruner et al., 2015). When traditional activities (which many Aboriginal children and youth are familiar with) were utilized in physical activity (e.g., the North American Indigenous Games), there was increased cultural pride and feelings of comfort in a sport environment (Bruner et al., 2015). McHugh et al. (2018) also examined the literature regarding the experiences of Indigenous youth within sport and recreation, specifically focusing on qualitative research. They found that involvement in sport and recreation resulted in enhanced positive emotions, pride in oneself and one's culture, and connectedness to others, nature, and culture (McHugh et al., 2018).

Involvement in physical activity can also promote social engagement and self-esteem – two indicators that were also cited often by participants (Beets, Cardinal, & Alderman, 2010; Li,

Bunke, & Psouni, 2016; Sallis, Prochaska, & Taylor, 2000; Young et al., 2017). A high level of social engagement and self-esteem may be protective factors against the racism experienced by First Nations people in Canada (Bombay, Matheson, & Anisman, 2010).

Many of the participants in Study I cited the importance of positive role models, parental or caregiver support, and a healthy home environment, which included structure and routine, in terms of the wellbeing of children. The First Nations Mental Wellness Continuum Framework emphasizes the importance of relationships to the wellbeing of all First Nations people and there is specific literature emerging relating the wellbeing of Indigenous children to the family and adults surrounding them (Assembly of First Nations & Health Canada, 2015; Stuart & Jose, 2014). Parents and caregivers can create vastly different environments for children, which will impact their resilience and success (Ungar, 2008).

Through an exploration of the literature, it was clear that many of the other indicators referenced by participants can be captured within other indicators that were cited more often. For example, the concept of purpose for a First Nations child may emerge from a variety of sources, including engagement in traditional activities, involvement in physical activity and sport, or family connection.

According to responses from participants in Study I, the importance of Traditional Activities accounts for a far greater proportion of First Nations children's wellbeing than any other indicator. While the other indicators are similar to those for majority culture children, this unique construct represents an important affirmation regarding the essential nature of traditional activities for the wellbeing of First Nations children.

Study II

As Factor 1 (General Wellbeing) and Factor 3 (Social Engagement) included many items similar to existing measures of child wellbeing (e.g., ABAS-III, BASC-3, CANS) the novelty of the First Nations Children's Wellbeing Measure relates to Factor 2 (Traditional Activities). Within the literature, traditional activities have been described as very important to the wellbeing of First Nations children and adults, however, this dissertation represents one of few attempts to psychometrically measure engagement in these activities.

Factor 1 (General Wellbeing)

Factor 1 has been designated as the General Wellbeing factor. The largest number of items (15) loaded onto this factor. The content of these items varied from respecting others to having healthy coping skills to manage emotions, however, all items did still evaluate a component of wellbeing. This factor was also highly correlated with all subscales of the CANS (a Western measure), with the exception of the Family/Caregiver Needs subscale. As the majority of items that were developed from a Western lens and Western understanding of wellbeing loaded onto Factor 1, this finding was expected. Further, the items on Factor 1 of the FNCWM did not evaluate family or caregiver functioning.

Factor 1 may also capture principles of wellbeing that are universal and detectable across cultures. The FNCWM items that loaded onto this scale are similar to items found on established measures of child wellbeing and mental health used in majority cultures, including the ABAS-III (Harrison & Oakland, 2015), BASC-3 (Reynolds et al., 2015), and CANS (Lyons, 1999). A relatively new measure, The Psychological Well-Being Scale for Children (Opree, Buijzen, & van Riejmersdal, 2018), also features similar items. The items on the FNCWM related to activities of daily living [e.g., "Takes care of themselves (physically; ex. brushes teeth, bathes,

dresses themselves)"] and communication [e.g., "Expresses/vocalizes/communicates their feelings and needs (to caregivers)"] are comparable to items on the Activities of Daily Living scales on the ABAS-III (Harrison & Oakland, 2015) and BASC-3 (Reynolds et al., 2015), the Functional Communication scale also on the BASC-3 (Reynolds et al., 2015), as well as the Functioning and Individual Strengths subscales of the CANS (Lyons et al., 1999). Items on the FNCWM such as "Shows love for family/friends/caregivers," "Refrains from saying or doing things that will upset others," and "Keeps promises that they make" are also comparable to the items on the BASC-III Social Skills scale (Reynolds et al., 2015) and items from the CANS Individual Strengths subscale (e.g., Interpersonal; Lyons et al., 1999).

Despite these similarities, the composition of Factor 1 (General Wellbeing) does vary from measures of wellbeing rooted in Western conceptualizations. The main distinction between Factor 1 and other measures is the amount of items that are relational in nature; that is, a large number of items require relationships with others to be evaluated. For example, six of the 24 items included on the longest form of the PWB-c concern interactions with other people (e.g., "Do you like meeting new people?" and "Can you trust your friends?"), compared to nine of the 15 items on Factor 1 (General Wellbeing) of the FNCWM alone. Additionally, Factor 3 (Social Engagement) has been conceptualized as a scale entirely pertaining to the manner in which a child or youth engage with others in their community and many of the items on Factor 2 (Traditional Activities) require relationships with others (e.g., "Knows what community they are from"). The PWB-c also features many items related to autonomy and independence, while the FNCWM includes no items related to these constructs.

This focus on relationships in the FNCWM aligns the measure with the First Nations Mental Wellness Continuum Framework. The Framework emphasizes that relationships foster

connection and balance, which are essential for the wellbeing of First Nations people (Assembly of First Nations & Health Canada, 2015).

Factor 2 (Traditional Activities)

A total of eight items from the FNCWM loaded onto Factor 2. Upon examination, it was evident that all eight items were related to spirituality and First Nations tradition and culture, therefore this factor was named Traditional Activities.

The items: "Respects themselves," "Respects others in the community," "Is truthful," "Shows humility," "Congratulates and celebrates others' success," and "Does what is right, despite consequences" were created by the research team to reflect several of the seven grandfather teachings, however, these items did not load onto the same factor as the item "Abides by/has experience with/has instruction in/has mentorship in the seven grandfather teachings." Instead, this item loaded onto Factor 2 (Traditional Activities). Despite this discrepancy in expected and actual factor loadings, this finding is still acceptable; all the seven grandfather teaching items that loaded onto Factor 1 may be present in mentally well children, regardless of their identification as First Nations or understanding of these teachings. Demonstrating respect, being truthful, etc. are values held as important by many cultures and also represent societal expectations in many countries (Schwartz & Bilsky, 1990). This socialization to cultural expectations likely represents a universal factor in the understanding of wellbeing (i.e., how well one can navigate their world and environment) and, therefore, should theoretically load onto Factor 1 (Amerijckx & Humblet, 2014; Ereaut & Willis, 2008). The majority of items that loaded onto Factor 2 were exclusively related to First Nations culture and traditions, so it is appropriate that the six items identified as being cross-cultural load onto Factor 1.

Spence, Wells, and Graham (2016) examined the influence that cultural resilience has on stress following experiences of discrimination. For this study, cultural resilience was operationalized using a 4-question measure that included items about engagement with First Nations culture, the environment, traditional languages, and ceremonies (Spence et al., 2016). For those who were higher on this measure of cultural resilience, discrimination had less of an affect on stress levels (Spence et al., 2016). Muriwai, Houkamau, and Sibley (2015) also examined the influence that cultural efficacy had on Maori adults in New Zealand. A high level of cultural efficacy was associated with psychological resilience and lower cultural efficacy was related to increased psychological distress (Muriwai et al., 2015). The sample utilized in this study featured individuals who identified as solely Maori and also individuals who identified as having mixed European and Maori descent. The relationships between cultural efficacy and psychological resilience and distress held constant for both groups, however the relationship between low cultural efficacy and high psychological distress was strongest for those who identified only as Maori. This may indicate that involvement in culture and traditional activities is a powerful predictor of wellness for those who identify as solely Indigenous. Stuart and Jose (2014) also found that engagement in cultural activities led to high ethnic identity (a sense of belonging and certain behaviours that develop from one's ethnic group), which was predictive of increased wellbeing in Maori youth.

Factor 3 (Social Engagement)

An interesting finding relates to Factor 3 (Social Engagement) and the results from Study I. Although the Traditional Activities node was referenced most often by qualitative interview participants (n = 45), Physical Activity was the second most cited factor in wellbeing (n = 18). The results of the principal components analysis of the pilot measure indicated that Factor 3

(Social Engagement) includes two (potentially three) items that correspond directly to this construct: “Likes being on the land” and “Participates in physical activity, through formal or informal means (ex. playing in an organized sports league OR playing outdoors).” The third potential item related to Physical Activity was “Plays appropriately with friends the same age (cousins, at school, in the community).” Despite playing indoors as well, many children play with their friends outdoors and in a physically active manner. Based on the results of the principal components analysis and the fact that these items loaded together, it can be assumed that the item “Plays appropriately with friends the same age (cousins, at school, in the community)” was also measuring this Physical Activity construct. The two remaining items on the scale (“Has pride in who they are” and “Has positive adult role models”) may not be as obviously related as the other three, however, there are several theoretical explanations for their inclusion on this scale. Social engagement is required for a child to rate the item “Has positive adult role models” highly; for example, if a child is not socially active in their family or community, they are unlikely to develop strong, lasting relationships with positive adult role models. Therefore, a child who has positive social connections with peers would be more likely to have similar connections with adults. There is also a body of literature that supports the notion that a child’s social support and physical activity levels are linked, such that a child with more positive social connections will also be more physical active (Beets et al., 2010; Li et al., 2015; Sallis et al., 2000; Young et al., 2017). This social support has been suggested as both tangible (e.g., purchasing equipment) and intangible (e.g., providing encouragement; Beets et al., 2010). Although the present study did not evaluate these two domains of social support, it can be assumed that children in this study benefit from both types of social support.

The physical activity level of adolescents, in turn, was also related to self-perception and self-esteem, which the item "Has pride in who they are" was theorized to be measuring to some degree (Li et al., 2015). When adolescents participated in physical activity, they were likely to perceive themselves as strong, possess a good level of fitness, and have an overall positive self-perception (Li et al., 2015). Further, there is evidence that cultural identity and self-esteem were highly correlated in children and adolescents, therefore the item "Has pride in who they are," was likely tapping into this construct as well within the current measure (Smith, Walker, Fields, Brookins, & Seay, 1999; Umana-Taylor, 2004; Young et al., 2017).

Bombay et al. (2010) also found that pride related to First Nations identity was a protective factor against the effect that perceived discrimination has on depressive symptoms in adults; individuals who possessed a higher level of positive feelings about their identity as a First Nations person appeared less susceptible to experiences of depression following discrimination. Bombay et al. (2010) also suggest that when pride regarding ethnicity is measured in research, it is often evaluated based on level of involvement in traditional activities, and this is problematic as one may be involved in traditional activities for a myriad of reasons that do not include pride in ethnic identity. The measure created and evaluated in the current study does not suffer from this disadvantage (as there are items focused on traditional activity involvement, cultural knowledge, and pride in themselves, not only their ethnicity). Further, the quantitative analysis completed as part of Study II supports the notion by Bombay et al. (2010): items related to practice of traditional activities and cultural knowledge loaded onto a different factor than the item related to pride in oneself. These results suggest that, while these two constructs are likely related, they are in fact distinct and should be evaluated as such.

This deconstruction of the item "Has pride in who they are" has important implications for health and wellbeing for Indigenous children and youth. Siddiqi, Shahidi, Ramraja, and Williams (2017) found that in a population of Canadian adults, those who experience discrimination more often were more likely to have a chronic health condition. Further, they echoed that individuals in this study who identified as Aboriginal reported high levels of discrimination and often the poorest health (Siddiqi et al., 2017). Pascoe and Smart Richman (2009) conducted a meta-analysis regarding adults' experiences of discrimination and physical and mental health outcomes; unsurprisingly, increased discrimination was related to poorer physical and mental health. In the studies examined by Young et al. (2017), experiences of discrimination were associated with poorer mental health outcomes for Indigenous children. If a positive view of one's self can buffer against these experiences of racism and discrimination, then fostering a child's self-perception (across several domains) may be considered to be an effective physical and mental health intervention.

Regardless of the source of a child's pride in their identity or self-esteem, this construct was a powerful predictor of wellbeing. Young et al. (2017) found that in 78% of studies included in their systematic review, Indigenous children with high self-esteem also experienced better mental health outcomes. Further, in half of the studies, Indigenous children who reported identifying with their own culture also had more positive mental health (Young et al., 2017). In addition, the construct of resilient mental health (i.e., positive mental health in the face of hardships) was associated with identifying with one's Indigenous culture (Young et al., 2017). Therefore, all five items on this scale were related, such that Social Engagement was common factor in all relationships.

Stuart and Jose (2014) found that high family connectedness was predictive of higher wellbeing in Maori youth, regardless of the family structure (e.g., one-parent vs. two-parent families). While the Maori are Indigenous to New Zealand as opposed to the sample of Indigenous children from North America, this finding may provide clarification regarding the relevance of the item "Has positive adult role models" to the wellbeing of First Nations children. In the Stuart and Jose (2014) study, family connectedness was not only conceptualized as a source of support (as is in majority culture), but also the vehicle by which cultural knowledge and activities are shared. In the current study, the positive adult role models reflected in the item "Has positive adult role models" may provide an additional source of connection to culture, thereby enhancing self-pride (referenced in item 33) and also engagement with the indicators assessed in Factor 2 (Traditional Activities).

Compared to the PWB-c, the items that loaded onto Factor 3 of the FNCWM were found to be similiar to items within the domains of Self-Acceptance and Positive Relations (Opree et al., 2018). The Self-Acceptance domain includes items related to pride in oneself, and while the items from the Positive Relations domain ask about relationships with important figures in the child's life, these were solely focused on friends and parents (Opree et al., 2018). The items on Factor 3 of the FNCWM were similar, but may be considered more comprehensive; for example, item 38 on the FNCWM asks about any positive adult role models in the child's life, not exclusively parents. This use of this broad language reflects both the First Nations Mental Wellness Continuum Framework regarding the importance of many community members in an individual's life and the wider definition of family for many Indigenous people, which may extend to any person involved in the care of the child (Assembly of First Nations & Health Canada, 2015; McShane & Hastings, 2004).

Validity of the First Nations Children's Wellbeing Measure

The scores from the FNCWM and the CANS were compared to establish convergent validity. The correlations for Factors 1 (General Wellbeing) and 3 (Social Engagement) were generally significant (at both $p < .05$ and $p < .01$ levels) and negative, establishing that children with greater needs (as identified by the CANS) were also likely to have lower wellbeing scores (as measured by the FNCWM). The correlations between Factor 2 (Traditional Activities) and the created subscales of the CANS partially emerged as predicted. The Individual Strengths subscale was reverse-coded and evaluates domains that can be considered important to the resilience of Indigenous youth, such as engagement in community, pursuing talents and interests, and spirituality (Kowatch, 2017; Toombs, Kowatch, & Mushquash, 2016). The relationship between this subscale and Factor 2 emerged in a negative direction, as predicted. This indicated that a child who was more engaged in traditional activities and culture also possessed more strengths (both related to culture and not). The other CANS subscales (Mental Health, Risk Behaviours, Family/Caregiver Needs and Strengths, and Care Intensity) were not. The correlation between the CANS Functioning subscale and Factor 2 was negative and trending towards significance ($p = .081$), however the relationships with other CANS subscales were not.

While those with higher General Wellbeing (Factor 1) and Social Engagement (Factor 3) may be less likely to experience any mental health issues, involvement in Traditional Activities (Factor 2), may not be a robust enough protective factor against this. Further, the CANS Mental Health subscale includes a wide range of disorders, including disorders understood to be more organic (e.g., psychosis) and those that can be highly influenced by environmental factors (e.g., anxiety or depression). This proposition was supported by additional inspection of the data: the

scores within the CANS Mental Health subscale for each participant were extremely varied (M = 9.60, SD = 6.28).

The Risk Behaviours subscale was endorsed infrequently, therefore, a floor effect may explain the lack of relationship between this subscale and Factor 2. The CANS Family/Caregiver Needs and Care Intensity subscales include information that is important for the agency to collect, particularly as child welfare and protection is within their mandate, however a child's participation in traditional activities likely has little impact on their parents' abilities to care for them. Thus, it was expected that there would be no statistical relationship between these two subscales and Factor 2. Overall, the convergent validity results psychometrically support the use of the FNCWM in the assessment of the wellbeing of First Nations children in the Robinson-Superior Treaty Area.

The First Nations Mental Wellness Continuum Framework

The FNCWM is a measurement tool and does not presuppose a theory of wellness for First Nations children and youth. This approach is similar to the use of the First Nations Mental Wellness Continuum Framework as a tool to guide service development and implementation. The items on the FNCWM describe indicators of wellbeing for this population, however these indicators do not comprise wellbeing itself (Assembly of First Nations & Health Canada, 2015). According to the First Nations Mental Wellness Continuum Framework, wellness is brought about by balance across a variety of domains and manifests in hope, meaning, belonging, and purpose (Assembly of First Nations & Health Canada, 2015). The indicators of wellbeing on the FNCWM, according to the participants in Study I, bring about this state of wellbeing and the hope, meaning, belonging, and purpose inherent in this experience.

The three factors and individual items featured on the FNCWM correspond with many of the domains of the First Nations Mental Wellness Continuum Framework.

Factor 1 (General Wellbeing). The items that loaded onto Factor 1 were related to General Wellbeing and included activities of daily living, coping skills, and social skills. These items are related to the concepts of physical wellness and the purpose that is revealed through taking care of one's body, for example the items "Takes care of themselves (physically; ex. brushes teeth, bathes, dresses themselves)" (Assembly of First Nations & Health Canada, 2015). Items such as "Shows humility" and "Does what is right, despite consequences" were based on grandfather teachings and were related to spiritual wellness that brings about hope (Assembly of First Nations & Health Canada, 2015). Other items were associated with social interactions, such as "Listens when being talked to," which exemplify the belonging that results from emotional wellness (Assembly of First Nations & Health Canada, 2015).

Factor 2 (Traditional Activities). The entirety of the First Nations Mental Wellness Continuum Framework is situated within culture as culture provides the foundation from which all other aspects of the Framework emerge (Assembly of First Nations & Health Canada, 2015). All eight items that loaded onto Factor 2 (Traditional Activities) were related to First Nations culture and spirituality. These items demonstrate the "cultural ways of being and doing" (p. 4) that result in purpose; Indigenous values that bring about hope; and the connection to family, community, and culture that culminates in belonging (Assembly of First Nations & Health Canada, 2015).

The unique contribution of this factor lies in the connection to meaning, which is brought about by mental wellness and "an understanding of how their lives and those of their families and communities are part of creation and a rich history" (Assembly of First Nations & Health

Canada, 2015, p. D). Despite a focus on relationships across all three scales, the items on Factor 2 (Traditional Activities) such as "Demonstrates an understanding of their First Nations history and culture" and "Knows their clan or spirit name" exclusively indicate an understanding of the child or youth's place in creation and the history of their people.

Factor 3 (Social Engagement). Factor 3 (Social Engagement) includes items related to relationships in a child or youth's life, such as positive adult role models and peers, which bring out belonging. This factor also features items that are associated with the purpose that results from physical wellness and Indigenous ways of being and doing, such as "Likes being on the land" (Assembly of First Nations & Health Canada, 2015).

Use of the First Nations Children's Wellbeing Measure

Despite similarities between Factor 1 (General Wellbeing) and other measures of wellbeing (e.g., ABAS-III, CANS, BASC-III, and PWB-c), the FNCWM evaluates wellbeing from a more relational perspective. This approach is aligned with the First Nations Mental Wellness Continuum Framework, which situates all wellbeing within culture and community (Assembly of First Nations & Health Canada, 2015). Considering this distinction, it may be most appropriate for the organization to continue utilizing the FNCWM, in conjunction with other well-established measures of wellbeing in children and youth, and continue to conduct research to analyze the suitability of each.

The FNCWM was piloted during the intake process, when children and youth were being enrolled in mental health services. The organization could continue to use the measure at this pre-treatment point, and also incorporate additional points of measurement throughout and following treatment (e.g., three or six months into treatment and post-treatment). This process

would allow for the organization to evaluate their services and determine if programming is meeting the needs of children and youth.

Considering that there are few available measures that evaluate the wellbeing of First Nations children, the organization may also want to utilize intake or pre-treatment scores on the FNCWM as a general, population-level indicator. The results of this information could support development of new programming or changes to existing programming that better suit the needs of children entering services. For example, if many children and youth are scoring low on the Social Engagement scale, then the organization may alter services to offer increased access to social skills training or opportunities to interact with positive adult role models.

The results of the interviews with mental health workers and the principal components analysis, as well as comparison to the First Nations Mental Wellness Continuum Framework, provided evidence that a set of questions from this measure (i.e., Factor 2) contributed uniquely to the impression of wellbeing generated for each child in assessment (Assembly of First Nations & Health Canada, 2015). The mental health intake workers noted that these questions were helpful in identifying which children and families may be receptive to the integration of both Western and First Nations approaches to healing and aided these workers and others in treatment planning. They also indicated that the FNCWM items were preferable to the single item on the CANS which evaluated this construct (item 37. Cultural Stress, within the Functioning scale). One of the interviewees transitioned from intake worker to counselor during the pilot of the measure and she was able to speak to this use. This worker highlighted that, if a child or family had been administered the FNCWM during intake, she could review the questions which ultimately loaded onto Factor 2 and determine if cultural approaches to treatment may be appropriate for the child. Further, if according to the responses on the FNCWM, a child was not

involved in any traditional activities, the counselor would also be able to glean this information from the measure. Given the results in Study I and II regarding the importance of engagement in traditional activities for wellbeing, the counselor would be able to suggest this as part of a larger treatment plan with the agency. In addition to this qualitative data, the principal components analysis also provided quantitative support for the addition of (at least) this scale in the regular assessment of children admitted to the service.

The FNCWM can be used to not only identify areas for improvement and treatment targets, but also strengths. A strengths-based approach stems from the acknowledgement that children and youth all possess inherent resources that they are able to utilize to improve their wellbeing and contribute to their communities (Aspy et al., 2004; Crooks, Chiodo, Thomas, & Hughes, 2010). If the responses given by a parent or caregiver are a 4 or 5 (Usually or Almost Always) on certain items, then the content of these items can be considered an area of strength for the child. For example, if the respondent indicated a 4 or 5 for items "Participates in physical activity, through formal or informal means (ex. playing in an organized sports league OR playing outdoors)" and "Plays appropriately with friends the same age (cousins, at school, in the community)," then play may be considered an area of strength for this child. Strengths are an important consideration when delivering intervention to any child, including First Nations children (Crooks et al., 2010).

Future Directions

Based on the results of this dissertation, further examination of the First Nations Children Wellbeing Measure is warranted. The measure was revised prior to and following data analysis, based on the results of both Study I and II, and will now include 28 items that load on three distinct scales: General Wellbeing, Traditional Activities, and Social Engagement. Collection

and analysis of additional quantitative data using this revised measure will provide added support for implementation within regular service delivery of the organization. It is recommended that an additional exploratory principal components analysis be conducted with a more robust set of data, and following that, a confirmatory principal components analysis. Unfortunately, the sample size in this study (n = 91) was not large enough to utilize this design.

An additional pursuit may be an evaluation of the integration of only the Traditional Activities scale in intake and subsequent assessment. Currently, mental health intake workers are delivering the entirety of the scale, however the results of this dissertation support the use of this single scale, if appropriate. The psychometric properties of the scale were acceptable and the qualitative results of Study II indicated that it may be mainly this scale that provided added value in assessment. The Child and Adolescent Needs and Strengths Measure (CANS) has been adopted by the organization as the main assessment measure at intake and discharge and as it features good psychometric properties and reliably measures the wellbeing of children (Anderson et al., 2003; Lyons, 1999). A future direction may be to administer both measures, in full, to one group and contrast both information gathered and treatment outcomes with another group who is given the CANS and only the Traditional Activities scale of the FNCWM. This recommendation was echoed in the qualitative data from interviews with mental health intake workers, who expressed that the Traditional Activities questions complemented the CANS and addressed the shortcomings inherent in measures designed for use with children of majority culture.

Exploring the FNCWM using the alternative, circular response method (Appendix C), which was considered with the Research Advisory in the project conceptualization stage may also be a worthwhile pursuit. The Likert-type rating scale that was ultimately utilized in the pilot

and final versions of the measure was derived from a Western perspective and it is unclear how this response format may have impacted the responses of First Nations participants. By comparing the responses of matched participants on the FNCWM using both the Likert-type and alternative, circular response method, it may be able to better understand how these factors affect the results of assessment measures.

Le Grande et al. (2017) identified the dearth of measurements designed for use specifically with Indigenous populations as a major contributor to the lack of evidence in relation to Indigenous mental health and relevant interventions. The measure created within the current project can be utilized by the partnering organization for both clinical purposes, but also to conduct research with the ultimate goal of closing this evidence gap.

Recommendations for administration. The mental health intake workers made several recommendations regarding improvement of the measure. Many of these recommendations were incorporated into the 29-item version of the measure used in the principal components analysis; however, other comments may be useful when considering future directions for the measure. Considering the opinions on numerous repetitive questions, it may be appropriate for an additional review of the measure to take place, specifically evaluating for repetitive questions. As the principal components analysis is now available, and, according to the results, removal of any items is not recommended to enhance alpha, this should be done with caution.

The mental health workers also identified several items that contained confusing wording, including the items “Shows humility and “Demonstrates spirituality.” Specifically, workers suggested that the research team provide further information to clarify the meaning of these questions for participants. This information will be incorporated into the next version of the measure.

Generally, added flexibility in administration appears to be appropriate. Workers expressed that they felt limited by the nature of the questions and the rigidity of the manual. For example, one worker shared that some older children and teens were confused by the word "play" and expressed doubt regarding whether or not she could change this word to more relevant phrases, such as "hang out." The workers also explained that the addition of explanations for the items featuring confusing wording could aid them in this pursuit. It would also be appropriate to update the item "Has stable and consistent, supportive caregivers (e.g., mom, dad, aunty, grandmother)" in their life to read, "Has the child always had a consistent caregiver that has always been around in their life?"; one worker suggested that the use of the word "stable" seemed to upset participants, particularly those involved in the child welfare system.

Conclusion

The findings of this project augment the existing literature regarding the wellbeing of First Nations children. Consistent with much of the research evidence, involvement in traditional activities and engagement in culture were cited as fundamental indicators of wellbeing of First Nations children. The instrument that was created and evaluated, the First Nations Children's Wellbeing Measure, represents one of few valid tools available to assess this construct. Throughout this project, a community-based participatory research approach was utilized, which included a research advisory that oversaw the project and directed measure development. A range of research methods were incorporated to ensure that the needs of the clients, families, and organization were being fully explored and met.

Dilico Anishinabek Family Care may continue to implement the full measure during intake assessments or utilize the Traditional Activities factor independently. Overall, the

relational nature of the items differs from the measures of child wellbeing that are currently available and reflects Indigenous conceptualizations of wellbeing, as well as recommendations from the Canadian Psychological Association regarding assessment (Assembly of First Nations & Health Canada, 2015; CPA, 2018). The FNCWM can also be used to identify strengths or weaknesses that a child may be experiencing, so that treatment can be directed appropriately. Lastly, the FNCWM can be utilized in further research efforts by the organization to ensure that their programs and services are effectively meeting the needs of Anishinabek children, families, and communities and address the current evidence gap with regards to the wellbeing of Indigenous people in Canada.

References

Adelson, N. (2005). The embodiment of inequity: Health disparities in Aboriginal Canada. *Canadian Journal of Public Health/Revue Canadienne de Sante'e Publique*, S45-S61.

Amerijckx, G., & Humblet, P. C. (2014). Child well - being: what does it mean?. *Children & Society,* 28(5), 404-415. doi: 10.1111/chso.12003

Anderson, R. L., Lyons, J. S., Giles, D. M., Price, J. A., & Estle, G. (2003). Reliability of the child and adolescent needs and strengths-mental health (CANS-MH) scale. *Journal of Child and Family Studies, 12*(3), 279-289. http://dx.doi.org/10.1023/A:1023935726541

Angel, R. J., & Williams, K. (2013). Cultural Models of Health and Illness. In Cuéllar, I., & Yamada, A.M. (Eds) *Handbook of Multicultural Mental Health: Assessment and Treatment of Diverse Populations* (Second Edition) (pp. 49-68). San Diego, CA: Academic Press.

Anishinabek Culture (2018). In *Dilico Anishinabek Family Care*. Retrieved July 2, 2018, from http://www.dilico.com/article/anishinabek-culture-161.asp

Aspy, C. B., Oman, R. F., Vesely, S. K., McLeroy, K., Rodine, S., & Marshall, L. (2004). Adolescent violence: The protective effects of youth assets. *Journal of Counseling & Development, 82*(3), 268-276. https://doi.org/10.1002/j.1556-6678.2004.tb00310.x

Assembly of First Nations & Health Canada. (2015). *The First Nations mental wellness continuum framework (Health Canada Publication Number 140358).* Retrieved from http://health.afn.ca/uploads/files/24-14-1273-fn-mental-wellness-framework-en05_low.pdf

Auger, M. D. (2016). Cultural continuity as a determinant of Indigenous peoples' health: A metasynthesis of qualitative research in Canada and the United States. *International Indigenous Policy Journal, 7*(4). doi: 10.18584/iipj.2016.7.4.3

Beets, M. W., Cardinal, B. J., & Alderman, B. L. (2010). Parental social support and the physical activity-related behaviors of youth: a review. *Health Education & Behavior, 37*(5), 621-644. https://doi.org/10.1177/1090198110363884

Ben-Arieh, A., Kaufman, N. H., Andrews, A. B., Goerge, R. M., Lee, B. J., & Aber, J. L. (2001a). Underlying Assumptions and Basic Guidelines for Measuring and Monitoring Children's Well-Being. In *Measuring and Monitoring Children's Well-Being* (pp. 33-46). Springer Netherlands.

Ben-Arieh, A., Kaufman, N. H., Andrews, A. B., Goerge, R. M., Lee, B. J., & Aber, J. L. (2001b). Possible Indicators of Children's Well-Being. *In Measuring and Monitoring Children's Well-Being* (pp. 67-90). Springer Netherlands.

Ben-Arieh, A., Kaufman, N. H., Andrews, A. B., Goerge, R. M., Lee, B. J., & Aber, J. L. (2001c). How to Measure and Monitor Children's Well-Being. In *Measuring and Monitoring Children's Well-Being* (pp. 91-105). Springer Netherlands.

Ben-Arieh, A. (2007). *Measuring and monitoring the well-being of young children around the world.* Paper commissioned for the EFA Global Monitoring Report.

Biddle, S. J., & Asare, M. (2011). Physical activity and mental health in children and adolescents: A review of reviews. *British Journal of Sports Medicine, 45*(11), 886-895. doi: 10.1136/bjsports-2011-090185

Bombay, A., Matheson, K., & Anisman, H. (2010). Decomposing identity: Differential relationships between several aspects of ethnic identity and the negative effects of

perceived discrimination among First Nations adults in Canada. *Cultural Diversity and Ethnic Minority Psychology, 16*(4), 507-516. http://dx.doi.org/10.1037/a0021373

Bombay, A., Matheson, K., & Anisman, H. (2011). The impact of stressors on second generation Indian residential school survivors. *Transcultural Psychiatry*, 48(4), 367-391. doi: 10.1177/1363461511410240

Bombay, A., Matheson, K., & Anisman, H. (2014). The intergenerational effects of Indian Residential Schools: Implications for the concept of historical trauma. *Transcultural Psychiatry*, 51(3), 320-338. doi: 10.1177/1363461513503380

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101. http://dx.doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2014). What can "thematic analysis" offer health and wellbeing researchers?. *International Journal of Qualitative Studies on Health and Well-Being,* 9. http://dx.doi.org/10.3402/qhw.v9.26152

Bronfenbrenner U. 1979. *The Ecology of Human Development. Experiments by Nature and Design*. Harvard University Press: Cambridge, MA.

Bruner, M. W., Hillier, S., Baillie, C. P., Lavallee, L. F., Bruner, B. G., Hare, K., ... & Lévesque, L. (2016). Positive youth development in Aboriginal physical activity and sport: A systematic review. *Adolescent Research Review, 1*(3), 257-269. doi: 10.1007/s40894-015-0021-9

Burgess, B. V. (2006). Elaboration Therapy in the Midewiwin and Gerald Vizenor's The Heirs of Columbus. *Studies in American Indian Literatures, 18(*1), 22-36. doi: 10.1353/ail.2006.0012

Canadian Institute for Health Information (CIHI; 2009). *Mentally Healthy Communities:*

Aboriginal Perspectives, Ottawa, Ontario.

Canadian Psychological Association (CPA; 2018). *Psychology's Response to the Truth and Reconciliation Commission of Canada's Report*, Ottawa, Ontario.

Chandler, M. J., & Lalonde, C. (1998). Cultural continuity as a hedge against suicide in Canada's First Nations. *Transcultural psychiatry*, 35(2), 191-219. doi:10.1177/136346159803500202

Chandler, M. J., & Lalonde, C. E. (2008). Cultural continuity as a protective factor against suicide in First Nations youth. *Horizons, 10*(1), 68-72.

Charmaz, K (2014). Grounded theory. In Jonathan A. Smith (Ed.), *Qualitative Psychology: A Practical Guide to Research Methods* (53-83). Birkbeck College, UK

Clarke, V. & Braun, V. (2014) Thematic analysis. In A. C. Michalos (Ed.), *Encyclopaedia of Quality of Life and Well-Being Research* (pp. 6626-6628). Springer, Dordrecht, Netherlands: Springer.

Colquhoun, S., & Dockery, M. A. (2012). *The link between Indigenous culture and wellbeing: Qualitative evidence for Australian Aboriginal peoples.* Centre for Labour Market Research and School of Economics and Finance Curtin University.

Conners, C. K. (1989). *Manual for Conners' rating scales*. Toronto: Multi-Health Systems.

Crooks, C. V., Chiodo, D., Thomas, D., & Hughes, R. (2010). Strengths-based programming for First Nations youth in schools: Building engagement through healthy relationships and leadership skills. *International Journal of Mental Health and Addiction, 8*(2), 160-173. https://doi.org/10.1007/s11469-009-9242-0

Dell, C., Seguin, M., Hopkins, C., Tempier, R., Duncan, R., Dell, D., . . . Mosier, K. (2011). From benzos to berries: How treatment offered at an Aboriginal youth solvent abuse

treatment centre highlights the important role of culture. *Canadian Journal of Psychiatry*, 56(2), 75-83.

Drawson, A. S., Mushquash, A. R., & Mushquash, C. J. (2017). First Nations community well-being research and large data sets: A respectful caution. *International Journal of Indigenous Health, 12*(2), 15-24. http://dx.doi.org/10.18357/ijih122201717782

Drawson, A. S. , Toombs, E. , Mushquash, C. J. (2017b). Indigenous Research Methods: A Systematic Review. *The International Indigenous Policy Journal, 8*(2) . Retrieved from: https://ir.lib.uwo.ca/iipj/vol8/iss2/5

Ereaut, G., & Whiting, R. (2008). *What do we mean by 'wellbeing' ?: and why might it matter?*. London: Department for Schools and Families.

Evans-Campbell, T. (2008). Historical trauma in American Indian/Native Alaska communities a multilevel framework for exploring impacts on individuals, families, and communities. *Journal of Interpersonal Violence*, 23(3), 316-338. doi: 10.1177/0886260507312290

Exenberger, S., & Juen, B. (2014a). Social Indicators and the Concepts of Quality of Life, Subjective Well-Being, and Resilience. In *Well-Being, Resilience and Quality of Life from Children's Perspectives* (pp. 1-13). Springer Netherlands.

Exenberger, S., & Juen, B. (2014b). Culture and Child Well-Being. In *Well-Being, Resilience and Quality of Life from Children's Perspectives* (pp. 15-21). Springer Netherlands.

Exenberger, S., & Juen, B. (2014c). Child Well-Being. In *Well-Being, Resilience and Quality of Life from Children's Perspectives* (pp. 23-30). Springer Netherlands.

First Nations Information Governance Centre (FNIGC; 2012). *First Nations Regional Health Survey (RHS) 2008/10: National report on adults, youth and children living in First Nations communities*. Ottawa, Canada: Author.

Fortier, J. M. (Writer), & Norrgard, L. (Director). (2002). Bimaadiziwin: A Healthy Way of Life [Television series episode]. In Fortier, J. M. (Producer), & Norrgard, L. (Producer), *Waasa Inaabidaa: We Look in All Directions*. Duluth, Minnesota: WDSE-TV.

Galabuzi, G. (2004). Social exclusion. In *Social determinants of health: Canadian perspectives*, D. Raphael (ed.), pp. 235-252. Toronto, ON: Canadian Scholars' Press Inc.

Gone, J. P., & Kirmayer, L. J. (2010). On the wisdom of considering culture and context in psychopathology. *Contemporary directions in psychopathology: Scientific foundations of the DSM-V and ICD-11*, 72-96.

Greenwood, M. (2005). Children as citizens of First Nations: Linking Indigenous health to early childhood development. *Paediatrics & child health*, 10(9), 553.

Greenwood, M. L., & de Leeuw, S. N. (2012). Social determinants of health and the future well being of Aboriginal children in Canada. *Paediatrics & child health*, 17(7), 381.

Harrison, P. L., & Oakland, T. (2015). *ABAS-3.* Western Psychological Services. Beaverton, Oregon.

Huebner, E. S. (2004). Research on assessment of life satisfaction of children and adolescents. *Social Indicators Research*, 66(1-2), 3-33.

Isaak, C. A., & Marchessault, G. (2008). Meaning of health: The perspectives of Aboriginal adults and youth in a northern Manitoba First Nations community. *Canadian Journal of Diabetes,* 32(2), 114-122. http://dx.doi.org/10.1016/S1499-2671(08)22008-3

Iwasaki, Y., Bartlett, J., & O'Neil, J. (2004). An examination of stress among Aboriginal women and men with diabetes in Manitoba, Canada. *Ethnicity & Health*, 9(2): 189-212. doi: 10.1080/1355785042000222888

Kant, S., Vertinsky, I., Zheng, B., & Smith, P. M. (2014). Multi-domain subjective wellbeing

of two Canadian First Nations communities. *World Development*, 64, 140-157. doi:10.1016/j.worlddev.2014.05.023

Kielland, N., & Simeone, T. (2014). *Current Issues in Mental Health in Canada: The Mental Health of First Nations and Inuit Communities.* Library of Parliament, Ottawa, Canada.

King, M., Smith, A., & Gracey, M. (2009). Indigenous health part 2: the underlying causes of the health gap. *The Lancet*, 374(9683), 76-85. doi:10.1016/S0140-6736(09)60827-8

Kowatch, K. R. (2017). *Analysis of the child and adolescent needs and strengths assessment in a First Nation population* (Masters thesis). Retrieved from Lakehead University Knowledge Commons.

Le Grande, M., Ski, C. F., Thompson, D. R., Scuffham, P., Kularatna, S., Jackson, A. C., & Brown, A. (2017). Social and emotional wellbeing assessment instruments for use with Indigenous Australians: A critical review. *Social Science & Medicine, 187*, 164-173. https://doi.org/10.1016/j.socscimed.2017.06.046

Li, R., Bunke, S., & Psouni, E. (2016). Attachment relationships and physical activity in adolescents: The mediation role of physical self-concept. *Psychology of Sport and Exercise, 22*, 160-169. https://doi.org/10.1016/j.psychsport.2015.07.003

Linley, P. A., Maltby, J., Wood, A. M., Osborne, G., & Hurling, R. (2009). Measuring happiness: The higher order factor structure of subjective and psychological well-being measures. *Personality and Individual Differences, 47*(8), 878-884. https://doi.org/10.1016/j.paid.2009.07.010

Lyons, J.S. (1999). *The Child and Adolescent Needs and Strengths for children with mental health challenges and their families.* Chicago, IL: Northwestern University.

Lyons, J. S., Griffin, G., Quintenz, S., Jenuwine, M., & Shasha, M. (2003). Clinical and forensic outcomes from the Illinois mental health juvenile justice initiative. *Psychiatric Services, 54*(12), 1629-1634. https://doi.org/10.1176/appi.ps.54.12.1629

Lyons, J. S., Weiner, D. A., & Lyons, M. B. (2004). Measurement as communication in outcomes management: The child and adolescent needs and strengths (CANS). In Maruish, M. E. (Ed.), *The Use of Psychological Testing for Treatment Planning and Outcomes Assessment. Volume 2: Instruments for Children and Adolescents.* Mahwah, New Jersey: Lawrence Erlbaum Associates, Inc.

Mandell, D. Clouston Carlson, J., Fine, M., & Blackstock, C.(2006). Aboriginal child welfare. In *Toward positive systems of child and family welfare: Current issues and future directions*, 115-159.

Marsella, A.J., & Yamada, A. (2000). In Cuéllar, I., & Paniagua, F.A. (Eds), *Handbook of multicultural mental health*, (pp. 3-24). San Diego, CA: Academic Press http://dx.doi.org/10.1016/B978-012199370-2/50002-X

McHugh, T. F., Deal, C. J., Blye, C. J., Dimler, A. J., Halpenny, E. A., Sivak, A., & Holt, N. L. (2018). A meta-study of qualitative research examining sport and recreation experiences of Indigenous youth. *Qualitative Health Research, 00*(0), 1-13. https://doi.org/10.1177/1049732318759668

McMahon, E. M., Corcoran, P., O'Regan, G., Keeley, H., Cannon, M., Carli, V., ... & Balazs, J. (2017). Physical activity in European adolescents and associations with anxiety, depression and well-being. *European Child & Adolescent Psychiatry, 26*(1), 111-122. http://dx.doi.org/10.1007/s00787-016-0875-9

McShane, K. E., & Hastings, P. D. (2004). Culturally sensitive approaches to research on child development and family practices in First Peoples communities. *First Peoples Child & Family Review, 1*(1), 33-48.

Mignone, J., & O'Neil, J. (2005). Social capital and youth suicide risk factors in First Nations communities. *Canadian Journal of Public Health/Revue Canadienne de Sante'e Publique*, S51-S54.

Moore, M. A., & Walton, B. A. (2013). Improving the mental health functioning of youth in rural communities. *Contemporary Rural Social Work, 5*, 85-103.

Mota, N., Elias, B., Tefft, B., Medved, M., Munro, G., & Sareen, J. (2012). Correlates of suicidality: Investigation of a representative sample of Manitoba First Nations adolescents. *American Journal of Public Health, 102*(7), 1353-1361.

Muriwai, E., Houkamau, C. A., & Sibley, C. G. (2015). Culture as cure? The protective function of Māori cultural efficacy on psychological distress. *New Zealand Journal of Psychology, 44*(2), 14-24.

Mushquash, C. J., & Bova, D. L. (2007). Cross-cultural assessment and measurement issues. *Journal on Developmental Disabilities*, 13(1), 53-65.

Neckoway, R., Brownlee, K., & Castellan, B. (2007). Is attachment theory consistent with Aboriginal parenting realities?. *First Peoples Child & Family Review*, 3(2), 65-74.

Nelson, S. E., & Wilson, K. (2017). The mental health of Indigenous peoples in Canada: a critical review of research. *Social Science & Medicine*, 176, 93-112. https://doi.org/10.1016/j.socscimed.2017.01.021

Norman, G. R., & Streiner, D. L. (2008). *Biostatistics: the bare essentials.* PMPH-USA.

Nunnally, J. C. (1978). *Psychometric theory*. Hillsdale, NJ: McGraw-Hill.

OECD. (2009). *Comparative Child Well-being across the OECD. In Doing Better for Children* (pp.21-63). OECD Publishing, Paris.

O'Hare, W. P., & Gutierrez, F. (2012). The use of domains in constructing a comprehensive composite index of child well-being. *Child Indicators Research*, 5(4), 609-629.

O'Hare, W. P. (2014). A research note on statistical methods used to create indices of child well-being. *Child Indicators Research*, 1-20.

Oesterheld, J. R., & Haber, J. (1997). Acceptability of the Conners parent rating scale and child behavior checklist to Dakotan/Lakotan parents. *Journal of the American Academy of Child & Adolescent Psychiatry*, 36(1), 55-64. doi:10.1097/00004583-199701000-00018

Pallant, J. (2013). *SPSS survival manual.* McGraw-Hill Education (UK).

Pascoe, E. A., & Smart Richman, L. (2009). Perceived discrimination and health: a meta-analytic review. *Psychological Bulletin, 135*(4), 531-554. http://dx.doi.org/10.1037/a0016059

Reading, C.L. & Wien, F. (2013). *Health Inequalities and Social Determinants of Aboriginal Peoples' Health*. Prince George, BC: National Collaborating Centre for Aboriginal Health.

Reynolds, C. R., Kamphaus, R. W., & Vannest, K. J. (2015). *BASC-3: Behavior Assessment System for Children.* PsychCorp.

Rothe, J. P., Ozegovic, D., & Carroll, L. J. (2009). Innovation in qualitative interviews:"Sharing Circles" in a First Nations community. *Injury Prevention*, 15(5), 334-340. doi: 10.1136/ip.2008.021261

Rowan, M., Poole, N., Shea, B., Mykota, D., Farag, M., Hopkins, C., ... & Dell, C. A. (2015). A scoping study of cultural interventions to treat addictions in Indigenous populations: methods, strategies and insights from a Two-Eyed Seeing approach. *Substance Abuse*

Treatment, Prevention, and Policy, 10(26), 1-9. https://doi.org/10.1186/s13011-015-0021-6

Royal Commission on Aboriginal Peoples (RCAP; 1996). *Looking forward, looking back: Report of the Royal Commission on Aboriginal Peoples* (Volume 1). Ottawa, Canada: Communication Group.

Ryff, C. D. (1989). Happiness is everything, or is it? Explorations on the meaning of psychological well-being. *Journal of Personality and Social Psychology, 57*(6), 1069-1081.

Sallis, J. F., Prochaska, J. J., & Taylor, W. C. (2000). A review of correlates of physical activity of children and adolescents. *Medicine & Science in Sports & Exercise, 32*(5), 963-975. doi: 10.1097/00005768-200005000-00014

Siddiqi, A., Shahidi, F. V., Ramraj, C., & Williams, D. R. (2017). Associations between race, discrimination and risk for chronic disease in a population-based sample from Canada. *Social Science & Medicine, 194*, 135-141. https://doi.org/10.1016/j.socscimed.2017.10.009

Schwartz, S. H., & Bilsky, W. (1990). Toward a theory of the universal content and structure of values: Extensions and cross-cultural replications. *Journal of Personality and Social Psychology*, *58*(5), 878-891.

Snowshoe, A., Crooks, C. V., Tremblay, P. F., Craig, W. M., & Hinson, R. E. (2015). Development of a cultural connectedness scale for First Nations youth. *Psychological Assessment*, 27(1), 249-259. http://dx.doi.org/10.1037/a0037867

Statistics Canada (2017a, October 10). Aboriginal peoples in Canada: Key results from the 2016 Census. *The Daily.* Retrieved from http://www.statcan.gc.ca/daily-quotidien/171025/dq171025a-eng.htm

Statistics Canada (2017b). *Diverse family characteristics of Aboriginal children aged 0 to 4*. (Catalogue number 98-200-X2016020). Retrieved from http://www12.statcan.gc.ca/census-recensement/2016/as-sa/98-200-x/2016020/98-200-x2016020-eng.pdf

Statistics Canada (2018). *First Nations People, Métis and Inuit in Canada: Diverse and Growing Populations.* (Catalogue number 89-659-x2018001). Retrieved from http://www.statcan.gc.ca/pub/89-659-x/89-659-x2018001-eng.pdf

Streiner, D. L., Norman, G. R., & Cairney, G. (2015). *Health measurement scales: a practical guide to their development and use*. Oxford university press.

Stuart, J., & Jose, P. E. (2014). The protective influence of family connectedness, ethnic identity, and ethnic engagement for New Zealand Māori adolescents. *Developmental Psychology, 50*(6), 1817-1826. doi: 10.1037/a0036386

Thomas, A., Cairney, S., Gunthorpe, W., Paradies, Y., & Sayers, S. (2010). Strong Souls: development and validation of a culturally appropriate tool for assessment of social and emotional well-being in Indigenous youth. *Australian and New Zealand Journal of Psychiatry*, 44(1), 40-48. doi:10.3109/00048670903393589

Toombs, E., Kowatch, K. R., & Mushquash, C. J. (2016). Resilience in Canadian Indigenous youth: A scoping review. *International Journal of Child and Adolescent Resilience. 4*(1). 4-32.

Ungar, M. (2008). Resilience across cultures. *British journal of social work*, 38(2), 218-235.

doi:10.1093/bjsw/bcl343

Ungar, M. (2011). The social ecology of resilience: Addressing contextual and cultural ambiguity of a nascent construct. *American Journal of Orthopsychiatry, 81*(1), 1-17. https://doi.org/10.1111/j.1939-0025.2010.01067.x

Unicef. (2007). *Child poverty in perspective: An overview of child well-being in rich countries* (No. inreca07/19). UNICEF Innocenti Research Centre.

Varni, J. W., Seid, M., & Rode, C. A. (1999). The PedsQL™: measurement model for the pediatric quality of life inventory. *Medical care*, 37(2), 126-139.

Verhulst, F. C., & Achenbach, T. M. (1995). Empirically based assessment and taxonomy of psychopathology: cross-cultural applications. A review. *European Child & Adolescent Psychiatry*, 4(2), 61-76.

Vukic, A., Gregory, D., Martin-Misener, R., & Etowa, J. (2011). Aboriginal and Western conceptions of mental health and illness. *Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health*, 9(1), 65-86.

Whitbeck, L. B., Hoyt, D. R., McMorris, B. J., Chen, X., & Stubben, J. D. (2001a). Perceived discrimination and early substance abuse among American Indian children. *Journal of health and social behavior*, 405-424.

Whitbeck, L. B., Hoyt, D. R., Stubben, J. D., & LaFromboise, T. (2001b). Traditional culture and academic success among American Indian children in the upper Midwest. *Journal of American Indian Education*, 40(2), 48-60.

Williamson, A., Andersen, M., Redman, S., Dadds, M., D'Este, C., Daniels, J., ... & Raphael, B. (2014). Measuring mental health in Indigenous young people: A review of the literature from 1998–2008. *Clinical Child Psychology and Psychiatry*,

doi: 10.1177/1359104513488373

World Health Organization (WHO; 2014), *Fact Sheet 220 - Mental health: strengthening our response*, viewed 21 September 2014, <http://www.who.int/mediacentre/factsheets/fs220/en/>

Young, C., Tong, A., Nixon, J., Fernando, P., Kalucy, D., Sherriff, S., ... & Williamson, A. (2017). Perspectives on childhood resilience among the Aboriginal community: an interview study. *Australian and New Zealand Journal of Public Health, 41*(4), 405-410. doi: 10.1111/1753-6405.12681.

Young, N. L., Wabano, M. J., Burke, T. A., Ritchie, S. D., Mishibinijima, D., & Corbiere, R. G. (2013). A process for creating the Aboriginal Children's Health and Well-Being Measure (ACHWM). *Can J Public Health*, 104(2), e136-e141.

Zimmerman, M. A., Ramirez-Valles, J., Washienko, K. M., Walter, B., & Dyer, S. (1998). Enculturation hypothesis: Exploring direct and protective effects among Native American youth. In H. I. McCubbin, E. A. Thompson, A. I. Thompson, & J. E. Fromer (Eds.), *Resiliency in Native American and immigrant families* (pp. 199–220). Thousand Oaks, CA: Sage.

Tables

Table 5

Means, Standard Deviations, and Bivariate Correlations

Measure	M	SD	1	2	3	4	5	6	7	8
1. General Wellbeing	50.44	10.87								
2. Traditional Activities	21.01	7.78	.401**							
3. Social Engagement	20.29	3.78	.523**	.385**						
4. CANS Mental Health	9.60	6.28	-.395**	-.104	-.245*					
5. CANS Risk Behaviours	1.44	2.30	-.258*	-.020	-.224*	.704**				
6. CANS Family/Caregiver Needs	1.30	2.48	-.099	.073	-.273*	.310**	.403**			
7. CANS Functioning	5.41	4.25	-.331**	-.189	-.379**	.638**	.463**	.296**		
8. CANS Care Intensity	0.65	1.33	-.244*	-.106	-.133	.490**	.407**	.408**	.408**	
9. CANS Individual Strengths	16.33	10.27	-.440**	-.380**	-.552**	.190	.206	-.044	.368**	.027

*$p < .05$; **$p < .01$; ***$p < .001$

Table 6

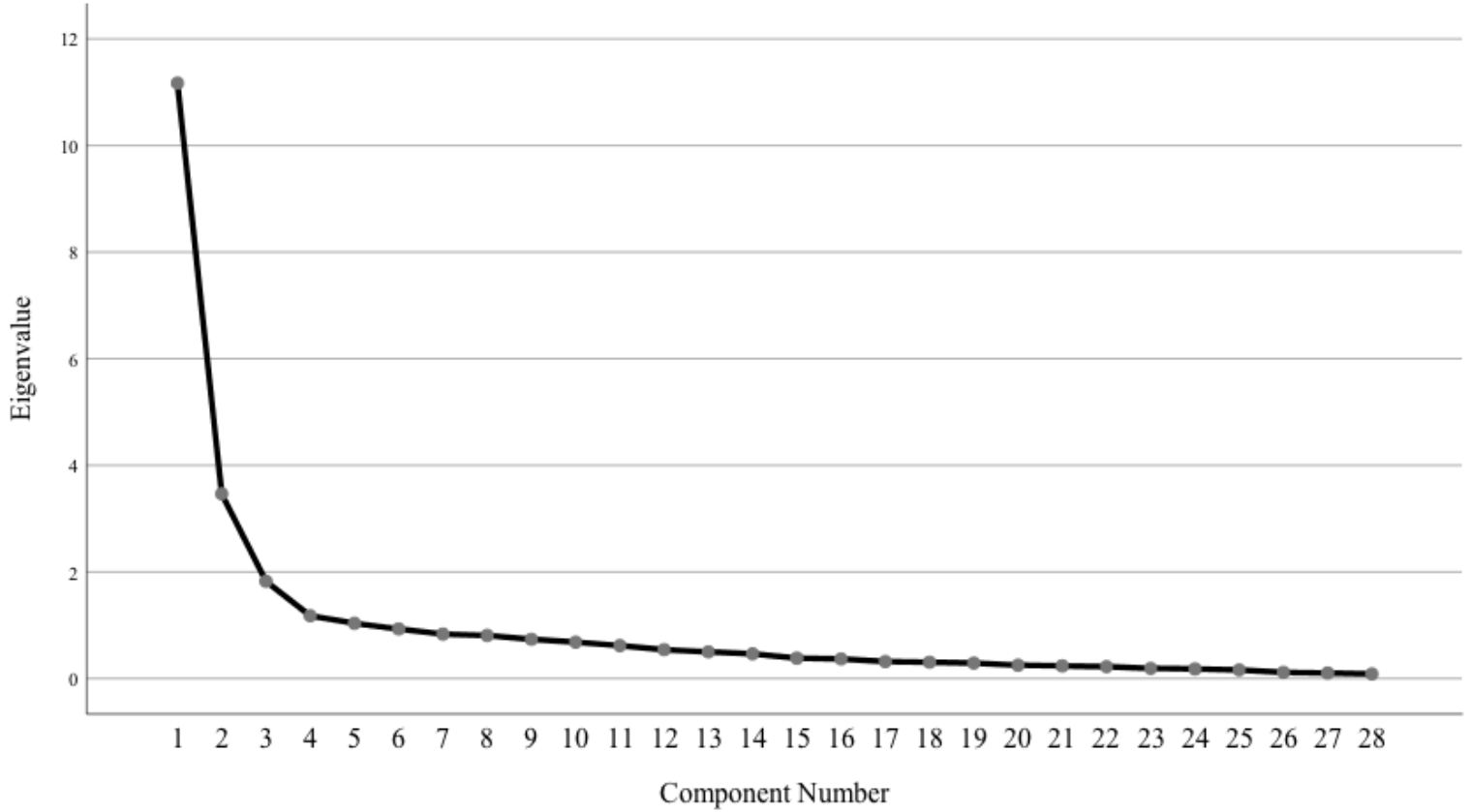
Eigenvalues and Percentage of Variance Explained

Component	Total	Percentage of Variance Explained	Cumulative Percentage
1	11.17	39.89	39.89
2	3.47	12.38	52.27
3	1.82	6.52	58.79
4	1.18	4.20	63.00
5	1.04	3.70	66.70

Figures

Figure 1

Scree Plot



APPENDIX A

Interview and Focus Group Questions:

1. Tell me about children in your community:
    a. What kinds of things do they like to do?
    b. What are their strengths/what are they good at?
    c. What areas do you think they may have challenges in/need help in?
2. What does reunification mean to you/your community?
    a. If a child is placed back with their family, what does that look like?
3. In your opinion, what does a successful reunification look like?
    a. A child is placed back with parent(s)?
    b. Grandparent(s) or aunt(s)/uncles(s)?
    c. Within their home community?
4. Are there any skills in your community that parents could benefit from learning?
    a. Do parents in your community need any help?
5. Where can they learn those skills/get that help?
6. What kind of supports does the community need?
7. What does mental wellbeing mean to you?
    a. What makes a healthy child?
8. What does your community do to promote child mental wellbeing/mentally healthy children?
9. Are there any barriers in your community to mental wellbeing for children?
10. What are signs that a child is:
    a. spiritually healthy?

b. emotionally healthy?

c. physically healthy?

d. mentally healthy?

11. How can a child achieve balance/health in:

a. the spiritual domain?

b. the emotional domain?

c. the physical domain?

d. the mental domain?

Additional Questions for Interviews:

12. What are some barriers to reunification in your community?

a. How could the reunification process be improved for First Nations peoples?

b. How can the reunification process meet the needs of people in the community?

13. Does the reunification process meet the needs of First Nations families? Why or why not?

a. If not addressed, ask specifically about children and/or parents.

14. In your opinion, what does a successful reunification look like?

a. What are the key factors/most important things to make a reunification successful? Why?

15. What does it mean to be a mentally healthy child in this community?

16. How important is it for children to be spiritually/emotionally/physically/mentally healthy?

APPENDIX B

The First Nations Children's Wellbeing Measure (Version 1)

DOB:_____ Gender:_____ Race/Ethnicity:_____

Date of Assessment:_____ CIMS:_____

Dilico Anishinabek Family Care is currently working on a new way of measuring children's mental wellness. In order to find out if the new tool is helpful, we will be working with Dr. Mushquash and his team. Please note, your privacy and confidentiality is very important. **There will be no identifying information provided (e.g., name, etc.) to Dr. Mushquash and his team**. If you are okay with Dr. Mushquash and his team looking at your answers to determine how the new tool is working, please say "yes".

Please read each statement below carefully. These represent behaviours that children sometimes engage in. Then, rate how often or how well the child engages in the stated behaviour on the following scale:

Not Applicable (1), Never (2), Sometimes (3), Usually (4), Almost Always (5)

1. Abides by/has experience with/has instruction in/has mentorship in the seven grandfather teachings	1	2	3	4	5
2. Respects themselves	1	2	3	4	5
3. Respects others in the community	1	2	3	4	5
4. Respects others' property/shows respect when using others' possessions	1	2	3	4	5
5. Is truthful	1	2	3	4	5
6. Shows humility	1	2	3	4	5

7. Congratulates and celebrates others' successes	1	2	3	4	5
8. Does what is right, despite consequences	1	2	3	4	5
9. Shows love for friends/family/caregivers	1	2	3	4	5
10. Gives hugs	1	2	3	4	5
11. Cares for friends or family	1	2	3	4	5
12. Thinks carefully before acting	1	2	3	4	5
13. Controls their impulses	1	2	3	4	5
14. Keeps promises that they make	1	2	3	4	5
15. Attends traditional ceremonies (ex. smudging, sweat lodges)	1	2	3	4	5

What ceremonies: _____

_____

_____

_____

16. Practices traditional activities (such as crafts or land-based activities)

1	2	3	4	5

What activites:

17. Likes being on the land

1	2	3	4	5

18. Participates in physical activity, through formal or informal means (ex. playing in an organized sports league OR playing outdoors)

1	2	3	4	5

19. Is physically active

1	2	3	4	5

20. Likes to play outside

1	2	3	4	5

21. Has a favourite outdoor activity

1	2	3	4	5

22. Expresses/vocalizes/communicates their feelings and needs (to caregivers)

1	2	3	4	5

23. Refrains from saying or doing things that will upset others

1	2	3	4	5

24. Talks back	1	2	3	4	5
25. Listens when being talked to	1	2	3	4	5
26. Engages with several appropriately aged friends	1	2	3	4	5
27. Has friends the same age	1	2	3	4	5
28. Plays with friends/cousins/neighbours	1	2	3	4	5
29. Plays with other children at school	1	2	3	4	5
30. Plays with other children in the community	1	2	3	4	5
31. Withdraws from social opportunities	1	2	3	4	5
32. Does not like playing with others	1	2	3	4	5
33. Has pride in who they are	1	2	3	4	5

34. Knows what community they are from	1	2	3	4	5
35. Knows their spirit name	1	2	3	4	5
36. Knows their clan	1	2	3	4	5
37. Feels/demonstrates/reports a connection to their First Nations ancestors	1	2	3	4	5
38. Has positive adult role models	1	2	3	4	5
39. Dresses themselves	1	2	3	4	5
40. Brushes their teeth regularly on their own	1	2	3	4	5
41. Bathes regularly on their own	1	2	3	4	5
42. Shows an interest in learning about their history and culture	1	2	3	4	5
43. Demonstrates an understanding of their First Nations history and culture	1	2	3	4	5

44. Explores their First Nations culture and history	1	2	3	4	5
45. Understands or speaks their First Nations language	1	2	3	4	5
46. If the child does not speak a First Nations language, is the child interested in learning their language?	1	2	3	4	5
47. Has stable and consistent, supportive caregivers (e.g., mom, dad, aunty, grandmother) in their life	1	2	3	4	5
48. Identifies with a religion	1	2	3	4	5
49. Demonstrates spirituality	1	2	3	4	5
50. Has healthy coping skills to manage emotions	1	2	3	4	5
51. Identifies emotions that they are experiencing	1	2	3	4	5

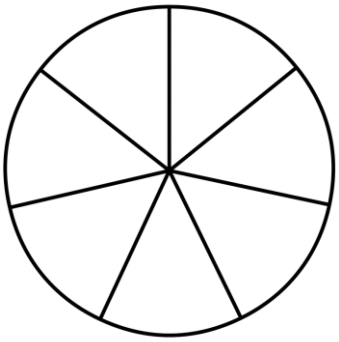
Total score (add all items): _____

APPENDIX C

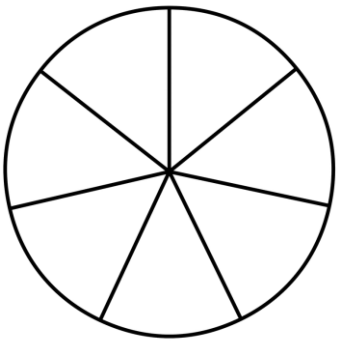
The First Nations Children's Wellbeing Measure (Circular Answer Format)

Please read each statement below carefully. These represent behaviours that children sometimes engage in. Then, fill in the number of sections that corresponds with how often or how well the child engages in the stated behaviour. More filled in sections of the circle would mean that the child engages in the behaviour more frequently or does the behaviour better than expected. If the child does not perform this behaviour at all, please do not fill in any sections.

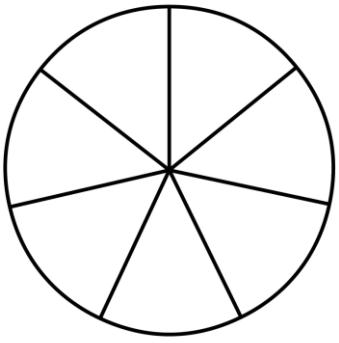
1. Abides by/has experience with/has instruction in/has mentorship in the seven grandfather teachings



2. Respects themselves



3. Respects others in the community



APPENDIX D

First Nations Children's Wellbeing Measure Manual

Introduction

The First Nations Children's Wellbeing Measure (FNCWM) is a comprehensive assessment of the wellbeing of First Nations children residing in the Robinson-Superior Treaty area. The measure can be completed by a worker, a parent or caregiver, an adult who has spent time with the child (e.g., an extended family member, a teacher, or coach), or the child themself. The FNCWM can also be completed through an interview between a professional and the respondent. The FNCWM is administered using printed forms and scored on paper by a professional. The FNCWM came about as a result of feedback from workers and caregivers in the area that the tools we were using to assess children's wellbeing do not include important factors such as spirituality and culture.

Table 1. Domains of wellbeing

Domain area	Description
Traditional Activities	Has experience with the seven grandfather teachings, respects themselves, others, and others' property, tells the truth, is humble, cares for others, keeps their promises, attends ceremonies, and engages in land-based activities
Physical Activity	Participates in formal and informal physical activity, and enjoys playing outside
Expression and Communication	Expresses their feelings and needs, contemplates before speaking, and listens well
Social Engagement	Has several age-appropriate friends and engages well with children who are around
Self-Worth & Self-Esteem	Takes pride in who they are and their Indigenous identity
Positive Role Models	Has positive adult role models
Healthy Appearance	Takes care of their hygiene and personal appearance
History and Culture	Shows an interest in or understanding of their First Nations history and culture and understands, speaks, or would like to learn their language
Structure and Routine	Has stable and consistent caregivers
Spirituality	Identifies with a religion or is spiritual
Coping Skills	Can identify and manage emotions they experience

Administration

Prior to administration, consult with the respondent about whether they would like to complete the FCWM independently or with a professional. It is important to offer the interview option as some respondents experience difficulty with reading or comprehension, while others may appreciate clarification with items as they complete the measure. Ensure that the measure is

being completed (by the respondent or with an interviewer) in a quiet, distraction-free space and that both a table and chair(s) are provided. If the respondent is to complete the form at home, remind them to find a distraction-free area and time to work on it.

Establishing rapport with respondents is important and ensures that the information provided is as accurate as possible. The process of completing measures may be new for respondents, so be open and friendly and offer to answer any questions they may have. Reinforce that they may have concerns and if they are confused about the meaning of an item, they should ask you.

Begin by explaining the purpose of completing the measure: to determine which areas their child is experiencing both success and difficulty in. All children and adults have strengths and areas where they could use some help and this measure will help us to figure this out. Once you have explained the purpose, ensure that the respondent is familiar enough with the child to answer the questions on the measure.

It is important to review the instructions for the measure with the respondent. Sometimes, respondents do not understand the response options and how to answer accurately. Read the instructions on the top of the printed measure aloud to the respondent and then provide a description of the response options.

Show the respondent the example question and the answer scale. Explain the scale anchors (printed on the top of the questionnaire) and that 2 means the child never does the activity and 5 means that they always do. "1" would be used when the child does not do the activity because they are not capable (for example, they cannot bathe on their own). At this point, it may be helpful to discuss the difference between a skill deficit, in which the behaviour is absent because the child cannot perform the behaviour (marked as a "1") and a performance deficit, in which the behaviour is absent because the child cannot perform the behaviour without assistance (marked as a "2").

Sometimes, the respondent completing the form may not have had the opportunity to see the child actually engage in an activity (for example, bathing themselves regularly). You should instruct the respondent to carefully consider if they think the child would be able to complete the activity if asked and/or what level of skill they would possess. Occasional guessing is acceptable, but if a respondent is guessing on too many items, then the results may not accurately represent the child's wellbeing.

Confirm that the respondent does not have any questions and then instruct them to complete the measure. If you have to leave the room, ensure you are nearby and available to answer any questions the respondent may have. Following completion of the questionnaire, double-check and ensure that all questions have been completed. If the respondent has not completed a question, please encourage them to review the item and answer appropriately.

Scoring

To score the measure, add up the scores (1 through 5) for all items and then write this number at the end of the questionnaire.

APPENDIX E

The First Nations Children's Wellbeing Measure (Version 2)

DOB:_____ Gender:_____ Race/Ethnicity:_____

Date of Assessment:_____ CIMS:_____

Dilico Anishinabek Family Care is currently working on a new way of measuring children's mental wellness. In order to find out if the new tool is helpful, we will be working with Dr. Mushquash and his team. Please note, your privacy and confidentiality is very important. **There will be no identifying information provided (e.g., name, etc.) to Dr. Mushquash and his team**. If you are okay with Dr. Mushquash and his team looking at your answers to determine how the new tool is working, please say "yes".

Please read each statement below carefully. These represent behaviours that children sometimes engage in. Then, rate how often or how well the child engages in the stated behaviour on the following scale:

Not Applicable (1), Never (2), Sometimes (3), Usually (4), Almost Always (5)

2. Respects themselves	1	2	3	4	5
3. Respects others in the community	1	2	3	4	5
4. Respects others' property/shows respect when using others' possessions	1	2	3	4	5
5. Is truthful	1	2	3	4	5
6. Shows humility	1	2	3	4	5

7. Congratulates and celebrates others' successes	1	2	3	4	5
8. Does what is right, despite consequences	1	2	3	4	5
9. Shows love for friends/family/caregivers	1	2	3	4	5
10. Gives hugs	1	2	3	4	5
11. Cares for friends or family	1	2	3	4	5
22. Expresses/vocalizes/communicates their feelings and needs (to caregivers)	1	2	3	4	5
23. Refrains from saying or doing things that will upset others	1	2	3	4	5
24. Talks back	1	2	3	4	5
25. Listens when being talked to	1	2	3	4	5
33. Has pride in who they are	1	2	3	4	5

39. Dresses themselves	1	2	3	4	5
40. Brushes their teeth regularly on their own	1	2	3	4	5
41. Bathes regularly on their own	1	2	3	4	5
50. Has healthy coping skills to manage emotions	1	2	3	4	5
51. Identifies emotions that they are experiencing	1	2	3	4	5
38. Has positive adult role models	1	2	3	4	5
47. Has stable and consistent, supportive caregivers (e.g., mom, dad, aunty, grandmother) in their life	1	2	3	4	5
1. Abides by/has experience with/has instruction in/has mentorship in the seven grandfather teachings	1	2	3	4	5
15. Attends traditional ceremonies (ex. smudging, sweat lodges)	1	2	3	4	5

What ceremonies: _____

_____

_____

_____

_____

_____

16. Practices traditional activities (such as crafts or land-based activities)	1	2	3	4	5

What activities: _____

_____

_____

_____

_____

_____

17. Likes being on the land	1	2	3	4	5
34. Knows what community they are from	1	2	3	4	5
35. Knows their spirit name	1	2	3	4	5
36. Knows their clan	1	2	3	4	5
37. Feels/demonstrates/reports a connection to their First Nations ancestors	1	2	3	4	5
42. Shows an interest in learning about their history and culture	1	2	3	4	5
43. Demonstrates an understanding of their First Nations history and culture	1	2	3	4	5

44. Explores their First Nations culture and history	1	2	3	4	5
45. Understands or speaks their First Nations language	1	2	3	4	5
46. If the child does not speak a First Nations language, is the child interested in learning their language?	1	2	3	4	5
48. Identifies with a religion	1	2	3	4	5
49. Demonstrates spirituality	1	2	3	4	5
12. Thinks carefully before acting	1	2	3	4	5
13. Controls their impulses	1	2	3	4	5
14. Keeps promises that they make	1	2	3	4	5
18. Participates in physical activity, through formal or informal means (ex. playing in an organized sports league OR playing outdoors)	1	2	3	4	5
19. Is physically active	1	2	3	4	5

20. Likes to play outside	1	2	3	4	5
21. Has a favourite outdoor activity	1	2	3	4	5
26. Engages with several appropriately aged friends	1	2	3	4	5
27. Has friends the same age	1	2	3	4	5
28. Plays with friends/cousins/neighbours	1	2	3	4	5
29. Plays with other children at school	1	2	3	4	5
30. Plays with other children in the community	1	2	3	4	5
31. Withdraws from social opportunities	1	2	3	4	5
32. Does not like playing with others	1	2	3	4	5

Total score (add all items): _____

APPENDIX F

The First Nations Children's Wellbeing Measure (Version 3)

DOB:_____ Gender:_____ Race/Ethnicity:_____

Date of Assessment:_____ CIMS:_____

Dilico Anishinabek Family Care is currently working on a new way of measuring children's mental wellness. In order to find out if the new tool is helpful, we will be working with Dr. Mushquash and his team. Please note, your privacy and confidentiality is very important. **There will be no identifying information provided (e.g., name, etc.) to Dr. Mushquash and his team**. If you are okay with Dr. Mushquash and his team looking at your answers to determine how the new tool is working, please say "yes".

Please read each statement below carefully. These represent behaviours that children sometimes engage in. Then, rate how often or how well the child engages in the stated behaviour on the following scale:

Not Applicable (1), Never (2), Sometimes (3), Usually (4), Almost Always (5)

2. Respects themselves	1	2	3	4	5
3. Respects others in the community	1	2	3	4	5
5. Is truthful	1	2	3	4	5
6. Shows humility	1	2	3	4	5
7. Congratulates and celebrates others' successes	1	2	3	4	5
8. Does what is right, despite consequences	1	2	3	4	5

9. Shows love for friends/family/caregivers	1	2	3	4	5
22. Expresses/vocalizes/communicates their feelings and needs (to caregivers)	1	2	3	4	5
23. Refrains from saying or doing things that will upset others	1	2	3	4	5
25. Listens when being talked to	1	2	3	4	5
33. Has pride in who they are	1	2	3	4	5
39. Takes care of themselves (physically; ex. brushes teeth, bathes, dresses themselves)	1	2	3	4	5
50. Has healthy coping skills to manage emotions	1	2	3	4	5
51. Identifies emotions that they are experiencing	1	2	3	4	5
38. Has positive adult role models	1	2	3	4	5
1. Abides by/has experience with/has instruction in/has mentorship in the seven grandfather teachings	1	2	3	4	5

15. Attends traditional ceremonies and activities (ex. smudging, sweat lodges)

1	2	3	4	5

What ceremonies: _____

_____

_____

_____

_____

_____

17. Likes being on the land

1	2	3	4	5

34. Knows what community they are from

1	2	3	4	5

35. Knows their spirit name or clan

1	2	3	4	5

43. Demonstrates an understanding of their First Nations history and culture

1	2	3	4	5

44. Explores their First Nations culture and history

1	2	3	4	5

45. Understands, speaks, or is interested their First Nations language

1	2	3	4	5

49. Demonstrates spirituality

1	2	3	4	5

12. Thinks carefully before acting

1	2	3	4	5

14. Keeps promises that they make	1	2	3	4	5
18. Participates in physical activity, through formal or informal means (ex. playing in an organized sports league OR playing outdoors)	1	2	3	4	5
27. Plays appropriately with friends the same age (cousins, at school, in the community)	1	2	3	4	5
32. Does not like playing with others	1	2	3	4	5

Total score (add all items): _____

APPENDIX G

CHILD AND ADOLESCENT NEEDS AND STRENGTHS (CANS)			CANS-MENTAL HEALTH ACUTE			
Child's Name:		DOB:	Gender: [ ] M [ ] F	Race/Ethnicity:		
Caregiver(s):		Form Status:	[ ] Initial	[ ] Subsequent	[ ] Annual	[ ] Discharge
		Case Name:				
		File #:				
Assessor:		Date of Assessment				

Insert an X into appropriate box

MENTAL HEALTH NEEDS				
0 = no evidence	1 = history, mild, suspicion			
2 = moderate, action needed	3 = severe, disabling, dangerous, immediate action needed			
	0	1	2	3
Psychosis				
Anxiety				
Mood				
Attention Deficit/Impulse Control				
Oppositional Behaviour				
Conduct Behaviour				
Emotional Control				
Parent-Child Relational Problems				
Adjustment to Trauma				
Autism Spectrum				
Situational Consistency				
Temporal Consistency				
Comments:				

RISK BEHAVIOURS				
0 = no evidence	1 = history, mild, suspicion			
2 = moderate, action needed	3 = severe, disabling, dangerous, immediate action needed			
	0	1	2	3
Suicide Risk				
Self-Injuring Behaviour				
Danger to Others				
Elopement				
Substance Abuse				
Social Behaviour				
Crime/Delinquency				
Involvement in Treatment				
Comments:				

FAMILY/CAREGIVER NEEDS AND STRENGTHS				
0 = no evidence	1 = history, mild, suspicion			
2 = moderate, action needed	3 = severe, disabling, dangerous, immediate action needed			
	0	1	2	3
Physical/Mental Health				
Knowledge				
Residential Stability				
Resources				
Safety				
Comments:				

Functioning				
0=no evidence	1=history, mild, suspicion			
2=moderate, action needed	3=severe, disabling, dangerous, immediate action needed			
	0	1	2	3
Sensory Processing				
Communication				
Motor				
Self-Care				
Sleep				
Family				
Peer				
School Achievement				
School Behaviour				
School Attendance				
Sexual Development				
Culture Stress				
Comments:				

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CARE INTENSITY AND ORGANIZATION				
0 = no evidence	1 = history, mild, suspicion			
2 = moderate, action needed	3 = severe, disabling, dangerous, immediate action needed			
	0	1	2	3
Monitoring				
Service Permanence				
Educational				
Comments:				

INDIVIDUAL STRENGTHS				
0 = Center-piece strength	1 = Useful strength			
2 = Identified strength	3 = No strength identified			
	0	1	2	3
Family				
Interpersonal				
Relationship Permanence				
Life Skills				
Well-Being				
Optimism				
Spiritual/Religious				
Talents/Interests				
Community Involvement				
Self-Expression				
Flexibility/Adaptability to Change				
Comments:				

Other Comments:

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