Improving Indigenous Access to Healthcare Services Through Interprofessional Collaboration

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Dedication

To the First Nation peoples of Canada, it is our non-Indigenous responsibility to achieve truth and reconciliation with you, our brothers and sisters, as we row in the river beside you in the two row wampum. Along with your lands, languages, and cultures, we offer this collaborative work to your community bundles, as a form of knowledge that can be passed on to future generations. This dissertation is dedicated to the First Nation member communities of Nokiiwin Tribal Council, and to any First Nation community that can find shared meaning and value from what we have learned about ourselves.

Abstract

In northwestern Ontario, interprofessional collaboration is needed to improve access to healthcare services for Indigenous people. The Truth and Reconciliation Commission of Canada identified 94 Calls to Action, four of which guided the design of this community action research project (No.18: acknowledge previous health policy is responsible for Indigenous health, No.19: identify appropriate health services, No.22: recognize the value of traditional health practices; No.23: provide competency training for health professionals). The purpose of this study was to examine whether the teaching of six interprofessional competencies to healthcare teams servicing northern First Nation communities enhances: 1) interprofessional collaboration and 2) Indigenous healthcare access. A two-eyed seeing approach supported an interprofessional collaboration (IPC) training intervention involving 30 participants. A convergent parallel mixed methods design, including a post-post test design survey and second-order narratives, supported the generation of community action-oriented goals. A statistically significant difference in each of the six interprofessional competency domains was found following the training. Qualitative analysis demonstrated that access to healthcare services does improve following collaboration training. The mixed analysis demonstrated that sustainable community resources focused on healthcare access were developed as a result of the action-oriented goals. Northern First Nation communities can benefit directly and indirectly from interprofessional competency training for the purpose of improving access to healthcare services. By incorporating Indigenous ways of knowing within a community action research framework, Calls to Action can be enacted.

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Prologue

There was a time, a long time ago, when Nanabush and all the other animals spoke freely to one another. Nanabush was always walking around looking for an easy meal. One time, Nanabush saw some ducks. He greeted them as his brothers and invited them to a dance that night. And so, the ducks went to the dance. Nanabush had prepared a beautiful dancing ground and invited them in. “Close your eyes, we are going to do the Shut-eye Dance” he said. “If you do not shut your eyes while I sing this song, your eyes will turn red”. And so, those ducks did shut their eyes and danced around. Nanabush drummed with one arm as he sang. With his other arm he began to reach out and wring each duck’s neck as they passed by. The sound of their wringing necks went along with the music, and so the ducks continued with their shut-eye dance. There was one duck however who secretly observed what was going on. Shingibiz was his name. When he saw what was happening, he called out to his fellow ducks, “My brothers, wake up. Nanabush is killing us!” The ducks that were still alive opened their eyes and quickly exited, escaping their confinement. Nanabush kicked Shingibiz in the rear and told him, “Now your eyes will turn red!” And that is why today Shingibiz has red eyes. (Chacaby, 2011). Reprinted with permission.

Figure 1: *The Loon - Shingibiz.* (CBC Kids, 2018).

The loon in Anishinaabek cultures often represents the leader, the one who is willing to challenge themselves and the status quo for the betterment of the community. It takes courage to be something greater than ourselves; to engage in community-based action research requires a lot of courage from the community, the leaders, the researchers, and anyone who opposes the concept of research. May we all have the courage to be *Shingibiz* and not engage in the shut-eye dance in our day-to-day lives. It is only then that we will be ready to take the longest journey from our heads to our hearts, and stay true to ourselves, our values, our cultures, and our lives (Ojibwe Elder teaching).

In this study, we acknowledge that First Nation knowledges are unique and widespread across the Americas and around the world (Smith, 1999). As part of the Truth and Reconciliation Process (TRC, 2015) process, university partnerships were formed with community partners to ensure a shared understanding of acceptable knowledge creation, rather than reinforcing past colonial research behaviours. Specifically, we looked to re-search or re-find knowledge that has been there all along (Wilson, 2008), in a community action research framework. This provided an opportunity for six First Nation communities to learn with, from, and about one another (CAIPE, 2002), for the purpose of collaboratively examining access to healthcare services. Overall, this experience has helped to strengthen existing relationships and help to build new relationships, while uncovering important wisdom and knowledge that can be shared with other Anishinaabek and non-Anishinaabek peoples. This re-search demonstrates one example of how ‘we’ can honour the two-row wampum; an example of how we can fulfil our individual roles to help one another when needed. When we talk about self-determination and strengthening First Nation communities, collaborative training by people on both boats, teaches us not to steer the boat of our neighbour, but to share our knowledge in exchange for knowledge shared.

Chapter 1: Introduction – The Two Row Wampum

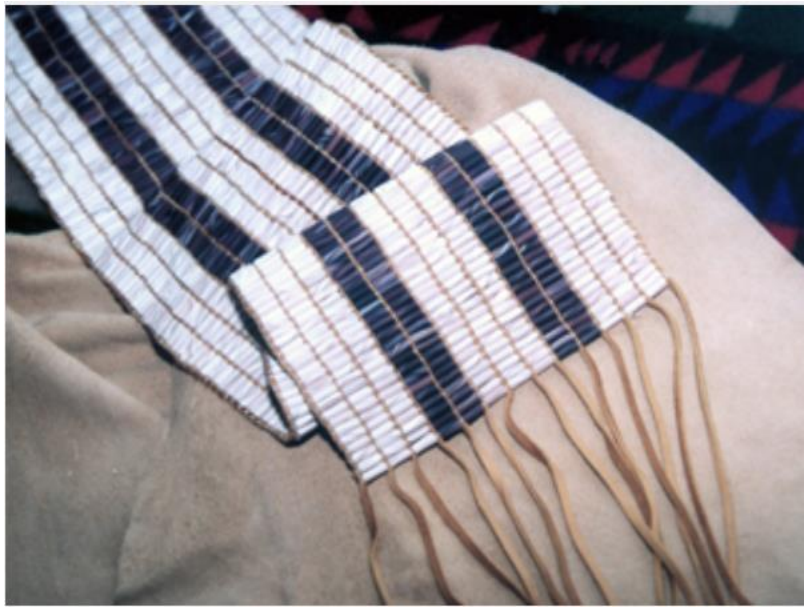


Figure 2: *Two Row Wampum Belt. (*Chitty, 2013).

[1]The Two Row Wampum Treaty Belt or Kaswentha symbolizes the relationship of the native people of North America, the Haudenosaunee, with the White man or Europeans. This treaty represents peace, friendship, and mutual respect by all of us. The white beads represent the purity of the agreement or the 'river of life'. One purple row represents the path of the natives' canoe which contains their customs and laws, while the other purple row represents the path of the White mans' vessel, the sailing ship, which contains his customs and laws. The meaning of the parallel paths is that neither boat should outpace the other, and the paths should remain separate and parallel forever. This is an Elder teaching of the Mohawk Council of Akewesasne speaking to the Tawagonshi Agreement of 1613. (Parmenter, 2013)

[1] The two row wampum belt, though not from the lands of the Anishinaabe Peoples where this research took place, is an important universal symbol of how the relationship between Indigenous and non-Indigenous peoples was formed over four centuries ago. For this reason, it has been included in the Introduction chapter of this dissertation.

Justine Jecker – Novice Community Action Researcher

It is customary in Anishinaabe culture when meeting people for the first time, to introduce yourself, your heritage, your homeland, your family, and your language prior to engaging in any business. I am a 35-year-old White, middle-class, university-educated French-Canadian woman of European descent. My ancestors arrived on Turtle Island between 1700-1725 from eastern France or western Germany. I have been told by my mother that I have Métis heritage with minor evidence dating back to the southern Manitoba area; however, there is no confirmation of this claim. Saul (2014) states that anyone whose ancestry dates back to pre-1760, could consider themselves to be Indigenous, although in this research journey of understanding Indigenous ways of knowing, I would not make this claim. I was born in rural Ontario but spent a great deal of time in Quebec as a child surrounded by the French language on my father's side, and the English language on my mother's side. In the 1980's, there remained a strong divide in Quebec between being French and English, so after my father passed away prior to starting school, my mother was forced to move back to English-speaking southern Ontario where we lost all connection with my paternal family.

It was in Hamilton, Ontario where I began my schooling, and was able to thrive in the Euro-centric schooling system, despite my family being considered low-income. I was very good at memorizing facts and figures, which would be a skill that would keep me in the top 5% at school until completing my master's program in occupational therapy at the age of twenty-five. Two placements in northwestern Ontario prior to graduating from the program, would be my first introduction to the damaging history of colonialism. Similar to Cusack (Hall & Cusack, 2018), I would begin to identify as a non-Indigenous woman who experienced a 'White-washed'

version of Canadian history, and needed transformative learning where I could 'learn to unlearn' (Srigley & Varley, 2018) non-critical ways of thinking and challenging the status quo.

Thus, it was ten years ago when I first began to learn about First Nation or Indigenous cultural practices, histories, languages, and differing worldviews. It was a tremendous uphill battle to develop a basic understanding of true 'Canadian' culture and history; a history that should have been a part of me the moment I was born. In essence, I needed to change fundamental parts of my thinking: 1) that colonialism was a part of ancient history, and 2) that 'Indians' had received their fair share of the land and governmental benefits a long time ago. It actually hurts me to write this now, but I feel these revelations in my thinking could be equivalent to a German citizen being raised without knowledge of the Holocaust [deep breath]. Duran et al. (1998), Simpson (2012) and Daschuk (2013) have referred to colonization of Turtle Island, as the 'Holocaust of the Americas'; despite coming to realize this experience deeply within my being, there continues to be 'great reluctance' on behalf of Canadians to publicly acknowledge that genocide took place in our country (Benvenuto, Woolford, & Hinton, 2014).

In my journey towards completing a PhD, my world view has evolved exponentially. Like many non-Indigenous researchers working with Indigenous communities, I hold an anti-racist position in a society that often denies the existence of racism (People's Knowledge Editorial Collective [PKEC], 2016). This has been an ongoing personal and professional challenge, which as a realist and optimist, has humbled me greatly. One of the most powerful articles that guide my current thinking, was written by Tuck and Yang (2012), *Decolonization is Not a Metaphor*. This work challenges me daily to consider my moves to innocence: Am I a settler? Do I have the Pocahontas Indian-grandmother complex? Do I justify colonialism, because we have all been colonized? Have I ever found myself as a footnote at the bottom of a

research paper? If I am being honest, my pragmatic self continually questions whether 'decolonization' can truly be achieved; however, I fervently recognize my role as an advocate for social justice and my position in building relationships with Indigenous communities.

Another contextual piece of information about me is that I have been a community occupational therapist for ten years, and have teaching appointments at two universities, one of which is situated in a medical school. My main teaching passion is in the area of interprofessional education, where I have the opportunity to facilitate learning with healthcare professional students from different backgrounds to learn with, from, and about one another (CAIPE, 2002) for the purpose of advancing individual and community-centred care. The following dissertation will recount the makings and doings of this research journey, experienced by me and others, through an interprofessional collaboration lens. Additionally, the two-eyed seeing lens influenced by the work of Elder / knowledge holder Albert Marshall (CIHR, 2014) reflects my journey towards recognizing and understanding Indigenous ways of knowing, and was used to guide the writing and incorporation of two ways of knowing in this dissertation.

After four years in this incredible program, I can say without a doubt that it has all been worth it – that is, the many evenings studying or reading in lieu of engaging in motherly duties (with my two beautiful children – Valentine and Alexandre), the persistent feeling of being pushed mentally and emotionally to my limits (a huge acknowledgment to my husband for his unwavering support), and perhaps most importantly, the acquired understanding of what it means to be a non-Indigenous person living in colonized country with new knowledge of how to move forward in the Truth and Reconciliation process with Indigenous peoples.[2]

[2] I will continue the discussion on my positionality in relation to the research on page 125.

Nokiwiin Tribal Council and the Origins of this Research

Nokiiwin Tribal Council (i.e. Nokiiwin), represents communities identified in the Robinson-Superior Treaty of 1850. These communities are dispersed on the north shore of Lake Superior. Nokiiwin comprises almost 6000 individuals belonging to six communities: Animbiigoo Zaagi'igan Anishinaabek (Lake Nipigon Ojibway First Nation); Biinjitiwaabik Zaaging Anishinaabek (Rocky Bay First Nation); Bingwi Neyaashi Anishinaabek (Sandpoint First Nation); Kiashke Zaaging Anishnaabek (Gull Bay First Nation); Pic Mobert First Nation; and Fort William First Nation (see Figure 3). Approximately half of this population lives within the city of Thunder Bay, as community and health services are minimal in most communities (Nokiiwin Tribal Council, 2016).

Figure 3: *Map of Nokiiwin Tribal Council Communities.* (Nokiiwin Tribal Council, 2018).

I met with staff of Nokiiwin Tribal Council in January 2016 as a result of a mutual interest to examine healthcare knowledge in First Nation communities. At the time, I had just completed a literature review on *Healthcare Knowledge Management* and was consumed with ideas of knowledge mobilization, creation, production, utilization, and ownership. We were both affiliated with a local knowledge management firm; however, we had interests beyond the idea of managing knowledge. Within two months of meeting, Nokiiwin requested my engagement in a research project focused on the issue of Indigenous healthcare access, and how collaboration and knowledge could be used to address this universal issue.

Over the following six months relationships were developed with staff members, the Board of Directors, the Executive Director, and most meaningfully, the Disabilities Coordinator and Mental Health Navigator. It was during this relationship-building phase that the idea of engaging specifically in community action research evolved, with a particular focus on improving access to healthcare for member communities belonging to this Tribal Council. To ensure the success of the project, I applied for a three-year funding grant from Indigenous and Northern Affairs Canada which was approved on an annual basis, with funds totalling more than $300,000 to be used towards the project.

An important agreement made between Nokiiwin and me prior to beginning the project, was that all knowledge generated from the research would be with, by, and for community members. It was important that we would formally acknowledge individual contributions with consent, and remove identifiers of specific communities or groups of people that would like to remain anonymous. Nokiiwin has been given the knowledge generated from this project, and looks forward to next steps in sharing this knowledge.

Brief Historical Overview

In 2017, Canada celebrated its 150th anniversary as a country. This celebration allowed for nationwide reflection on how we define being Canadian and obliged non-Indigenous persons to reflect on our ongoing colonial practices over Indigenous peoples. Until the beginning of this century, popular historical narratives supporting Canadians as peaceful colonizers have persisted, differing greatly from historical narratives seen south of the border (Benvenuto et al., 2014). These narratives stem from a foundation of Canadian Law, the Royal Proclamation of 1763, which acknowledged the prior settlement of Indigenous Peoples thereby partially recognizing their rights (Benvenuto et al., 2014; Borrows, 2010). Over the course of two and a half centuries, these narratives would continue to be revived through countless federal policies aimed at controlling the lives of Indigenous Peoples.

Prior to Confederation in 1857, the *Gradual Civilizations Act* was created to raise 'Indians' up to British Status; in other words, to marry White, become Christian, and give up Indian land or status (Leslie, Maguire, & Moore, 1983). The measure used to determine success or to recognize the remaining problem to be dealt with, was the Indian status number. In 1860, reserves not unlike concentration camps were created with the purpose of exterminating Indians (Annett, 2001; Chacaby, 2011; Joseph 2018). It is for this reason in present-day literature, that we see colonization of Indigenous Peoples being equivocated to the Holocaust (Annett, 2001; Benvenuto et al., 2014; Simpson, 2012). However, for most Canadians, the idea that the impact of our governmental policies could be analogous to that of Nazi death camps, does not align with the persistent narrative of Canadian benevolence (Benvenuto et al., 2014).

Moving forward in 1867, the *Indian Act* was created as the previous Acts were not acting fast enough to eradicate Indigenous Peoples (M. Chacaby, personal communication, November

11, 2017). The Indian Act has been described as a form of apartheid, which directly influenced apartheid practices in South Africa (Galloway, 2013) and continues to control Indigenous people's lives today (Talaga, 2018). Duncan Campbell Scott was the chief architect of Canada's notorious Indian Residential School system, and was responsible for amending the Indian Act to include mandatory enrolment for Indigenous children between the ages of seven and fifteen:

> I want to get rid of the Indian problem…Our object is to continue until there is not a single Indian in Canada that has not been absorbed into the body politic and there is no Indian question and no Indian department. (National Archive of Canada, Duncan Campbell Scott, 1920)

Over 85 years later, the Indian Residential Schools Settlement Agreement (IRSSA) would be signed to attempt to redress the very actions of Duncan Campbell Scott. This document would be signed by the government, churches, legal representatives, the Assembly of First Nation, and other Indigenous organizations to provide lump-sum payments to eligible former students (Benvenuto et al., 2014). In essence, the policy would fail to be implemented despite its horrific intentions and devasting impacts on countless Indigenous families across Canada.

Both the relocation of Indigenous peoples to reserves and the residential school system, led to the severing of people from the land, their cultural practice, and their languages (Talaga, 2018). The irony of the Indian Act was that its intention was to assimilate Indians; however, it enforced segregation practices that put children in all-Indian schools and parents on foreign lands out of the view of White men (Elder Tony DePerry, in communication, September 30, 2018). As it turned out, it was not sufficient to simply relocate Indigenous persons. In order to have control on reserves, the Canadian government placed Indian agents in control of the communities which would later evolve into Chief and Council, a non-First Nation governing practice (Joseph, 2018). By 1885, the Pass System was implemented to control movement of First Nations peoples which resulted in people being cut off from their winter camps, hunting practices, fishing lakes, and

migration rituals (Barron, 1988). If not oppressive enough, traditional practices subsequently became illegal, where groups of three or more could not convene unless in a church setting (Barron, 1988). It was evident that be enacting the Indian Act, Prime Minister John A. MacDonald was determined to put 'Indians' in their place at whatever means necessary:

> We have been pampering and coaxing the Indians; that we must take a new course, we must vindicate the position of the white man, we must teach the Indians what law is, we must not pauperize them, as they say we've been doing. (cited in Joseph, 2018)

Before the turn of the twentieth century, the Indian Act legislation would also: prevent Indigenous women from voting (until 1985); encourage voluntary and enforced enfranchisement (until 1985), expropriate portions of reserves for public works (until 1985), continue to construct reserves (until present day); and rename individuals with European names until an undetermined time (Joseph, 2018). Specifically, on the Canadian west coast, biblical names were used by Indian Agents to rename Indigenous Peoples, who had names that dated back to creation (Joseph, 2018). Bob Joseph, also known as k'ack-sum nakwala, is often asked if he is related to the Josephs from Squamish First Nation, to which he replies, "No, but I'm sure we had the same Indian agent" (Joseph, 2018, p. 36).

Specifically, between 1920 - 1980, if Indigenous Peoples were not either forcibly placed on reserve or in residential schools, they were taken away from their families and put into foster care, or quarantined in racist and discriminatory Indian hospitals for both physical and mental health reasons (Talaga, 2018). The segregation was enforced because many hospitals refused to treat Indigenous patients, viewing them as unwanted burdens in society (Lux, 2016). They would go on to receive unfair treatment, being relegated to basements and poorly-ventilated areas, with subpar medical treatments (Lux, 2016). By 1953, the Indian Act was amended so that Indigenous persons could be charged with a crime if they attempted to leave the hospital without

authorization. By the 1960's, there were 22 fully functioning Indian hospitals across Canada (Lux, 2016), and in some Northwestern Ontario communities such as Sioux Lookout, these Indian hospitals were only replaced in the 1990's (Talaga, 2018). This is one reason that Indigenous peoples have a distrust of the Western health system and believe that their health and well-being is not equal to non-Indigenous Canadians (Talaga, 2018).

Fifty years ago, the Hawthorne Report (1966-67) was released, which exposed the Canadian public to the marginalization and mistreatment of Indigenous people, as a result of the Indian Act (Frideres, 2016). Imaginably even more damaging, the White Paper of 1969 attempted to abolish the Indian Act focusing on the need for Indigenous persons to 'integrate' by giving up all Indigenous practices – language, culture, way of life, and land (Dudziak, 2000). Then Minister of Indian Affairs, Jean Chretien, ignored consultation with Indigenous groups and instead "proposed a policy of assimilation through the elimination of the Department of Indian Affairs and the Indian Act, which, despite its many problems, offered protections for Aboriginal and treaty rights that remain essential to the preservation of Indigenous cultures" (Benvenuto et al., 2014, p. 5). The government acknowledged at this time that the Indian Act was discriminatory and an embarrassment to the country; however, Indigenous Peoples refused to be erased as 'Indians' in place of becoming equal to all other Canadian citizens (Joseph, 2018). When the government refused to negotiate a new agreement, the White Paper was withdrawn in 1970. In response to the 'Indians', Pierre Trudeau is quoted as saying: "we'll keep them in the ghetto as long as they want" (Joseph, 2018, p. 92).

In considering the chronological implementation of these government policies, it has been mere decades that Canadians have had the wherewithal to reflect on the impacts colonization, or even the impact of Canadian policies on First Nations peoples. In 1991, the

Royal Commission on Aboriginal Peoples was established to examine the troubled relationships between Indigenous peoples, the Canadian government, and Canadian society as a whole (Brant Castellano, 2000). Several years later, a culminating report identified that Indigenous people should have equitable opportunity for participation in Canadian life, and that their cultural, historical, and legal rights should be formally recognized (Royal Commission on Aboriginal Peoples, 1997). Simultaneously, the Aboriginal Health and Wellness Strategy was developed between 1990-1994 with a focus on Indigenous health policy aimed at providing culturally appropriate health services (Dudziak, 2000). These policies, reports, and strategies demonstrate that it has only been in the past quarter-century that efforts have been made to examine and address health and cultural maleficence towards Indigenous peoples of Canada.

Beyond the generation of policy, grassroots movements including *Idle No More* (November, 2012), is an example of large protestations by various Indigenous groups who are opposing government bills that: violate treaty rights, encourage privatization of First Nation lands, and eliminate the responsibly of government to consult Indigenous peoples (Benvenuto et al., 2014). Further to our understanding in the 21st century of previous colonization and inhumane practices on Indigenous people, are recent reports uncovering government-sponsored biomedical experiments on Indigenous children of residential schools (Mosby, 2013). Canadians are finally starting to wake up, and realize that engaging in practices where anemia can be induced on malnourished Indigenous children being used as test subjects in a free country known as Canada, is fundamentally wrong and needs to be addressed at the national and global levels (Benvenuto et al., 2014).

In this decade, there is a new historic document—the Truth and Reconciliation Commission of Canada [TRC] (2015). This document calls all Canadians to act by finding truth

in and reconciling ongoing government-supported colonial policies by non-Indigenous persons and institutions. Particularly, Canadians are challenged to learn about the true history of colonialism dating back over four hundred years, in order to best understand in which ways reconciliation may be achieved. Reconciliation is not an Indigenous but a Canadian problem, where every Canadian needs to engage in the reconciliation process (Joseph, 2018). As a milestone for all of us, Joseph (2018) purports that a future without the Indian Act is a true example of reconciliation, as it "was designed for a specific purpose that no longer exists in a country committed to reconciliation" (p. 103).

Calls to Action. The word Anishinaabe is an Ojibway word referring 'the people', while Anishinaabek refers to 'Aboriginal or Indigenous Peoples' (Absolon, 2011). More specifically, Anishinaabe refers to the original peoples of Turtle Island including First Nation, Métis, and Inuit peoples who all have unique cultures, languages, knowledge systems and ways of being (Peterson, Horton, & Restoule, 2016) [NB: in the following subsection, additional terms will be reviewed]. In the Robinson-Superior Treaty Territory where this research study took place, the term 'Nish', short for Anishnaabe, is used to refer those living in First Nation communities locally (Audrey Gilbeau, personal communication, January 16, 2017). In November 2017, at a local Nokiiwin Tribal Council gathering called *Journey to Wellness,* [3]non-Anishinaabek peoples were specifically challenged by a respected advocate from Fort William First Nation, Maya Chacaby, to: 1) find ways to answer the Truth and Reconciliation Calls to Action, and 2) return truths/knowledge to First Nation communities for the purpose of building community bundles.

[3] The term Anishinaabek is also spelt Anishnabek or Anishinabek in Ojibwe/Ojibway depending on local literature, and the different spellings of these terms may be found in other parts of this dissertation depending on the spelling preferred by authors being referenced. The same holds true for the term Anishinaabe and Anishnaabe. For Nokiiwin Tribal Council, all forms of spelling are embraced which will be later observed in the Seven Grandfather Teachings.

Maya stated that there is a shared belief among local First Nations that non-Anishinaabek are responsible for Truth and Reconciliation through truth and honesty, while Anishinaabek are responsible for reclaiming and restoring their culture and ways of life. Absolon (2011), a well-known Anishinaabe/English scholar, supports this notion of restoring local knowledge, stating that Anishinaabe peoples have been "given the task to re-write and re-right our own realities and truths" (p. 27). For non-Anishinaabek individuals, Anishinaabe researcher Lorrilee McGregor (2018), offers 16 recommendations for 'returning truths or knowledge gifts' through research. Foremost, an awareness of local histories and cultural diversities is needed, to engage in effective relationship-building and allying with First Nation community champions. Moreover, permission from community leadership is needed to effectively collaborate by identifying knowledge gathering and analysis methods. Additionally, engaging in local gift-giving protocols such as providing food and incentives, is key for non-Anishinaabek peoples to assist local communities in contributing to their bundles (McGregor, 2018).

As a non-Indigenous or non-Anishinaabe researcher, the Truth and Reconciliation Commission of Canada (2015) has challenged me to examine my White privilege (Nelson, 2009) by embedding health-related Calls to Action directly in the foundation of this research. For this study, four Calls to Action were collaboratively selected. In simple terms, these Calls include the need to: acknowledge that previous health policy is responsible for the current state of Indigenous health and to implement Indigenous healthcare rights under the law (Call No. 18); publish reports identifying the availability of appropriate health services (Call No. 19); recognize and support the value of Indigenous medical practices with healers and Elders (Call No. 22); and provide culturally-appropriate competency training for healthcare professionals (Call No. 23) (TRC, 2015). The first chosen call to action (Call No. 18) is being realized in this opening

chapter, and will continue to be examined in Chapter 2, as we more closely examine the current state of Indigenous health and well-being. The remaining three Calls to Action will be addressed throughout Chapters 3, 4, and 5 as these actions have been imbedded into the design and delivery of the re-search intervention. Finally, Chapter 6 will demonstrate how these Calls were enacted to differing extents, and how this research can contribute to finding Truth and Reconciling with Indigenous peoples.

Defining Indigenousness. In the brief historical background section, the terms: Indian, Aboriginal, First Nation(s) and Indigenous are used, which are not representative of how Peoples were referred to in North America prior to colonization. These terms have historical, political, geographical, and derogatory connotations that have been used mainly by non-Indigenous persons to exert control over a variety of populations (Allan & Smylie, 2015). Additionally, these terms carry different meanings reflecting different periods in federal policies.

The historical term *Indian* as defined by the Indian Act **(**1867) referred to "any male person of Indian blood reputed to belong to a particular band; any child of such a person; and any woman lawfully married to such a person" (Furi & Wherrett, 2003). This term is outdated and offensive to many, but still holds significance in Canada as it incorporates the terms: 'status Indian', 'non-status Indian', and 'treaty Indian' (Canadian Geographic Indigenous Peoples Atlas of Canada, 2018). In 1985, the Indian Act was amended with the introduction of Bill C-31 which reinstated thousands of women and children who had lost their status under previous law; however, women are still currently responsible for proving paternity in order to secure status for their children (Furi & Wherrett, 2003) – a practice not experienced by any other culture group.

The term *Aboriginal* was, and still is, a government-imposed term referring to all Indigenous peoples of Canada, having directly come from the term Indian (Allan & Smylie,

2015). However, according to the *Aboriginal Law Handbook,* Aboriginal persons in the 1990's were described as being either 'Indian', 'Inuit', and sometimes 'Metis' (Imai, Logan, & Stein, 1993). On June 21st, 2017, Prime Minister Justin Trudeau renamed National Aboriginal Day to National Indigenous Peoples Day in response to the offensive nature of this term, referenced in the Truth and Reconciliation Commission's Calls to Action (The Canadian Press, 2017). Over the past five years, dozens of federal government documents, peer-reviewed journal articles, Indigenous and non-Indigenous strategic documents, and institutional policies have adopted the term *Indigenous*, in lieu of using Aboriginal due to its government-imposed meaning (Indigenous and Northern Affairs Canada, personal communication, November 17, 2017). At present, academic institutions remain committed to multiple terms, and it is not uncommon to see a student enrolled in Indigenous Studies under the Department of Aboriginal Education (Scully, 2014).

The term *First Nation* also came into common use in the 1970's to replace *Indian*, although it has a more specified meaning relating to land. (Allan & Smylie, 2015). This term for example, is not interchangeable with *Inuit* or *Métis*, as Indian or Aboriginal may have been. *First Nation* individuals are people belonging to one of 634 recognized First Nation communities in Canada (Assembly of First Nations, 2017). Those identified as *First Nation* individuals by the government, represent approximately 900,000 people across Canada in both rural and urban areas (Canadian Geographic Indigenous Peoples Atlas of Canada, 2018). The term *Inuit* conversely, means 'the real people', referring to the land, water and ice contained in the arctic region (The Canadian Encyclopedia, 2018). Because Inuit do not live in First Nation communities, the terms on-reserve and off-reserve do not apply. Lastly, *Métis* refers to descendants of First Nations people and French Europeans, who have consciously chosen to

identify as being *Métis* and have a shared identity, kinship, language, and culture (Canadian Geographic Indigenous Atlas of Canada, 2018).[4]

Currently, the neo-colonial term that appears to be most encompassing and least offensive in referring to pre-colonial inhabitants of Turtle Island, is *Indigenous* (Allan & Smylie, 2015; Bartlett et al., 2007). The United Nations (1987) defines Indigenous people as those with a historical connections to pre-colonial societies, while Wilson (2008) uses this term to refer to "people coming from the land and being of the land" (p. 371). Wilson's (2008) expression of this term aligns most closely with meaning of the term *Anishinaabe* - the people (Absolon, 2011). Dei (2000) supports using terms that: 1) recognize the collective origins and collaborative dimensions of knowledge and being, and 2) support the concept of *Indigenousness*, meaning that consciousness arises "locally and in association with the long-term occupancy of a place" (p. 73). Therefore, after careful consideration of the terms reviewed in this section, words referring to 'the people' or 'the land' were intentionally selected to reference those who participated in the research study; that is, *Anishinaabe, Indigenous,* and *First Nation*.

To be clear, language matters and the three chosen terms are used intentionally and not interchangeably throughout this dissertation. This research took place on Anishinaabe lands with Anishinaabek, many of whom are cited or referenced throughout this work (Absolon, 2011; Bell, 2018; Cormier & Ray, 2018; Manitowabi & Maar, 2018; McGregor, 2018; Srigley & Varley, 2018). The background for this dissertation did not limit its search to Anishinaabe culture; however, there is a strong representation of Elders, scholars, and writers who come from Anishinaabe roots, and specifically Ojibwe-speaking Anishinaabe people. Bell (2018) for

[4] The terms Inuit and Métis and have not been incorporated into this PhD dissertation due to their geographical and historical contexts; however, the knowledge generated from this work may be applicable to individuals of these groups.

example, states that she focuses on 'Anishinaabe research' rather than 'Indigenous research' because she looks at life through the worldview of an Anishinaabe person. She acknowledges strong overlap between both forms of research but is careful not to assume that one type equates another. In this dissertation, Anishinaabe peoples, lands, cultural protocols, and works, will be specifically acknowledged when referring to local knowledge and ways of knowing.[5]

Phase 1: Defining 'Research' and 'Problem'

> Many researchers, even those with the best intentions, frame their research in ways that assume that the locus of a particular research problem lies with the indigenous individual or community rather than with other social or structural issues…. It becomes somewhat complicated for indigenous researchers to discuss 'research', 'problem' and 'indigenous' without individuals or communities 'switching off' because of the history of defining indigenous peoples as the problem. (Smith, 2012, pp. 95-96)

The term research "is probably one of the dirtiest words in the Indigenous world's vocabulary" (Smith, 2012, p. 1). With this frame of reference, the simple act of defining a research problem is a colonial practice that will have implications for the communities involved. For this dissertation, we[6] adopted Wilson's (2008) concept of *re-search* which refers to the process of rediscovering existing knowledge, in a manner that does not separate researchers from the participant. Specifically, Wilson's (2008) concept and meaning of the word 're-search' will be used in this dissertation when referring to the discovery of existing knowledge, while the conventional term 'research' will be used when discussing the acquisition of new knowledge or when referring to the overall notion of research.

[5] Bell (2018) acknowledges that: "[Anishinaabe] research without a spiritual connection is a 'dead' piece of work – one which cannot provide life to the people it should be serving" (p. 183). Thus, reference to Anishinaabe peoples, lands, and cultures will presumably include a strong representation of the spirit.

[6] For this research, 'we' refers to me and the collaborators of Nokiiwin Tribal Council and its member communities who participated on the research committee. Throughout the dissertation, relationships will be discussed in more detail to support how 'we' made collaborative decisions.

The 'research problem' in the Western sense, was experienced by me for several years. After reading Wilson's (2008) work, it became a challenge to identify how re-search could be used not only to identify but to address a problem. The term 'problem' has a strong meaning for Indigenous peoples as they were referred to as the "Indian Problem" (TRC, 2015) for decades. Therefore, after reviewing Indigenous literature and policies with First Nation organizations for many years, it made the most sense to collaboratively identify the re-search problem using the Truth and Reconciliation Commission of Canada (2015) as a guiding entity. Our first step was to acknowledge that certain existing federal policies continue to support colonial practices; our second step was to identify literature and policies that support decolonization practices, specifically, in relation to Indigenous access to healthcare services.

Re-search problem – access to healthcare services.

The following section is going to identify the 're-search problem' by examining Indigenous access to culturally-appropriate healthcare services in Canada and the region[7]. Article 24 of the United Nations Declaration on the Rights of Indigenous Peoples states that Indigenous people have the right to access the same standard of healthcare as non-Indigenous people (United Nations General Assembly, 2008). Specifically, Section 1 states that "Indigenous individuals also have the right to access, without any discrimination, to all social and health services" (p. 9); and Section 2 states that "Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health" (p. 9). The challenge for Canada in meeting these expectations, is that Indigenous peoples receive healthcare service provision under the conditions of the Indian Act and Constitution Act of 1867, where the federal government is

[7] Articles supporting the research problem with a participatory action research framework, will specifically be discussed in Chapter 3 with the methodological orientation of the study, *community action research*.

mandated to provide health services to registered Indians living on reserve (Talaga, 2018). The disconnect from provincial healthcare service provision, creates jurisdictional ambiguity which continues to undermine healthcare delivery and access (Lavoie, 2013).

Despite the purpose of the Canada Health Act (1985), to protect and promote the well-being of Indigenous persons by facilitating reasonable access to health services without financial or other barriers, "generations of Indigenous children have grown up largely in communities without access to the basic determinants of health" (Talaga, 2018, p. 16). Dr. Kirlew challenges this contradiction, stating: "the system isn't broken; it is designed to do what it is doing" (cited in Talaga, 2018, p. 165). However, Canadians are now starting to take notice of the inequitable and unacceptable access issues plaguing Indigenous persons (Allan & Smylie, 2015), and are beginning to challenge the existence of colonial policies, acts, and structures supporting the Indian Act (Falconer, Churchill, & Byrd, 2018). Things are slowly changing. On November 17, 2017, a health transformation work plan was signed by Nishnawbe Aski Nation, demonstrating for the first time an example of where First Nation communities can be in full control of their healthcare (Nishnawbe Aski Nation, 2017).

This success is only the beginning, and is supported by Indigenous political frameworks objectives. The *Blueprint on Aboriginal Health* (2005) was generated as the first plan in Canadian history to provide a longitudinal strategy for Indigenous healthcare access and service delivery (Health Canada, 2005). Its objectives focused on the provision of health services, shared knowledge in healthcare, teaching people about health and wellness, and collaborating with all levels of health service delivery. The full objectives of this blueprint have still not been realized today, and subsequent reports (Health Canada, 2007; 2015) have acknowledged that there is a

serious crisis in both the health status of Indigenous Canadians and their access to effective healthcare services.

One of the biggest challenges in understanding how Indigenous persons are being impacted by lack of healthcare services, lies in the definition of the word *access*. A report by the Office of the Auditor General of Canada (2015) reviewed access to health services for remote First Nation communities. In the report, access is defined as: 1) having available medical transportation benefits, 2) having comparable healthcare service provision to other residents in similar geographic locations, and 3) having access to service provision by registered clinicians. Based on this definition, the Auditor General reported that Health Canada had not made any attempt to improve access to healthcare services for Indigenous populations in the past decade.

Specifically, and with regards to service provision, Health Canada did not ensure that clinicians had completed mandatory training courses; did not put in place supporting mechanisms for nurses who performed activities beyond their scope of practice; could not demonstrate whether deficiencies related to the health and safety requirements of building codes were addressed; and had not assessed the capacity of health stations to provide essential health services. Perhaps most damaging was that Health Canada did not consider First Nation community health needs when allocating support and comparable access with non-First Nation communities, and that First Nation individuals who were not registered could not receive medical transportation benefits. In response to the 2015 Auditor General report, Health Canada agreed to move toward the creation of interprofessional teams where possible, to support culturally appropriate, safe, and effective delivery of essential services (Office of the Auditor General of Canada, 2015).

Bourassa and Peach (2009) explain that government agreements (e.g. as is the case with Health Canada and First Nations peoples), do not support existing Canadian law. These agreements thereby contribute to limiting Indigenous access to health services by excluding Indigenous people who are not registered Indians, with no concern for how individuals define themselves (Bourassa & Peach, 2009). To be clear, for those registered or are considered status Indian under the Indian Act, access to healthcare services continues to be a problem (Allan & Smylie, 2015; Office of the Auditor General of Canada, 2015). Particularly, Kulig and Williams (2012) highlight the challenges (e.g. geographical limitations, quality and availability of services) of status First Nation peoples who try to access similar healthcare services available to other Canadians living in rural areas. A solution to enhance Indigenous services has been identified through Non-insured Health Benefits (NIHB); however, this government policy is slow to update policy changes and distribute equitable funding (Allan & Smylie, 2015).

For those with status living on reserve, services which are considered accessible are typically delivered to, and not in partnership with, Indigenous persons as a result of colonial policies and geographical challenges (Kulig & Williams, 2012). It is difficult to measure the true national healthcare access issues for many First Nation communities, as they are typically not involved in census data used for research, even data representing 98% of rural and remote locations (Sibley & Weiner, 2011). The reason for non-inclusion is often attributed to the vastness of northern regions, where many people need to travel long distances to receive care, often limited by poor weather and road conditions (Kelly et al., 2012). In these rural and remote environments, access has been defined as: having had an influenza vaccine in the past two years; having seen a physician or specialist in the past year, having unmet needs in the past year; or having a regular medical doctor (Sibley & Weiner, 2011).

Despite improved access to healthcare being frequently identified as a goal for policy-makers, McIntyre, Thiede, and Birch (2009) write that the meaning of access to healthcare remains unclear. In order to address the quagmire of definitions regarding *access*, they established a conceptual framework built on the original work of Penchansky (1977). This framework includes three distinct definitions often used to describe access (Figure 4): availability (physical access), affordability (financial access), and acceptability (culturally access) have been identified as multi-dimensional concepts contributing to one's ability to access care. The framework acknowledges that "access is not a passive concept but relates to the communicative interaction between individuals and the health care system" (McIntyre et al., 2009, p. 188). Interactions between the dimensions of access determine level of access to care. For example, the *availability* of male-only health providers for the provision of women's health services may pose *acceptability* problems for those whom the services are intended. Where the *availability* of specific drugs is left to private pharmacies, *affordability* may be a problem (McIntyre et al., 2009).

When considering the meaning of access in northern Indigenous communities, this framework evaluates access holistically by including the term 'acceptability'. If we examine the base of the model in Figure 4, the terms training, power relations, and professionalism are identified as the root causes that can inhibit culturally-acceptable access to healthcare services. They are therefore the focus of the re-search problem, and require direct attention in the implementation of the intervention. For the purposes of this dissertation, we will accept the notion that available and affordable access to healthcare services are supported for those living in First Nations belonging to Nokiiwin Tribal Council, and that the key issue related to access, is acceptable healthcare services. By focusing on this specific concept of access, this research is

more equipped to handle scope creep (i.e. other concepts of access that could be considered in the re-search problem).

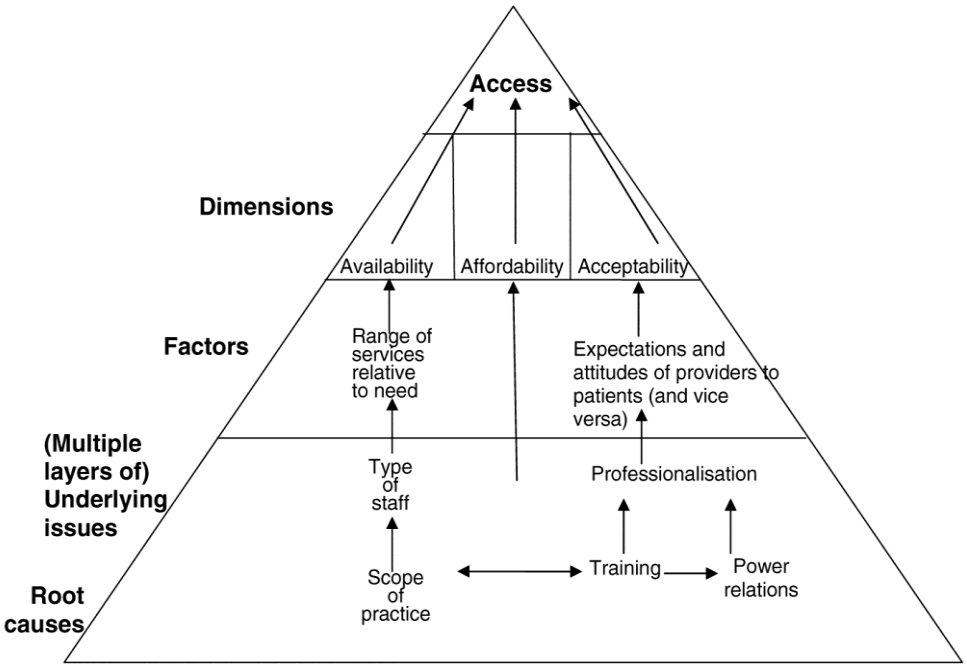


Figure 4*: Access Evaluation Framework*. (McIntyre, Thiede, & Birch, 2009)

Re-search problem – access to healthcare services in the region.

Acceptable access to healthcare services is an issue for Indigenous people living in Canada, and more specifically in northwestern Ontario. In a letter from Nishnawbe Aski Nation Grand Chief, Alvin Fiddler, on January 18, 2017 to Prime Minister Justin Trudeau, the issue of acceptable access to healthcare services is identified following the deaths of children from preventable illnesses, ranging from strep throat to suicide:

> First Nations are not sitting on their hands and expecting the federal government to solve the tragedies of their communities. But, we have been legislated into a position where our power is to make proposals and seek program dollars from your bureaucracy. When we are then ignored, our hands are tied and our children continue to needlessly die. (cited in Talaga, 2018, p. 11)

The current research study focused particularly on Indigenous access to healthcare services for those living on the Robinson-Superior Treaty Territory in Northwestern Ontario. The impetus for choosing this geographical location and associated populations was born out of recommendations made from local scholars in the 1990's and early 2000's representing the Centre for Rural and Northern Health Research (CRaNHR) at Lakehead University. Specifically, multiple publications have acknowledged Indigenous access to healthcare services as an issue, and have recommended that interprofessional collaborative care is one solution in a northern context (e.g. Boone & Katt, 1997; Boone, Minore, Katt, Kinch, 1994; Minore & Boone, 2002; Minore & Katt, 2007). Moreover, researchers identified that there is a need to reform healthcare access, prepare healthcare workers for northern practice, and enhance interprofessional teamwork for the provision of health services to northern First Nation communities (Boone & Katt, 1997; Nokiiwin Tribal Council, 2016; Minore & Katt, 2007). Interprofessional collaborative teamwork will be explored in Chapter 2's Literature Review section.

One of the most important challenges identified locally, is that geographical access impairs both availability and acceptability of services due to people being dispersed over a large land mass with under-supplied physical and human resources (Minore & Boone, 2002). Additionally, communication practices in rural Indigenous healthcare practice reinforce silos and barriers, which exclude interprofessional teams from effectively providing care (Minore & Boone, 2002). It has been proposed that creative, low-cost, sustainable solutions are required in order to successfully serve these hard to reach places where healthcare needs are high (Boone & Katt, 1997; Minore & Boone, 2002). This change is supported in the Northern Policy Institute's report, *Northern Ontario Health Care Priorities: Access to Culturally Appropriate Care for Physical and Mental Health* (Al-Hamad & O'Gorman, 2015).

A real-life example of the re-search problem is reflected in the story of Brian Sinclair, whose story represents dozens of Indigenous people each day in northern Ontario (Dr. Richard Matthews, personal communication, November 8, 2017). Mr. Sinclair waited 34 hours in the hallway of an emergency room to be treated for a urinary tract infection; however, he did not receive the needed care for this routine illness as it was assumed he was drunk despite negative alcohol testing results. 150 people were triaged in advance of Mr. Sinclair before his body was found in a state of rigor mortis. The family believed that he was ignored not because of the false assumption of being drunk, but because he was disabled, marginalized, and 'Aboriginal'. Following his death alongside dozens of people, it was determined that systemic, interpersonal, epistemic and internalized racism permeating the healthcare system, made appropriate and acceptable access impossible despite his presence in a hospital (Allan & Smylie, 2015). As a result of incidents like this, Al-Hamad & O'Gorman (2015) emphasize that culturally appropriate access to healthcare is needed and can be achieved by implementing technologies and/or practices whereby interprofessional teams can be united, patient services can be improved, and professional relationships can be strengthened.

The re-search problem was investigated at the local level through a needs assessment completed with Nokiiwin Tribal Council (Nokiiwin Tribal Council, 2016) prior to the REB re-search period. Semi-structured interviews, accompanied by an online survey targeting healthcare access issues and interprofessional collaboration, were completed by 31 care providers representing each of the six communities. The Needs Assessment (Nokiiwin Tribal Council, 2016) recommended that even though the First Nations and Inuit Health Branch supports the availability of, and access to, health services, northern communities require additional approaches that focus on interprofessional collaborative care to ensure that culturally appropriate

healthcare access is universally provided and available within and between local First Nation communities.

The needs assessment findings support Coffey and Anyinam's (2015) recommendations at the time of the 2011 and 2015 federal elections. They suggest that Canadian healthcare "must undergo change based on more effective and efficient ways to deliver care" (p. 1), and propose that interprofessional collaboration is needed to facilitate this change. Specific recommendations made to address access include: 1) ensuring information is shared effectively between healthcare providers, 2) reducing replication of services through enhanced communication, and 3) enhancing resource utilization. Through the national and local identification of barriers for Indigenous persons to access appropriate and acceptable healthcare services, interprofessional collaborative care was identified as a mechanism that may impact access (Coffey, 2015).

Research purpose. As previously stated, Wilson's (2008) concept and meaning of the word 're-search' will be used in this dissertation when referring to the discovery of existing and new knowledge, while the conventional term 'research' will be used when discussing the acquisition of new knowledge or when referring to the overall notion of research. This section will identify the research purpose based on the previously discussed re-search problem. Thus, the purpose of this study was to examine whether the introduction of interprofessional collaboration competencies (CIHC, 2010) to healthcare teams servicing northern Ontario First Nation communities, enhances: 1) interprofessional collaboration and 2) whether this training leads to improved Indigenous healthcare access.

Provincial and municipal policy documents highlighting how interprofessional teams collaborate effectively to provide services were reviewed in preparation for this research (CIHC, 2010; Health Canada, 2005; HealthForceOntario, 2009, 2007; Interprofessional Care Steering

Committee, 2007; Northern Ontario School of Medicine [NOSM], 2017). Moreover, peer-reviewed articles that have recommended the implementation of culturally-competent service delivery for interprofessional teams servicing Indigenous populations were incorporated into the research process (Boone, Minore, Katt & Kinch, 1994; Oelke et al., 2013; Purden, 2005; Salvatori et al., 2007). A more detailed literature review on the interprofessional collaboration/education model and intervention will be covered in Chapter 2 and Chapter 4.

The purpose of this re-search is predicated on the belief that not all research should be conducted because a void in literature needs to be filled (Creswell, 2014). To identify the research purpose and subsequent research questions, Creswell's (2014) *inverted triangle* concept was used (See Figure 5). The inverted triangle brings together two different concepts in order to address a research problem. This strategy can be used by researchers who are more than just interested in addressing a gap in the literature; rather, it supports a creative, outside-of-the-box way to address a research problem. For this study, Indigenous and Non-Indigenous ways of knowing in healthcare were brought together with interprofessional education collaborative training or simply interprofessional collaboration training (IPC Training) [NB: content to be covered in Ch.2], for the purpose of improving collaboration in a community action research framework [NB: content to be covered in Ch. 3]. At the apex of the triangle is the focus of the re-search, to increase Indigenous access to culturally-appropriate healthcare services (i.e. research problem). Thus far, I have only discussed literature supporting the research problem and purpose, as it was important to identify the starting point of the research. Chapter 2 will focus on literature reviews covering both points at the base of the triangle, while Chapter 3 will provide the methodological orientation as to how this re-search problem was undertaken.

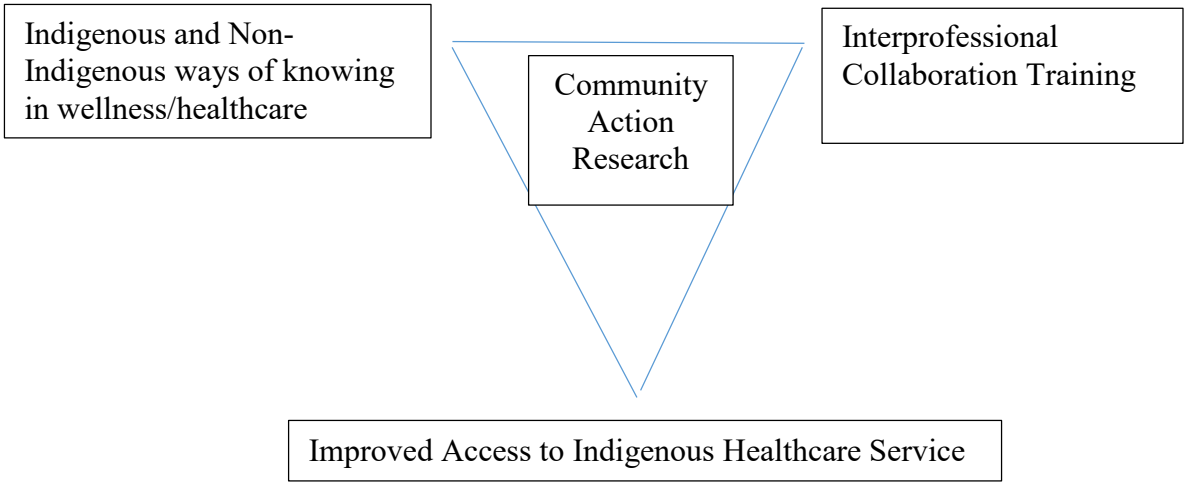


Figure 5*: Re-search Inverted Triangle*.

Research questions. Schram's (2003) concepts of considering both breadth (i.e. open-ended questions) and precision (close-ended questions), attending to what matters to address the research problem and purpose, and assessing goodness of fit with Nokiiwin Tribal Council's communities' worldviews, were all considered in the generation of three research questions. It took about six months to generate the following research questions working in coordination with Nokiiwin Tribal Council's Disabilities' Coordinator, who consulted with each of the six communities from the conception of the re-search project. Following the research questions below, is a timeline referencing relationship-building that took place in 2016 (Table 1), representing individuals and organizations who contributed to the conceptualization of the study. In Table 2 that follows, is a research project overview chart, which highlights the major activities that took place over a four-year period.

The three research questions include:

1) Does interprofessional collaboration improve, following the introduction of interprofessional collaboration training, for providers servicing Nokiiwin Tribal Council communities? (Quantitative Question)

2) What are the experiences of service providers after introducing interprofessional collaboration training for the purpose of improving healthcare access? (Qualitative Question)

3) Can improved access to healthcare services be achieved for Nokiiwin Tribal Council as a result of the interprofessional collaboration training? (Mixed Methods Question)

Table 1:

Relationship-Building Phases

Date	People Introduced to Re-search	Engagements
December – January 2015/2016	Lisa French, Disabilities Coordinator; Audrey Gilbeau, Executive Director (Nokiiwin Tribal Council) Justine Jecker, Lakehead University	I was invited to engage in community-based research in partnership with Nokiiwin's communities based on my experience teaching Interprofessional competencies, and clinical work as an occupational therapist, with First Nation communities. My name was given to Nokiiwin based on work completed with a local Knowledge Management company.
February 2016	Nokiiwin Board of Directors Dr. Brian Dunn, Lakehead University (research assistant) Disabilities Steering Committee (one healthcare representative from each of the six communities who supported the research project)	The Board of Directors approved the relationships between Nokiiwin and me to move forward in contacting communities interested in participating in community-based research. A needs assessment was conducted with all six communities to help validate the initial research problem identified by Nokiiwin – i.e. that there is a need for increased access to culturally-appropriate services
March - May 2016	Introductions to community members and Chiefs of all six Nokiiwin-affiliated communities Dr. Richard Matthews (Bioethicist, Lakehead University)	Communities invited me to introduce myself and discuss my work in interprofessional education and collaboration. Thoughts were exchanged on the idea of re-search and how communities could see themselves being involved. Dr. Matthews agrees to be a consulting ethicist on the project based on his experience working with Indigenous communities.
June 2016	Indigenous and Northern Affairs Canada Elder Tony DePerry	A three-year funding application is approved for community-based research, but is subject to renewal each year and dependent on progress made. The proposal includes three distinct phases: planting the seed (2016-2017), pathway to inclusion and community engagement (2017-2018), capturing the picture and sustainability (2018-2019)
August - December 2016	Meetings with community organizations servicing communities (e.g. Northwest LHIN's, CMHA, Dilico, Partners in Rehab)	We begin to map community services being offered in each of the six communities by all local, provincial, and federal organizations. Through working with these organizations and Nokiiwin communities, we are able to begin drafting re-search questions collaboratively

Table 2:

Research Project Overview: 4-Year Plan

2015 - 2016 *Phase 1: Identifying the Re-search Project*	**2017 - 2018** *Phase 2: Re-search Design* *Phase 3: Planning & Action*	**2018 - 2019** *Phase 4: Evaluation* *Phase 5: Moving Forward*
Literature Reviews completed examining interprofessional collaboration models and assessments, healthcare knowledge management, Indigenous knowledge practices Needs Assessment completed with Nokiiwin health professional members to establish a foundation and relationship within the six communities Indigenous and Northern Affairs Canada Grant is received ($100,000/year) based on three-year research project plan Community partnerships formed and knowledge transfer with Nokiiwin staff members; Visit Communities to establish and maintain ongoing relationships and completion of first draft of service provider web-maps	Connections made with providers servicing communities; establishment of available interprofessional teams using web-maps; consultation with clinical master's students servicing communities and gain feedback on the web-maps Review Ethics Board approval received and recruitment within the communities begins with Opening Action Research Conference. Action Research is initiated: i) community workshops are held focusing the delivery interprofessional collaborative competency training ii) quantitative surveys are administered iii) qualitative data is collected by way of interviews to create narratives over the course of the year	Data collection and analysis is finalized Preliminary results are shared early on in the year, followed by the full presentation of results late in the year Communities continue to engage IPC trainings offered by the Mental Health Navigator to ensure equity Develop a research framework with Nokiiwin Tribal Council based on community action research Publish findings in Indigenous and Non-Indigenous peer reviewed journals, and make accessible in the grey literature findings and benefits of the research (e.g. website, newsletters, books)

Note: A similar version of this table was submitted to Indigenous and Northern Affairs Canada (INAC) to support the three-year funding grant.

Research Expectations

The intention of this study was to demonstrate that by improving interprofessional collaboration for healthcare providers servicing Nokiiwin Tribal Council communities, issues regarding access to healthcare would be mitigated as suggested in the research literature (e.g., CIHC, 2010; Frenk et al., 2010; HealthForceOntario, 2007; WHO, 2010). It is known that interprofessional collaborative care improves health outcomes (CIHC, 2010; Frenk et al., 2010; WHO, 2010), and literature has supported interprofessional collaboration training as an intervention to address healthcare access issues for Indigenous persons (Boone, Minore, Katt, Kinch, 1994; Duckett, 2009; Dunn, 2016; Health Canada, 2005, 2007, 2015).

As will demonstrated in Chapter 3, this research project incorporates a mixed methodology guided by a two-eyed seeing lens (Bartlett, Marshall, & Marshall, 2012; Marshall, 2017; Martin, 2012) to speak to the impact and experiences of an interprofessional collaboration training intervention involving healthcare providers servicing Nokiiwin Tribal Council's six communities. Field notes and observations support the convergence of qualitative and quantitative findings during the analysis phase. By implementing the cyclical concept of action and reflection (Marshall, 2017), a picture was painted of what currently exists in terms of accessible services, and what is needed to improve accessible services for Nokiiwin Tribal Council communities. Lavoie and Gervais (2012) acknowledge the importance of "innovations that build on the idea that the community is the constant" (p. 390). Therefore, it is necessary to embrace existing healthcare system limitations of Nokiiwin Tribal Council's affiliated First Nation communities (i.e. the constant), in order to overcome barriers such as funding limitations and inadequate service provision, through innovative approaches.

Overview

This chapter was entitled *Introduction - The Two Row Wampum* to both introduce and remind the reader that the work in which this dissertation is based, is grounded in centuries of history between Indigenous and non-Indigenous Canadians. As was stated in the traditional Magna Carta of 1613, we have agreed to acknowledge two distinct ways of life where settler and Indigenous traditions can both be embraced and respected. According to Latulippe (2015), "methodologically, separate rows signify epistemic difference, while the shared space – the bridging rows of peace, friendship, and respect – mirrors the conceptual space shared by Indigenous and Western [research] methodologies" (p. 9). This dissertation is another example of an agreement made between Indigenous and non-Indigenous peoples, however as required by the academy, only I am responsible for its presentation and delivery. I have sought to do my best to demonstrate how the non-Indigenous pathway of the Two Row Wampum, may effectively communicate with the Indigenous pathway, to work towards a shared goal.

As an ancestor of the Two Row Wampum agreement, I accept the notion that we can learn from one another to better our own ways of life. There is a particular onus for non-Indigenous peoples such as myself, to restore the balance in our relationship by acknowledging the truths of the past and the current impact of ongoing colonial practices in our present and future. The national call to recognize inequity, inequality, and injustice of Indigenous peoples, forms the basis of the Truth and Reconciliation Commission of Canada report ([TRC], 2015). Through its Calls to Action, this declaration provides a roadmap for non-Indigenous people to engage in actions that can help restore the balance of our centuries old agreement. It has reminded us of the colonial actions that have led to our present-day reality, and is powerfully obliging all non-Indigenous people to take responsibility of our own actions and the actions of

our ancestors. In this study, four Calls to Action have been identified as foundational stepping stones that need to be realized, to support the integrity of the research.

A research problem was identified in this Chapter using an Indigenous understanding of the term re-search (Wilson, 2008). In order to make explicit the national and local challenges involved for Indigenous persons accessing healthcare services, it was necessary to review the ongoing colonial policies that support racist and unequal practices in northern Ontario. A local needs assessment that examined healthcare access issues for Nokiiwin Tribal Council, was responsible for the context in which the research took place. More information can be found on this needs assessment in section of Chapter 4. Ultimately, its findings support the need for culturally-appropriate access to services for those living in Nokiiwin Tribal Council communities representing the Robinson-Superior Treaty Territory.

As a key solution to the issue of improving Indigenous healthcare access, education involving interprofessional collaboration training for healthcare teams servicing communities, was identified through local literature written by Indigenous and non-Indigenous researchers. This information, which was demonstrated in the pre-research needs assessment, was shared with all six Nokiiwin communities to assist in formulating the research purpose and three research questions. Thus, this chapter has identified the environmental context of the research problem and purpose, and through the inverted triangle approach (i.e. merging of Indigenous/Western ways of knowing with Interprofessional Collaboration/Education), has acknowledged the mechanism in answering the research questions.

Chapter 2: Literature Review – Two-Eyed Seeing

Figure 6: *Sweetgrass and Tobacco.* (Rosey's Trading Post, 2014)

Sweet grass is a gift from Mother Earth. It is said to be part of her hair and the use of sweet grass promotes strength and kindness. When braiding sweet grass each strand of the braid represents mind, body and spirit. It is also important to remember the teaching of the sweet grass braid and walk that way when wearing a braid in our own hair.

(Anishnaabeg Bimaadiziwin: An Ojibwe Peoples Resource, n.d.)

Tobacco is the medicine that is offered to spirits to ensure safe passage, or to make requests or ask questions of the spirit world. Tobacco is offered to others when seeking knowledge. In some communities, such an offering may be expected when representing spiritual knowledge, ceremony or advice.

(Canadian Geographic Indigenous Atlas of Canada, 2018)

In this Chapter entitled *Literature Reviews – Two-Eyed Seeing*, ontological and epistemological theories will be discussed. The base of Creswell's (2014) inverted triangle approach, which includes Indigenous/Non-Indigenous ways of knowing in healthcare and Interprofessional Collaboration Training will be unpacked to give context on how the research purpose was achieved. By the end of Chapter 2, you will begin to ask how the base of the triangle (Figure 5) is able to answer/address the research questions/purpose identified at its apex. The 'how to' will be fully explored in Chapter 3's action research methodological orientation review. Thus, you will notice that the literature review for this dissertation has been intentionally split over three chapters, to address the complexity of scaffolding knowledge needed to engage in community-based and action-oriented research. To remain focused on what has been covered, Chapter 1 answers: What is the research problem?, Chapter 2 answers: What do we need to know to address the research problem?, while Chapter 3 answers: How will we tackle the research problem?.

At the core of this chapter is the idea that in order to translate or share knowledge effectively within and between Indigenous and non-Indigenous peoples, there needs to be an understanding of how to support both ways of thinking. This is effectively referred to as the *two-eyed seeing lens* (Bartlett, Marshall, & Marshall, 2012; CIHR, 2014; Hall et al., 2015; Hatcher, Bartlett, Marshall, & Marshall, 2009; Marshall, 2017; Martin, 2012). For instance, in Indigenous teaching, stories about animals may represent behaviours of humans; whereas in Western teachings, stories about animals represent stories about animals (Battiste, 2002). The former Indigenous understanding does not make the knowledge production less valuable because it has not been validated with a Western lens.

After reviewing differential ways of knowing in healthcare, the National Interprofessional Health Collaborative Framework (CIHC, 2010), which supports the intervention for this study, will be reviewed. This model was chosen for this re-search because it honours a two-eyed seeing approach. Latulippe (2012) challenges non-Indigenous researchers who engage in research with Indigenous communities, to respectively pursue Western research with an appreciation of Indigenous epistemologies and research methodologies. Kovach (2009) supports that this engagement works to unsettle White privilege and minimizing alternative ways of knowing in the academy. For me, this challenge fits well into my worldview, being both non-Indigenous and at the novice-level of learning Indigenous ways of knowing. Given that this dissertation will be read and experienced by both Indigenous and non-Indigenous knowledge holders, I have tried to ensure the content, intention, and readability of this work does not explicitly adhere to a Western worldview on how research should be conducted and presented (e.g. creating a fluid movement of the literature review over three chapters, defining Indigenous terms, acknowledging the importance of the two-eyed seeing lens).

Indigenous Knowledges

For the purposes of this dissertation, the term *Indigenous knowledges* refers to the shared commonalities between Indigenous groups' ways of knowing (Kovach, 2009), as well as "the understandings and skills developed by communities and passed from generation to generation over long periods of time" (Keane, Khupe, & Muza, 2016, p. 164). It is important to recognize that the term "traditional knowledge" is often used synonymously with "Indigenous knowledge" (Bartlett et al., 2012; Latulippe, 2012). This epistemology differs from the generalized *Western* epistemology which supports a qualitative-quantitative dichotomy in thinking (Kovach, 2009). Thus far in this dissertation, the terms 'Western' and 'non-Indigenous' have been used

interchangeably, and therefore represent the same meaning. Four subsections are used to organize this section: 1) an overview of Indigenous knowledges, 2) an understanding of colonizing Indigenous knowledge, 3) Indigenous knowledge translation, and 4) Indigenous knowledge recovery. It should be noted, that an honest attempt was made to incorporate the voices of local Indigenous scholars, and to provide an inclusive overview of Indigenous knowledges while acknowledging that entire dissertations and books have been written on Indigenous ways of knowing (e.g. Absolon, 2011; Archibald, 1997; Ermine, 1995; McGregor, Restoule, & Johnston, 2018; Simpson, 1999). The authors' works that are referenced in this section were encouraged by Nokiiwin Tribal Council and my PhD Committee, and most importantly exhibit an understanding of how knowledge is intertwined with health and well-being.

To start, and in the context of Indigenous knowledge, a literature review can be viewed as an oxymoron "because Indigenous knowledge is typically embedded in the cumulative experiences and teachings of Indigenous people rather than in a library" (Battiste, 2002, p. 2). Therefore, it is important to note that typical literature searches or reviews may not accurately reflect the Indigenous knowledge locally or globally. Rather than assuming that certain knowledge does not exist, it is important that we know where to look for it. Battiste (2002) explains that Indigenous knowledge is often seen as local or traditional knowledge, otherwise known as wisdom. Traditional knowledge shares genealogies and ancestral rights by those who have memorialized battles, boundaries, and treaties (Brant Castellano, 2000). In this context, traditional knowledge does not refer to 'old data' passed down generationally and unchanged; instead, it reflects knowledge tied to the land. Knowledge is evoked "where ceremonies are

properly held, stories properly recited, medicines properly gathered, and transfers of knowledge properly authenticated" (Battiste, 2002, p. 13).

Knowledge can also be observed or revealed. According to Brant Castellano (2000), "revealed knowledge is acquired through dreams, visions, and intuitions that are understood to be spiritual in origin" (p. 24). There is a recognition that knowledge in this sense is a form of power, and explains why many Indigenous persons refuse to be videotaped or recorded for research as they do not want their words to be misused. As such, there is an ethical responsibility that ensures Indigenous knowledges are not exploited (Battiste, 2007). Additionally, knowledge can be seen as a gift in a moment of need and conveyed in a narrative or metaphor:

> If Joseph X reports that he saw signs of a moose in a given direction, the information will be weighed in light of what is known of Joseph X, how often in the past his observations have proven accurate, what is known about this part of the territory, and the habits of moose. His observations would not necessarily be accepted uncritically, nor would they be contradicted or dismissed. (Brant Castellano, 2000, p. 26)

This example in Simpson's (2004) work may be referred to *Traditional Ecological Knowledge;* knowledge that is biodiverse and can be used to sustain land and our connection to living and non-being things. For many Western researchers, this knowledge is highly sought because it is "a resource for baseline data in areas where Western scientific data is lacking" (p. 374). Colonization has made availability to this form of traditional knowledge scarce, and is one of the reasons both Indigenous and non-Indigenous researchers are promoting recognition and protection of traditional knowledges (Simpson, 2004). Another way of considering this form of traditional ecological knowledge, is by acknowledging that knowledge is relational (Wilson, 2008). This means that knowledge must be shared holistically, and cannot be 'amputated' or examined in individual components as is typical in Western practices. Engagement with the land, ancestors, cosmos, and people are seen as a relational way of being which is at the heart of being

Indigenous (Wilson, 2008). In the context of Indigenous re-search knowledge, *relational accountability* is needed; this means that all living and non-living beings and environments are directly connected to the research environment (e.g. the non-participants, the trees, the air, computers, phones), and it is the researcher's job to ensure that their place is fairly represented in the generation of knowledge. In this way, re-search or research can be done in 'a good way' that is respectful of how we are connected to all living and non-living things (Wilson, 2008). Kovach (2009) supports that despite the commonalities in qualitative research with Indigenous ways of knowing, there is a stronger focus on relationships, research processes and self-reflection.

When speaking locally about Indigenous knowledge or *Kaandossiwin – How we come to know*, Absolon's (2011) work is on every Indigenous and non-Indigenous researcher's shelf. Kaandossiwin refers to the process of acquiring knowledge, it is a living word that speaks to the journey of learning, being, and doing (Absolon, 2011). This author uses the analogy of collecting blueberries (ripe knowledge) to make a blueberry pie (knowledge translation) that can be shared for all those in the communities. Like Wilson (2008), Absolon hyphenates the term re-search to signify looking for knowledge from her community's location in search of Anishnaabek ways of knowing in re-search. After reviewing 11 graduate theses, Absolon (2011) created The Petal Flower framework which conveys Indigenous methodologies in search for knowledge. The leaves on the flower represent how knowledge transforms through the research journey, because re-searchers are also on a journey of discovery. The leaves are nourished through the sun and its roots symbolizing that the knowledge is inter-related to the environment. To understand the context of the knowledge, one needs to travel to the flower's roots which symbolize Indigenous

paradigms, worldviews, and principles. In this way, the knowledge can be appropriately understood and shared with others.

In the context of Indigenous healthcare research, I did not come across the previously discussed notions of Indigenous Knowledges, and it is important to understand why. Indigenous scholarship and research related to healthcare service provision, is usually found in hardcover or open-sourced books, as opposed to peer-reviewed journal articles (Radassao et al., 2017). A recent global literature review conducted by four masters' students in occupational and physiotherapy **(**Radassao et al., 2017**)** elicited only nine Indigenous-related peer-reviewed articles pertaining to healthcare access and the role of rehabilitation professionals with First Nations populations. These students identified early in their research studies, that in order to access existing traditional knowledge by Indigenous scholars, a scoping review incorporating grey literature was needed. In order to gather data, the students reviewed: websites, newsletters, pamphlets, textbooks, and had discussions with both Indigenous and non-Indigenous scholars focusing on healthcare access for First Nation communities.

Similarly, for this literature review on Indigenous Knowledges and its subsections, dozens of books were reviewed (often as a result of speaking to local Indigenous scholars), whereas only a dozen articles met the search criteria in peer reviewed journal articles. Table 3 includes Indigenous works that had a profound impact on me and the assembly of this dissertation, considering Indigenous ways of knowing and knowledge-sharing. Authors that are not mentioned in this chapter, will be incorporated at other significant points in this document. Their influence cannot be understated. Notably, Kenny and Fraser's (2012) collection of female First Nation authors, researchers, mothers, and grandmothers includes case studies and stories supporting the power of Indigenous women to build strong communities through traditional ways

of knowing and being. The principle of *seven generations* is at this work's foundation, meaning we must reflect on our current knowledge and actions, to be aware of consequences seven generations hence. This means that Indigenous knowledges transcend the past, present and future. These authors recognize that even though this book is a great way to exchange traditional knowledge, its uptake is most likely to be achieved in the Indigenous community through the *Moccasin Telegraph;* a mechanism where word travels through networks of family, friends, and the community (a.k.a Indian country).

Table 3

Indigenous Scholars

Absolon (2011)	Kaandossiwin: How We Come to Know
Archibald (2008)	Indigenous Story Work: Educating the Heart, Mind, Body, and Spirit
Coulthard (2014)	Red Skin White Masks: Rejecting the Colonial Politics of Recognition
Davis (2010)	Alliances: Re/Envisioning Indigenous-non-Indigenous Relationships
Dei, Hall, & Rosenberg (2000)	Indigenous Knowledges in Global Contexts: Multiple Readings of Our World
Frideres (2016)	First Nations People in Canada
Jorgensen (2007)	Rebuilding Native Nations: Strategies for Governance and Development
Joseph (2018)	21 Things You May Not Know About the Indian Act: Helping Canadians Make Reconciliation with Indigenous Peoples a Reality
Kenny & Fraser (2012)	Living Indigenous Leadership: Native Narratives on Building Strong Communities

Kimmerer (2013)	Braiding Sweetgrass: Indigenous Wisdom, Scientific Knowledge, and the Teachings of Plants
King (2012)	The Inconvenient Indian: A Curious Account of Native People in North America
Kovach (2009)	Indigenous Methodologies: Characteristics, Conversations, and Contexts
Mihesuah & Wilson (2004)	Indigenizing the Academy: Transforming Scholarship and Empowering Communities
Lawrence-Lightfoot & Davis (1997)	The Art and Science of Portraiture
People's Knowledge Editorial Collective (2016)	People's Knowledge and Participatory Action Research: Escaping the White-Walled Labyrinth
Saul (2008)	A Fair Country: Telling Truths about Canada
Simpson (2008, 2017)	Lighting the Eighth Fire: The Liberation, Resurgence, and Protection of Indigenous Nations As We Have Always Done: Indigenous Freedom Through Radical Resistance
Smith (1999, 2012)	Decolonizing Methodologies: Research and Indigenous Peoples 1st and 2nd Edition
Talaga (2017, 2018)	Seven Fallen Feathers: Racism, Death, and Hard Truths in a Northern City CBC Massey Lectures: All Our Relations
Wilson (2008)	Research is Ceremony: Indigenous Research Methods

From colonization to de-colonization of Indigenous knowledge. As a result of colonialization, Indigenous knowledges, referring to stories and ways of being (Wilson, 2008), have been discovered, extracted, appropriated and distributed through positional superiority (Smith, 2012). Smith (2012) explains that the colonizing of Indigenous knowledges was a result of the Enlightenment period where Western culture's idea of gaining knowledge, was to interpret it in a way that made sense to the White man. For Indigenous cultures, the written representation

of their knowledges by colonialists was seen to be the first encounter with being a part of 'research' (Smith, 2012). This attack on traditional ways of knowing was often carried out in the name of progress. Simpson (2004) contends that Indigenous Knowledge "came under attack at precisely the same time Indigenous nations lost control over their land" (p. 377). Moreover, in this process of taking land, almost every aspect of Indigenous knowledge systems (e.g. environmental, emotional and spiritual knowledge) were targeted with the intent of destruction, conversion, or assimilation of knowledge into mainstream culture (Simpson, 2004). Given that settler political and legal systems replaced Indigenous sovereignty, "Indigenous Peoples lost the ability to protect Indigenous Knowledge from desecration because they lost the ability to protect their lands from environmental destruction" (Simpson, 2004, p. 378).

In our present-day reality, Western knowledge in academia has been used as a platform for dismissing the existence of Indigenous knowledge (Smith, 2012). Using a metaphor from the story entitled *Coyote Goes to School,* Heather Harris (2002) vividly captures how the expert White man has taken over the responsibility of educating 'Indians' on 'native knowledge'; a practice which continues to be carried out in Native Studies departments across Canada. In reflecting on the past two decades, Wilson (2008) speaks to a recent shift in how knowledge is acquired through the use of an Indigenous research paradigm; a way of thinking which acknowledges fundamental time periods in Indigenous history (i.e. Empty Land, Traditionalization, Assimilation, Early Aboriginal Research, Recent Aboriginal Research, and Indigenous Research). Wilson (2008) purports, "we are beginning to articulate our own research paradigms and to demand that research conducted in our communities follows our codes of conduct and honours our systems of knowledge and worldviews" (p. 8). Any Indigenous Research Methodology book written in the past decade would support Wilson's claim that

Indigenous paradigms and ways of knowing are strongly alive and growing (e.g. Archibald, 2008; Absolon, 2011; Kovach, 2009; McGregor, Restoule, & Johnston, 2018; Smith, 2012).

The two-eyed seeing approach referenced at the beginning of this chapter, is one example of how we, Indigenous and non-Indigenous researchers, can begin to decolonize Indigenous Knowledge (Kovach, 2009; Smith, 1999; Wilson, 2008). It is important to note that Mi'kmaq Elder and knowledge holder, Albert Marshall, introduced this model, for the purpose of building capacity "within Indigenous communities and the need for community resources that reflect true partnership in health research, knowledge translation and exchange" (CIHR, 2014, p. 37). Elder Albert suggests that two-eyed seeing is the gift of multiple perspectives recognized by Indigenous peoples; a gift that can be used to decolonize knowledge (i.e. overturn the belief that Western ways of knowing are the truth) through the process of 'co-learning' (Bartlett et al., 2012). This approach encourages inter-cultural collaboration, as Indigenous Knowledges are represented as one eye, and Western knowledges are represented as another eye (Marshall, 2017). These eyes are expected to work together, as they do in binocular vision, rather than tweaking one's view to accommodate components of the other (Marshall, 2017).

A strong example of the two-eyed seeing approach in action was captured in a three-year study looking at the effectiveness of cultural interventions in First Nation alcohol and drug treatment in Canada (Hall et al., 2015). This team carried out an Indigenous-focused research project with the two-eyed seeing as a guiding principle. Western methods included performing an environmental scan representing social, economic, technological, and political contexts, while Indigenous methods incorporated storytelling as a way to connect knowledge to traditional cultural practices and ceremonies (Hall et al., 2015). As a result, these authors state, "our team's facilitation of storytelling in our environmental scans…offered us solid insight into how [two-

eyed seeing] research can contribute to First Nations governance and cultural renewal" (p. 7). In this example, Indigenous ways of knowing combined with Western science, contributed towards Indigenous governance.

Two-eyed seeing is as much about Indigenous and non-Indigenous ways of knowing, as it is about understanding the differing perspectives within Indigenous Knowledge creation (Marshall, 2017). Smylie, Kaplan-Myrth and McShane's (2009) work was selected to identify how different Indigenous communities can come together in research, to learn with, from, and about one another (CAIPE, 2002). This research study used an Indigenous-focused participatory action research (PAR) design with one urban Inuit community, one urban Metis community, and one semi-rural First Nation community in Ontario. In order to effectively design, implement, and evaluate their PAR study, involvement from Indigenous leaders, healthcare providers, traditional healers, knowledge holders, and elders was needed (Smylie et al., 2009). [NB: The inclusion of Elders in research is both an honour and a privilege, as Elders are considered to be very important members of their communities given that they are knowledgeable in many areas. Elders typically have a high degree of understanding in history, traditional teachings, ceremonies, and healing practices (Canadian Geographic Indigenous Peoples Atlas of Canada, 2018)].

Data were gathered looking at health information sources, information dissemination strategies, community decision-making processes, and concepts of Indigenous health (Smylie et al., 2009). Following data analysis, the study found that each community had unique and specific values influencing the ways health knowledge was translated via existing social structures and practices. This suggests that it is essential in Indigenous-based research to have a strong understanding of how knowledge is translated and mobilized in community settings. Overall

however, focus groups from each of the three communities elicited common themes regarding knowledge which include: 1) the need to value experiential knowledge (e.g. testimonials of an effective service); 2) the influence of the community structure on health information dissemination (e.g. word of mouth) 3) the recognition of how health messages are generated within the community; 4) the dissemination of information through family and community networks; and 5) the impact and local effects of colonization. In summary, findings demonstrated that "understanding local Indigenous processes of knowledge creation, dissemination, and utilization is a necessary prerequisite to effective knowledge translation in Indigenous contexts" (p. 436) even if Indigenous communities share universal values.

As part of the decolonization process, Smylie et al.'s (2009) work employed a theoretical framework that focused on the historical context of health-based Indigenous knowledge systems (p. 437-438). The principles of this framework include: 1) prior to colonization, Indigenous peoples had their own systems of health knowledge; 2) these systems were rooted in local ecosystems and therefore are themselves diverse; 3) these systems were distinct from modern biomedical scientific traditions, which decontextualize knowledge from local contexts to discover generalizable principles; 4) Indigenous systems of health were suppressed and outlawed as part of colonization; and 5) The health of Indigenous peoples continues to be negatively affected by colonization. Even though the present research did not formally adopt the same framework chosen by Smylie and colleagues, all principles of this framework are recognized in this work. The historical elements support the notion early in this chapter that knowledge transcends time, and therefore an understanding and acceptance of the past is the only way that we may be successful in decolonizing research for the future.

Indigenous knowledge recovery. "A critical analysis of why Indigenous Knowledge is threatened or is becoming 'lost' rarely move beyond the rather simplistic assertion that the 'Elders are dying'….Elders have always passed into the next realm and [Indigenous Knowledge] systems have always been" (Simpson, 2004, p. 374). Decolonizing knowledge is as important as the recovery of Indigenous knowledge; both are considered to be an anticolonial endeavour (Wilson, 2004). In our twenty-first century, "the recovery of Indigenous knowledge is a conscious and systematic effort to revalue that which has been denigrated and revive that which has been destroyed" (Wilson, 2004, p. 359). Wilson (2004) suggests that in one sense the colonizers were correct; "Indigenous traditions are of little value in a world based on the oppression of whole nations of people and the destructive exploitation of [resources]" (p. 360).

Wilson's publication was printed as a special issue in the American Indian Quarterly for the purpose of validating and recovering Indigenous knowledge as a decolonization strategy, and for the purpose of addressing modern day issues impacting Indigenous communities. Wilson (2004) argues that in order to regain control of knowledge, control of the land is vital. As will be seen in Chapter 4 of this dissertation, participatory or community-based action research is a decolonizing mechanism that can encourage people to become involved in community transformation on their own land. The revaluing of traditional knowledge must begin in Indigenous communities because these communities are the holders of knowledge. In this way, Indigenous peoples can take part in the decolonization process by preventing knowledge from being further appropriated by the colonial system (Wilson, 2004).

Wilson (2004) writes that all Indigenous scholars are inherently working towards knowledge recovery, and that "academics are in a prime position to assist communities in the recovery of knowledge, so that Indigenous nationhood is strengthened" (pp. 370-371), and so

that Indigenous leaders remain of service to the people whom they represent. Consequently, the complexity of Indigenous knowledge recovery is the responsibility of both Indigenous and non-Indigenous peoples. This recovery process should take place in Indigenous communities, where community members and scholars can collect and preserve knowledge for future generations. Wilson's concepts of Indigenous Knowledge recovery, support Simpson's (2004) notion that, "to recover Indigenous Knowledge, Indigenous Peoples must regain control over their national territories" (Simpson, 2004, p. 379).

In summary, the historical understanding of Indigenous Knowledges, the colonization of Indigenous Knowledges, and our current concepts of decolonizing and recovering knowledge, reflect a national responsibility to those enacting Calls to Action identified in the Truth and Reconciliation Commission (2015) report. This literature review provides an important understanding for how I and other researchers need to consider the creation of knowledge involving Indigenous peoples moving forward. In the TRC (2015) report, it is identified that non-Indigenous researchers should participate in archiving Indigenous ways of knowing and being, adopt appropriate research methods involving Indigenous peoples, and write reports that reflect truth and two-eyed seeing approaches. This section has provided a glimpse into the world of Indigenous Knowledges, while highlighting important considerations that ensure this dissertation contributes to decolonization and knowledge recovery for those Indigenous communities involved.

Non-Indigenous Healthcare Knowledge Management

After reviewing Indigenous ways of knowing in research, it is not the most natural transition to discuss non-Indigenous healthcare knowledges. In particular, readers will notice a significant shift in: how information is presented, the choice of words used by non-Indigenous

academics and clinicians, and a change in focus on how knowledge is created and experienced. In 2015, when I started the PhD program, this literature review reflected my worldview as a non-Indigenous health education researcher, and was, in fact, completed in advance of the previous review of literature on Indigenous Knowledges. This review did not include an Indigenous focus for two reasons: first, I initiated this literature review prior to engaging in a formal commitment with Nokiiwin Tribal Council when I was not sure if I would be re-searching with predominantly Indigenous-led healthcare teams; and secondly, the focus on healthcare knowledge management had a direct link to the research problem identified in Chapter 1 and the proposed intervention, interprofessional collaboration training. In coming to understand Indigenous Knowledges through the two-eyed seeing approach, I realized this literature review was the Western version of how I understood knowledge. The following section will provide an overview of how healthcare knowledge is understood, managed, and utilized in traditional Western healthcare practices. By the end of this section, the reader will recognize differing ways of knowing, both essential to understand how we collaborated in this re-search study.

There are many terms that describe knowledge in non-Indigenous literature, some of which include: knowledge translation, knowledge acquisition, knowledge creation, experiential/practical knowledge, transformational knowledge, tacit/explicit knowledge, and knowledge management (Hislop, 2013). In this review, the terms knowledge translation and knowledge management will be reviewed in the context of healthcare. Knowledge translation (KT) "is the study of how biomedical knowledge is taken up and shaped by health care providers, policy makers, and populations" (Smylie et al., 2009, p. 437). To compare, Healthcare Knowledge Management (HKM) is more inclusive, as it "advocates a healthcare delivery system

that values healthcare knowledge as a vital resource and strives to translate it into clinical practice in order to improve health outcomes" (Abidi, 2008, p. 3).

Abidi (2008) highlights the importance of healthcare professionals having the ability to provide the most appropriate care at the right time to the right people, stating: "healthcare is knowledge-rich; yet healthcare knowledge is largely under-utilized at the point-of-care and point-of-need" (p. 1). El Morr & Subercaze (2010) support this idea by referring to the rapidly growing knowledge base in healthcare as not being congruent with our ability to effectively disseminate, translate and apply healthcare knowledge in clinical practice. More than a strategy, Abidi (2008) considers HKM to be a change agent that helps "healthcare professionals make high quality, well-informed and cost-effective patient care decisions" (p. 2).

Traditionally, emergency medical records (EMRs) have been used as means of interprofessional communication, but they are usually limited to one organization and do not often benefit community-centred care (Bordoloi & Islam, 2012; Razzaque & Karolak, 2011). Healthcare knowledge management can be broken into technology-centred (e.g. web-based technology & EMRs) and people-centred systems (e.g. HKM skill development, and HKM culture and leadership), where explicit, tacit and clinical knowledge can be translated into improved outcomes for patients (Bordoloi & Islam, 2012). Brannen et al. (2012) suggest that e-health as a community-based and interprofessional approach can improve access to healthcare services, enhance collaborative team interactions, and empower Indigenous communities to take control over the access and dissemination of healthcare knowledge. However, for the purposes of this dissertation, knowledge management focusing on people-centred systems is reviewed as a necessary component of interprofessional collaboration. Specifically, studies from professional development, continuing education, and communities of practice literature are included.

Professional development and continuing education. In 2001, a medical doctor acknowledged that, "evidence-based clinicians of the future may not need to be experts in clinical epidemiology but instead could manage with several high-quality knowledge products" (Evans, 2001, p. 1). This author contributed to the development of future clinicians, through the delivery of professional development courses that incorporated fundamental principles of knowledge management. Evans (2001) stated that at one point in medical education history, it was possible to attend a journal club or read specific articles related to one's field; however, with the era of information overload and time constraints that prevent evidence-based practice, knowing how to find knowledge is more valuable than knowing knowledge content itself. This publication was released at the turn of the millennium, prior to the introduction of the term healthcare knowledge management. It demonstrates that clinicians were already thinking about ways to try and filter, store and utilize knowledge in a meaningful manner, acknowledging that the human brain is limited with its ability to store information.

Until relatively recently, Continuing Education (CE) has not been viewed as a reliable HKM mechanism as many CE providers "do not question the sources of evidence presented at continuing education events" (Davis, 2006, p. 7). In order to close the 'clinical care gap', Davis (2006) proposed that CE should be used more systematically as an effective knowledge translation medium given that clinical evidence is being generated at increasingly rapid rates making it not readily available to clinicians. If done incorrectly, CE does not address the significant gap between high-quality evidence and practice, and may be seen as simply a medium to enhance clinicians' awareness of the available evidence (Davis, 2006). In conjunction with Davis' (2006) views on clinical application, Ho et al. (2004) state:

> Although formal continuing health education activities, such as conferences, workshops and rounds, provide opportunities for acquisition of explicit knowledge, this type of

> learning alone falls far short in helping health professionals in the translation of this knowledge into clinical practice (p. 92).

In contrast, McWilliam (2007) found that clinicians who participate in continuing education are more connected to research findings relevant to everyday practice, as well as ownership and application of that knowledge. Knowledge translation is described in this setting as being "an ongoing interactive human process of critically considering relevant, quality research results and findings… and constructing an understanding and knowledge application to advance the quality of health care" (McWilliam, 2007, p. 73). Through a demonstration of case-based facilitated learning, McWilliam (2007) used transformative learning theory to help bridge the gap between information uptake (i.e. explicit knowledge) and clinical application (i.e. clinical or tacit knowledge).

In further support of this people-centred approach to managing knowledge, continuing education can also be seen as a medium to prevent loss of knowledge, whether intentional or accidental, as a consensus is needed by the consumer that the knowledge is no longer valuable (Hislop, 2013). This means that knowledge needs to be universally determined as ineffective or no longer useful by a group, and cannot simply be deleted from a system as is the case with technology-focused knowledge management systems (Hislop, 2013). Regardless of its evidence-based impact, continuing education and professional development courses will continue to be used as mechanisms to support knowledge translation and management, especially for those working in healthcare or education.

Communities of practice. Communities of practice (CoP) have become a well-known mechanism to support healthcare knowledge management (Bordoloi & Islam, 2012; Bullock, 2014; Guptill, 2005; Hislop, 2013; Lave & Wenger, 1991). Lave and Wenger (1991), are

typically acknowledged as developing the CoP concept in its modern-day form. Communities of practice can be defined as "informal groups of people who have some work-related activity in common" (Hislop, 2013, p. 155). Given that individuals come together for the purpose of sharing information and expertise in a specialized area, the skills of interprofessionalism and collaboration are acknowledged as essential for effective communities of practice (Guptill, 2005). Typically, health professionals engage in CoPs because of the "distribution of tacit wisdom" (Ho et al., 2004, p. 92), which is easier to extract from conversation, than explicit knowledge from a computer system (Evans, 2001). To support this, Al-Hamad and O'Gorman (2015) identified that virtual or online healthcare services which are publicly available, can serve as an efficient mechanism to generate, retain, and utilize health knowledge in a meaningful way that is useful to health providers.

In a 2014 study, Evans et al. explored an online physiotherapy community of practice. For this group, knowledge creation and sharing via discussion board was central to the way in which knowledge was valued. Nineteen physiotherapists engaged in a ten-week online continuing education course in manual therapy. The community of practice accompanied the course, and was fairly structured with weekly modules and assignments that were completed individually and as a part of smaller groups. In contrast with other CoP styles, this group "relied solely on interactive, online, asynchronous discussions, which are often difficult to sustain" (p. 221). The results of the study demonstrated that there is benefit to semi-structured communities of practice where knowledge translation can occur for the purpose of improving performance. As synthesized in Hislop (2013), CoPs facilitate interpersonal knowledge sharing, and are advantageous to both individuals and organizations as they project a collective identity. Hislop (2013) acknowledges that there is an extensive field of literature to support CoPs, which is

beginning to appear in the knowledge management and knowledge translation literature base. In summary, communities of practice are acknowledged as another component of HKM as they provide professionals a socio-cultural platform which motivates professionals to move individual and collective knowledge-sharing initiatives forward in a trusted environment (Hislop, 2013).

Knowledge governance. "Knowledge management, implemented well, will transform the health care delivery system over the next few decades into a more cost-effective, error-averse, and accountable public resource" (Guptill, 2005, p. 10). Guptill (2005) was one of the first authors to synthesize existing information on HKM and suggest that system transformation is possible given our systems currently have the capacity to track healthcare outcomes, processes, and satisfaction measures. Referencing the need for committed leadership, Guptill acknowledges that a long-term sustainable commitment is required to change healthcare culture "to become more collaborative, more transparent, and more proactive" (p. 14).

To better understand the barriers to optimal healthcare, Cochrane et al. (2007) consolidated 256 articles that were categorized into barriers: cognitive-behavioural, attitudinal-emotional, professional (i.e. age, experience, and gender), guideline-oriented, patient-centred, supports-/resources and system-processes. These authors suggest that it is important to understand the gaps between knowing and doing to better achieve optimal health outcomes. In a systematic review of the knowledge management and translation literature, it was identified that there is only a 55% adherence to evidence-based care (Cochrane et al., 2007). These authors uncovered a significant gap between the development of scientific research and knowledge implementation into clinical practice guidelines: "at the clinical front, providers are caught in the gap between global evidence and local realities" (Cochrane et al., 2007, p. 95).

In Stauss et al. (2009), the School of Social Work found that culture in academia was an important factor to consider when evaluating a program involving a knowledge management system. These authors acknowledge that regardless of the knowledge management system, "an environment conducive to success includes a culture based on shared values and beliefs around innovation, collaboration and cohesion" (p. 327). This article was unique, in that, the implementer of the KM system (i.e. the IT manager) also had an MSW degree and therefore, truly understood the nature of the work being communicated. Throughout the process of implementing this system in the School of Social Work, lessons were learned about academic culture and leadership. These lessons include: 1) relationship-building is important to truly identify the needs of consumers, 2) the organization must have a genuine spirit of collaboration, and 3) a change in leadership will impact commitment to knowledge management system implementation (e.g. "the new director needed to be convinced that KM [system] was an appropriate change" {p. 336}).

As indicated throughout the healthcare knowledge management literature, leadership is a necessary component of implementation (Abidi, 2008; Bordoloi & Islam, 2012; Frost, 2014; Gowen et al., 2009; Hislop, 2013). Specifically, Gowen et al. (2009) proposed transformational leadership as a mechanism to address patient safety in the healthcare field. These authors performed an exploratory survey involving all 50 American states with 370 hospitals that looked at transformational leadership and quality management in relation to the delivery of an HKM system using the Multifactor Leadership Questionnaire. The take home message was that transformational leadership improves healthcare knowledge management processes, and both good leadership and a good knowledge management system are needed to enhance patient care

and safety. Supported in Hislop (2013), transformational leadership represents 'new leadership' and is becoming an integral part of healthcare knowledge management.

In this section on healthcare knowledge management (HKM), professional development and continuing education, communities of practice, and knowledge management systems have been discussed. These Western concepts of knowledge management demonstrate similarities and differences in ways of knowing between Indigenous and non-Indigenous groups. Some similarities in knowledge practices include: the need for collaborative discussions to take place in a safe and known place; the need for knowledge to be flexible and evolve over a given period of time; and the need for knowledge practices to support the knowledge developers and users in a way that respects cultural values and beliefs. However, it is apparent that that the focus of knowledge generation for non-Indigenous researchers is not relational (Wilson, 2008); meaning, that where knowledge comes from is not necessarily tied to the land or the cosmos.

To summarize the intent of reviewing Indigenous and non-Indigenous ways of knowing, the People's Knowledge Editorial Collective [PKEC] (2016) challenges Western researchers to think about how knowledge is generated, and how Western ways of knowing have the power to elevate or diminish the value of Indigenous Knowledges. Western thinkers are cautioned about accepting all Western knowledge as truth, as this can take away from the voices of Indigenous thinkers, who are forced to work and think in a system that refuses to admit failure (PKEC, 2016). As a guiding principle moving forward, the two-eyed seeing approach maintains the importance of not favouring one knowledge system over another, but rather simultaneously accepting and incorporating the differences of both ways of knowing, into our own worldviews (Martin, 2012).

Interprofessional Collaboration Framework

The following section will introduce the theoretical and practical model at the core of the literature review. This model examines interprofessional education and collaboration and supports the concepts previously discussed involving Indigenous and non-Indigenous ways of knowing. Prior to introducing the model, definitions and theories supporting interprofessionalism will be discussed. Following the model, literature relating to the three re-search questions will be reviewed in relation to the concept of interprofessional collaboration training.

Effective interprofessional collaboration is dependent upon the delivery of interprofessional education (CIHC, 2010). One of the most recognized definitions of *interprofessional education* (IPE) is when two or more professions learn with, from and about one another to improve collaboration and the quality of care (CAIPE, 2002). Formal engagement in learning about interprofessional education is needed for healthcare providers to effectively engage in *interprofessional collaboration* (IPC). IPC is best described as:

> A different way of thinking and approaching patient care. Instead of doing it all yourself, you harness the expertise of a number of individuals to bring the best care to the patient. Not only does the patient benefit, but we do too—we share the burden, which means less stress, less burnout, and greater job satisfaction. (HealthForceOntario, 2010, p. 9)

Many of the theories and models that support the construct of IPE are used to support the concept of IPC (D'Amour & Oandasan, 2005; Frenk et al., 2010; Hall, Weaver, & Grassau, 2013; World Health Organization, 2010). Hall et al. (2013) published a 'theoretical toolbox' paper identifying concepts of IPE and IPC as well as their associated impact on patient health outcomes. Some of these theories include: professional socialization, models for group process, reflective learning, and scaffolding the social domain of learning. One of the first frameworks to acknowledge the connection between IPE and IPC was introduced by D'Amour and Oandasan (2005). This framework linked the healthcare education system to the healthcare practice

environment, demonstrating that a symbiotic relationship exists between education and collaborative practice. A unique feature of the model acknowledged the need for ongoing collaboration between the provincial Ministries of education and health in Ontario to successfully engage in interprofessional collaboration.

In 2010, the World Health Organization [WHO] (2010) and The Lancet (Frenk et al., 2010) released similar frameworks confirming that interprofessional education enables effective interprofessional collaboration, which optimizes healthcare service delivery, strengthens health systems, and improves health outcomes and access to appropriate care. These foundational IPE/IPC models made way for the development of the National Interprofessional Health Collaborative Framework (CIHC, 2010) (see Figure 7). This framework demonstrates that to translate interprofessional education (i.e. knowledge acquisition) into interprofessional collaboration (i.e. knowledge application and integration), specific *competencies* need to be acquired and subsequently evaluated (AIPHE, 2012; Curran et al., 2011; D'Amour & Oandasan, 2005; Frenk et al., 2010; IPEC, 2011; HealthForceOntario, 2009; Vernan et al., 2010; WHO, 2010). This framework was chosen to guide the research process because: 1) it has been widely accepted and implemented by post-secondary health programs across Canada (AIPHE, 2012; HealthForceOntario, 2009; NOSM, 2017), and 2) it has guided the development of well-established and utilized IPE/IPC instruments (MacDonald, Archibald, Trumpower, Casimiro, Cragg, & Jelly, 2010; Orchard, King, Khalili, & Bezzina, 2012).

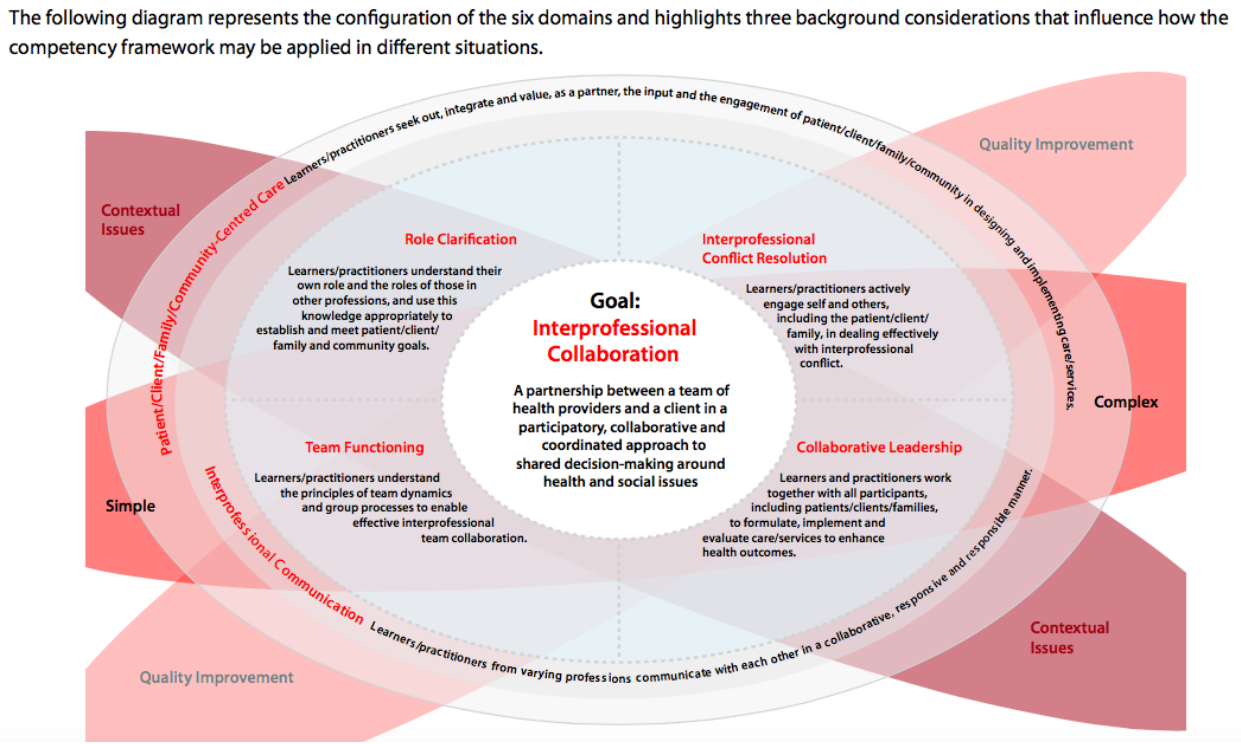


Figure 7: *Interprofessional Competency Framework.*
(Canadian Interprofessional Health Collaborative, 2010).

The six interprofessional education competencies needed to achieve interprofessional collaboration within the framework include: role clarification, interprofessional communication, patient/client/family/community-centred care, interprofessional conflict resolution, team functioning, and collaborative leadership. Furthermore, the model accounts for *contextual issues*, meaning that it is designed to be respectful of the environment in which it is applied (i.e. what role clarification looks like in a hospital, may be different from how clinicians define roles in the community setting). This was a necessary characteristic in choosing to use this model with an Indigenous population. As a notation, when Nokiiwin Tribal Council approached me regarding knowledge in interprofessional collaboration at the beginning of our journey, I showed them this model that I use regularly as an educator. After taking time to explain the model and its use with non-Indigenous populations, Nokiiwin Tribal Council felt the competencies listed in the

framework overlapped with their beliefs regarding how teams and communities can work together. As a result of a shared understanding of this model, no other collaborative models were consulted.

Each of the six interprofessional competencies can be explicitly measured based on performance indicators at the: 1) exposure level, 2) immersion level, and 3) mastery level (NOSM, 2017). These three levels refer to learning stages of either students or healthcare providers who engage in organized interprofessional education and/or collaboration in the academic or clinical practice setting (NOSM, 2017; Vernan et al., n.d.). Exposure-level IPE typically involves: shadowing a clinician of another background, interprofessional case-based learning, engagement in interprofessional rounds, and reflection on interprofessional communication and collaboration (NOSM, 2017). Immersion-level IPE involves: applying communication and collaboration techniques; regulating behaviour based on reflection of interprofessional engagement; identifying conflict resolution styles; and developing leadership skills (NOSM, 2017). Finally, mastery-level IPE typically occurs at the macro level where leaders project IPE knowledge, attitudes and behaviours that are expected to be modelled by those on the healthcare team (e.g. starting up a student-run interprofessional healthcare clinic, facilitating engagement in interprofessional simulations, teaching IPE competencies) (NOSM, 2017).

To put the varying levels of IPE competence into context, a healthcare provider with twenty years' experience may still be considered to have exposure-level IPE competency if they have not engaged in organized or intentional interprofessional education. That being the case, many instruments have emerged that focus on evaluating interprofessional competency collectively and at the varying levels of engagement for both students and clinicians. They are:

Assessment of Interprofessional Team Collaboration Scale [AITCS] (Orchard et al., 2012); Interprofessional Collaboration Scale (Kenaszchuk, Reeves, Nicholas, & Zwarenstein, 2010); Interprofessional Collaborative Assessment Rubric [ICAR] (Curran et al., 2011); Interprofessional Collaborative Competency Attainment Survey [ICCAS] (Archibald, Trumpower, & MacDonald, 2014); Interprofessional COMPASS, Interprofessional Education Collaborative Assessment [IPEC] Tool (Dow, DiazGranados, Mazmanian, & Retchin, 2014); Interprofessional Socialization and Valuing Scale (King et al., 2010); and the Team Observed Structured Clinical Encounter (Lie et al, 2015). Two interprofessional competency assessment tools were chosen for this research based on their ability to help answer the proposed research questions, and my familiarity with them from my clinical teaching experience. They are the AITCS and ICCAS.

Focused literature review - interprofessional collaboration. In this section, literature is reviewed on interprofessional collaboration (IPC), and what is known in relation to the three re-search questions (i.e. does IPC improve following training? what are the experiences of providers following IPC training? and what has IPC training led to for increased access outcomes?). Specifically, literature was targeted that included the interprofessional assessment tools chosen for this research [i.e. Assessment of Interprofessional Team Collaboration Scale (AITCS) and the Interprofessional Collaborative Competency Attainment Survey (ICCAS)], as this was a useful way to determine research expectations in relation to the IPC training. It should be noted that specific literature relating to IPC and Community Action Research will be reviewed in Chapter 3, and specifics of the IPC Training intervention for this re-search study, will be reviewed in Chapter 4. This section also includes a subsection that explores cultural

competency considerations, when employing an interprofessional competency framework (CIHC, 2010).

As part of the re-search, it was expected that the following outcomes would be achieved: 1) an alternative interprofessional approach to healthcare access that enhances existing healthcare processes for Indigenous populations, 2) an extension of health and wellness beyond the individual to include the community, and 3) the enhancement of cultural competence for healthcare providers engaging in a new form of interprofessional collaboration (Nokiiwin Tribal Council, 2016). These assumptions align with two decades of provincial recommendations, policies and research for improved healthcare access for all Indigenous peoples (Health Canada, 2005, 2015; Lavoie & Gervais, 2012; Minore & Boone, 2002; Minore et al., 2004; Purden, 2005; Rukholm, Carter & Newton-Mathur, 2009). It is expected that the research from this study will strengthen the local healthcare system servicing Indigenous persons belonging to Nokiiwin Tribal Council. Particularly, it is expected that interprofessional collaboration training and its benefits will allow for the expansion of local capacity and integration of healthcare providers at the community level.

Recent publications demonstrating the use of Assessment of Interprofessional Team Collaboration Scale (AITCS) have incorporated a mixed method design to explain the complexities involved in engaging in effective IPC. Adams et al. (2014) examined the experience of clinicians engaging in interprofessional collaboration (IPC) at three points of time (i.e. baseline, two months' post, seven months' post) using the AITCS and comparative case study analysis. Results from their study were promising, suggesting that engaging in intentional interprofessional collaboration helps to shape team formation and working relationships in community settings. In another example, Iddins et al. (2015) used semi-structured interviews and

the AITCS to assess the impact of team processes on team satisfaction and function in an urban clinical setting. With regards to statistical testing, only non-parametric tests were used due to small sample sizes and non-normal distribution of data. Recommendations were made in both studies for researchers to: 1) examine IPC in more community settings using mixed methods, and 2) to use mixed methods given the holistic nature of the results which can be used to enhance interprofessional collaboration interventions that may lead to better team functioning and patient-centred care.

The AITCS has shown that despite the barriers and challenges accompanying interprofessional practice, positive clinical outcomes in conjunction with the benefits experienced by clients and practitioners make it well worth the effort (Adams et al., 2014). Moreover, by developing interprofessional qualities inclusive of respect, shared-decision making, clear communication, and accountability, providers can more easily use the synergy of the team to deliver accessible quality healthcare (Treadwell et al., 2015). Additionally, the AITCS can be used to assess more structured interprofessional collaborative practice interventions. Scotten, Manos, Malicoat and Paolo (2015) examined a standardized interprofessional training program by having faculty complete AITCS pre and post training at one, six, and twelve months while gathering interview data. This experiment aligns with research completed by Treadwell, Binder, Symes and Krepper (2015) who used the AITCS to evaluate the same interprofessional program following a 12-week intervention. In essence, this assessment tool can be used to examine interprofessional team processes that involve basic introduction to the National Interprofessional Competency Framework (CIHC, 2010) competencies or following the introduction of a structured IPC intervention.

Findings from the Interprofessional Collaborative Competency Assessment Survey (ICCAS) demonstrate that interprofessional training has a positive effect on improved communication, collaboration, grasp on roles and responsibilities, patient-centred care, conflict management, and team functioning (Baker & Fowler Durham, 2013). Additionally, participants of interprofessional training tend to show improved knowledge, skills and attitudes in the area of interprofessional collaboration (Bain et al., 2014), which "may influence their professional practice at the point of care and enhance patient safety" (Baker & Fowler Durham, 2013, p. 713). Furthermore, providers from different settings who engage in interprofessional activities perceive themselves as being more competent and better able to help those for whom they care (Brajtman et al., 2012). In these studies, the ICCAS was chosen over other assessment instruments due to the ease of administration, as well as the instrument's ability to capture large amounts of information on collaboration. Overall, quantitative findings from these assessment tools demonstrate the potential of interprofessional collaboration to benefit service providers.

Interprofessional and cultural competency considerations. Cultural competency has been described as behaviours, attitudes, and thinking that are needed by healthcare professionals to work effectively in cross-cultural situations (Cross, Bazron, Dennis, & Issacs, 1989). Cultural competency has also been described as involving interventions aimed at improving accessibility and effectiveness of healthcare services for minority groups (Truong et al., 2014). In essence, cultural competency is seen in one's ability to navigate a culture different from one's own, and to do so in a respectful manner (Fassinger & Morrow, 2013). This dissertation focuses on the concept of cultural competency in relation to Indigenous access to healthcare services, meaning that the intervention used in this study respected culturally-appropriate ways of knowing and engaging in collaboration. It should be noted that there are dozens of models that have been

generated since the 1980's which focus specifically on culturally competent knowledge, skills, and attitudes which will not be reviewed, as it is outside the scope of this literature review. This is because after several discussions on the meaning of cultural competency between me, Nokiiwin Tribal Council, and community representatives supporting the research project, there was consensus that this term was a Western term that did not currently have a strong meaning for the communities. In other words, my cultural competency certificate obtained at the Northern Ontario School of Medicine in 2014, did not make me any more or less qualified to work with Nokiiwin's communities.

It was through our two-year process of relationship-building that my 'competency' as a non-Indigenous researcher was tested and ultimately accepted. I was educated by Elders, community health workers, and Nokiiwin Tribal Council staff on the ways of knowing and being that are acceptable in the communities. This notion is supported by Maar et al. (2009) who state that culturally competent care can be achieved when clients or communities feel safe with those who are providing care (i.e. meaning that they trust and understand the 'outsider' who is working with them). Without being labelled 'cultural competency training', this is in fact what I received over the two-year pre-research timeframe, which honours Call to Action #23 that requests cultural competency training for all healthcare professionals. In essence, and for the parameters of this re-search project, I became knowledgeable and accepting of Indigenous beliefs, spiritual practices, backgrounds, and histories (Maar et al., 2009), as part of my journey towards cultural competency.

To speak to the idea of cultural competency from a Western perspective, a few articles have been included to support that this concept was strongly considered in conjunction with the National Interprofessional Health Collaborative Framework (CIHC, 2010). To start, a systematic

review which examined 19 literature reviews on cultural competency, found some evidence that interventions to improve cultural competency could improve client outcomes (Truong et al., 2014). Common interventions to improve cultural competency include training workshops and cultural competency programs for healthcare providers (Truong et al., 2014). In their systematic review, the majority of literature found moderate evidence of improvement in healthcare access and utilization outcomes. This was achieved through the use of bilingual community health workers, interpreters, and patient navigators. In another study, Fisher et al. (2015) also found that interventions using culturally specific navigators and community health workers were among the most successful. In other words, for these examples cultural competency meant having someone available who shared the same culture so that they could communicate information effectively. Overall, Truong et al. (2014) found that interventions which are designed to influence the individual's ability to access healthcare resources and services, can also help bridge the organizational cultures of the communities involved.

In a local Canadian study, Purden (2005) examined cultural competency and interprofessional collaboration in a participatory action research study. In this research, the values of Ojibway persons played a crucial role in the healthcare delivery for patients, traditional healers, and the community. One of the impacts of the study was the reconsideration of what constitutes a 'healthcare team'. Specifically, community counselors, mental health workers, police officers, traditional healers and elders, were acknowledged as team members despite their expertise not being rooted in the Western idea of a healthcare team. Cultural competency played an important role in establishing 'interprofessional teams' within the current research context. Purden (2005) also examined 'essential ingredients' of culturally competent practice, and concluded that rural and remote healthcare delivery requires "advanced clinical skills, knowledge

of the culture and health practices of rural society, and experience with interprofessional approaches to health care delivery" (2005, p. 230).

An extension of cultural competency is the term *cultural safety*, which "emphasizes explicit attention and action to address power relations between service user and service provider" (Allan & Smylie, 2015, p. 35). This is particularly important when working with Indigenous populations as it recognizes respect, reciprocity and responsibility (Wilson, 2008), and should be the ultimate goal for healthcare researchers working with Indigenous populations. If cultural competency is considered to be at the micro-level (i.e. working one-on-one with research participants) then cultural safety reflects systems-level or macro-level thinking where there is a commitment to delivering high-quality care to Indigenous communities while responding to racism impacting care in these settings (Browne et al., 2016). Cultural safety considers social and historical contexts that have contributed to 'the current state of Indigenous health' (Call to Action #18), where practitioners are required to be self-reflective and self-aware with regards to their position of power (Ward, Branch, & Fridkin, 2016). In Ontario, the rise in training focused on cultural competency and cultural safety is correlated to the release of the TRC (2015) report (Churchill et al., 2017; Sjoberg & McDermott, 2016).

Prior to initiating this study, I was aware of the definitions of cultural safety as related to the TRC (2015) report and McIntyre et al.'s (2009) access to services framework. After a four-year relationship with Nokiiwin's communities, I can say that this is not a term that is yet used; however, its concept is strongly understood and supported. The local language that ensures 'cultural safety' in research was found in the Tree of Research Ethics in Indigenous Education (Ray, 2016), which became the ethical model that guided the research project and now the post-research phase. In Chapter 3, the reader will see how this model reflects culturally safe and

ethical research that was able to guide me, a non-Indigenous researcher, working with Indigenous communities.

To link this discussion back to the beginning of this section, a non-Indigenous competency-based healthcare framework, the National Interprofessional Health Collaborative Framework (CIHC, 2010) was introduced as the basis for the re-search intervention. Prior to the introduction of this model, Indigenous and non-Indigenous ways of knowing related to research and healthcare, were examined to understand how mixed healthcare teams have the potential to come together for the purpose of collaboration. In the examined CIHC Framework (2010), Indigenous knowledge practices can be incorporated within the teaching of collaborative competencies. This framework is unique in that its competencies are designed to be taught in a manner that is respectful of culture. For example, cultural factors such as community location, cultural practices, and local histories, can be examined within the competency client/family/community-centred care. This competency is an over-arching competency that is expected to remain central when learning about the other five competencies (CIHC, 2010; NOSM, 2017).

Typically, the first two competencies to be acquired for collaborative practice are role clarification and interprofessional communication (HealthForceOntario, 2009). Instruction involving these two competencies incorporating an Indigenous lens, is one way to ensure that a culturally-appropriate intervention is successful (NOSM, 2017). The remaining competencies (i.e. conflict resolution, team functioning, and collaborative leadership), build on these foundational competencies, which reinforce the focus of a culturally-appropriate framework that is focused on interprofessional competence (NOSM, 2017). Al-Hamad and O'Gorman (2015) found that culturally-appropriate collaboration can lead to positive outcomes for healthcare

access. Thus, the National Interprofessional Competency Framework (CIHC, 2010) is a framework that naturally supports a two-eyed seeing lens (Martin, 2012).

It is understood that interprofessional teams who provide culturally competent services in rural and remote locations, are more adequately able to address the issue of access to healthcare through customized services, than those who do not provide culturally competent service (Al-Hamad & O'Gorman, 2015; Hooper et al., 2007; Rukhom et al., 2009; Salvatori, Berry, & Eva, 2007). As an advantage, these healthcare providers are also better able to recognize their own and other cultural beliefs once they have undergone cultural competency training (Rukhom et al., 2009). To close this Chapter, I will review how the two-eyed seeing approach is able to support the concepts of Indigenous and non-Indigenous ways of knowing in healthcare research, through collaboration. This approach specifically contributes to the decolonization of Indigenous knowledge practices (Tuck & Yang, 2012), and supports a pathway forward to address Calls to Action in research that equally support Indigenous and non-Indigenous ways of knowing.

Decolonizing Healthcare Knowledge: A Two-Eyed Seeing Approach

To effectively decolonize non-Indigenous or Western healthcare knowledge, a two-eyed seeing lens is needed (Hatcher et al., 2009; Martin, 2012). As a reminder, this approach "embraces the contributions of both Indigenous and Western 'ways of knowing' (worldviews)" (Martin, 2012, p. 21). Until recently, non-Western forms of health knowledge have been largely ignored (Denzin & Lincoln, 2008) which has impacted the health and well-being of Indigenous populations (Martin, 2012), as well as the presence of Indigenous perspectives in health research (Smith, 2012). For instance, the randomized control trial method continues to be the gold standard in Western research, while storytelling is still understood as being anecdotal (Denzin & Lincoln, 2008; Martin, 2012). If knowledge is to evolve from this form of treatment and lack of

respect, then decolonization of knowledge is necessary. For this re-search study, it was necessary to explicitly challenge whether the knowledge obtained in the research process would contribute to the oppression and colonization of Indigenous peoples (Smith, 1999).

Simonds and Christopher (2013), in *Adapting Western Research Methods to Indigenous Ways of Knowing,* suggest: "the Indigenous community have long experienced exploitation by researchers and increasingly require participatory and decolonizing research processes" (p. 2185). Firstly, this includes acknowledging that data collection does not equate with *knowledge acquisition*. For knowledge to be generated, one must consider: Is it alive? Is it in current use? Can it be transmitted orally? Secondly, *generalizable* knowledge is knowledge that can be useful to another Indigenous population. These concepts of knowledge acquisition and generalizability are often not respected in western research as they do not bring tangible benefits to non-Indigenous researchers (Simonds & Christopher, 2013). If we are to decolonize healthcare knowledge, it is important to accept that previously applied western research methods have disempowered First Nation communities, reinforced internalized racism, and benefitted the careers of researchers or science at large (Simonds & Christopher, 2013). These two concepts will be re-examined in Chapter 5 to determine if new knowledge was rediscovered in this study, and whether it is in fact generalizable (i.e. useful to other Indigenous populations).

If we are to participate in the process of decolonizing knowledge and ultimately research, then Indigenous voices and epistemologies must be placed at the center of the research process (Simonds & Christopher, 2013). For this, community-based and participatory approaches are best suited. Within these approaches, it is assumed that narrative methods are a natural fit; however, it is important to consider what narrative westernized methods look like. In 1996, a research case study looked at a partnership between Crow Nation and Montana State University

called Messengers for Health (Christopher et al., 2008). At this time, Indigenous theories were not being applied in mainstream research and so the student researcher was forced to choose a Western theory for data collection and analysis of community interviews. Western narrative analysis was strongly supported by the student's advisors as a way to organize and analyze data. In choosing this method which involved the researcher's interpretations of another's story, rather than the storyteller's interpretation, western concepts of research knowledge were imposed on the participants of Crow Nation. It was only during the analysis phase that it became evident there was no way to analyze interview data without pulling it apart (Christopher et al., 2008).

From an Indigenous perspective, there were three fundamental issues with this form of narrative analysis (Christopher et al., 2008). First, by breaking apart the interviews, the researchers were losing the relationship to the story being told. Wilson (2008) emphasizes the importance of context and relationship to Indigenous methods, and writes that the credibility of the storyteller is solidified by knowing who is talking; therefore, if things are broken into small components, relationships are destroyed in the process. Secondly, relating themes from different transcripts can be disrespectful to the storytellers, as their stories are being combined as though they are one experience. To remove a storyteller's name, either literally or metaphorically, from their work is seen as an ethical issue (Christopher et al., 2008). Thirdly, to create themes in a prescribed model, disempowers and disconnects the storyteller from their own story. There may be no how-to guide on how to decolonize research; however, lessons can and should be learned from previous research, such as the case with storytelling.

An important lesson about decolonizing healthcare-focused research and implementing a two-eyed seeing approach, is that narrative research can be represented by: 1) full narratives respectful of Indigenous ways of knowing, and 2) westernized coding and categorization for

theme generation. The difference between the two approaches requires an understanding of who is sharing information and for what reasons. Additionally, the researcher must make explicit their research paradigm and whether methods are being used based on Indigenous or non-Indigenous ways of knowing. When we implement a culturally safe approach to re-searching knowledge, we acknowledge colonial histories, understand how these histories impact research, and are present with community members on their time and in their choice of space (Christopher et al., 2008). It is then that we, non-Indigenous researchers, can be upfront about our expectations, intentions, and ideas of research methods that can be explored and considered by the community (Christopher et al., 2008). Not all Indigenous communities believe that narratives cannot be coded based on Western ways of analyzing research, and we will see an example of this in Chapter 4 of this dissertation; but we must also find ways in which both ways of knowing (reading full narratives and coded themes) can be presented together and not be fearful that one method is less acceptable than the other.

Overview

This chapter was entitled *Literature Reviews – Two Eyed Seeing,* which covered Indigenous and non-Indigenous concepts of knowledge creation, sharing, and utility representing different cultures and ways of knowing. To make sense of how knowledge was acquired and used in this re-search study, an interprofessional model focusing on the goal of collaboration was discussed. This literature review has demonstrated that this model has the potential to support Indigenous ways of knowing and engagement in effective healthcare knowledge management practices. This is because the model provides both a conceptual and practical approach to generating competencies or skills needed to improve access to healthcare services, in a culturally

competent manner that respects two ways of knowing. At the core of collaboration, is the competency of communication or knowledge-sharing.

On the title page for this chapter, is an image focused on Indigenous medicines, including sweet grass and tobacco. Just like when the sweet grass comes together to form a three-part braid, this chapter brought together the concepts of Indigenous Knowledge practices, healthcare knowledge management, and interprofessional collaboration to demonstrate how the research problem and questions identified in Chapter 1, will be addressed and answered. Tobacco reminds us that knowledge must be exchanged in ways that support decolonization; which means understanding that knowledge is not only transmitted orally or by hand, but rather through cultural practices and traditions that bring people together. Some examples of how this re-search can decolonize knowledge and research were reviewed. This was necessary to guide me and the research team, and to ensure that existing colonial practices would not be reinforced. The following chapter will now focus on a decolonizing methodological orientation, *community action research*, which was chosen as the research approach by Nokiiwin for this study.

Chapter 3: Methodological Orientation – Community Action Research

Figure 8: *Community Logos*

The following chapter will examine the pre-research activities completed in support of this study, as well as literature supporting and critiquing action research as a methodological orientation. Two years of pre-research activities will be briefly reviewed, as these accomplishments were a critical component of ensuring that action research, as defined by both Indigenous and non-Indigenous scholars, could be achieved. Nokiiwin Tribal Council, representatives from each of the six communities, and I, collectively chose community action research as our orientation.

Pre-Research Activities

Engaging in pre-research activities prior to community action research is highly encouraged (Coghlan & Brannick, 2014; Gray et al., 2010; Marshall, 2016). First, this phase allows for an opportunity to build relationships within the community. By being in the community, the researcher has the opportunity to examine her worldview and determine if it aligns well with the worldviews within the community (Coghlan & Brannick, 2004). For example, if I believed that colonization was an historical action achieved by settlers, an action not currently taking place, then this belief would not align with the beliefs of Nokiiwin's First Nation communities.

Secondly, the pre-research timeframe allows the community to take part in the pre-planning phase of the research (e.g. determining the methodological orientation, choosing appropriate research methods, reviewing ethics protocols, discussing ethical principles). This research consisted of a two-year pre-research phase where relationships were built with members of six communities, the Board of Directors, staff and administrators representing Nokiiwin, and many other academics with like-minded interests. In particular, three pre-research activities were completed to support the research project: 1) a needs assessment, 2) web-maps of healthcare

services, and 3) a student research project examining the role of healthcare providers in Nokiiwin Tribal Council's affiliated First Nation communities.

i. Needs assessment. A year and a half before data collection, a needs assessment (Nokiiwin Tribal Council, 2016) was completed by an assistant hired by me, using funds from Indigenous and Northern Affairs Canada. This community needs assessment involved semi-structured interviews with 31 healthcare and other service providers from Nokiiwin Tribal Council's six communities. In the report, the most urgent healthcare needs were identified, as well as available and desired healthcare services. The assessment was evaluated using a grounded theory approach which identified the communities' top ten health concerns and top ten required healthcare services. Overall, the data gathered for this report highlighted that communities typically support a western view of healthcare service provision, but also desire traditional healthcare services.

Specifically, several communities identified the need for holistic interprofessional care, inclusive of non-traditional healthcare roles. Some suggested roles included: elders, community educators, healthcare system navigators, and healthcare providers considered to be unregulated, such as wellness workers or spirit-builders. There was consensus that there is a place for both Western and Traditional medical models; however, to achieve appropriate access to healthcare services, both models need to be embraced (Nokiiwin Tribal Council, 2016). Mainly, participants highlighted the urgent need for traditional healing and counseling services directly within community, as well as greater access to physicians and rehabilitation professionals throughout the year. Additionally, participants identified a cultural need for healthcare services to target the mental, physical, emotional, and spiritual well-being of the community. In this assessment,

strengths and limitations within the existing healthcare system were taken into consideration, in conjunction with existing resources being offered in Nokiiwin's communities.

ii. Web-mapping. Following the needs assessment, I needed to identify which healthcare teams were servicing Nokiiwin's communities, by considering who was providing services, what services were being provided, and where the supporting resources were located. In collaboration with the Disabilities Coordinator at Nokiiwin, Lisa French, and Dr. Brian Dunn, I began a process called web-mapping which was used to identify healthcare services in the northwest Local Health Integrated Network of Ontario. Figure 9 shows an example of three circular web-maps representing acute, chronic, and mental health needs which are divided into four quadrants (i.e. crisis, healing, recovery, and community integration). On the back of these one-page documents (Figure 10) is the healthcare provider contact information, with all contact information on one page. Web-map layouts were influenced by the Disabilities Coordinator's training with both Indigenous and Western healthcare models. There were three web-maps generated per community, for a total of 18 web-maps to assist with identifying existing service providers. These web-maps were paramount in identifying what culturally-appropriate services were not currently known, or being provided.

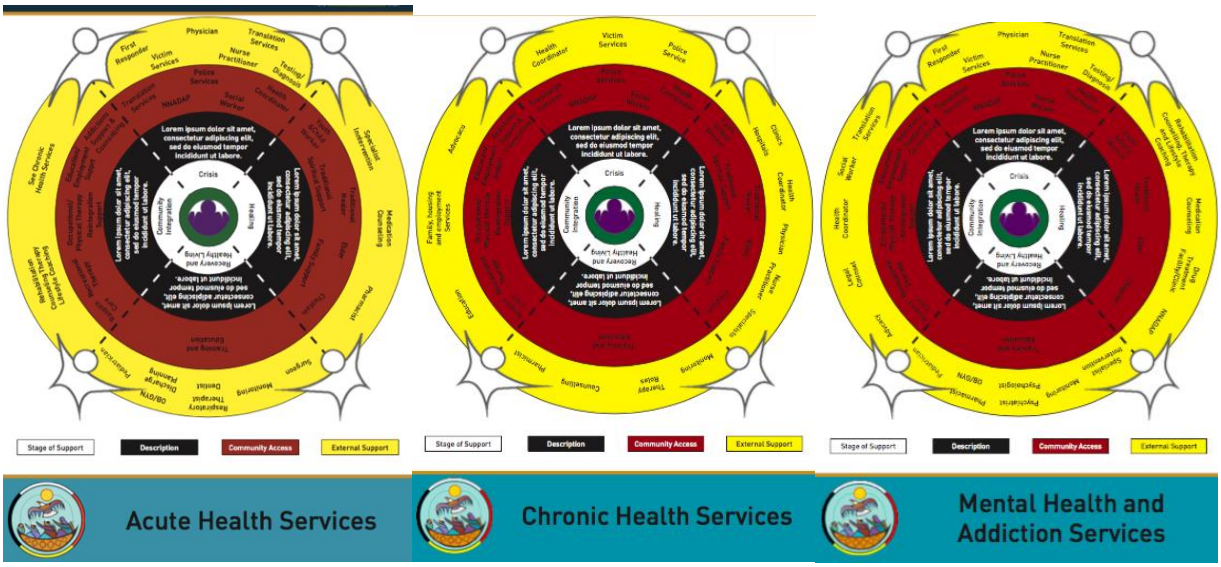


Figure 9: *Examples of Web-Maps*

Figure 10: *Example of Web-Map Contact Information*

iii. Early research model. The last pre-research activity to be reviewed, involved a master's level student research project, encompassing two Student Physiotherapists and two Student Occupational Therapists from McMaster University. An eight-month evidence-based project (EBP) was used to further contextualize the needs assessment and web-maps in two Nokiiwin-affiliated communities who agreed to participate in this re-search study. Prior to engaging in the EBP, both groups of students provided clinical services to Nokiiwin Tribal Council under my supervision, for a total of fourteen weeks. Throughout the course of placement, a scoping review was completed that examined Indigenous access to rehabilitation services in rural and remote regions (Radassao et al., 2017). Following clinical placement and the completion of the scoping review, students had four months to work with Nokiiwin's Disabilities Coordinator (who is also an Indigenous educator) to generate a First Nations Access to Healthcare Model (Radassao et al., 2017). The following conceptual model identifying current healthcare access pathways (Figure 11), was generated based on the needs of Nokiiwin Tribal Council and its communities.

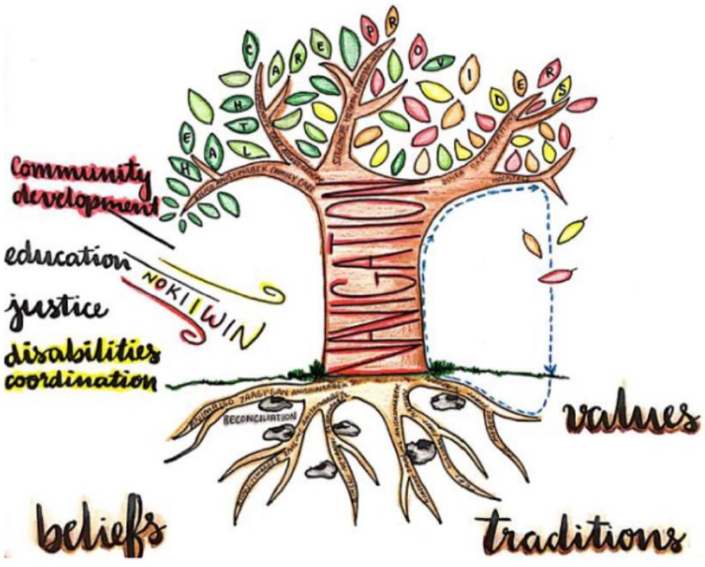


Figure 11: *Model Supporting First Nation Access to Healthcare.* (Radassao et al., 2017).

This model has not been officially adopted by Nokiiwin Tribal Council, but has served as an example of how one can view Indigenous access to healthcare services utilizing a two-eyed seeing approach (Martin, 2012). *The tree* symbolizes growth, the interconnection of parts, and overall strength to withstand the forces of nature. *The soil* represents the values, beliefs, and traditions of the communities. *The six roots* represent the six communities who provide stability for the tree and allow it to grow. *The rocks* represent the historic and ongoing trauma that have shaped the communities. *The trunk* represents navigation, a necessary role for everyone to bridge the healthcare gap between communities, organizations, and providers. The organizations (*the branches*) are all connected to the navigation process and represent increasing continuity of care and service provision.

The leaves represent the individual healthcare providers, whose changing colour and shedding represent the life cycle of the tree as it transitions from summer to winter (NB: quite often there are no services available in the winter, as there are no leaves on deciduous trees in winter). Finally, *the wind* represents Nokiiwin Tribal Council which has the ability to create movement and contact between the branches and leaves, and can promote communication and advocacy between individual healthcare providers. This model, in combination with the other two pre-research activities, reveals my attempts to understand the people, their needs, and the land on which the research would be taking place. Through these formative projects, I was able to gain insight into how collaborative relationships between Indigenous and non-Indigenous participants (myself included) could be formed by people with differing ontological and epistemological beliefs.

Action Research

> Many action researchers would have to admit that they came to theory largely as a way of justifying what they knew was correct to begin with; to legitimize a politically informed and effective form of knowledge generated through experience. (Brydon-Miller, Greenwood, & Maguire, 2003, p. 15)

In this section, an overview of *action research* and *community-based participatory research* will be discussed. Elements from these two methodological orientations were chosen by Nokiiwin Tribal Council to create the methodological orientation used in this re-search called, *community action research.*

According to Reason and Bradbury (2008), action research is defined as a participatory process that "seeks to bring together action and reflection, theory and practice, in participation with others" (p. 4) in the pursuit of practical solutions for individual persons and their communities. Outside of the English-speaking world, the term *action research* is rarely used (PKEC, 2016). In areas where this term was once embraced, Germany for example (Altrichter & Gstettner, 1993), it has become very unpopular as it has historical links to people's movements and Marxism (PKEC, 2016). Looking globally, Fals-Borda (1987) applied action research approaches in the Global South. For example, in Latin America in the 1970's, action research contributed to changing societal processes in constructive non-violent ways in Nicaragua, Mexico, and Columbia. Fals-Borda (1987) purports that this methodological orientation is political by nature, as it does not require a monopoly of experts or academics. The move away from a subject/object relationship to a subject/subject relationship, allows participants to be directly involved in each phase of the research process (Fals-Borda, 1987). Specific techniques which may include participants involve: collecting research from public assemblies; fact-finding trips; recovering history using the collective memory of participants; and valuing or applying folk culture that represents the values of the people (Fals-Borda, 1987).

Fals-Borda (1987) has compared action research to that of a sleeping volcano becoming active. It may be for this reason that other researchers have shied away from choosing action research as a methodology. Altrichter & Gstettner (1993) examined the important contextual pieces associated with the words 'action research' by consulting 61 researchers from Germany, Austria and Switzerland in the 1980's. Two decades prior, action research was being used as a social reform mechanism by youth standing up to the government who were lobbying for collective change. In essence, this form of research raised political consciousness and encouraged social movements, so that citizens could have more influence over their own daily practices of learning, work, leisure time, and family time (Altrichter & Gstettner, 1993). Despite its disappearance in German research, action research "was influential in developing a new mentality in social research which emphasised social commitment and participation" (p. 347).

In 2003, Brydon-Miller et al., published a seminal editorial article on action research which launched the *Action Research* journal. Like many authors before them **(**Altrichter & Gstettner, 1993; Hodgkinson, 1957; McTaggart, 1994**)**, the works of John Dewey, Kurt Lewin, Jacob Moreno, and Paulo Freire were referenced as foundational works in support of action research as a methodology. Hodgkinson (1957) notes that although Dewey was never mentioned as an initiator of action research, "it is likely that some of his works would reveal specific evidence that Dewey knew of, and approved of, the concept of action research" (p. 138). Brydon-Miller et al. (2003) had experienced great difficulty working within other methodologies and thus began to explore how valid and vital knowledge could be generated that reflected the well-being of individuals and communities, and could ultimately bring about needed change.

Researchers continue to grapple with the challenge of choosing action research as a methodological orientation (van der Meulen, 2011). Those who choose this orientation can

typically handle a certain degree of chaos, uncertainty and messiness, and do not do well with boundaries (Brydon-Miller et al., 2003). These researchers tend to be practical and concerned with achieving real outcomes with real people; they believe in the possibility of change "that strikes us with amazement and wonder" (Brydon-Miller et al., 2003, p. 18). Action is viewed as being experimental, knowing that one cannot draw a straight line or control interventions (Marshall, 2016). If inventions are too controlled, this could jeopardize the action outcomes which could lead to unintended consequences (Marshall, 2016).

Generally, action researchers are more willing to admit limitations, are inventive, encourage new ideas, and allow for experimentation (Hodgkinson, 1957). While conventional researchers worry about objectivity and control, action researchers worry about social change and action by those involved (Brydon-Miller et al., 2003). Since action is seen to be central to the research, investigators become both researchers and practitioners at once (Herr & Anderson, 2015). This means that action researchers require: 1) knowledge in and for practice; 2) engagement in the phases of action and reflection, promoting participation and collaboration; 3) recognition of others' values and worldviews; 4) respect towards multiple forms of knowing; and 5) attention to issues of power, sensitivity to context, and timing (Marshall, 2016). This research embraced the principles of this orientation, and I wholly acknowledge the messiness and chaos that challenged the rigour of the scientific process. I committed to this orientation knowing that it is both a reflection of my best abilities, and best represented the possibility for a decolonizing way to engage in Indigenous-focused research.

Benefits of action research. Action research respects people's knowledge and their ability to address issues confronting their communities (Brydon-Miller et al., 2003). In practice, action research begins with the idea that there is a desire to act; an idea that some kind of

improvement or change is needed (McTaggart, 1994). The problems being studied are in the actual situations in which they occur (Hodgkinson, 1957), often reflecting a society "characterized by conflicting values and unequal distribution of resources and power" (Herr & Anderson, 2015, p. 4). While action research challenges academic agendas, it does not discard the need to accumulate and systematize knowledge (Fals-Borda, 1987). At its core, action research "provides a social validation of objective knowledge which cannot be achieved through individual methods based on surveys or field work" (Fals-Borda, 1987, p. 338). Additionally, action research has an individual aspect where the researchers change themselves, by working with others to achieve change (McTaggart, 1994). Acknowledging these benefits, action research has provided researchers an opportunity to work with Indigenous people in a holistic and collaborative manner (Brydon-Miller et al., 2003).

For those completing a PhD using action research as a methodological orientation, the dissertation forces one "to think not only about what knowledge they have generated that can be fed back into the setting (local knowledge), but also what knowledge they have generated that is transferrable to other settings (public knowledge)" (Herr & Anderson, 2015, p. 11). van der Meulen (2011) engaged in action research as part of her doctoral dissertation and found the methodology to be tremendously rewarding. For her, action research provided a "socially beneficial way to offset academic isolation" (p. 1291). She recommended this approach for other graduate students who enjoy working in collaborative environments, and who are interested in social policy or organizational change through action-oriented research:

> I believe that building bridges between graduate student researchers and local communities can lead to benefits for both; graduate students can develop a greater sense of purpose in their research projects and communities can participate in studies that seek answers to questions they themselves deem as important. (van der Meulen, 2011, p. 1292)

van der Meulen (2011) contends that her connection to the community was a strong motivator to complete the study and ultimately her degree. She proposes that graduate programs could benefit from encouraging doctoral students to engage in action research, which may act as one solution to the 48-76% attrition rate in Canadian PhD programs.

There have been other action research dissertations that paved the way for graduate-level researchers (e.g. Cormier, 2016; Cullen, 2008; Mock, 1999; Paradise, 2009). Baker Collins' (2005) work stands out as a strong example of how action research can directly address existing and future needs of a community. She used participatory action research, a type of action research, in a study on community poverty. It allowed her to: "incorporate voices from marginal populations, honour community knowledge, shift the role of researcher to listener, work towards social justice, and fulfill basic human needs" (p. 1295). In her work, the pros and cons of graduate-level action research are discussed, specifically speaking to the challenge of staying within timeframes imposed by funding bodies. Important reflections from Baker Collins (2005) include: 1) the importance of having a relationship with the study population before the research, and 2) that collaborative data analysis may not be realistic if the community does not have the time, resources or desire to participate.

When collaborative data analysis is possible in action research, Smylie et al., (2009) support the use of collaborative coding and analysis techniques. They suggest that if academic and community researcher interpretations differ, the community interpretation should be adopted. This manner of triangulating and validating data is not typical outside of action research, and can be an important consideration that may sway communities who are undecided about different methodologies. The key piece supporting community inclusion in data analysis, is that the researcher is seen as an equal to the community in interpreting data (Smylie et al., 2009).

Additionally, Baker Collins (2005) wrote that a key benefit of action research is the potential for the community to be involved in publication. In the event that publication cannot be done collaboratively, for example, if others are not interested or available to do so, individual publications remain possible (Baker Collins, 2005). In this instance, the researcher would need to examine ways for community research partners and participants to be formally acknowledged, to ensure that the research is equitably and fairly reflected.

Criticisms of action research.

> Because action research is not mainstream research in universities, it is often necessary to defend it as a legitimate form of research for a dissertation. (Herr & Anderson, 2015, p. 61)

In 1957, the quagmire of terms used to describe action research was just as complex as it is today. Included in this definition were the terms: field experimentation, operational research, research action, cooperative research, evaluation research, service research, in-service training, and evaluative research (Hodgkinson, 1957). Altrichter and Gstettner (1993) also acknowledged frustration with *action research*'s array of aliases: participatory social research, action-oriented research, research toward the people concerned, and interventive practice-research. In 2018, it is almost impossible to name all the terms that encompass action research, but some notable terms include: community-based participatory research, participatory action research, first-person action research, critical action research, mixed methods action research, and collaborative action research[8] (Ivankova, 2015). Due to the challenge in identifying the origin of *action research*, the overwhelming use of terms can cause major challenges for researchers and can contribute to the criticism surrounding action research as a chosen methodology (Altrichter & Gstettner, 1993).

[8] Upon completing this dissertation, I discovered a good example of *collaborative action research* (Peterson, Horton, & Restoule, 2016) which aligns very closely to this study and the concept of *community action research.*

In examining its historical roots, Hodgkinson (1957) believed that action research strongly emerged in the conventional American White classroom of the 1950's, as an untamed or uncontrollable form of research. Hodgkinson (1957), further contended that "action research is a symptom of the times in which we live" (p. 147), where we are living in a 'doing' age; a notion strongly supported by Altrichter and Gstettner (1993). There was fear that because teachers did not receive adequate training in research, it would be viewed as a 'common-sense' approach (Hodgkinson, 1957). Action research was equivalent to 'hobby games for little engineers', was statistically unsophisticated, ungeneralizable, and a method for amateurs:

> What does this [action research] mean to a teacher? It means that she may do an action research project in 1955 with an all-white class. In 1957 she may have four or five Negroes and a few Mexicans. Instead of educating the children of office workers, she may be teaching the progeny of the workers who labor on the assembly line of the big new factory which has just come to town. (Hodgkinson, 1957, p. 144)

Hodgkinson (1957) inadvertently identified that even if a 'socially responsible' methodological orientation such as action research is chosen, it may not be intended to transcend cultures. In this example, Hodgkinson could not imagine how a Western-defined research intervention could be applied to those from another ethnic or social culture. This thinking has come to be known as the White-walled labyrinth (PKEC, 2016). This means that the research led by universities dominated by White, upper-middle class culture, removes non-White communities interested in research from even the most participatory of approaches (PKEC, 2016). Whiteness in this sense equates to how educated one is, as in the example provided by Hodgkinson (1957) on Negro and Mexican families working the assembly line.

Despite the criticisms of it roots, action researchers have faced bigger challenges—in getting their research published. In the 1990's, McTaggart (1994) identified that research writing, was very academic and not suitable for knowledge translation in non-academic settings.

In fact, action research publications sometimes sabotaged the knowledge generated within the projects they published, as action researchers tended to over-promise its benefits of empowerment, liberation, and emancipation:

> It is unreasonable to think that 'critical pedagogy' or 'action research' will inevitably cause people to feel better or to be more powerful. It is normal for people to feel overwhelmed when they begin to understand what some of the large struggles are and what their obligations might be for them….In any case, understanding how the world works may give one a sense of power. (McTaggart, 1994, p. 326)

Additionally, because action research data are typically collected using naturalistic and narrative techniques (i.e. observation, interview, field notes, logs), there remains a reliance on 'critical friends' during the validation and triangulation process (Herr & Anderson, 2015).

According to Herr and Anderson (2015), the collection of narrative data does not translate well into propositional knowledge, also known as factual or justified knowledge. If data does not translate well into utilizable knowledge, then action research loses its purpose. Salimi et al. (2012) support the idea of inadequate action research publications, in a systematic review of community-based and action-oriented research articles. They reviewed 14,000 articles published between 2000 and 2009, and assessed articles using levels of evidence for methodological quality for three types of CBPR approaches (i.e. interventional, observational, and qualitative research designs). From this large review, 70 articles identified the methodological design in sufficient detail, and only eight of which included quantitative methods. Ultimately, seven of these papers were able to demonstrate CBPR effectiveness through: study design, recruitment and retention, measurement instruments and data collection, intervention development, interpretation/dissemination of findings, and application of findings to the health issues identified. Moreover, the results demonstrated that CBPR can be effective in different contexts; however, little has been written about the organizational capacities required to make this

methodological design successful. In other words, there is no clear understanding what makes a CBPR 'generalizable', as previously defined in an Indigenous sense, or useful in other environmental contexts.

Another criticism of action research targets: minimal use of practical methods, over-reliance on ideology, and absence of practical frameworks compared to other methodologies (van der Meulen, 2011). Given there is no how-to guide for engaging in, or evaluating, action research, "the lack of specified methodological practices can leave the researcher with questions about how to actually conduct the study" (van der Meulen, 2011, p. 1293). Without having a predetermined formula rooted in the practical methods of previous studies, it can be challenging to specify start and end dates on an ethics application, or even to truthfully outline detailed processes requiring ethics approval (Stiegman & Castleden, 2015). The absence of a practical framework can lead to issues with intellectual property and copyright legislation, as well as questions of authority and ownership over knowledge generated from the research (van der Meulen, 2011). By not having experienced researchers engage in action research, it is possible that power imbalances can arise between the community and academic institution (Minkler, 2004), making it very challenging for doctoral students to commit to and execute an action research project. Even if community researchers had experience and the university researcher did not, a power imbalance could remain given the status of universities. This is especially true if the university-based researcher controls the funds.

Lastly and until recently, the writing of PhD dissertations is not typically designed to encourage collaborative work (Herr & Anderson, 2015). In the many iterations of this dissertation, I have had a difficult time using the word "I" given the enormity of who has influenced my thinking over the past four years. It is only in the results section that the voices of

'participants' can be heard; otherwise, those who contributed to the process (i.e. two years pre-research and one year post-research) are talked *about* in the dissertation. In Indigenous ways of knowing, I would have opened this dissertation with the introductions of all of those who participated in the research, each stating how they have been involved and what they have done. The challenge with this approach is the fact that this dissertation could be 500 pages, or the dissertation would end up looking like a compilation of works rather then 'my work', the work of Justine Jecker. That being the case, Herr and Anderson (2015) suggest that students choosing to engage in this methodological orientation must be willing to take greater risks than more conventional and academically accepted approaches. For me, choosing to disperse my literature review over three chapters, was a necessary risk to help build the global knowledge needed to move forward with re-search.

In the following section, *community-based participatory research* will be reviewed as elements from this methodological orientation were incorporated into the re-search project. Following this section, our chosen methodological orientation of *community action research* will be discussed, as well as the elements that were combined from the two methodological approaches.

Community-Based Participatory Research

> Community-based research allows, no, *requires* us to remain open to choosing ways of doing research that draw on ways of knowing/doing/being/perceiving that those communities and those people who we are supporting and working with value and respect. (Hall, 2015, pp. 162)

To start, the term *participatory research* was first acknowledged in the *International Journal of Adult Education* in a special issue entitled, Convergence, by Dr. Budd Hall in 1975. This term was coined based on his experiences working and researching with communities in

Tanzania and Latin America. Between 1975 and 1989, this methodological approach evolved to include the term *community-based* (Hall, 2015) as this was the fundamental identifier on where the research needed to take place, and the term *community-based participatory research* (CBPR) was born. Hall (2015) identifies that CBPR combines the teaching, learning, and activism that Paulo Freire talked about in the 1970's; and that it was not conceived in Western society, but rather came from existing practices in Africa, Latin America and Asia. Hall (2015) states that CBPR was practiced for 20 years before publications began to appear in journal articles in the late 1980's and early 1990's. This is because CBPR is conceptually linked with the concept of 'action', which has shared the same challenges as action research in the face of publication (Minkler, 2004).

Community-based participatory research (CBPR) has become an umbrella term which represents one of many names used to describe an array of research methods in the health and social sciences (Balazs & Morello, 2013). As part of what defines CBPR, this approach allows for academic-community partnerships where power is shared among partners in all aspects of the research process – the conceptualizing, the doing, interpreting, and acting (Balazs & Morello-Frosch, 2013). Minkler (2004) states that a key feature of CBPR involves commitment to ensuring the topic being investigated comes from the community. If this does not occur, then how can 'true CBPR' take place when the research question comes from an outsider (Minkler, 2004)? Mitchell (2018) refers to this level of community involvement as *community engagement*, where countless hours are spent getting to know people, recruiting participants, collecting data, and disseminating findings in a coordinated effort with the general membership of a community.

As a selling point, O'Fallon and Dearry (2002) outline eight key beneficial outcomes of CBPR: 1) increased relevance of research, 2) increased quantity and quality of data collection, 3)

increased use and relevance of data, 4) increased dissemination, 5) research translated into policy, 6) emergence of new research questions, 7) research and intervention extended beyond the specific project, and 8) building infrastructure and sustainability. Moreover, Wallerstein and Duran (2010) acknowledge CBPR as a valid method which "represents a transformative research opportunity to unite the growing interest of health professionals, academics, and communities" (p. S40). It has been in the healthcare setting specifically, that community-based research has garnered the most support from a range of varying professional backgrounds (Wallerstein & Duran, 2010).

To tackle the full concept of CBPR or community-based research, dozens of textbooks have been written (Coughlin, Smith, Fernandez, 2017). This approach "often includes a 'pre-research' period of community engagement where time is spent developing rapport before the official research process begins" (Coughlin et al., 2017, p. 27). As was performed in advance of this re-search project, this can include a health needs assessment, a focused literature search, and a review of grey literature to identify priority health concerns. Fundamental elements of CBPR were used to guide Coughlin et al.'s community research project, and include:

> The need to ensure openness, trust, and power sharing among partners; the need for a genuine partnership approach; capacity-building of community partners; and the importance of shared decision-making, colearning, shared ownership of research products, applying findings to benefit all partners, and including community partners in all phases of the research from the identification of health priorities to evidence translation and the dissemination of research. (pp. 3-4)

Perhaps most importantly, the principles of CBPR align holistically with the worldviews of Indigenous peoples (Castleden, Morgan, & Lamb, 2012; Mitchell, 2018). For example, given that a core principle of CBPR is to increase community capacity, it is common practice to have a community advisory board or steering committee guide researchers working with Indigenous populations (Coughlin et al., 2017). As an alternative strategy, Mitchell (2018) was able to

secure the vice chairperson of a Tribal Council as the 'guardian of research', which helped to mitigate issues with tribal council turnover (i.e. advisory board) that can impact the research process. When working with Indigenous communities, Coughlin et al. (2017) and Mitchell (2018) acknowledge that CBPR includes activities not normally thought of as research methods which align naturally with Indigenous worldviews (i.e. approaching communities well in advance of engaging in formal research activities; building and maintaining trust with multiple community members; collaboratively identifying topics and questions for research; participating in community activities by balancing research with action; and staying connected with communities beyond the scope of research).

In relation to Indigenous and First Nation health-related research projects, Jerrigan et al. (2015) provide examples of American Indian/Alaskan Native (AIAN) communities engaged in community-clinic-academic partnerships for the purpose of advancing community-based research. For their study, "the goal of building tribal capacity and infrastructure to conduct health disparities research" was paramount (Jerrigan et al., 2015, p. S424). Relationships were established years before the study when several pilot studies looked at community health priorities. These smaller studies allowed for academic partners to visit the tribal communities to learn about cultures and build relational accountability and trust. As part of the CBPR project, community members were recruited under the title 'Community Research Trainees' and were paid for their training (Jerrigan et al., 2015).

The reason for this high-level investment is that similar to action research, without proper training on how to engage in CBPR and its sustainability, efforts can dissolve once research has been completed (Jerrigan et al., 2015). The research itself involved focus groups which gathered data on community capacity to engage in research, individual capacity to express needs,

community-academic trust, and co-learning for the purpose of building partnerships. Following a two-year intensive collaboration training, the findings: demonstrated important challenges and opportunities in interprofessional partnerships; identified gaps in conducting health disparities research at the community, clinical, and university levels; and led to important policy change in all the partner settings (Jerrigan et al., 2015). Sustainable impacts of this study which speak to the long-term impacts of CBPR supporting Indigenous practices, include: the development of a community research review board, the establishment of formal research process, and the implementation of data-sharing agreements between the communities and the university.

In another example of Indigenous-focused CBPR, Mitchell (2018) uses a critical narrative to project a 'counter story' of the CBPR experience as a doctoral student, which adds to the work of van der Meulen's action research study (2011), and supports the concept of relationships over time (Wilson, 2018). Mitchell (2018) identifies that most non-Indigenous research supervisors discourage the use of CBPR based on their own linear concepts of time, where tasks are "heavily structured and every minute counts" (p. 387). Specifically, Mitchell (2018) identifies that "space and time move differently in community work than in academia" (p. 391), and it is because of the slow-nurturing and deep relationships formed during the beginning of the research process, that the author was able to receive continued funding with the same community as a new faculty member post-graduation. Therefore, it is important for universities to acknowledge the limitations of traditional research methods in working with Indigenous populations, and support doctoral students in respecting and honouring cultural nuances of time (Mitchell, 2018).

In these CBPR examples, the development of strong relationships in research is key to both the impact on communities and the scientific processes in which the research unfolds.

Research is as much about empowering researchers and communities (Walters et al., 2009), as it is inclusive of the concepts of: rigour, relevance, and reach (Balazs & Morello-Frosch, 2013). For this study, these terms will be examined in relation to Indigenous-focused research. First, *rigour* refers to the practice of good science in its design, data collection, and interpretation phases, and will be collectively considered with Nokiiwin's affiliated communities. Secondly, *relevance* refers to whether the right questions are being asked and explored (i.e. who will benefit from these questions). Finally, *reach* looks at how knowledge has been disseminated to diverse audiences and translated into policy. In Figure 12, these concepts are applied to a typical research process starting with the development of research goals; this figure will be revisited in Chapter 5 to review mixed method findings.

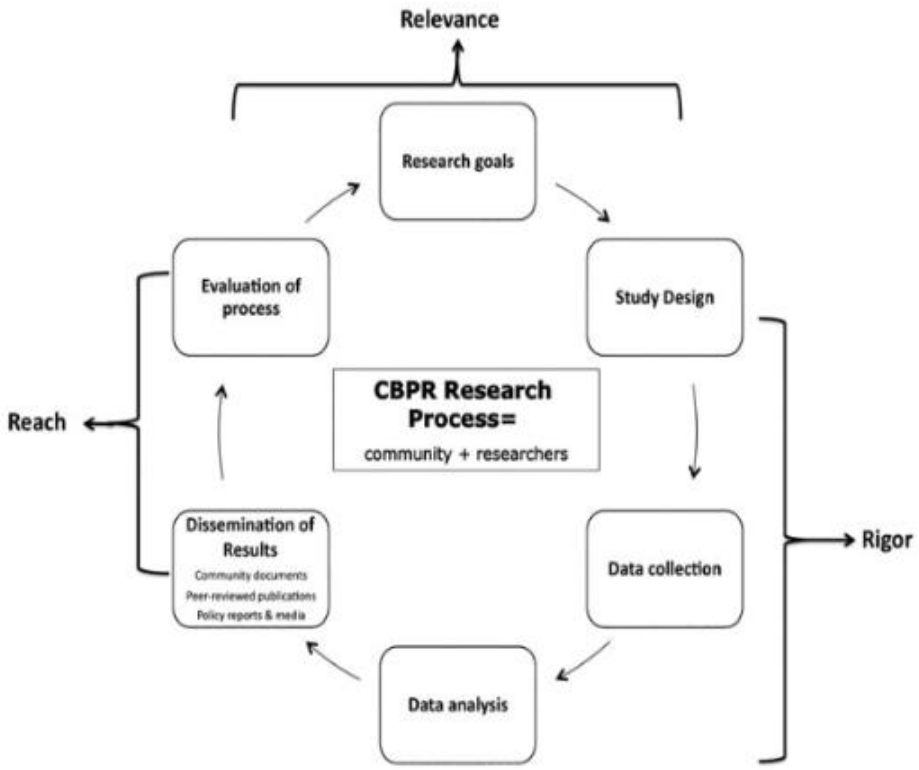


Figure 12: *Research Goodness: Rigor, Relevance, and Reach*. (Balazs & Morello-Frosch, 2013)

Orientation: Community Action Research and Interprofessional Collaboration

Based on the previous section, it is evident that the core elements of CBPR align well with the previously introduced concepts of action research. For this re-search project, it was necessary to reflect on both methodological orientations, to identify what would work best for Nokiiwin Tribal Council and its member communities. In its purest form, action research attempts to understand social systems' problems, and identify actions that can change those systems through implementing action. In concert, community-based research is with, by, for, and in, the community. Both methodological orientations have a strong focus on benefitting the community immediately and aim for sustainable long-term benefits (Hall, 2015). Therefore, in response to the criticism that action research encompasses an unknown array of aliases, this re-search project has consciously added one more term to the mix.

This re-search originated as an action research project involving core elements of community-based participatory research; however, following many discussions with community members, it became evident that the term 'action research' came across as a command. The term *participatory action research* was considered; however, the term 'participatory' was seen as offensive, as it implied that if you chose not to engage in the research, that you were 'not participating'. For others, the term 'community-based' implied a physically situated form of research that did not follow community members into urban areas. Thus, after much thought and consideration with Nokiiwin Tribal Council and community representatives involved in the re-search, the term *community action research* was conceived. This orientation reflects overlapping principles that were used to guide the re-search. Perhaps serendipitously, a supporting literature review demonstrated that our expressed concept of community action research had been around for some time (even if unlabelled) in Indigenous communities in northern Ontario (Agbo, 2003,

2004, 2005, 2007, 2010; Cockburn & Trentham, 2000; Cormier, 2016; Dickson & Green, 2001; Green et al., 1995; Maar et al., 2009; Minore et al., 2004; Singhal, 2001; Walker et al., 2010; Wilson, 2008).

Minore et al. (2004)'s work is a powerful example of how community-based action-oriented research can be used to advance the well-being of entire communities in northern Ontario. This form of research employs local people, "creating an environment for reciprocal learning that transfers skills to community members and enhances the accuracy of data interpretation" (Minore et al., 2004, p. 366). In their study, three remote Indigenous communities in the Shibogama First Nation (i.e. Kingfisher Lake, Wapakeka, & Wunnimun Lake), ranging from 340-500 inhabitants, engaged in action research focused on the impact of lack of continuity in the delivery of health services. Extensive collaboration and a reciprocal education process defined the 'participatory' component of this study. Similar to the present research, Minore et al. (2004) employed mixed methodology. A five-year retrospective review of patient charts drawn at random from a sample representing the population was employed, using incidence rates of disease to calculate the size of the target sample. Data were also obtained from referral agencies, combined with in-depth interviews with healthcare providers servicing the communities. Findings led to community formulated policy and program recommendations, with a specific request that future research focus on the need for enhanced interprofessional communication.

In Maar et al.'s (2009) *Innovations on a Shoestring,* collaborative community action research was used as a mechanism to strengthen access to mental healthcare for First Nation individuals at Knaw Chi Ge Win. Interviews were used to collect data from care providers, clients, and focus groups of community workers. Moreover, a steering committee consisting of elders, community members, local decision makers, and researchers was formed to oversee the

process. As part of the intervention, Maar et al.'s (2009) research allowed for formal opportunities to share information and protocols with the research team—particularly, a model that was recommended "to inform collaborative care in other rural and Indigenous mental health systems" (p. 1). This 'hub' model included a centrally located office where interprofessional teams made up of a program manager, psychologist, traditional coordinator, mental health workers, and nurses, could provide services with specialist consults such as psychiatrists, physicians, First Nation paraprofessionals, and traditional healers (i.e. 'spokes') once a month. It was important as part of the model, that service integration and case coordination would occur in conjunction with traditional healing services, without long waitlists.

Maar et al. (2009) and Maar & Shawande (2010) found that strategies to promote interprofessional education and collaboration (e.g. weekly intake meetings, peer supervision, informal case consultation, case management), and traditional healing protocols, generally supported an increased understanding between First Nation and non-traditional care providers. These publications demonstrate that interprofessional teams have the opportunity to address and confront professional rivalry and negative stereotyping barriers, as well as form a better understanding on how to incorporate traditional medicines into the clinical setting. The sustainable element to this form of community action research is the extensive education and capacity-building (e.g. exposure to traditional teachings, ongoing professional development opportunities) which was targeted at the team, community-based workers, clients, and other community members.

Finally, Maar et al. (2009) employed the OCAP (i.e. ownership, control, access, and possession) principles, which ultimately allowed providers to see the practice environment as collaborative, positive, and a desirable place to work, overall reducing professional isolation.

Through research, this integration model made real change in a practice setting focusing on the needs of Indigenous clients. It addressed both process and task components of the day-to-day workings of an interprofessional team, while ensuring culture competency of those providing care.

In another example community-oriented research, Walker et al. (2010) looked at integrating traditional and contemporary knowledge practices into Meno-ya-Win Health Centre in Sioux Lookout where 85% of patients are Anishinaabe. The name of this centre comes from an Oji-Cree word that represents health, wellness, and well-being. Considered one of the northernmost hubs, Sioux Lookout continues to experience access issues for many of its patients who rely heavily on plane transportation. This comprehensive model guided a program that targeted five aspects of service: governance and leadership; patient and client support; traditional healing practices; traditional medicines; and traditional foods based on previously identified needs. In order to create this program, knowledge was needed by the local community that reflected traditional practices that could be implemented in a hospital setting. As the program was implemented, four main areas of importance were identified, and the following recommendations were made. Patients should have: 1) access to language (i.e. three Indigenous language translators should be available 24/7); 2) access to comfort (i.e. traditional foods, the serving of foods without spices, cultural activities in the hospital); 3) access to medical escorts who should be a paid service with knowledge in CPR and First Aid; and 4) spiritual access (i.e. availability of both traditional healing and Christian materials at the hospital). Although not a traditional example of community action research (i.e. given that patients fly in to receive hospital services from remote First Nations), this article demonstrates the importance of

centering community needs in the research process for the purpose of achieving culturally-appropriate outcomes.

In the first three sections of this chapter, action research, community-based research, and community action research were discussed. Local examples incorporating the concept of community action research were examined using the methodological orientation of this study with the concept of interprofessional collaboration. At the core of these research studies, it has been discussed that culturally-appropriate and ethical practice is an important component of community action research in northern Ontario. Therefore, the following section will focus on the current ethical guidelines that oversee research involving Indigenous persons.

Ethical Engagement with Indigenous Peoples

OCAP and TCPS2. A strong understanding of OCAP (ownership, control, access and possession) is paramount when working and researching with First Nation communities. It is almost impossible to consider positionality without considering the OCAP framework, which first came into existence in 2002 when the First Nations Information Governance Committee (FNIGC) published its first paper. Schnarch (2004) and Maar et al. (2009) speak to the importance of understanding OCAP, a self-determination component of research in First Nation communities. Simply put, the terms explained are as follows: ownership acknowledges that the community owns information collectively, in the same way that an individual can own information; control respects that communities control all aspects of the research from conception to completion; access means that Indigenous peoples must have access to information and data about themselves and communities regardless of where it is being held; and possession refers to the literal possession of data (Schnarch, 2004).

Today, OCAP represents the standard for conducting research with First Nation communities and has grown beyond research to include the governance of all First Nation information (FNIGC, 2014). OCAP was created in response to ongoing colonialist behaviours associated with the role of knowledge production; that is, 'being researched to death', lack of community involvement, misuse of data, poor consent processes, inaccurate conclusions, distorted information, and sensationalizing Indigenous problems to name a few (FNIGC, 2014). According to the 1997 report of the Royal Commission on Aboriginal Peoples:

> The gathering of information and its subsequent use are inherently political. In the past, Aboriginal people have not been consulted about what information should be collected, who should gather that information, who should maintain it, and who should have access to it. (p. 4)

In 2015, Stiegman & Castleden published an article entitled: *Leashes and Lies: Navigating the Colonial Tensions of Institutional Ethics of Research Involving Indigenous Peoples in Canada.* They debate the concept of 'doing research in a good way' because of, or despite, the Tri-Council Policy Statement (TCPS2) document. In 2010, during the first revision of the TCPS2, Chapter 9 was created to address research involving First Nations, Inuit, and Metis peoples of Canada (CIHR, NSERC, & SSHRC, 2010). In Chapter 9, researchers are encouraged to engage in community-based and participatory approaches when conducting research with Indigenous groups. It should be noted that adhering the Chapter 9 of the TCPS2 is the minimal expectation of researchers working with Indigenous peoples (CIHR, NSERC, & SSHRC, 2010). Stiegman and Castleden (2015) acknowledge however, that the TCPS2 guidelines can be in conflict with Indigenous research methodologies. In these circumstances, if researchers choose to follow Indigenous ethical guidelines in place of TCPS2 guidelines, they could lose funding or it could be considered an 'ethical breach', thereby reinforcing colonialist practices.

A good example of this conflict is seen in the overly-exhaustive Research Ethics Board (REB) process (Stiegman & Castleden, 2015). For researchers adhering to Chapter 9, there have been instances where a six-page consent form complete with a breakdown of activities and timelines was needed; "committing us to a project design so detailed it completely disempowered the ability of our partners to guide the evolution of the research over time" (Stiegman & Castleden, 2015, p. 3). The re-writing of REB application sections can delay research up to three months or longer, and strain relationships between community and academic partners. For research groups who have spent years establishing rapport and building trust with Indigenous communities, this can create a high-stress environment. The researchers concluded that Indigenous partners should be empowered, and that the REB's focus should shift towards demonstrating and operationalizing Kirkness and Barnhardt's (2011) principles of respect, relevance, reciprocity, and responsibility.

In our re-search project, the Disabilities Coordinator at Nokiiwin along with the six community re-search representatives, were consulted for submission. Questions from the REB application were cut and pasted onto a Word document, and answers were collectively filled in based on our re-search proposal submitted in March of 2017. As part of the evidence for the REB, community letters of support were submitted (Appendix A), the needs assessment (Nokiiwin Tribal Council, 2016), and the web-maps identified earlier in this chapter. Evidence of a pre-established relationship was relatively easy to support as we had been formally working together for two years prior to the REB process. Areas where we experienced challenges included: our decision to include quantitative data analysis instead of solely qualitative methods; identifying the support person who communities would contact in case of harm or unintended consequences; and clearly identifying the anticipated outcomes of the study. After two months of

revisions, we were able to use the literature to support: 1) why we were incorporating quantitative analyses (NB: refer to Chapter 4 for details), 2) the identification of the Disabilities Coordinator as the point of contact for research consequences, and 3) a list of expected outcomes as defined in Chapter 1, based on the intervention tools that were used.

At that point in the process, I was surprised to learn that the two years leading up to the re-search project and the one year following, did not have a strong impact on the written portion of the REB application. The additional concern was that Nokiiwin Tribal Council did not have its own Research Framework or Ethics Review Board to guide the periods of time outside of the research period. Thus, our team reviewed additional Indigenous ethical considerations, in search of a supportive framework to guide us beyond the re-search timelines.

Indigenous ethical considerations beyond OCAP and TCPS2. In combination with the OCAP and TCPS2 regulations, there are other ethical considerations to fully appreciate the selection of methodology and methods in this re-search project. According to Smith (2012), for Indigenous persons, ethical codes of conduct are necessary to ensure that respect and humanity can be achieved throughout the research process, especially for researchers working with marginalized and vulnerable populations. There are many ethical codes to which we could adhere; for example:

> Indigenous peoples have attempted through the development of instruments such as treaties, charters and declarations to send clear signals to the world's scientific and research communities that open-case mining approaches to research (see, take, and destroy) are absolutely unacceptable. (Smith, 2012, pp. 123)

Wilson-Forsberg and Easley (2012) acknowledge that in remote settings, disseminating research results can have major consequences for participants as well as the entire community. As a result, these authors suggest that it is necessary for healthcare researchers to acknowledge

the close bonds and rivalries that exist within the community prior to engaging in research. This can be achieved by making a presence within the community prior to research, attending to local cultural mores and attending community events, and by assessing the potential harm or benefit of boundary crossings in advance of research. From December 2015 – March 2017, I engaged in weekly meetings with several Nokiiwin representatives (i.e. Chiefs, Band Council, Board of Directors, Health Directors, Disabilities Coordinator, other researchers) and attended several networking workshops for the purpose of getting to know the community and establishing relationships with each of the six represented First Nation communities of the Robinson-Superior Treaty. Through these early networking opportunities, many ethical insights came to light regarding: some beliefs and values of the communities (e.g. which communities were more open to the concept of research and inviting a non-Indigenous researcher on their land); recognition of various healthcare system challenges and their impacts (e.g. systemic racism experienced by those receiving care in urban setting by non-Indigenous healthcare providers); as well as communities who were eager for professional development (e.g. some communities immediately saw the value of interprofessional collaboration training).

Another important consideration was the concept of individual and community confidentially and anonymity. Wilson-Forsberg & Easley (2012) suggest that confidentiality and anonymity can pose exceptional challenges in small communities, “where strangers are few and personal information seems to belong to everyone” (p. 281). Even if location identifiers were removed from data to avoid stigmatization, places in rural and remote communities can still be identifiable which can limit opportunities for publication of work (Wilson-Forsberg & Easley, 2012). In contrast, some participants may not want to by anonymized and in fact would prefer if research about the community would become public; this however cannot constitute ‘community

consent', and may still have unanticipated consequences for the communities (Wilson-Forsberg & Easley, 2012).

For Nokiiwin's communities, research representatives identified early on that when the re-search is complete, giving credit to communities who participate was essential, as well as acknowledging individuals who wanted to be acknowledged (e.g. those who participated in creating a narrative). For the purposes of the written dissertation, communities decided that it would be appropriate to keep communities and individuals anonymous, until the information is assembled for publication. For the purposes of verbally referencing communities involved in the research, all participants who completed narratives and the communities who engaged in the re-search, requested to be identified if knowledge is being shared in front of an Indigenous audience. These conditions are reflective of Wilson's (2008) concept of relational accountability, and also reflect the difference in how information is presented in Western and Indigenous ways of knowing.

Another consideration, is the need to examine overlapping roles and relationships in small communities where the role of healthcare professional and family member, can be easily confused (Wilson-Forsberg & Easley, 2012). This role-blurring may also be experienced by the researcher after prolonged periods of time in the community (Wilson-Forsberg & Easley, 2012). As such, prior to and throughout the re-search project, I engaged in weekly role-clarification whether I was at the Tribal Council or in the communities (e.g. "today I will be grant writing", "we are here to discuss the needs assessment development", "our collective role is to find consensus on the research proposal", or "I am here to share the status on the REB application"). I became very aware in the first year with Nokiiwin, that "it takes but a tiny stone to make big waves in a small pond" (Wilson-Forsberg & Easley, 2012, p. 286). It was through ongoing

discussions regarding my role as a researcher, occupational therapist, and advocate, that I was able to share my critical thinking and clinical reasoning from which I was able to receive feedback regularly.

In collaboration with Nokiiwin Tribal Council, we were able to identify Dr. Lana Ray's (2016) *Tree of Research Ethics for Indigenous Education (TREIE): An Indigenous Research Framework* (see Figure 12), as the ethical framework that incorporated all elements discussed in the literature. This framework supports Indigenous learning in differing communities at the regional, national and international levels (Ray, 2016), and goes beyond the basics of the TCPS2 (Ray, 2019). From an Anishinaabek worldview, this framework incorporates the elements of: truth; creating space; mutuality; Indigenous worldviews and values; relationships, protocols and ceremony; Indigenous and participatory approaches; and the concept of 'good medicine' (Ray, 2016, 2019). This symbolic model was chosen as it literally surrounds the physical space in which the research was performed; a constant reminder of the need for daily ethical practice.

Figure 13: *Tree of Research Ethics in Indigenous Education.* (Ray, 2016)

As the grounding symbol of all these elements, the jack pine represents: resilience, transparency, the ability to grow in diverse landscapes, and the ability to balance extremes in weather (Ray, 2016). The roots of the tree are seen as the thread, symbolizing the need for Indigenous worldviews in research – in this re-search study, Indigenous worldviews have influenced decisions made from its conception to its completion. The inner trunk signifies the food supply, representing the need for nourishment during research – during any community visit, whether for planning, implementing, or evaluating research design, food was always provided by local Anishinaabe chefs recommended through communities. The boughs of the tree represent the need for housing and bedding – for us, this meant that the re-search would never supersede the immediate needs of communities. Additionally, the cones are used to present 'good medicine' that is relevant, tangible and sustainable – our medicines included: tobacco (Elder gifts), sweetgrass (kindness offerings), cedar (workshop tables), and sage (smudging) which not only represented good medicine, but the need for ceremony to initiate and conclude gatherings.

Ethical space. Ray (2016) talks about the importance of 'creating space' for ethical research to take place. If intentional space to discuss ethical principles is not created, then ethical issues can undoubtedly arise. Ermine (2007) originally coined this notion as 'the ethical space of engagement'; the space between two cultures which allows us to reflect "on the electrifying nature of that area between entities that we thought was empty" (p. 195). In this ethical space, cross-cultural conversation can happen between Indigenous and non-Indigenous researchers which creates 'a level playing field'. In our re-search, this space was often experienced when talking about the purpose of 'research' during the pre-research phase. When we talked about the

ideas of Indigenous and non-Indigenous ways of knowing, we were able to unpack our true beliefs.

Additionally, significant moments where I felt I was in this space, was when I traveled two to four hours by car, to the rural communities with Nokiiwin Tribal Council staff. As I would explain the purpose of the re-search to different staff en route, I often felt the "Indigenous gaze" (Ermine, 2007). This gaze represents mindful observation of Western practices; "a gaze that remembers a time before colonialism" (p. 200). I embraced these moments, as I knew that if I made mistakes in my use of colonial language, or projected ideas of 'moves to innocence' (Tuck & Yang, 2012), that I would be easily challenged on the spot. I also realized that I would more likely be challenged on my ethical stance in a small-circle space amongst friends, then I would in front of a large group of community members. Within the community itself, the ethical space was created almost immediately during the distribution of the research letter and consent forms for re-search (Appendix B). I could sense when participants read the research letter with the university logo, that we were not in a shared ethical space. In order to create this space, I needed to allow an open opportunity for Q & A prior to signing the consent forms, so that participants could ask me what they were really thinking about 'benefits' and 'consequences' to research.

Overview

This chapter was entitled: *Methodological Orientation – Community Action Research*, and began with the introduction of pre-research activities to support the importance of becoming educated about and building relationships within First Nation communities, to ensure that colonial practices are not reinforced. Each of these pre-research activities took several months to complete, and have briefly been covered in this dissertation for the purpose of demonstrating scientific rigour as defined by the Research Goodness model (Balazs & Morell-Frosch, 2013). Subsequently, this chapter covered a focused literature review on action research, including its proposed benefits and criticisms, and community-based participatory research. Both methodological orientations were examined as specific elements were collectively chosen for this study's research orientation– community action research. Specifically, literature has been presented involving examples of interprofessional collaboration in community action research frameworks.

To reflect back on Creswell's (2014) inverted triangle, this chapter has therefore provided the "how will re-search be achieved" connection, by explaining the 'how' process of community action research. In other words, through Indigenous and non-Indigenous ways of knowing in healthcare *and* the concept of interprofessional collaboration training, community action research was employed to explore improving access to culturally-appropriate healthcare services. The following Chapter will now focus on mixed methodology; specifically, a convergent parallel mixed method design which was chosen for this study to honour multiple ways of knowing. This will include the introduction of a practical mixed method action research framework, as well as processes for data collection and analysis.

Chapter 4: Mixed Methodology – Multiple Ways of Knowing

Figure 14: *G'minoomaadozimin Vision*. (Belmore, 2015)

This image was drawn using an infant, child, adult, and elder in a traditional canoe, denoting a return to cultural ways and values. The six circles on the canoe represent each community being serviced. The Eagle watches over us. On the Medicine Wheel, we are moving forward in one direction in unison. (Belmore, 2015)

Introduction

> Within an Indigenous research context, the result has been an attempt to weld Indigenous methods to existing bodies of Western knowledge, resulting in confused efforts and methodological floundering. (Kovach, 2009, p. 36)

To reconfirm my position, I am a non-Indigenous researcher who was invited by an Indigenous organization to conduct research using non-Indigenous research methods. I had no previous experience researching with Indigenous participants, and only became familiar with Indigenous methodologies throughout this research journey. The research design you will read about involved cultural protocols, such as including an Elder and Ojibwe translator in the research process. These inclusions were not the result of combining Indigenous methods to Western methods as in Kovach's quote above; rather, it was necessary to follow existing protocols when interacting with Indigenous knowledge holders. Kovach (2009) supports the use of protocols to strengthen the ethical foundation of the research project, which can contribute to decolonizing research.

With the help of Nokiiwin Tribal Council and its research community representatives, we chose a methodology that has credibility in both Western and Indigenous research practices (i.e. community action research). We did not just "add Indigenous and stir" (Kovach, 2009, p. 157); we used the best research design knowledge available to me and Nokiiwin at the time the methods were conceived. To ensure that non-Indigenous methods could support Indigenous ways of knowing, we continuously applied Elder Albert Marshall's two-eyed seeing lens, discussed in the literature review. In summary, this chapter focuses on research design, beginning with my positionality. A mixed method action research framework used to systematize the study design will be reviewed. Additionally, the interprofessional collaboration (IPC) training, also known as

the 'intervention', will be discussed in detail. Lastly, mixed method analysis procedures will be reviewed, inclusive of preliminary data analysis used to support the findings.

Insider-Outsider Positionality

Fassinger and Morrow (2013) advise researchers to examine their motivations for conducting research with communities, since this is where the 'insider/outsider' status of the researcher can impact the research process. In particular to the 'outside researcher', there is a responsibility to question whether a position of power or privilege will be created as a result of taking part in the research (Fassinger & Morrow, 2013). Moreover, for non-Indigenous researchers working with Indigenous communities, Burnette and Billiot (2015) suggest that researchers may experience tension when striving to reach harmony along a continuum of polarities in the research context: a) colonizing – decolonizing research, b) insider – outsider identities, c) mainstream – Indigenous paradigms, d) quantitative – qualitative methods.

The initial idea to engage in community-based research, was initiated by the Disabilities Coordinator of Nokiiwin Tribal Council, Lisa French. I was contacted by the Coordinator in December 2015, based on my reputation as a passionate educator in interprofessional education and collaboration. I was viewed as a person of knowledge who could contribute expertise to, and engage collaboratively with, Nokiiwin's communities (i.e. a person of power and privilege). In the beginning, it was not known what exactly would be studied (i.e. Indigenous or non-Indigenous paradigms/methods); however, the Coordinator was aware of Nokiiwin's communities' limited access to culturally-appropriate healthcare services (i.e. a result of colonizing processes). With limited knowledge on what could constitute 'best practice' (i.e. the appropriate paradigm and methods selection), the seeds of a long-term relationship were sewn, and I became fully aware that my purpose would be scrutinized within the communities.

Herr and Anderson (2015) suggest a six-place continuum of positions where researchers can assume an 'insider' and/or 'outsider' positionality. Based on this classification system, it was clear that I was not a true insider nor outsider, but rather fluctuated between three varying descriptions. Thomson and Gunter (2011) contend that shifting between positions throughout the research period should be expected, given that positions are multilayered and fluid. Based on Herr and Anderson's (2015) continuum, I was likely considered to fall in the category of an *Insider in Collaboration with Outsider (i.e. consultation),* where "an administrator of an organization might invite an action researcher to work with an organization" (p. 48). The Disabilities Coordinator represented the insider, while I represented the outsider providing consultation. In most action research studies, this positionality is less common than an outsider requesting to be a part of an insider research project (Herr & Anderson, 2015).

As the terms and conditions of the research study were evolving during the pre-research phase, my place on the continuum shifted to *Reciprocal Collaboration of Insider-Outsider Teams (i.e. cooperation).* Herr and Anderson (2015) state that, "If there were an ideal form of PAR [participatory action research], the insider-outsider team would probably fit the bill" (p. 48). To achieve this level of collaboration often requires years of negotiation by all involved, and there are few examples in the literature that strongly support this type of engagement (Herr & Anderson, 2015). Mock's (1999) dissertation falls into this category as it involved many pre-research meetings between the university and community organization, to build a level of trust that allowed the research to move forward collaboratively and ultimately become successful.

A strong indication of the shift in my positionality was validated upon receiving a three-year ($100,000/year[9]) funding grant, in conjunction with Nokiiwin Tribal Council, through

[9] This grant was written in collaboration with the Disabilities Coordinator at Nokiiwin Tribal Council which totalled $169,000/year x 3 years. The $69,000 was used to cover the salary of the coordinator while the remaining $100,000

INAC. The application process to successfully obtain this grant required demonstration of a pre-research relationship (see Table 1), a longitudinal re-search process (see Table 2), as well as post-research commitments. The monies from this grant supported the re-search project and ongoing commitment to Nokiiwin's resources (e.g. dedicated time from the coordinator, administration fees, elder stipends, food, supplies, etc.). In this positionality, there was a strong sense of cooperation and collaboration as I worked closely together with the coordinator and community research representatives, to design and implement the re-search processes.

Three months into data collection, the Disabilities Coordinator position was unexpectedly terminated. The absence of a coordinator left a void in the data-gathering process which would later be supported by varying personnel throughout the duration of the data collection period. This unforeseen shift in personnel pushed my positionality to an *Outsider in Collaboration with Insider (i.e. co-learning)* (Herr & Anderson, 2015). [NB: The 'insiders' would now represent a various mixture of Nokiiwin Tribal Council staff who were assigned to work with me at different points of time over the course of the following year.] In reflection, this third shift for me in positionality was quite challenging as I felt like an outsider trying to engage with insiders [other Nokiiwin staff members], who were superficially aware of the re-search purpose and goals. This was because the Disabilities Coordinator played a key role in connecting the community action research project to the other programs at Nokiiwin Tribal Council. She had knowledge of the re-search process for two years, inclusive of engagement in pre-research activities and the signed community research agreements that were made between me, the Coordinator, the Executive Director, and the six community representatives. By September 2017, which was four months

was used for research (i.e. $30,000 for Justine Jecker; $10,000 for travel/food/gifts to communities; $5000 for research committee support; $10,000 for two annual gatherings; $45,000 for additional research personnel, IT support, graphics support, communications, administration support, office supplies).

into data collection, I needed to shift resources and build new relationships that would support the ongoing coordination of re-search. In particular, the Mental Health Navigator, Executive Director, and Health and Safety Coordinator were all necessary to compensate for the absence of the Disabilities Coordinator's role in the re-search.

Herr and Anderson (2015) suggest that in this positionality, the motives of the researcher need to be strongly considered. This is because I went from being contacted by Nokiiwin to conduct re-search, to being an equal contributor to the re-search, to requiring additional support from Nokiiwin in order for the re-search to continue. All roles played by me (i.e. student researcher, clinician, community figure, co-funding recipient) were brought into question as there was a higher degree of vulnerability and uncertainty in the absence of the Coordinator.

This third shift during the data collection period signified a true test of the chosen methodological orientation for the re-search study. That is, if we really were engaging in 'community action research', then in practice, the communities would remain the driving force. This was as much a test for me as a researcher as it was for Nokiiwin Tribal Council, since we both believed that what we were doing was community-led. In the end, the community research representatives were able to provide the support and commitment needed for the re-search project continue forward, even in the absence of one of our key coordinating partners. The fact that we were able to continue to collect data until March of 2018, demonstrated the integrity of the chosen methodological orientation and processes, as the re-search project did not collapse.

By shifting positionality to the outside researcher, Minkler (2004) cautions researchers to consider ethical challenges. Firstly, a community-driven agenda can take over the intentions of the initially agreed-upon research and can have a direct impact on participation. This was evident when the Executive Director requested that I deliver additional professional development

training sessions in the communities, which were outside of the scope of interprofessional collaboration training. Furthermore, the community action research lost some traction following the third shift in positionality, given that it was now supported by individuals who had commitments to other research initiatives overlapping with our community action research data collection timeframe. To work through the challenge of shifting positionalities, I met with our research team's bioethicist, Dr. Richard Matthews, on a bi-weekly basis. It was necessary to reflect on and find solutions for these difficult situations which evolved directly due to shifts in positionality. It was because of these discussions and daily journaling, that I believe I was able to make ethically-sound decisions as identified by Minkler (2004). Now in the post-research phase of the re-search project, my positionality has shifted again to a consultative relationship.

Phase 2: Research Design - Mixed Methods

The re-search purpose and questions (i.e. quantitative and qualitative questions) supported a mixed methods approach in this study for a variety of reasons. First, mixed methods are useful when either the quantitative or qualitative approach alone is inadequate to best understand a research problem (Creswell, 2014). Thus, we chose methods, techniques, and procedures that best met the purpose of the study and were able to successfully answer the re-search questions (Creswell, 2014; Fassinger & Morrow, 2013; Johnson & Onwuegbuzie, 2004). Health Canada (2015) suggests that when engaging in Indigenous research, quantitative information facilitates the sharing of findings, supports decision-makers to improve client care and outcomes, and supports the audit and evaluation process for the National Treasury Board. Additionally, quantitative methods can capture practical numerical data necessary for federal governmental funding (Minore & Katt, 2007) or policy development (Cokley & Awad, 2013). With regards to qualitative research, Health Canada (2015) supports that it is necessary to

provide a picture about the research process, and to identify areas for improvement that represent the collective through language. Pictures can support how research can be used positively to respond to shared experiences by Indigenous persons (Mitchell, 2016; Ng-a-fook, 2007). Finally, through multiple forms of knowledge generation, mixed method studies can become catalysts for social change which can impact the global consciousness (Fassinger & Morrow, 2013).

In the case of community action research, choosing to only use a quantitative or qualitative approach would have rendered an incomplete response to the proposed purpose and re-search questions. Quantitatively, we examined whether or not interprofessional collaboration (IPC) improved for service providers in First Nation communities following IPC training intervention. Qualitatively, we gathered the experiences of those who engaged in the IPC training in interviews which were translated into narratives. This dual approach allowed our team to consider the impact of change (Bamberger, 2012), through our third re-search question which looked at access to healthcare services as a result of the IPC training. The use of mixed methods allowed our team to use strengths from recognized methodologies, while supporting the exploration of different viewpoints on the same issue (Plano Clark, 2010; Teddlie & Tashakkori, 2009). Lastly, by combining multiple methods, we were able to bridge worldviews with those on the research team who had post-positivist or pragmatic thinking with social constructivist worldviews (Greene, 2007). A more simplistic but realistic way of looking at these differing worldviews, would be the merging of Western and Indigenous ways of knowing.

Mixed method action research—convergent parallel design. Mixed Method Action Research (MMAR) was coined by Ivankova (2015), and involves a six-phase conceptualization framework (see Figure 15) reflecting the work of Lewin (1948). It has been used in another community-based research study, which examined stakeholders interested in promoting client-

centredness (Ivankova, 2017). In our re-search study, the six phases of the MMAR framework were used to systematically guide the delivery, implementation, and writing of the research proposal and dissertation.

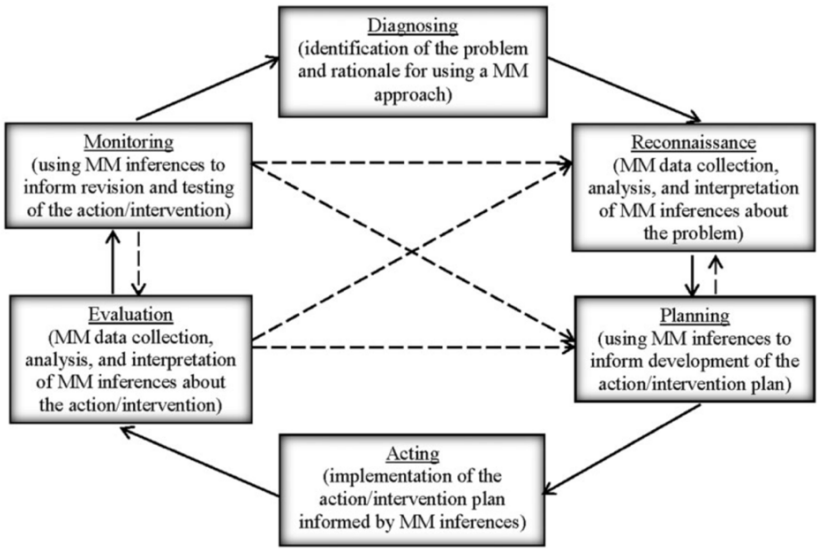


Figure 15: *Mixed Methods Methodological Framework for Action Research*. (Ivankova, 2015)

In this dissertation, Ivankova's (2015) phases have been reworded to demonstrate cultural sensitivity and to support the use of decolonizing language. For example, instead of writing that Phase 1 is the 'Diagnostic Phase', Phase 1 has been retitled *Identifying the Re-search Purpose*; this phase is identified in Chapter 1. Phase 2 has been changed from the 'Reconnaissance Phase', to *Re-search Design* which involves selecting a mixed methods design, identifying the study sample and types of data to be collected, data collection, analysis and validation. Phase 3 in this dissertation incorporates two of Ivankova's (2015) phases and is called *Planning and Action*. Both phases 2 and 3 are examined in this chapter. Phase 4 is called *Evaluation*, and involves evaluating action to determine if the results led to change within the community, which will be addressed the next chapter. Finally, Phase 5 is called *Moving Forward* and involves presenting

the results, found in Chapter 6. The re-search purposely engaged all phases of the MMAR design to address previously discussed criticisms in the literature, that action research is not clear in its methodological approaches (van der Meulen, 2011).

It is worth mentioning that after choosing to use Ivankova's (2015) non-Indigenous mixed methods framework to organize the study, I discovered Kovach's (2009) Nehiyaw Indigenous Research Framework, which also proposes a six-phase research process: 1) research preparation involving standard protocols, 2) research preparation involving standard research design, 3) decolonizing & ethics, 4) gathering knowledge, 5) making meaning of knowledges gathered, and 6) giving back. Kovach (2009) acknowledges that she mirrored her framework after Western frameworks so that the knowledges generated from research could be "more easily translatable to non-Indigenous researchers" (p. 45). Notably however, the difference in language used in each model, acted as a reminder to be cognizant of the differences in Indigenous and non-Indigenous language expression, similar to Ray's (2016) language used in the Indigenous ethical model.

Despite the benefits of Ivankova's (2015) mixed methods framework, there have been notable instances throughout this re-search project, where we have felt that we were: "designing the plane while flying it" (Herr & Anderson, 2015). As an amateur researcher, I needed to learn about action research and community-based research, as well as how to best represent these concepts in a mixed methodology. Prior to meeting with Nokiiwin Tribal Council, I had not planned on engaging in action research based on many of the challenges previously mentioned. It was through Kemmis and McTaggart's (1988) action research spiral of self-reflective cycles (i.e. plan, act, observe, and reflect), that I began to think that implementing a mixed method action research framework was possible. It was necessary to take a verbal oath and acknowledge: 'I will

have very little control', 'the process will require ongoing attention and adjustment in the face of complexity', and 'it is OK if things are messy, unpredictable, and go completely off track' (Ivankova, 2015).

Smith (2012) identified 25 different research methods that can be used when working with Indigenous communities (e.g. storytelling, action research, making familial and community connections, self-representation, envisioning a new future, reframing social issues). In reflecting on these possible Indigenous research methods, the principles for mixed methods action research closely align. Some of the shared working principles include: 1) that the community invited the project, and participated in setting parameters; 2) that stakeholders who were involved were willing to engage in the change process (e.g. redirect policy, design new programmes, train staff differently); and 3) that change is directed at the institutions that work for and with Indigenous peoples rather than changing Indigenous peoples to fit structures. Smith (2012) encourages that these methods can be used independently or in combination with one another depending on the focus of the study.

A convergent parallel mixed methods design was chosen for this study. The selection of this design respects both Indigenous and non-Indigenous ways of knowing (Christopher et al., 2008). In this design, the methods are equally prioritized and data are simultaneously collected; keeping strands of data independent during initial analysis (Creswell & Plano Clark, 2011). The mixing of data occurs during the mixed method analysis and interpretation of findings, ensuring that blending does not happen too prematurely. This merging process is also known as the point of interface (Morse & Niehaus, 2009). The biggest advantage of this design is that it offers opportunities to examine both verifying (quantitative) and exploratory (qualitative) knowledge without needing one to justify the other (Ivankova, 2015).

Participants. The First Nation member communities of Nokiiwin Tribal Council who were invited to take part in the research include: Animbiigoo Zaagi'igan Anishinaabek (Lake Nipigon Ojibway); Biinjitiwaabik Zaaging Anishinaabek (Rocky Bay First Nation); Bingwi Neyaashi Anishinaabek (Sandpoint First Nation); Kiashke Zaaging Anishnaabek (Gull Bay First Nation); Pic Mobert First Nation; and Fort William First Nation (Dunn, 2016). Any health or service provider, educator, or community member who directly or indirectly provided services to Nokiiwin Tribal Council members were invited to participate in this study.

Based on service providers listed in Figure 5 of the Needs Assessment (Nokiiwin Tribal Council, 2016) and Nokiiwin's affiliated community service organizations, the following professionals servicing Nokiiwin Tribal Council were intentionally invited to participate in the re-search study: traditional healers; mental health counsellors; health coordinators; dietitians; educators; nurses; translators; dentists; personal support or respite workers; legal counsellors; podiatrists; chaplains; doctors; recreation therapists; occupational therapists; audiologists; social workers; pharmacists; youth and childcare workers; speech-language pathologists; physiotherapists; respiratory therapists; and any other regulated or non-regulated clinician or service provider who self-identified as part of the healthcare team. Participants were geographically located between Thunder Bay and Wawa, inclusive of small communities in between.

Recruitment process. Healthcare service providers and interprofessional teams servicing Nokiiwin Tribal Council were identified by Nokiiwin's Disabilities Coordinator, the Needs Assessment (Nokiiwin Tribal Council, 2016) and the community web-maps (Appendix A). An introductory email or phone call was made to those healthcare providers servicing Nokiiwin to

request engagement in the community action research project. Participants were encouraged to share the invitation for research with colleagues who may be interested.

An outline and description of the research project, similar to the Re-search Plan Overview in Table 2, was provided following the registration of interested participants the Community Action Research Orientation Workshop held on May 23, 2017. If unable to attend, participants were updated by me on discussions and materials covered at the workshop. This workshop acted as an official starting point to the research process, and formally introduced participants to the three-year process identified in Table 2, and its implications for the participants and communities involved. Many of the participants were already aware of the research project as it had been advertised in newsletters and Nokiiwin Tribal Council communications since September of 2016. The Ethics Review Board approval that allowed data from the research to be used for my doctoral dissertation, was received three weeks following this orientation session.

Eligibility criteria. The following eligibility criteria were used to recruit participants: 1) that participants had current engagement in health referral practices within and between organizations that service Nokiiwin communities; 2) that participants had ongoing professional relationships between at least two or more healthcare providers or community members that help service Nokiiwin communities (i.e. professionals working in isolation were not included in the study); and 3) participants could be identified by their communities or interprofessional team members (i.e. if the Needs Assessment was not inclusive of all potential service-providers, the communities had opportunities to inform me of other providers).

Phase 3: Re-search Plan—Interprofessional Collaboration Training (Intervention)

Following the Community Action Research Orientation workshop, research participants took part in a one-day, approximately seven-hour, interprofessional collaboration training session focused on delivering education on the interprofessional competencies identified in the National Interprofessional Competency Framework (CIHC, 2010). Time was given for a ten-minute break in the morning and afternoon, along with 30-minute lunch break. Prior to the session, the research cover letter was reviewed and signed consent was obtained from willing participants **(**Appendix B**)**. [NB: All participants who received the training, had also consented to being a part of the re-search]. The training specified below was delivered in a format based on the Northern Ontario School of Medicine's Interprofessional Education Program Curriculum (NOSM, 2017). I have been teaching these interprofessional competencies to students, clinicians, faculty, and community healthcare organizations within the District of Thunder Bay since 2012.

Minor modifications were made to the delivery of the program, to ensure that culturally-appropriate language was used. Most notably, one of the educational activities involving a case-based scenario required modifications to represent a northern and Indigenous context. Further details are provided in the section on *interprofessional communication.* All experiential activities in each competency were reviewed and approved by the research committee, which included a representative from each of the six Nokiiwin communities. The two surveys used in this research, the Assessment for Interprofessional Team Collaboration Scale (AITCS) and the Interprofessional Collaborative Competency Attainment Scale (ICCAS), examined the six collaborative competency domains. Specific competency behaviours that were evaluated can be found in Appendix C**.** The following subsections will review in detail, the training that was delivered for each of the six interprofessional competencies.

i. Role clarification. In interprofessional teams of 6-8 persons, participants had the opportunity to examine their own role as well as the roles of other professions through an activity called the Talking Wall (Appendix D). They explored role-blurring, potential gaps in team membership, and scope of practice using provincial healthcare guidelines. In conjunction with professional roles, team roles were examined (e.g. leader, mediator, note-taker) using the True Colours exercise (Appendix E). These activities gave participants a foundation to understand related and unique roles supporting the community role. Additionally, participants were challenged to seek information on personal skills of team members, and identify areas for growth via reflection. The competency of *role clarification* is taught first, as it is considered the foundational stepping stone of the interprofessional competencies (CIHC, 2010; HealthForceOntario, 2009). Each subsequent competency is dependent on the fact that every team can clearly explain their individual roles, as well as those of other professionals.

ii. Interprofessional communication. Interprofessional communication focuses on learning about different modes of communication. Specifically, participants developed an appreciation of the use of language between different professionals representing a diverse range of clinical and educational backgrounds. Participants had the opportunity to communicate with one another using different types of language (i.e. non-verbal, verbal, and para-verbal communication). Following this introduction to communication, participants identified its impact on interprofessional collaboration based on a revised Team Observed Structured Clinical Encounter (TOSCE) case-based learning scenario (Appendix F), involving a woman named Jasmine who is experiencing chronic pain (Lie et al., 2015; The McMaster-Ottawa Team, 2010).

The revised TOSCE incorporated character and place revisions that reflect a culturally-appropriate example of someone living in a First Nation community (e.g. Jasmine is a

grandmother in her forties rather than a mother; she is seen as the matriarch in the family and is expected to care for the men, children and grandchildren; she is trying to quietly deal with the pain without troubling her family). Individually, participants had the opportunity to identify and demonstrate the mode of communication preferred by team members (i.e. verbal, non-verbal, and para-verbal strategies) to assist Jasmine in a real-life community setting. This activity challenged all team members to play an active role in Jasmine's health, even if their traditional role did not require involvement. Additionally, themes such as active listening, giving and receiving feedback, and confidentiality were included in discussion.

iii. Interprofessional conflict resolution. For approximately half of this session (i.e. 30 minutes), participants had the opportunity to learn via PowerPoint about types of conflict (i.e. interpersonal, intrapersonal, inter-team, intra-team), and how they are experienced by oneself, with others, and with the family and community (NOSM, 2017). Conflict resolution strategies were discussed with each of teams, as well as themes related to task/process balance, team roles, professional capacity, and burnout. It was encouraged that participants acknowledge at least one of the following elements within their teams: 1) perceived power imbalances, and the stereotypes or historical hierarchies on which they rest; 2) conflict styles and those of team members; 3) conflict management models or procedures; and 4) how conflict styles can contribute to barriers and opportunities in the community setting.

For the second half of the session, the conflict resolution activity focused on reflection and sharing rather than engaging in an experiential exercise. This competency domain is typically taught following *interprofessional communication* and before *team functioning,* as the concepts of communication are used to support proactive conflict resolution strategy development (NOSM, 2017). Participants were also able to apply their learning on role

clarification, which reinforces the scaffolding technique (Hall et al., 2013) used to support successful interprofessional collaboration interventions

iv. Team functioning. As a basis for team collaboration, participants learned about the principles of team dynamics using Tuckman's Model (1979), which examines five stages of group processes: Forming, Norming, Storming, Performing, and Adjourning. This model continues to be used in interprofessional and medical education (NOSM, 2017), and is intended to demonstrate circular rather than linear group functioning (Coffey & Anyinam's, 2015). *Forming* refers to the stage where a team or group 'forms', which can happen every time a member joins or leaves a team. *Norming* refers to the group processes that become familiar when a team is comfortable in their day-to-day functioning. *Storming* refers to the conflict phase, where group or team members feel comfortable enough with one another to express dissatisfaction with group processes. *Performing* refers to group processes that are functioning optimally, and *Adjourning* refers to the process of a team concluding, which may not be experienced by teams.

By engaging in an activity called the Marshmallow Challenge (www.youtube.com/watch?v=H0_yKBitO8M), teams had the opportunity to experience the five stages of group development in a short period of time. In the forming stage, teams needed to negotiate roles (e.g. thinker, builder, marshmallow holder) to plan and execute team tasks over the course of a 20-minute exercise. In the norming phase, team members were adapting to each other's' behaviours (i.e. following the leader, taking notes, offering support and encouragement). For some teams, the storming phase involved giving up on the task all together, or arguing about why the activity could not be completed. The performing stage demonstrated participants engaging in reflection for the purpose of capitalizing on strengths, while the adjourning phase

allowed an opportunity for participants to integrate life and work experiences to inform the success or failure of the team activity.

v. Collaborative leadership and community-centred care. The competency domains of collaborative leadership and community-centred care were combined in the IPC training, as these competencies require full team involvement (NOSM, 2017). Examples of community leadership were discussed, as well as current initiatives focusing on the wellness of the community. After reviewing community content and real-life examples, teams were asked to collaboratively identify community-based initiatives that could increase access to healthcare services. Teams were instructed that their top three suggestions would form the basis of an action plan implemented following the IPC training.

Action items identified in these plans became the basis of the community action research. Throughout this process, participants explored the community's role as an interprofessional team member, as well as their own views on community-centeredness. Additionally, teams discussed the modes of communication preferred by the community to support the enactment of collectively identified action items. The culminating impact of the six competency domains were reviewed prior to finishing the interprofessional collaboration training. Participants ended the workshop by formulating new community action goals designed to improve Indigenous healthcare access. At the end of the IPC two instruments were completed which will be discussed below. [NB: Both of the following instruments have been 'validated' using Western psychometric testing which may or may not have included Indigenous participants].

Researcher Bias

After reviewing my positionality throughout this re-search project, as well as the chosen re-search design, it is timely to review the biases I had from the start of this project. Given my past experiences teaching interprofessional collaboration, and knowing that Nokiiwin invited me to deliver IPC Training to its communities as part of the re-search process, I had expectations that we would see quantitative and qualitative improvements in the competencies defined in the CIHC Framework (2010), as well as participant experiences. As was identified in Chapter 3, Brydon-Miller et al. (2003), state that action researchers engage in research because they need to justify and legitimize what they knew to be correct all along.

Through a trusting relationship established with the communities two years prior, I knew that I would likely receive positive feedback on the impact of the intervention, but would be equally as likely to receive constructive feedback given that participants would feel comfortable enough to tell me what they really thought. This is because as real relationships formed, there was no need to be 'polite' and not express true opinions and feelings. Examples of these truths will be shared in the narratives and themes developed in Chapter 5. With this being said, it is important to recognize in this re-search, that the quantitative and qualitative results should be collectively considered in the context of what the IPC Training led to (i.e. action-oriented outcomes). What I could not have expected or predicted was the chosen action-oriented goals that evolved out of the IPC Training, and led to the mixed method action research outcomes.

Additionally, when engaging in the true principles of community action research, it differs greatly from other forms of research, in that my biases could be considered irrelevant when it comes to what the communities want. For instance, even if I expected to see the IPC Training succeed in terms of statistical significance, this would have little to no meaning for the

communities if a tangible outcome was not presented. In another regard, expressing my biases (i.e. that IPC Training was beneficial and would have positive outcomes) was an important deciding factor for participants to engage in this community-based re-search in the first place. It would have been entirely inappropriate for me to introduce an 'intervention' that I had little or no knowledge of, on a macro-level scale (i.e. to a Tribal Council representing 6000 community members), without a strong belief and foundation in what I was doing.

The wonderful benefit of having had six to ten people challenge me on a weekly basis about my beliefs, intentions, predictions, behaviours, and ideals, was that these biases were always on the table in plain sight for others to see. I identified in the first few pages of this dissertation as an optimist, and this is something that guided my actions each and every day. In my role as facilitator and re-searcher, I believed strongly that we could accomplish something meaningful and long-lasting. If another researcher were to attempt this exact re-search without that belief, there is a good chance that the outcomes would not have been as positive or beneficial for the communities.

Data Collection Instruments

Instrument #1: Assessment of Interprofessional Team Collaboration Scale.

The Assessment of Interprofessional Team Collaboration Scale (AITCS) (Appendix G) (Orchard et al., 2012) is a valid and reliable 37-item quantitative assessment tool measuring three subscales: 1) partnership/shared decision-making, 2) cooperation, and 3) coordination, and uses a 5-point Likert scale to measure the level of collaboration within teams. According to Orchard (2012), the AITCS can be used as a pre and post ongoing performance assessment tool by health educators and researchers for the purpose of helping teams "focus on key aspects of their team practice or to gain a snapshot measure of collaborative teamwork within a health care

organization" (p. 65). Therefore, it has the potential to be used with both intervention and control groups. Content validity was favourable and based on: a literature review of collaboration, teamwork, cooperation, shared decision making, and partnership; fast survey completion time; and the consensus of 24 IPE experts who reviewed the scale for clarity and comprehensiveness (National Centre for Interprofessional Practice and Education, 2015). Moreover, internal reliability was high for the overall measure (Cronbach's alpha = 0.98).

Instrument #2: Interprofessional Collaborative Competency Attainment Survey. The Interprofessional Collaborative Competency Attainment Survey (ICCAS) (Appendix H) is an interprofessional instrument from a larger toolkit that has been validated for use in isolation (MacDonald et al., 2010). Like the AITCS, this instrument assesses the six competencies highlighted in the National Interprofessional Competency Framework (CIHC, 2010). This tool requires participants to "reflect and self-assess their change in level of competency following completion of an IPE [IPC] intervention" (Douglas, Trumpower, & MacDonald, 2014). Psychometric properties of the tool were found to be strong with "evidence in support of the validity and reliability of the ICCAS as a self-assessment instrument for interprofessional collaborative practice" (Douglas et al., 2014, p. 553). Moreover, high internal consistency between items and the ability to predict meaningful outcomes was found (Douglas et al., 2014). Content validation was performed in both French and English using a Pan-Canadian Delphi process (Curran et al., 2009). Given the measure has limitations comparable to other self-report measures, the test was intentionally designed as a retrospective pre- and post-test measure (or post-post test measure) where the participant only evaluates performance upon completion of the IPC intervention (MacDonald et al., 2010).

Researchers utilizing the ICCAS to date, typically administer this measure following the completion of an interprofessional training session, workshop, or program (e.g. an interprofessional series, an arthritis interprofessional training program, or a self-learning module on end-of-life-delirium) and typically in conjunction with one or more measures (Bain et al., 2014; Baker & Fowler Durham, 2013; Brajtman et al., 2012). Both parametric (Baker & Fowler Durham, 2013) and non-parametric statistics (Bain et al., 2014; Brajtman et al., 2012) were used to interpret ICCAS results which were limited in generalizability due to small samples sizes, convenience sampling, and non-normal distribution of data. Researchers encourage the ongoing evaluation of the ICCAS in conjunction with other measures, due to the positive statistical significance found in post-test administration of the measure (Bain et al., 2014; Baker & Fowler Durham, 2013; Brajtman et al., 2012). Finally, similar to the AITCS, Bain et al.'s (2014) use of the ICCAS in association with qualitative data lends support to the incorporation of this tool in a mixed methods study[10].

Data Collection Procedures

> Action researchers are proposing to document what can seem like a moving train where they are both passengers as well as part of the train crew. (Herr & Anderson, 2015, p. 90)

Communities and their participants were chosen based on purposeful sampling (Plano Clark, 2010; Yin, 2009) which considered the setting, actors, events and processes involved in the overall research (Miles & Huberman, 1994; Yin, 2009). Data collection included: surveys, interviews, community observation, and relevant associated grey materials (e.g. newspapers, online newsletters, websites, and observational notes) (Creswell, 2014; Yin, 2009).

[10] It is not known in results of either of these instruments (AITCS, ICCAS), if Indigenous persons contributed to knowledge produced. What was important for our team when selecting these tools, was that the CIHC (2010) Framework aligned very clearly with the evaluation tools in language and intent.

Community action research orientation workshop feedback. The Community Action Research Orientation workshop feedback was used to help fine tune the data collection procedures. The REB application included language that spoke to the need to reflect on and implement feedback to improve the research process when possible, starting with the Community Action Research Orientation Workshop. On May 23rd, 2017 a six-hour orientation session was held for all community members who were interested in participating in the research study. The morning was dedicated to explaining the partnership between Lakehead University and Nokiiwin Tribal Council, the needs assessment completed in March 2016, web-mapping of community services, and the student service provision and research model. The Indigenous and Northern Affairs Canada Grant for 3-Year funding was also shared. In the afternoon, a detailed presentation and discussion of the community action research project was facilitated, and focused on: 1) What is interprofessional collaboration (IPC) and why engage in research? 2) The IPC training intervention, and 3) Identifying teams within the communities that would be interested in engaging in this research.

Seventeen community leaders were in attendance representing four communities, as well as staff members of Nokiiwin Tribal Council. Session evaluations were filled out focusing on the content, presentation, and community engagement components of the day. Evaluations stated that overall the presentation was either excellent or good. Specific feedback included: the orientation session made the research process clear; interprofessional collaboration (IPC) training should be offered during work hours to ensure a high number of participants; frontline workers should be involved in the IPC training; the band office, medical centre, and schools should be invited to attend the IPC training; a meal should be offered during the IPC training as well as other incentives; face-to-face training should be provided in the communities; training should be

offered at a community hall with good visuals and acoustics; and training should be advertised at the school, in paper announcements (i.e. posters and flyers), as well as postings on Facebook.

Quantitative data collection. Prior to the IPC training delivery in community, participants reviewed the research letter and signed the research consent form (Appendix B**).** All participants who took part in the IPC training, consented to being a part of the community action research project for a one-year period. This meant that participants could engage in any action-oriented goals identified during the training over the course of the following year. For both quantitative surveys (i.e. ICCAS and AITCS), participants were asked to identify their profession. In attendance, were: mental health workers, recreation therapists, post-secondary students, teachers, early childhood educators, educational assistants, secretaries, social workers, community development workers, and management. Many of these participants were also involved in other roles in the community, including but not limited to: band administration, Chief and Council, and federal government positions supporting Indigenous health. Specific titles have not been included to preserve anonymity of participants for the purposes of this dissertation.

A post-post test design was planned for the quantitative component of the mixed methods. This design was chosen to test the impact of an intervention (i.e. introduction of interprofessional collaboration competencies) on an outcome (i.e. improved interprofessional collaboration). The overall data collection procedure was conceptualized following review of Borg & Gall (2006). After reviewing studies that examined interprofessional collaboration using the AITCS measure at three time points (Adams, 2014; Scotten, Manos, Malicoat, & Paolo, 2015), it was planned to collect data at baseline, two months, and four months post IPC Training.

Changes to the collection of survey data were needed due to the changes in researcher positionality. Despite a collaborative approach to designing the methodology, a pre-test and post-

test design with the AITCS survey was not possible to implement. Following the departure of the Disabilities Coordinator, my direct access to the communities was compromised; therefore, I was not able to organize visits to the communities to collect AITCS post-test results (i.e. 2 months and 4 months post-test). Based on discussions with my supervisor and colleagues (Herr & Anderson, 2015), the revised data collection procedures are next described.

Participants engaged in the one-day interprofessional collaboration training, and completed the AITCS and ICCAS assessment tools directly following the training (i.e. baseline). Demographic information was gathered from the AITCS as well as baseline measurements of each individual's interprofessional competency. A session evaluation distributed by Nokiiwin Tribal Council was also completed by participants and addressed the appropriateness of the session delivery (e.g. IPC training was well laid out, activities were reflective of the needs of participants, environmental factors were appropriate such as room location, lighting, temperature, etc.). The administration of the ICCAS tool was unchanged, as this survey is designed to collect pre- and post information at the same time (i.e. post-post test).

Qualitative data collection. The qualitative phase was conducted following the quantitative data collection phase. Based on the number of participants who took part in the quantitative surveys (i.e. n = 30), five participants from different healthcare backgrounds were invited to take part in the interview process. Creswell (2013) recommends interviewing four-six participants when attempting to capture a shared experience amongst a sample of this size; five participants from different backgrounds, provided a varied interview sample for this re-search purpose. Thus, to ensure a holistic story representative of the individual and also reflective of the community, a second-order narrative was generated from the interview questions (see next page) to capture a story that represents the lives of many (Creswell, 2013; Riessman, 2008). Riessman

(2008) states that narratives serve different purposes for individuals than they do for groups, in that, "individuals use the narrative form to remember, argue, justify, persuade, engage, entertain, and even mislead an audience" while "groups use stories to mobilize others, and to foster a sense of belonging" (p. 8). In our re-search, a second-order narrative (i.e. interview process that evolved into a narrative over the course of a year), allowed participants to ensure that their stories were reflective of others' experiences in their communities.

This second-order process involved: first, arranging a first interview with all five participants, where the four interview questions (see next page) were asked and information was gathered. Interviews ranged from 30 – 60 minutes, and data were recorded via digital recorder and transcribed for participants to review within a week following the meeting. When possible, data were collected through spontaneous incidents of storytelling (Czarniawska, 2004) that did not always follow the four-question interview format. Secondly, at four months following the initial interview, participants were contacted by either email or phone to re-read their responses to the initial four questions, and then combine all four responses to form short narratives reflecting the responses to the four questions. At eight months post-intervention, participants were contacted once more to review their second-order narratives which involved clarifying the intention of the information provided, and examining and enhancing flow in the narrative. In follow-up meetings, transcribed interview-narratives were discussed and elaborated upon. This back-and-forth approach to generating a narrative based on the interview questions, gave participants time to reflect on thoughts that may have been shared in the moment, and allowed participants to rephrase concepts that would publicly reflect the community. Participants had the opportunity to review their narratives at any point prior to data analysis.

Menzies (2004) and Agbo (2010) acknowledge that a university-community research team and welcoming environment is integral to the interview process; therefore, a strong effort was made to ensure that interviewees felt as comfortable as possible (i.e. initial interviews were conducted via phone (n = 1), face-to-face (n = 4), and in the participant's place of choice). Follow-up reviews at four and eight months, were mostly completed via phone and email. Prior to the interview process, the following questions were piloted with the research committee, to ensure comprehensiveness and cultural sensitivity supporting the qualitative research question: *What are the experiences of service providers after introducing interprofessional collaboration training for the purpose of improving healthcare access?*

The interview questions included:

1. What is the meaning of interprofessional collaboration, and how do you feel about this concept as a way to improve access to healthcare services?
2. What have you learned following the introduction of interprofessional collaborative competencies? Were you able to apply this information over the course of the past four months?
3. How do you feel you have made better connections with team members as a result of implementing interprofessional collaboration?
4. How do you see access to healthcare being improved?

Preliminary data analysis occurred after each interview (Adams et al., 2014, Yin, 2009). This opportunity allowed for a reflection on whether the interview questions were directly addressed, and notes were taken for follow-up discussions. Holistic analysis of the entire narrative took place at the end of the intervention period, and consent was received from all

participants to have their narratives examined using coding, categorizing, and theming processes. Under the guidance of Elder Tony (Lazar) DePerry, narratives were kept in full form to support a two-eyed seeing lens (Martin, 2012). Lastly, an Ojibwe translator was accessed to assist with translating these second-order narratives for the communities. This translation was not initially planned as part of the re-search project; however, participants requested an opportunity for this to take place following data analysis. Descriptions of our research team Elder and Translator are now provided with their consent. These descriptions are based on personal conversations and written communications of how they would like their backgrounds to be represented.

Elder and translator. Our research team Elder, Tony (Lazar) DePerry was born in mid-1940's in a town called Trudeau, a logging camp along the Canadian Pacific Railway. The nearest town for trading and supplies was east, a seven mile walk along the railroad track to Hudson Bay Co. General Store. The Ojibway language was the only language Tony knew for the first nine years of his life. Tony almost died at the age of four, but was chosen by eight generations over 200 years, to share knowledge and wisdom in a good way of life with all who seek guidance towards a healthier way of life. Moving from the days as a child to days as a young man, Tony shifted into urban society. He found a culture that was not consistent with traditional ways.

Although the lifestyle differed from life in the bush, this did not stop him from encouraging others to learn about who they were within their own life. Tony gained knowledge of becoming a carpenter, electrician, construction worker, heavy equipment operator, and instructor. The lesson of 'paying attention' from his grandfather, helps him to share his wisdom and knowledge with others. Tony teaches that our five senses can help us see beyond our immediate needs and fears to use what knowledge is available in our lives to live in harmony

with nature. Tony's mission is to counsel people; to help them seek their true potential, their internal meaning in life and who the individual really is to live a good life. With the gained wisdom and knowledge from the eight generations of teachings, Tony guides and encourages all walks of life, inviting them to seek a true purpose and meaning in their life.

Our research translator Joyce Waswa, from Eabametoong First Nation, is a Residential School Survivor from Shingwaulk, Sault Ste. Marie, Ontario. In her words, she was shipped away from the protective comfort of home to attend kindergarten and suffered from abuse with a fellow Native older girl. She completed grade eight in her home community, then was shipped off to attend high school in Geraldton, ON. She graduated in 3½ years from a four-year high school program. She attended Confederation College, to get educated in a skill and return home to work there forever. "Each time I walked to work looking south at the horizon, I knew there was more to my life out there" (J. Waswa, personal communication, September 30th, 2018). She left her community and wandered for many years; as a sexual abuse Survivor, she was a 'runner' and never stayed in one place for too long. Eventually, Joyce married and had two children; this ended in divorce because she 'fell apart' in her mid-thirties when her children were babies. The flashbacks of Residential School hit her hard, and she did not know what was happening, nor did her husband. She did not know who to turn to for help, but left to go back to school.

Joyce received a Bachelor of Education degree from Lakehead University, with additional qualifications to teach the Ojibwe Language and to be a guidance counsellor. Her hope and vision are to obtain her credentials as a certified counsellor, to help others in their healing journeys. She has been actively on a healing journey for the past ten years or so, and says that she is a lot better than she was before. She holds onto hope for her children's healing. We are incredibly honoured that Joyce committed to translating these local narratives into Ojibwe.

This process challenged her to personally dig deep, and convey the meaning of collaboration and understanding in her own language; something she did not personally experience for many years of her life.

Phase 4: Data Analysis Procedures

Quantitative analysis procedures. Descriptive statistics (i.e. mean, standard deviation, frequencies) were used for both the ICCAS and AITCS (Bain et al., 2014; Iddins et al., 2015; Treadwell et al., 2015). Paired sample t tests were used to examine differences between pre- and post-measurements of self-perceived interprofessional competency in the ICCAS. Bain et al.'s (2014) research study provides an example of how qualitative data was used to support the results of the ICCAS following data analysis. A similar process took place in the present study subsequent to the coding and theme generation of qualitative data.

It was the original intention of this study to analyze the AITCS, using a one-way analysis of variance (ANOVA) to determine if pre- and post-test survey scores were significantly different between communities. If post-test data had been collected, Cronbach's alpha would have been used to examine internal consistency of three subscales of the AITCS tool – Partnership/shared decision-making, Cooperation, and Coordination given that the original author suggested that further psychometric analysis is needed (Orchard et al., 2012). Lastly, the effect size would have been measured using Cohen's *d*, to indicate whether the variance could be explained by the intervention. Without any post-test scores, the descriptive data of the AITCS pre-test score was collected and results are discussed in Chapter 5. Excel was used to enter data and converted it to the Statistical Package for Social Sciences (SPSS) for statistical analysis.

Qualitative analysis procedures. It was the original intention of this study to use Atlas.ti (Friese, 2012) to code both field notes and narrative data; however, following a serious computer

malfunction, it was decided that manual coding was preferable. This incident at the start of data analysis was a reminder of the challenges of relying on computer-assisted programs that are not accessible from other computers. Prior to fully committing to manual coding, another software program was considered (i.e. Dedoose) with mixed method capabilities. Time restraints on learning new software, as well as recognizing the value of manual coding as a novice researcher (Bazeley, 2007; Saldaña, 2013), ultimately supported the decision to forgo computer-assisted analysis. Specifically, Saldaña (2013) and Bazeley (2007) recommend that for first-time studies, coding on hard-copy printouts and not via a computer monitor, is beneficial to equip the novice researcher with the know-how of coding practices. This concept is comparable to when students first learn how to generate equations of quantitative analysis before using computer software.

Weston et al. (2001) states: "coding builds a team through the creation of shared interpretation and understanding of the phenomenon being studied" (p. 382). Monthly dialogic exchange of ideas in a round-table discussion, allowed the research team to generate new and varying perspectives for the researcher (Saldaña, 2013). These monthly data review sessions with the research committee were held from May to October 2018. This committee had the opportunity to: discuss the overall process of data analysis (May); review first cycle coding processes (June); review second cycle coding progress (July); review overall categorization of codes (August); review themes (September); and provide input on how the results of the quantitative findings support those of the qualitative findings (October). Overall, the research committee assisted with triangulating the re-search findings, and acted as a sounding board for me to pose questions about my understandings of the qualitative data. In the end, I was fully responsible for generating the qualitative codes, creating categories, and selecting themes.

Overview on coding practices. Several considerations were made before engaging in the coding process. One of the reasons that a second-order narrative style was chosen, was to assist in translating the interview responses into a story that gave meaning in the context. Some researchers (Lawrence-Lightfoot & Davis, 1997) have commented that coding reduces and objectifies the story of First Nation people, so it was important to keep narratives intact. The research committee supported this thinking, but also chose to identify with Saldaña's (2013) coding practices, which are viewed as a symbolic process that forces one to reflect deeply on the meanings of each datum. Therefore, it was necessary in this study to support the sharing of: 1) second-order narratives, and 2) themes resulting from the coding process which support Indigenous and non-Indigenous ways of generating knowledge.

The following recommendations by qualitative researchers were taken into consideration prior to initiating the coding process: the number of data chosen to support codes does not indicate their significance (i.e. popular codes do not mean that their content is necessarily of high quality) (Saldaña, 2013); the coding technique chosen represents the researcher's worldview, and it is important to be selective when coding (Saldaña, 2013); the level of involvement of the researcher can impact the coding selection (Adler & Adler, 1987); "all coding is a judgment call" (Sipe & Ghiso, 2004, p.482); it is important to look for key moments (Sullivan, 2012); and lastly, code what rises to the surface (Auerbach & Silverstein, 2003).

Two codebooks were created identifying the code, sub-code, content description, and data example (Saldaña, 2013) for both the narratives and field notes. Thirty-two coding profiles from Saldaña's (2013) *The Coding Manual for Qualitative Researchers* were reviewed, and several coding techniques were chosen for both the narratives and field notes (see subsections below). Ten months of data collected from field notes (NB: also inclusive of email

communications, advertisements, and observations) were examined using descriptive coding, emotional coding, and in-vivo coding in the first cycle coding method. Narrative data were also examined using first cycle coding procedures with structural coding as the chosen method. During the second cycle coding process, field note codes and narrative codes were collectively re-coded, before being placed into categories in preparation for theme development.

Coding field notes. Saldaña (2013) acknowledges that choosing a coding method can happen before, during or after the initial review of the data. Oftentimes with field notes, an emerging conceptual framework can evolve, and so coding techniques may not be predetermined (Creswell & Plano Clark, 2011; Tashakkori & Teddlie, 2003). Following the end of data collection, seventeen pages of field note data was pre-coded using *in vivo* (Strauss, 1987) and *descriptive codes* (Wolcott, 1994). One-word descriptions of clusters of data were used to capture quotes or phrases because: 1) they save time and 2) support a holistic review of data (Dey, 1993). Following the pre-coding, it became evident that there were a lot of words related to feelings and emotions. Therefore, Goleman's (1995) *emotion coding* was used to capture emotions expressed over the ten-month data collection period.

When two coding methods are applied to the same data, this is referred to as *simultaneous coding* which can enriches the coding process (Miles & Huberman, 1994; Saldaña, 2013). Prior to coding, different strategies were reviewed (Creswell 2013; Friese, 2012; Lichtman, 2010; MacQueen et al., 2009; Wolcott, 1994), and I decided to aim for 30-40 codes (MacQueen et al., 2009) supporting Wolcott's (1994) suggestion to keep themes to a minimum. The field note code book is found in Appendix I**,** which includes the code and description; the field note examples were removed for confidentiality. Field notes were categorized using the National Interprofessional Competency Framework (CIHC, 2010) (See Table 4). Six categories

reflect each of the six interprofessional competencies in the order in which they were taught (Health Force Ontario, 2009), while the seventh category represents the goal of interprofessional collaboration. Codes were chosen for each of the following categories based on commonality of concepts (Saldaña, 2013).

Table 4

First Cycle Coding – Field Notes

Role Clarification	IP Communication	Team Functioning	Conflict Resolution	Community-Centred Care	Collaborative Leadership	IP Collaboration
Director's role Disabilities Coordinator Mental Health Coordinator Role Clarification	Conferences or gatherings Connectedness Disconnect Exclusion Communication	Grant Funding IPC Training Recruitment Resources Travel	Challenges Colonialism Concerns Disappointm't Lack of Access	Nokiiwin Tribal Council & Communities Other research Ethical Conduct Supports	Change or movement Emotion or energy Leadership Optimism Progress	Politics Positionality Timelines Reflections

Coding narratives. The pre-coding process from raw data to preliminary codes was performed by way of circling, highlighting and underlining important quotes and words supporting the interview questions (Layder, 1998; Saldaña, 2013). All five narratives were on printed paper in a double-spaced format, separating paragraphs, with room in the right-hand margin to take notes (Gee, Michaels, & O'Conner, 1992). Creswell's (2013) concept of *lean coding* was implemented where 10 provisional codes were generated, representative of the qualitative research questions. Three categories emerged focusing on the research questions (Table 5). Given that four interview questions were posed to answer the re-search study's qualitative question, a pre-determined codebook (Appendix J) was created to examine the narratives; specific examples were removed to ensure confidentiality. Saldaña (2013)

recommends with a priori goals, that "a provisional list of codes should be determined beforehand to harmonize with your study's conceptual framework or paradigm, and to enable an analysis that directly answers your research questions and goals" (p. 62). *Structural coding* (MacQueen et al., 2008) was used to code the narratives to ensure codes related directly to the research questions asked. Additionally, *in vivo coding* (Strauss, 1987) was used to capture actual language or quotes. Saldaña (2013) supports that this form of coding is applicable to action-oriented or practitioner-based research.

Table 5

First Cycle Coding – Narratives

Access to Healthcare Services	**Competency Outcomes**	**IPC in Daily Practice**
IPC meaning Access to healthcare IPC and access Policy	Competency training IPC Implementation Research experience	Availability of healthcare services Connections Traditional practices

Second cycle coding. Following the coding and categorization of both sets of qualitative data, reflective analytic memo writing took place for the purpose of fully explaining the essence of the categories (Saldaña, 2013). As previously mentioned, this memo writing has not been included for the purpose of maintaining confidentiality. Following first cycle coding processes, all codes from field notes and narratives were condensed in the second cycle coding method (i.e. focused-coding). A wordle was created (www.wordle.net) using all 42 qualitative codes as a means to re-examine both field notes and narrative codes with a fresh lens; this technique is considered to be a form of *code mapping* (Saldaña, 2013). Wordle automatically creates an image without any knowledge of what a word, phrase, or code means. It can also separate words

such as Nokiiwin Tribal Council or Mental Health Navigator into three single words. Figure 15**,** represents the first image that was created, as subsequent word entries will elicit a different image. Personally, I found it surprising that the intervention, "IPC Training," was placed at the centre, surrounded by the terms "Coordinator" and "healthcare," while the term "Access" is distantly located from the intervention and support mechanisms. This disconnect, is in fact, what has been identified as the re-search problem.

Figure 16: *Coding Wordle.* (Wordle, 2014).

Second cycle coding or focused coding, involved reorganizing and reanalyzing data coded through first cycle methods (Saldaña, 2013). This secondary process also involved analytic memo writing to support decisions made in condensing codes and their associated concepts. Focused coding searches for the most significant codes and "requires decisions about which initial codes make the most analytic sense" (Charmaz, 2006, p. 57). All qualitative research was brought together for the second cycle coding process. Table 6 captures how the first cycle coding was transformed into second cycle codes, seen in the right column. The previously identified seven field note categories (32 codes) and three narrative categories (10 codes), were collectively re-coded from 42 codes to 21 codes. The *italicized codes* represent narrative codes, while remaining codes represent field notes. In one instance, a first cycle code was split into two codes (i.e. Nokiiwin Tribal Council and Communities was split). Four codes did not change at all

and include: traditional practices, supports, communication, and policy. These revised codes were used to identify categories in the next phase.

Table 6

Second Cycle Coding

Former 1st Cycle Codes	**2nd Cycle Codes**
Disabilities Coordinator, Mental Health Navigator, Director's Role	Coordination
Connectedness, Disconnect, and *Connections*	Connectedness
Challenges, Colonialism, Concerns	Challenges
Resources, Grant Funding	Resources
Competency Training, Role Clarification, Leadership	Competency Training
*Research Experience***,** Other Research, Ethical Conduct	Research Involvement
Conferences and Gatherings, Travel	Gatherings
Optimism	Hopefulness
Emotion or Energy	Energy
Disappointment, Lack of Access, Exclusion	Setbacks
IPE Meaning, IPC Training, *IPC Implementation*	Community-Building
Change or movement, Timelines, Progress	Progress
Politics, Positionality, Recruitment	Beliefs
Reflections	Reflective Practice
Access to Healthcare, IPC and Access, Availability of Services	Collaboration
*Nokiiwin Tribal Council and Communities were split as two codes ** Codes that did not change: *Traditional Practices*, Supports, Communication, *Policy*	

Developing categories. The Seven Grandfather Teachings followed by the Anishnaabek, are believed to have been placed in this part of the world by the Creator (Peterson et al., 2016).

At Nokiiwin Tribal Council, these Teachings represent "how we are to treat one another and ourselves on a daily basis" (Bo Sault - Nokiiwin's Health and Safety Representative, personal communication, April 12, 2017), and are embedded within G'minoomaadozimin Model (Figure 14, Appendix K). These Teachings were recommended by Nokiiwin to analyze the narratives with existing knowledge. In particular, Bo specified "we already have perfectly good Teachings that we have been using for generations", and his rational was secondarily supported by the research committee. This concept to utilize local knowledge or existing methods to analyze community-based research, contributes to the basis for others' work (Riessman, 2008).

In reflecting on the qualitative findings of the research journey, the Teachings not only hold knowledge about: wisdom, love, respect, bravery, honesty, humility, and truth; but also help us see the opposites of each: ignorance, hate disrespect, cowardliness, dishonesty, superiority, and biases (Peterson et al., 2016). Supporting the Teachings in a clockwise direction, Anishinaabe peoples tend to share similar beliefs regarding the order of the Medicine Wheel (Bouchard, Martin, Cameron, & Swampfox, 2009). Notably, there are local differences; for instance, Nokiiwin uses the Teachings of: humility (down), truth (north), bravery (east), trust (west), respect (south), love (within) and wisdom (up); while Bouchard et al. (2009) use: humility (east), honesty (south), respect (west), courage (north), wisdom (up), truth (down), and love (within). In Table 7, the reader will view the Teachings and their descriptions (in English and Ojibwe), as supported by Nokiiwin's Our Respectful Community model, with the second-cycle codes in the middle row. To provide an alternate context , Bouchard et al.'s (2009) Teachings and definitions have also been incorporated.

Table 7

Categorization of Codes – The Seven Grandfather Teachings [11]

Nokiiwin's[12] **Teaching**	**Humility** *Dbaadendizin* (Down)	**Truth** *Debwewin* (North)	**Bravery** *Aakdehewin* (East)	**Trust** *Apenimowin* (West)	**Respect** *Minaadendmoin* (South)	**Love** *Zaagiidwin* (Within)	**Wisdom** *Nibaakaawin* (Up)
Definition	*This is a safe, welcoming workplace where we treat each other with respect, dignity, and equality*	*To recognize our differences and to speak our truth in a good way*	*Doing what is right for self and others.*	*The confidence to speak up with the belief that you will be heard and supported*	*Act in a way you would expect to be treated. Acknowledge individual opinions and points of view*	*To walk together to find balance and take care of one another towards common goals*	*Consider your words and how they could affect others*
Second-Cycle Codes	Competency Training Setbacks Supports	Communication Collaboration Research Involvement	Challenges Coordination Progress	Community Building Beliefs Nokiiwin	Connectedness Resources Policy	Gatherings Energy Hopefulness	Communities Reflective Practice Traditional Practices
Bouchard et al. (2009) Teaching	**Humility** *Dibaadendizo-win* (East)	**Truth** *Debwewin* (Down)	**Courage** *Zoongide-ewin* (North)	**Honesty** *Gwayakowaa-diziwin* (South)	**Respect** *Manaaji'iwewin* (West)	**Love** *Zaagi-idiwin* (Within)	**Wisdom** *Nibwaakaawin* (Up)
Definition	*Learn not to be arrogant. Do not think too highly of yourself. Become humble.*	*Pray, every day. Ask for yourself only when there is no other recourse. And give thanks always.*	*In your life, you will need courage to transform fears that might prevent you from living a good life.*	*To want more than you have been given is to suggest that the Creator has not given you enough.*	*Do not waste. Use all things wisely. Never take more than you need and always give away that which you do not use.*	*Look within yourself for love. Love yourself, and then love others…Love is the key to life.*	*You will come to use your gift to direct your life's journey. Do not live based on what you wish you were. Live on what you are.*

[11] The Teachings of Truth, Love, and Wisdom are the most similar between the two Teachings in terms of the description and location on the Medicine Wheel. The different translation of the Teachings in Ojibwe demonstrates the differences locally in the written word of Ojibwe. The definitions of the terms used in both Teachings helped to support the creation of themes in Chapter 5.

[12] See Appendix K for Our Respectful Community poster incorporating The Seven Grandfather Teachings

Developing themes. Different from categories, themes are written in complete sentences to best explain why a category belongs under the selected theme (Saldaña, 2013). Categories converged to form themes after consulting with the research committee and Elder Tony DePerry. Given the important meaning of the Seven Grandfather Teachings, it was explained that it would not be appropriate to change the categorical names; rather, it would make sense to link supportive categories together to form themes. Therefore, the essence of each category was considered in combination with other teachings, and the following four themes were created: Humility and Truth, Bravery and Trust, Respect and Love, and Wisdom (NB: 'wisdom' remained both a category and theme on its own). Based on the Seven Sacred Teachings of Bouchard et al. (2009), these categorical pairings formed themes using Nokiiwin's understanding of the Teachings, which in fact represent contrasts on the medicine wheel (i.e. east and down, north and south, west and within, and up). Specific descriptions of each theme can be found in Chapter 5's Findings.

Four types of thematic analyses were considered: thematic analysis, structural analysis, visual analysis, and dialogic analysis (Riessman, 2008). Simply put, thematic analysis can examine large-scale sample data from narratives; structural analysis is interested in how narratives are organized, and visual analysis can be used to visually capture a narrative. These forms of analyses did not support the overall design of the re-search study (i.e. we did not collect large-scale data, did not examine chronological events, and did not paint a picture of the narratives or field notes). Dialogic analysis was chosen as it requires the researcher to read the contexts, and include "the influence of the investigator, setting and social circumstances on the production and interpretation of the narrative" (Riessman, 2008, p. 105).

This form of analysis forced me to think about what was not included in the narrative (i.e. field notes), and went beyond taking the narrative verbatim (Riessman, 2008). This is because the narrative represents a dialogue "between speaker and listener, investigator and transcript, and text and reader" (Riessman, 2008, p. 139). Riessman (2008) argues that researchers play a major role in constituting the qualitative data; "through our presence, and by listening and questioning in particular ways, we critically shape the stories participants choose to tell" (p. 50). In its essence, field notes and narratives were captured in the overall theme development in verbatim quotes, observational descriptions (Creswell, 2013), and metaphors (Lawrence-Lightfoot & Davis, 1997, p. 185). The themes representing the overall qualitative data are reviewed in Chapter 5. The following section examines the concept of portraiture, which is used to integrate the qualitative and quantitative findings.

Mixed methods analysis procedures. The qualitative and quantitative findings merge at the point of interface (Morse & Niehaus, 2009), where a new understanding of what happened in the re-search emerges. The integration of findings is a key feature of the convergent parallel mixed method design. At this point, both verifying (quantitative) and exploratory (qualitative) knowledge have been created, and so one of the final steps is to make sense of what these findings mean when examined together. In the following section, Portraiture will be reviewed as a mixed methods analysis tool, as well as how the creation of the Community Action Research Portrait and subsequent Community Action Research Blueprint, speak to the concepts of research quality, credibility, goodness, and validity.

Portraiture as a mixed methods analysis tool. Portraiture was used to merge the results of the qualitative and quantitative research. In portraiture, a picture or portrait is used to capture the essence or context of the situation, rather than capturing the picture of how the participants see themselves (Lawrence-Lightfoot & Davis, 1997). The portrait itself includes an image of the research journey, as well as the interpreted analyses and lived experiences of the researcher over the research timeframe. According to Lawrence-Lightfoot & Davis (1997), "portraitists seek to record and interpret the perspectives and experience of the people they are studying, documenting their voices and their visions – their authority, knowledge, and wisdom" (p. xv).

As a mixed methods representation, the goal of the portrait is to be succinct, acknowledging that "the footprints of process that lead up to the portrait form an extensive trail" (Lawrence-Lightfoot & Davis, 1997, p. 61). As the portrait began to take shape, some details that may at first have seemed potentially important, were not included. For example, I had originally intended to specifically acknowledge the two Nokiiwin communities that participated in the research, but realized that the outcome of the research may be beneficial to all six communities; thus, all six communities were included in the final portrait. Deciding what to include or not, required reflection of what was considered relevant in the big picture as opposed to what was relevant in the moment. This portrait which will be reviewed as part of the findings, provides both a macro and micro viewpoint of what was learned and experienced by me and the communities. Additionally, my personal worldviews and beliefs strongly shaped the layout and presentation of the portrait. Lawrence-Lightfoot and Davis (1997) purport that the portraitist should sketch herself into the context of the research, and do so at an early point in time:

> The person of the researcher – even when vigorously controlled – is more evident and more visible than in any other research form. She is seen not only in defining the focus and field of inquiry, but also in navigating relationships with the subjects, in witnessing and interpreting the action, in tracing the emergent themes, and in creating the narrative (p. 13)

The portrait developed in this re-search, has attempted to capture the complexity of a unique experience, "hoping that the audience will see themselves reflected in it, trusting that the readers will feel identified" (Lawrence-Lightfoot & Davis, 1997, p. 14). Given that the portrait represents the overall research, an authentic interpretation of the data should be reflected. The *credibility* (Herr & Anderson, 2015; Lincoln & Guba, 1985)*, goodness* (Balazs & Morello-Frosch, 2013; Lawrence-Lightfoot & Davis, 1997), *transferability* (Lincoln & Guba, 1985), and *validity* (Reason, 2006) of the research were also examined in response to the portrait created.

Validation meetings where ongoing findings were discussed (i.e. which aligned with the qualitative data analysis review meetings previously discussed identified) provided an opportunity for the research team to act as a devil's advocate (Lomas, Woodward, & Parker, 1996) where the research integrity could be consistently challenged. Monthly emails to the PhD committee also proved to be very helpful in receiving ongoing feedback that challenged credibility, goodness, and validity of the research. Lastly, action researchers are interested in looking at action outcomes that go beyond the generation of knowledge (Herr & Anderson, 2015). Therefore, Herr and Anderson's (2015) criteria on how to engage in quality action research was used to analyze the overall impact of the community action research study.

Research quality, credibility, goodness, validity. In Chapter 5: Findings, the community action research portrait was used to bring together the research processes and outcomes over the past four years. This is because portraiture supports the need for boundary-crossing amid: timeframes (e.g. pre-research, post-research), methods (e.g. surveys, narratives), concepts (e.g. ways of knowing, interprofessional collaboration), and phases (e.g. seasons, years) (Lawrence-Lightfoot & Davis, 1997). In the following section, the concepts of research quality, credibility, goodness, and validity will be explored. As an overview of this section, the portrait itself demonstrates the *quality* of the re-search (Lawrence-Lightfoot & Davis, 1997; Reason, 2006), using the medicine wheel as its foundation (Bell, 2014). The *credibility* of the re-search (Lincoln & Guba, 1985) is discussed in the community action research blueprint—an action-item that was born out of the development of the portrait. I realized that for the results to be viewed as credible beyond myself, the creation of a detailed blueprint of the research process was necessary. The research *goodness* inclusive of rigour, relevance, and reach, were examined using the Research Goodness Model (Balazs & Morello-Frosch, 2013), and is best demonstrated in the creation of the online Community Resource Guide (Figures 20, 21, 22). Finally, Reason's (2006) concepts of *validity* and Lincoln and Guba's (1985) idea of *transferability* were reviewed to support whether the re-search study achieved its purpose and answered the quantitative, qualitative, and mixed methods re-search questions.

i. Research quality. The process of portraiture, as detailed by Lawrence-Lightfoot and Davis (1997), was used to capture the *quality* of mixed methods. A key component of quality research is the transparency about choices made during each stage of inquiry (Reason, 2006). Two months of reflection was needed following the data collection period to create a portrait that was both explanatory and illustrative. It was necessary to review weekly self and team

reflections captured in my field notes (Herr & Anderson, 2015), to craft a still-shot frame of a mixed analysis. Upon careful consideration, Nokiiwin Tribal Council's medicine wheel in conjunction with Bell's (2014) meanings of the medicine wheel, were used to capture the mixed analysis. According to Bell (2014), the medicine wheel contains all traditional teachings and can "therefore be used as a guide on any journey" (p. 14).

Each section and colour of the medicine wheel carries a different meaning. For Nokiiwin Tribal Council, the east (yellow) quadrant represents mental well-being, the south (red) quadrant represents emotional well-being, the west (black) quadrant represents physical well-being, and the north (white) quadrant represents spiritual well-being (B. Dunn, personal communication, June 12, 2018). These quadrants are referred to as *rings* (Bell, 2014) which can represent: the seasons (spring, summer, fall, winter), times of day (morning, afternoon, evening, night), stages of life (infant, youth, adult, elder), and life givers (earth, sun, water, air). In this study, the four seasons and four types of well-being as defined by Nokiiwin, were used to capture the essence of the mixed methods findings, which will be discussed further in the community action research blueprint and community resource guide (Figures 19-22) subsections of the Findings.

Each year was labelled based on the teachings of Cree Elder Michael Thrasher, beginning in the east quadrant (i.e. seeing the vision, realizing the vision, figuring out the vision, doing the vision) (Bell, 2014). According to Michael Thrasher, 'the gift' is when one is able to *see* the vision, then have the ability to *relate* to the vision, then be able to *figure out* the vision, and finally to *do or actualize* the vision (Bell, 2014). In our study, the vision refers to the *Research Project Overview*: *4-Year Plan* (Table 2). By collaboratively achieving these annual milestones requiring a high-level of transparency (e.g. pre-research activities, literature reviews, ethics approval, federal funding), we were able to demonstrate the quality of the evidence. At each

checkpoint, the process involved many stakeholders, which impacted the choices made supporting data collection and analysis. These milestones and those involved in the process, will be reviewed in the next chapter on findings.

ii. Research credibility. *Credibility* in research looks at whether the findings are believable, based on the richness of information gathered. This is typically accomplished through data triangulation and member-checking with research participants (Lincoln & Guba, 1985). Credibility is considered one of the most important concepts supporting the trustworthiness of research data/findings; second to the data's ability to be generalizable or transferable (Lincoln & Guba, 1985). In other words, examining the credibility of one's research extends beyond the concept of research quality, and should support the transferability of findings outside of the study's scope. Therefore, a community action research blueprint was created (Figure 19), which elaborates on the context of the re-search portrait, and best demonstrates *credibility* of the study. The Community Action Research Blueprint (see Findings) represents how credible action research can be completed at a doctoral level.

We reviewed opportunities where triangulation and member-checking took place over the four-year research process. In the first year, the web-mapping of healthcare services required a great deal of triangulation with community members and Nokiiwin Tribal Council staff, to ensure that all possible services in the Robinson-Superior Treaty territory were represented. Moreover, the Needs Assessment (Nokiiwin Tribal Council, 2016) which formed the basis of the re-search, involved triangulation of findings with 31 service providers. Each of these service providers were interviewed about services offered in their communities, and were asked to identify their top health concerns and most important needed services. Prior to publishing the

needs assessment, all interviewees were contacted once again to validate the content of the assessment.

In the second year, the research committee assisted with ensuring that the IPC training intervention was culturally-appropriate for Nokiiwin's communities. This led to making changes to the interprofessional language used in the delivery of the intervention, as well as the revision of a case-based scenario (Appendix F). Furthermore, the Indigenous Access to Healthcare Model (Radassao et al., 2017) received feedback from the research committee and other community members, to ensure it accurately represented the current pathways supporting access to healthcare services within the tribal council communities. This information was shared with the Model's authors prior to publication.

During the third year (i.e. REB re-search year), survey data reflecting the IPC training were collected and verified with 30 participants. This verification took place at Nokiiwin's annual community gathering in late March 2018 at the Prince Arthur Hotel. For our workshop, it was entitled the *Community Action Research Preliminary Results* session, and all participants had a chance to learn about the quantitative outcomes (NB: qualitative data had not been fully analyzed at this point). Additional trips were made into the communities between April and July of 2018 to share the quantitative results of the data gathered.

Prior to the session, and to ensure accurate analysis of the survey data, Dr. Tanya Kaefer assisted me in reviewing data equations in SPSS. Additionally, five participants who engaged in interviews leading to second-order narratives, individually met with me on two occasions following the IPC training. These multiple encounters supported member-checking opportunities, where participants reviewed and sometimes revised their ideas to accurately reflect the impact of the intervention. Correspondingly, when the community action plans identified the

need to create an online community resource guide for the purpose of improving knowledge regarding local healthcare services, all six communities were consulted (see next subsection for further details). At the end of the third year, preliminary results of the re-search study were shared with Nokiiwin Tribal Council members attending the Annual General Meeting to gather further feedback and input on the representation of the data.

In this fourth and final year, triangulation of findings took an extra step to ensure that the communities have ownership and agreement of the findings in ways that are culturally meaningful. First, a local Ojibwe translator was contacted to translate all five narratives into Ojibwe (Appendix L). This process took more than three months, as several meetings were needed to ensure accurate understanding of metaphors used in the narratives. Secondly, the artist responsible for creating the *G'minoomaadozimin vision* of the four generations in a canoe (Figure 13) was contacted to paint a final portrait of the community action research project based on the views of participants (Appendix N) [NB: This portrait has been symbolically placed on the last page of this dissertation; it is likely to be the only evidence of this research project a hundred years from now]. Lastly, triangulation of research findings continues as we move towards publication of the research knowledge through books, peer-reviewed journal articles, newsletters, and in the development of a research framework at Nokiiwin Tribal Council.

If I had not considered the entire context of the re-search process (i.e. three years outside of the ethics review board timelines), then an incomplete picture of credibility would have been presented. This concept supports Wilson's (2008) idea of relational accountability, and how we must consider the bigger environmental context if we are to understand the concept of re-search. Lincoln and Guba (1985) suggest that credible research does not necessarily need to be generalizable, rather it can be *transferable*:

> If there is to be transferability, the burden of proof lies less with the original investigator than with the person seeking to make an application elsewhere. The original inquirer cannot know the sites to which transferability might be sought, but the appliers can and do. (Lincoln and Guba, 1985, p. 298)

The Community Action Research Blueprint (see Findings) provides a framework for any researcher interested in attempting a similar re-search process in a different context. Given that the 'burden of proof' lies with the new researcher seeking to replicate or transfer a research process elsewhere (Lincoln & Guba, 1985), this blueprint can act as a guide for those researchers embarking on action research.

iii. Research goodness. In community-based research, *goodness* considers three concepts: rigour, relevance and reach (Balazs & Morello, 2013). In community-based research: relevance explores whether the right questions have been asked; rigor accounts for study design, data collection, and data analysis; and reach looks at how knowledge has been disseminated to different audiences and translated into policy. In reflecting on *relevance*, the re-search purpose and questions evolved from recommendations made by previous researchers who examined Indigenous healthcare access issues and collaborative practices more than two decades ago (Boone et al., 1994; Boone et al., 1997; Minore & Boone, 2002; Minore et al., 2004; Minore & Katt, 2007**).** Perhaps more importantly than the literature, Nokiiwin Tribal Council itself recommended that interprofessional collaboration is needed, if access to healthcare services is to be improved in the region (Nokiiwin Tribal Council, 2016). McIntyre et al.'s model (2009) was used to define the re-search purpose's definition of access, which also supports recommendations made by the Auditor General of Canada (2015). Therefore, the creation of re-search questions focusing on Indigenous access to healthcare services, supports this concept of relevance.

Research *rigour* is supported in the collaborative design of the re-search study, data collection and analysis procedures. The re-search study was grounded in the belief that interprofessional collaboration training would have an impact on access to healthcare services. Therefore, an intervention that had been implemented outside of the research environment for several years, was selected as the medium of choice by Nokiiwin Tribal Council. Culturally-appropriate changes were made to the training to ensure community acceptance; and validated research surveys focusing on interprofessional competency attainment were administered. The collection of narratives supported the need for Indigenous ways-of-knowing to be captured. Data analysis has involved the use of SPSS for quantitative data; coding and categorization for qualitative data; translation of narratives; and the generation of a re-search portrait to represent the overall re-search. Each of these phases was overseen by the research committee representing the six communities.

Research *reach* is currently unfolding in ongoing presentations, abstract submissions, newsletters and in this dissertation. The concept of reach is impacted by the Indigenous belief that knowledge is only generalizable or useful if it can be used by another Indigenous population (Simonds & Christopher, 2013). I have already discussed the potential benefits of the blueprint to be used by others. At this point, I will now examine what is *useful* to the communities.

iv. Research validity. To conclude the mixed method analysis, Reason's (2006) five types of validity were chosen to examine the overall mixed methods: the generation of new knowledge (i.e. dialogic/process validity); the achievement of action-oriented outcomes (i.e. outcome validity); the education of both participants and researcher (i.e. catalytic validity); results that are relevant to the local setting (i.e. democratic validity); and a sound and appropriate

research methodology (i.e. process validity). In this re-search, all forms of validity have been demonstrated.

Firstly, *dialogic validity* is demonstrated in qualitative findings, which were yielded from narratives, field notes, observations, and email communications. New knowledge reflecting the meaning of collaboration and its impact on the community was collected from five local leaders, and has been presented in both full narrative forms, and in the traditional Western theme-generating practices. The translation of the narratives into Ojibwe by a local educator have increased access to this new knowledge. Perhaps more importantly, as part of the IPC training participants were able to identify existing collaborative practices (e.g. members filling in for other roles when needed), as well as new practices (e.g. generation of policy that represents everyone) that have contributed to Nokiiwin's understanding of how interprofessional collaboration can increase access to healthcare services.

Secondly, *outcome validity* has been demonstrated in the action-oriented outcomes that were achieved. Primarily, this includes the IPC training intervention involving 30 participants from two communities. As part of the training, certain community action-oriented goals led to the generation of health and safety policy focused on bullying, and conflict resolution implementation. The collective development of the Community Resource Guide is the biggest action item supporting outcome validity, as it is something that was collectively achieved and is currently being used by both Nokiiwin and its member communities. For me, the Community Action Research Blueprint is an action-oriented outcome, as it serves as a practical tool for Nokiiwin and other northern communities who are interested in engaging in community action research. This tool is also being currently used to create Nokiiwin's research framework for future research endeavours. Finally, the IPC train-the-trainer model has been passed on to

Nokiiwin Tribal Council's Mental Health Navigator, who now delivers IPC training post-research.

Thirdly, statistically significant quantitative results can demonstrate *catalytic validity* for participants (Reason, 2006). In other words, these results demonstrate 'a reality-altering impact' of the research process, where participants gained self-understanding and self-determination through participation (Lather, 1986). In the case of the IPC training, evaluating any or all of the six competency domains (i.e. role clarification, interprofessional communication, team functioning, conflict resolution, collaborative leadership, and community-centred care) is the first evidence of its kind supporting the ICCAS survey, in First Nation communities. Similar to Kovach (2009) creation of an Indigenous research model from a non-Indigenous framework, this evidence can be used to support the quantitative evaluation of Indigenous tools that reflect similar competencies. Reason (2006) states that catalytic validity also needs to be experienced by the researcher. For me, catalytic validity or a 'reality-altering impact' is represented throughout the re-search process – from meeting with Nokiiwin to identify a research purpose, to establishing community relationships, to providing and evaluating IPC training, and to participating in the action-oriented outcomes that followed. Some catalytic skills acquired throughout this journey to become a mixed methods action researcher include: developing macro-level healthcare policy knowledge, grant writing for a federally-funded organization, engaging in qualitative coding practices, and bridging people together across Nokiiwin's First Nation communities.

Fourthly, the post-research phase has and will continue to demonstrate *democratic validity*. The development of the Community Resource Guide has been instrumental in providing a local solution that is relevant to healthcare and non-healthcare service users. It has effortlessly

transitioned from a relevant result, to a tool that is being accessed on a daily basis. Moreover, it is expected that the ongoing provision of IPC training sessions will continue to be relevant to local communities, as is evidenced in the re-search study. As was the case with previous action research studies (see Chapter 3 action research criticisms), this study did elicit results that are relevant to the local setting. This success can be attributed to the community-based methodology that was implemented to ensure local needs would be met.

Lastly, *process validity* has been demonstrated since Phase 1 of this dissertation which has been captured in the Community Action Research Blueprint. Ivankova's (2015) MMAR Framework was embedded into the overall re-search process, to ensure a sound and appropriate research methodology could be followed (see Chapter 2). Correspondingly, a two-eyed seeing approach (Hatcher et al., 2009; Martin, 2012) was implemented in both the re-search and writing of this dissertation to ensure that the processes and results could be understood in Indigenous and non-Indigenous research practices. Additionally, the processes used in this re-search now support the publication of knowledge in various forms for both the academic and local communities. The next phase will be to receive feedback on the Community Action Research Blueprint from other researchers, who can challenge the process validity and propose additional suggestions.

Political Considerations

One final consideration regarding validity that Reason (2006), and Herr and Anderson (2015) suggest, is that valid action research should consider the political context of research. This is important for action research, given that its purpose is to address issues of concern in the everyday lives of individuals and communities (Herr & Anderson, 2015). The discussion around politics has been intentionally limited in this dissertation, as Nokiiwin Tribal Council considers itself an apolitical organization. However, exposure to 'micro-politics' (Herr & Anderson, 2015)

was acknowledged as an anticipated challenge in the study, and became evident in the coding of field notes reflecting daily practices in the field. Community micro-political situations in this study included: 1) daily behind-the-scenes negotiations over how to best spend our time and energy, and 2) the challenges associated with booking IPC training in communities over the course of the data collection phase.

These two reoccurring situations were certainly related to the departure of the Disabilities Coordinator, and also to my shifts in positionality. At times, there could be a one-week delay in decision-making if certain Nokiiwin staff were not available for consultation. Moreover, if the research committee was not in agreement with weekly goals, discussions could be followed by awkward silences making it challenging to come to a resolution. In these instances, it was better to respect the political environment, and let decisions be made by those in decision-making roles representing Nokiiwin. We learned that achieving team consensus was more important than having more research participants/communities take part in the re-search process. As the principal researcher, I became aware over the years of when micro-politics was at play, and found it important to respect insider processes by being led rather than leading.

Overview

This chapter was entitled *Mixed Methodology – The Best of Both Worlds* and has provided a detailed layout of: why mixed methods were chosen; specific methods that supported an Indigenous and non-Indigenous research lens; as well as the specific methods that evaluated quantitative, qualitative, and mixed method data. For our re-search team, the convergent parallel mixed method design represents an example of the two-eyed seeing lens; that is, the quantitative data collection (typically Western ways of collecting data) and the qualitative data collection (typically Indigenous ways of collecting knowledge) came together at the end of the re-search

project to inform the three re-search questions through the practice of portraiture. This two-eyed seeing method which collectively represents knowledge, includes: the interpretations of the overall data collection and analysis methods (i.e. including surveys, narratives, field notes, observation, research validation summary), as well as the longitudinal impact of the interprofessional collaboration training. It will be through interpretation of findings in Chapter 5, or the point of interface (Morse & Niehaus, 2009), that this re-search begins to inform its purpose.

At the heart of the research design is the understanding and acceptance of the G'minoomaadozimin vision painted by Belmore (2015). As we worked our way through the re-search methods, we experienced some of the natural life transitions represented by the medicine wheel (Bell, 2014); from infant (limited knowledge), to child (foundational knowledge), and to adult (working knowledge). The vision reminds us that we are in our parallel canoes, Indigenous and non-Indigenous, making our way down an infinite river trying to re-find our knowledges. With the circles represented on the traditional canoe, we were reminded that this re-search is with and for all of Nokiiwin's communities regardless of who participated directly. Belmore (2015) reminded us that the Eagle watches over us as we moved forward in one direction in unison.

Chapter 5: Findings & Results – Our Respectful Communities

Figure 17: *Nokiiwin Tribal Council Logo*. (Nokiiwin Tribal Council, 2016)

Nokiiwin Tribal Council's symbol unites each of its six communities in a hand-holding circle representing the medicine wheel. In the east, yellow represents the rising sun and spiritual well-being; in the south, red represents the heat and emotional well-being; in the west, black represents the last place to see night fall and physical well-being; and in the north, white represents the artic, and mental well-being. (Nokiiwin Tribal Council, 2016)

This chapter is entitled “Our Respectful Communities” because the findings were authenticated and accepted by the communities, prior to writing this chapter. In the writing of the findings, there was a commitment to document in a manner that supported the two-eyed seeing approach (Bartlett et al., 2012; Marshall, 2017; Martin, 2012). An overview of the feedback from the IPC Training sessions is provided. This section is followed by findings organized into: 1) quantitative results, 2) narratives generated, 3) themes generated from all of the qualitative data, and 4) the mixed method action research outcomes. After each section, the re-search questions will be directly answered.

IPC Training Sessions

Following the Opening Action Research Conference, it became evident that the terms ‘healthcare team’ or ‘service providers’ included anyone in the community who felt they could contribute to the overall health and wellness of the community. This supported the findings in the needs assessment (Nokiiwin Tribal Council, 2016), where the recruitment of unregulated healthcare providers was suggested. The Review Ethics Board process began mid-March 2017 and took three months and two sets of revisions, before approval was received to engage in research. Out of six communities invited to participate in the re-search study, two communities were able to commit to the one-year process supported by staff at Nokiiwin. Two of the communities did not respond to the invitation, and two communities voiced a strong interest and made several attempts to schedule the IPC training, but needed to cancel on several occasions due to: deaths in the community, community reorganization processes, elections, inclement weather, and because other professional development opportunities were being provided.

Seventeen participants were in attendance for the IPC Training held in the first community on June 16th, 2017, and thirteen participants were in attendance in the second

community on September 12th, 2017. Thus, a total of 30 community members who are also service providers took part in the IPC training. Verbal feedback regarding the IPC training for both training days included that the training: helped participants to better understand and respect their roles and the roles of others; allowed participants the opportunity to interact with people that they usually do not communicate with; showed participants that every member of the team had something valuable to contribute; and demonstrated how poor communication processes can jeopardize well-functioning teams.

Participants particularly enjoyed the team-building exercises as they were 'effective' and 'positive'. Most people felt that this training could be used in all aspects of life, beyond the work environment. A couple of participants humbly admitted that they were regretting committing to the session initially, but were very grateful to have participated as the training exceeded their expectations. Moreover, participants felt that the IPC training should be offered to all community members. According to participants, the training was able to show the community how to work better together; provided real-life tools to handle difficult situations; and allowed participants to build stronger relationships in ways not previously considered.

This positive feedback was not only directed at me, but also at Nokiiwin Tribal Council for supporting the IPC training in the first place. Participants referenced system-level changes that they anticipated could happen as a result of the training: "The school and the health center might have more communication in the future because of this training"; and "Let's take this to the next level and educate our community on our roles (i.e. council roles, community member roles, band administration roles)". Additionally, participants expressed that ongoing IPC training would be beneficial to the groups that participated, as it gave them a platform to discuss real community issues. Perhaps most complementary, was feedback from an individual participant

stating: “we now know [because of the IPC training] how to adapt to changes in team dynamics and identify our collective strengths and weaknesses”.

With regards to constructive feedback, some participants felt that the school gym was not the best area for the first training session as it was hot and not well ventilated. Five participants voiced a need for further training on conflict resolution strategies to help work through some specific community examples. Lastly, one participant in particular was hoping for more specific solutions to bullying in the workplace when the conflict resolution competency was discussed. The previous two sections discussed session feedback from both the orientation session, and the two IPC training sessions delivered in community. The next section will examine the quantitative, qualitative, and mixed method data collection and analysis procedures.

Quantitative Results

Assessment of Interprofessional Team Collaboration Scale (AITCS). Twenty-four of 30 participants between two communities completed the AITCS, a 37-item diagnostic measure of interprofessional collaboration among team members encompassing three subscales: partnership, cooperation, and coordination. This survey was administered to capture participants’ current perceptions and beliefs with working on an interprofessional team. Four participants chose not to complete the survey, while two surveys were omitted due to large amounts of incomplete data. The AITCS (2001 version) has a maximum score of 185. The total mean score of all participants (n = 24) was 148.9 or an 80% agreement that teams felt they were working as an effective interprofessional team. Under *Section 1: Partnership / Shared Decision-making* which consisted of 19 items, the total mean score was 80.88/95 or 85% agreement. Under *Section 2: Cooperation* which consisted of 11 items, the total mean score was 44.88/55 or 82% agreement. Finally, under *Section 3: Coordination* which consisted of 7 items, the total mean

score was 26.9/35 or 77% agreement. Despite not completing a post-test survey, these baseline results suggest that participants felt they were already working on, and with, an effective interprofessional team.

Interprofessional Collaborative Competencies Attainment Scale (ICCAS). Twenty-five of 30 participants representing two communities completed the ICCAS, a post-post test self-perceived interprofessional competency rating tool covering six categories of interprofessional collaboration (i.e. communication, collaboration, roles/responsibilities, patient/family centred care, conflict resolution, and team functioning). Two participants left the training twenty minutes early and were not able to complete the survey, while three participants chose not to complete the survey. The ICCAS has a maximum score of 140. The pre-intervention mean score of all participants (n = 25) was 111.4/140 (0.795 – 80% of total). The post-intervention mean score was 124.92 (0.892 or 89% of total), a 13.52-point increase or almost a 10% increase in mean score.

A paired sample t test was used to determine the statistical significance of the scores pre- and post IPC training. After the mean difference was determined, the paired sample t test was run looking at whether there was a statistically significant difference between the six categories of interprofessional collaboration, pre- and post-intervention [NB: the confidence interval chosen before administration of the test was $p = 0.05$]. The results indicate that there was a significant difference between the mean values for all categories pre and post IPC Training (Communication: $t(24) = -2.663$, $p = 0.02$; Collaboration: $t(23) = -6.033$, $p = 0.001$; Roles and Responsibilities: $t(24) = -5.279$, $p = 0.001$; Community-Centred Approach: $t(20) = -5.203$, $p = 0.001$; Conflict Resolution: $t(23) = -4.271$, $p = 0.001$; Team Functioning: $t(23) = -3.795$, $p = 0.001$). All participants scores improved regardless of their community.

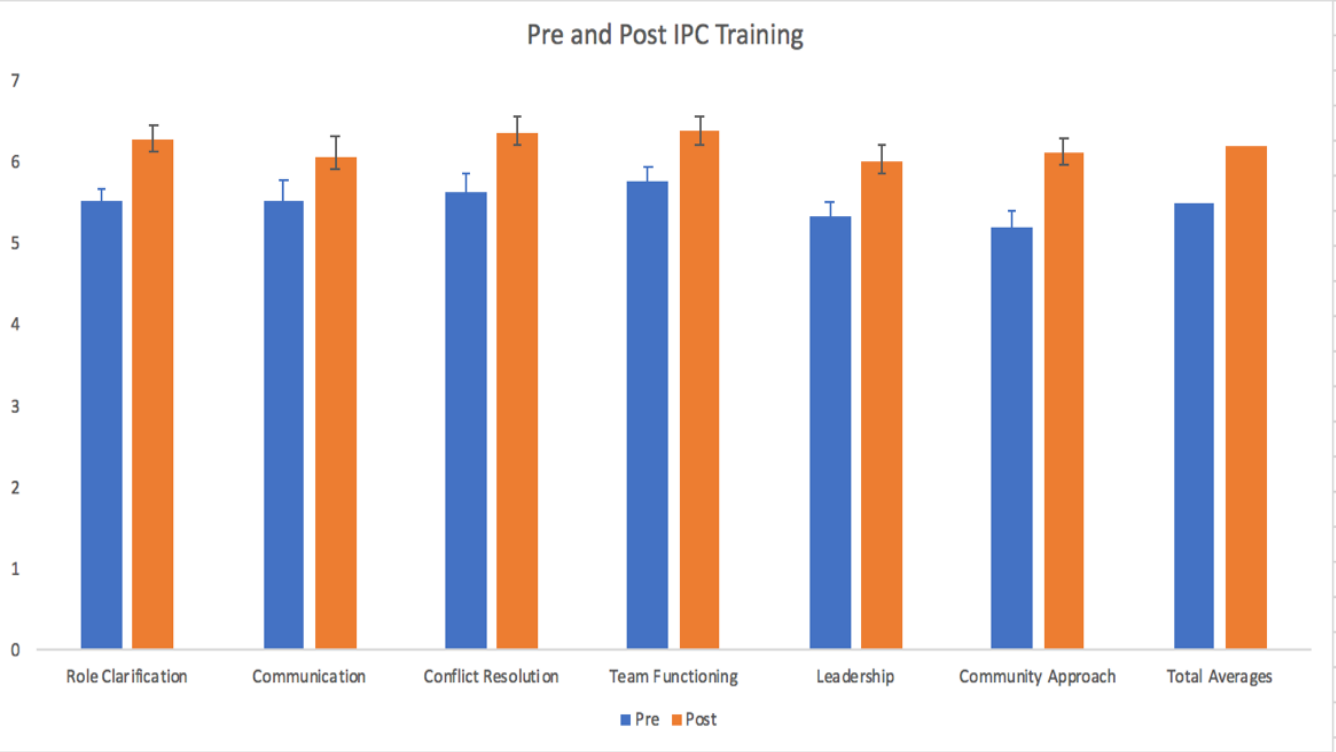


Figure 18: *ICCAS Results*

Quantitative question. *Does interprofessional collaboration (IPC) improve following the introduction of interprofessional collaboration, for providers servicing Nokiiwin Tribal Council communities?*

Yes. According to the Interprofessional Collaboration Competency Attainment Survey (ICCAS) tool, interprofessional collaboration improved following the administration of IPC training in a one-day workshop. A paired sample *t* test was used to determine the statistical significance of the perceived scores pre- and post- IPC training. After the mean difference was determined, the paired sample t test was run looking at whether there was a statistically significant difference between the six categories of interprofessional collaboration pre- and post-intervention (i.e. Interprofessional Communication, Collaboration, Roles and Responsibilities, Collaborative Patient/Family-Centred Approach, Conflict Management/Resolution, and Team

Functioning). The results indicate that there was a significant difference between the mean values for all categories pre- and post- IPC Training. All participant scores improved regardless of their community. The Assessment of Interprofessional Team Collaboration Scale (AITCS) demonstrated that participants felt they were 80% working as an effective interprofessional team before the training; thus, the ICCAS results demonstrate that even self-identified highly collaborative individuals, can increase in their interprofessional competency levels following a one-day training intervention.

Qualitative Findings

Prior to reviewing the themes generated from the narratives, participants requested that their narratives be shared and appreciated individually in the Findings chapter of this dissertation. This request honours Indigenous ways of knowing and sharing. For those who can read in Ojibwe, each of the narratives have been translated by Joyce Waswa, and can be followed line-by-line in Appendix L. Five second-order narratives reflect the interprofessional collaborative experiences of: a coordinator, an educator, a councillor, an administrator, and a spirit-builder. The qualitative question will be addressed following a review of both the narratives and the themes.

i. Coordinator narrative. Interprofessional collaboration for me is when thoughts and ideas come together for the betterment or improvement of a situation, a direction, a project, or whatever it may be. With everything, everyone brings different strengths and gifts to the table – as far as collaboration improving access to care, I think it is extremely important, if not the most important thing. This gives a voice to a lot of people and different situations, to ensure this is

achieved in an all-encompassing way. I think there are too many times that we get caught in our own perspectives and belief systems, that we miss out on a whole area that is imperative.

I would like to believe that I had a lot of these [interprofessional skills] already, especially given the background that I have in health and education. But, I really appreciated watching the other people evolve with this; watching their thought processes, their minds open up, gaining a better understanding of themselves, and watching other people's strengths to see what they bring to the table. Observing the communication was so interesting…. I noticed that it is so essential to allow other people to take the lead. Everyone was involved rather than one person taking the lead – they took turns sharing, feeling valued in the group, and all had something special to contribute. I saw some very introverted and shy people share more than they would typically do; the shyness was being shed.

The whole experience was extremely positive – I could see the community members becoming excited as they engaged in the True Colours exercise. This exercise showed people that they are similar in ways they could not have imagined (i.e. a sense of shared ownership evolved from each colour). This session allowed me to see these competencies at the forefront and be humble about what I bring to the table. The experience made me reflect and listen. Sometimes it was better to sit back and listen in order to appreciate what others had to say. I realized that we always try to comprehend why things are the way they are, despite the complexity beyond our comprehension. I do believe that the relationships were strengthened, and the appreciation following the training for our individual skillsets, was better. Overall, I feel that I became stronger with the community and on an individual basis. The training created an awareness that everyone on the team has different skills. We were able to identify different resources directly in the

community that can be accessed. Increased guidance from individual community members created a wealth of information for the larger group.

I think another area that was a concern, which needed to be identified on a larger scale, was people experiencing mental health issues (e.g. individuals not transitioning back to community with supports). There are a lot of areas in the current system where people can fall through the cracks. It becomes especially difficult when we lose important community engagement personnel whose job it is to connect people to appropriate resources. The communities quite often do not have regulated healthcare providers; however, their qualified workers need to access sensitive information. Most of the time this is not possible, as when clients are discharged from the hospital, there is no release of personal information to the families. This directly impacts community access as they do not know how to support members with health issues in the community.

In closing, I will say that one thing that was frustrating for me, is that the whole of Nokiiwin did not engage in the training. This loss of an opportunity made it challenging for Nokiiwin workers to know what exactly was happening in the community. In the beginning, this explains why the project may have been viewed as 'siloed'. The training itself, unveiled pre-existing and new forms of conflict that it was intended to address. I see possibilities for this training to reach new heights with all members of the Nokiiwin communities.

ii. Educator narrative. Collaboration to me is coming together as a team, working together, sharing ideas, sharing practices, and sharing strategies. Collaboration to me means unification – to become unified. This is absolutely needed if we are going to access services as we cannot run a school otherwise. Our collaboration with Nokiiwin has been very strong, as well as with APS, Dilico, Chief and Council, and parents. But collaboration can also mean not just with other services externally, but within the school – the staff collaborate very well with each

other and the students. When it comes to building connections with parents, I see that we need to work 'with' each other not just 'for' each other.

With regards to the interprofessional collaboration training, I don't remember much about the training in June as I had school issues to address. Because of these pressing concerns, it did not allow me to have the full experience. With that said, today's session [follow-up Conflict Resolution session 4 months post- IPC Training] has been awesome; what a beautiful day! How liberal and free everyone is to speak – they don't hold back, they have opinions and they express them. Having days like this needs to happen more often. I can absolutely apply this learning to everyday life – work in the school, work with admin, work with each other.

These PD trainings help me to connect, relax, and talk about issues that we usually don't have time to talk about. Next week people will come and talk about what was learned during the conflict resolution training. What's great about PD in general is that it's like going to a conference; you're not sure what you're going to get out of it, but you know it's going to be worthwhile. One thing I would like to acknowledge is that circumstances are changing. When it comes to access to services, I don't see services expanding any more at this point in time. Dilico is here visiting on a regular basis, we have a school councillor, a speech-language pathologist who is here 4/5 days, an occupational therapist once every 3 months, and Creative Therapy services from Thunder Bay three times a year to assess students and help teachers. Where we're short is with Ojibwe language teaching. In our community, we have always received 100% support from the band manager, Chief and Council, and others serving the school.

iii. Councillor narrative. Interprofessional collaboration is something that requires all facets of the community - council, leaders, members, administration - to come together and work towards a common goal. Collaboration can become greatly impeded when: 1) there are particular

individuals who are not collaborative and harm the process for others, 2) when all team members are not present (i.e. physically or figuratively) for the collaborative process, and 3) when a common identity is missing that can unite the collaborative process. Currently, there are tremendous resources in the community, however the mechanism to identify those resources, such as a resource booklet, is not available. Better access to resources could be achieved once the community begins working together in sync. Despite the importance of resource acknowledgment and utilization, this takes a back seat when the community itself is struggling with cultural identity and vision.

Following the interprofessional collaboration session where occupational health and safety issues were identified, such as bullying in the workplace, community members have begun working on a Code of Conduct policy to be put in place that will pertain to everyone (Council, Administration, Membership), and hopefully be implemented by next spring. Collaboration can be achieved when inter-council and leadership continue to work towards building a better rapport with one another in a team-based environment. With new people joining the team and others having belonged for decades, it is inevitable that conflict will be experienced.

Sessions like the interprofessional collaboration training should include the presence of Chief and Council to enhance the overall benefits to the community. Certain individuals are exceptional in their roles and really focus on serving the community as a whole. With this said, community members have varying ties to the community – some are more tied to the lake rather than familial ties - so focusing on finding a communal identity and engaging in cultural practices (e.g. language, land-based teachings) is very important. We need to work together to achieve the same goal and be on the same page. It is only then that services can be better accessed.

As a councillor, I have gained different perspectives regarding access issues and community needs. The location of where the community will be built, is an important discussion piece as there's a disconnect between where the community has come from, and where the community is going to be built. It will take a community to build a community, so our inclusion of membership is strongly needed. There is a desire for progress to happen here and now which can create a disconnect with membership, given that the challenges involved in getting funds are not well understood. An important step, is the need to unroll our Community Plan to move things forward. Following the IPC session, I found that it was a very beneficial session that allowed us to be engaged in a round-table discussion.

As a council member, this was the first time that the Chief was heard in quite some time and it was beneficial to those who were present. It is important to understand what everyone does even though the disconnect may be specific to one person. Currently, there is a lack of respect towards collaborative goals; the focus is on individual goals. With this said, there is a strong connection between team members – most of us are open to listening to each other. Staff do not feel that they have support for all of Council which is something we need to build on to avoid disconnect. When council members or the Chief are not present, this can lead to issues with the administrative staff feeling disrespected. Physical presence is incredibly important to be seen and to belong. In the future, training needs to be made mandatory for everyone to ensure that we can all be on the same page. Through this communication, we will be able to achieve community goals.

The training allowed for building team skills by understanding what everyone does and appreciating the level of their work. The session also allowed for better respect of everyone in the room and to listen to one another's contributions; it was an opportunity to be friendly and

build trust. For myself, I try to practice this regularly. Recently, I sent out a nice email to ensure ongoing communication; it allows for professional and personal relationships to be strengthened. Observations that I have made regarding negative email communications, tell me that examples need to be set; respect can only be gained if projected. In the end, it is very challenging to address issues when problems arise with the one individual who is making it challenging to everyone. We are attempting to address this issue by working on generating a Code of Conduct policy which spawned out of discussions generated at the IPC Training.

With regards to improving access to healthcare services, I think we have phenomenal services. A booklet/resource guide is currently being put together. With our AGM coming up in January/February, we need the community to be updated and informed on last year's progress and available programming. Lastly, there are mental health and addictions concerns with cannabis becoming a legal drug being mixed with other prescription drugs. This is a universal concern for all First Nations requiring us to be proactive about and aware of, especially when changes happen in policy.

iv. Administrator narrative. The interprofessional collaboration training was very eye-opening. I particularly liked the exercise where we needed to describe our roles. We do something similar at our AGM's where visuals of people are presented with their names to ensure that everyone knows who we are and what we do. A constant re-education of our roles with the members is needed; this helps to showcase our work and to build relationships. It is important to acknowledge work achieved as this will give us a better appreciation of our roles. At the band office, we are entirely reliant on each other. Some staff, for example, are able to jump into other roles when needed.

Our work partners can be more than our family, even when we are not amicably close, because we spend so much time together. When new people come on, they can feel like an outsider, so we've learned to use each other's strengths and weaknesses to make the most of situations. For example, with Aboriginal Day there are all sorts of activities, teachings and cultural experiences taking place. In the beginning, Council would lead us on how the day would unfold so that people had the opportunity to see where their strengths are. Nowadays, some people who have already participated in the past, take a head start, and so natural roles have been established. This shows that ongoing collaborative group work ensures success of the overall event. There is an underlying assumption by the community that, *if you take an event, you take it from start to finish* – that is, digging horse shoe holes if you have the horse shoe event. Although people know that they will be supported no matter what.

Despite these positive experiences, some of our staff may underestimate their value. At the AGM [Annual General Meeting], some people started to complain about the AA's [Administrative Assistant's] behaviour without understanding that we all wear multiple hats. What [community] members do not often understand is that *we can never be band members*. We are constantly represented in our occupational role, and the only power we have as a member is during election time when we cast our votes. This can be a very challenging experience for staff as family tensions and rivalries will surface. It is known in our work space that we are not allowed to share political views or *pick a side*; Facebook can be a major instigator.

To ensure safety, honest discussions are needed within the band office to allow people to speak freely. We are the only support system for each other, and we know that we cannot bring this home. Being able to leave here in a good space at the end of each day is paramount. At one time, we had a nurse here who wanted to give everyone sick notes (*insert laughter)*. We realized

that staff members were bringing work home regularly, making us question: *where is the safe haven? What can we do for each other?* We were once told that we should not hire familial-related band members into the office; this is impossible! We are all related either through bloodline or by marriage, and so this is the daily reality that we need to work within.

Following the IPC training, I learned that communication is needed on an ongoing basis but is difficult to do when we are busy. We can fail to communicate because we have so much trust in one another – *Oh, I thought you were doing that* – This can be a danger of being a high-functioning team, as it is easy to gloss over the small things. We meet every Monday for group sharing, and to reflect on where we are all at. Sometimes we get busy and rush through this meeting, so we need to be sure not to do this.

Another communication snafu that occurs is when people do not know where people are. We have realized the importance of emailing a communication spreadsheet on our whereabouts rather than saying *we don't know where people are.* This has been especially helpful to Council as we have worked hard to intentionally separate our working spaces into two different environments. It was necessary to draw this line to ensure that both groups could be productive and successful in achieving their goals without people stepping on one another [figuratively and literally]. This has strengthened our working relationships and has increased our appreciation and respect for one another. We know that *at the end of the day, what Council says goes,* but we have much better channels of communication now.

Following the collaboration workshop, I noticed that there were more opportunities for people to truly learn about one another. One of our members was called the 'traveler' because everyone thought that's all he did. The training gave him a voice and gave others a strong understanding of why he needs to travel so much for work. Overall, appreciation was noticeable,

and staff members knew who to go to when needing help for certain things. Practicing people skills and spending time with one another in a meaningful way was very important. What was really special was that all participants had the chance to experience the full day from beginning to end, completing many group tasks that were focused on strengthening relationships.

When I think of the big picture, such as accessing care or services for our community, I feel that there is an *us against them* mentality. For some reason, members are "us" and the Council/Staff are "them". *We are those people.* I think if we were physically settled in our community, that bringing the collaboration training at a wider level would really help us (i.e. groups for elders, youth, parents). Members for instance, would not forget that they have a role and that they are needed; they would be able to see what is happening behind the scenes. For the members, the physical visuals are very important. It is not sufficient to say "I did the following" without having visual proof. It's not that people intentionally dislike Band Council or staff, it's just that only one side of the story is available.

The other issue is that everyone questions the finances. Our Financial Manager is always available for this conversation; however, no one takes these offers up as they see it as not their responsibility. We have always talked about having a "true and honest" finance meeting; those not in the know always see the worst despite an annual audit presentation. When we say "we've spent three million dollars", this can shut down a conversation before it starts. High salaries are made known to the public which can also cause conflict. The bottom line is how do we get from A to B when people always think the grass is greener on the other side, and that other First Nation communities are doing better than "we are". Moving forward, we know that community engagement is needed. Also, policy generation is needed to protect Council, staff, and members, when they are both on and off of work time (e.g. walking in the mall and being stopped to

explain work matters). True and ongoing collaboration is an important piece to ensure that we get to where we want to and need to be.

v. Spirit-builder narrative. Following the training, I can say that I see this as an opportunity to bring co-workers together, which can be a challenging thing to do logistically, geographically and personally. We have seen that there are events that overshadow planned trainings, such as a death in the community, or there can be resistance from different people who are resistant and fearful of change. I see the collaboration training as an opportunity to improve access to care because we become aware of what others are doing. Specifically, we learn to piggyback other trainings, such as the kindness training and sweet grass teachings, so that we can expand to more members in the communities. This also allows us to see what is happening within Nokiiwin, and to translate programming in a meaningful way to the communities.

Nokiiwin's role as an advisor and neutral facilitator helps communities with identifying supports. I see that Nokiiwin is making changes every day, and in some ways, is leaps and bounds ahead with regards to embracing change. From the IPC training, I learned that it's important to give people the opportunity to talk and share in a safe space. In order for true sharing to happen, a safe space is needed; this also allows opportunities for finding resolutions to identified problems. Since the training, I've made it a point in my own training [facilitating] to engage participants without fear of having them share their stories. I have learned that I cannot be afraid of the direction of the conversation and know that I need to let certain conversations be had. At four months post-training, I feel that the experiences and learnings have stuck, and that I can carry them forward with me as part of what I do on a day-to-day basis.

I wasn't expecting to make any new connections in the IPC Training. However, I found that everyone I knew was lighter and more engaging with one another during the IPC training. With

two of the leaders in particular, I had a solid working relationship, but the training still helped to improve these relationships. With regards to Council, it was because of this session that I realized that they had full-time jobs on top of being Council members. This recognition gave me an overall appreciation and understanding of what the days and responsibilities might look like. I can see how when dedicating time to understand one's role, even with those whom I have great relationships, access to services can be improved. Also, working with a researcher who has similar values as I do, allows for progress to be made with community members.

After teams experience this training, it is evident that more options are available regarding access. By collectively sharing our skillsets, we learn better how to connect with other people and share information. Going forward we no longer need to work in silos as we feel comfortable working with others. It is through this training that people can learn to be vulnerable because their voices can be heard without judgment. Regardless of what the evaluations say about this training, I have heard voluntarily a lot of positive comments and feedback; this has been a major turning point for the community. The excitement voiced by the two communities who have engaged, is creating positive energy for us at Nokiiwin and in other communities.

Re-Search Themes: Reflecting on The Seven Grandfather Teachings

Four themes emerged that represent the research committee, research participants, Nokiiwin Tribal Council staff, and me. A holistic view of the experience of engaging in Interprofessional Collaboration has merged from: field notes, observations, email communications, and narratives. As presented in Chapter 4, the categories that emerged from the first and second cycle coding processes, have generated the following themes representative of relationships between The Seven Grandfather Teachings (Appendix K). These four themes include: Bravery and Trust; Humility and Truth; Respect and Love; and Wisdom.

Theme 1: Bravery and trust. Prior to engaging in this re-search study, Nokiiwin Tribal Council staff members had full-time jobs with defined roles targeted at serving the needs of First Nation communities. Thus, a commitment to the community action research project had a direct impact on these roles. All of us were required to be *brave*, or *do what is right for self and others* (Nokiiwin Tribal Council, 2016), to successfully move forward with implementing the IPC Training and subsequent community goals. In this theme, bravery is best demonstrated by how challenges were collectively overcome through communication and coordination; skills that were not only part of the IPC Training, but essential to the day-to-day experiences in the re-search journey. Bravery has been linked to trust in this theme because a high level of *trust,* or *the confidence to speak up with the belief that you will be heard*, was needed in order for the IPC Training to be successful. Examples of trust are best represented through: community building, shared beliefs, and the Nokiiwin Tribal Council staff who ensured community voices could be heard. The bravery and trust of three persons in particular (i.e. the Executive Director, the Disabilities Coordinator, and the Mental Health Navigator), were needed in order for the IPC Training to unfold in the first place. Therefore, pre-research examples of bravery and trust will be reviewed before discussing this theme in relation to the IPC Training.

The Executive Director's approval of the IPC Training and the subsequent community action-oriented processes, were paramount in justifying its purpose and potential. In an email sent the fall before receiving REB approval, the Executive Director writes: "Miigwetch Justine, I am so very pleased to be able to present this [research] to the Board…I invite you to join us for lunch that day" (A. Gilbeau, personal communication, October 4, 2016). This official endorsement of the research gained the trust of the Board of Directors, and would set in motion a

committed relationship moving forward. This support continued throughout the pre-research phase, is demonstrated in an organizational memo sent to the First Nation communities:

> June 5, 2017 – Action Research Partnership with Lakehead University's Justine Jecker
>
> On behalf of Nokiiwin Tribal Council, we are announcing our partnership and support of the proposed action research initiative with Justine Jecker, a PhD Candidate and researcher with Lakehead University. A working relationship with Justine was initiated in January 2016 through the Disabilities Initiative, as it was identified that there are gaps in access to health-care and support services for persons with disabilities living in the First Nation communities in northwestern Ontario. Following a formal Needs Assessment and Web-mapping of service providers in Nokiiwin's six Member First Nation communities, it was collaboratively decided that action research focusing on improving interprofessional collaboration could be greatly beneficial to improving access to health-care and support services for the communities. We are greatly looking forward to participating in this research. Nokiiwin, the Board of Directors and the communities agree, and support the implementation of the action research project.
>
> Audrey Gilbeau, Executive Director, Nokiiwin Tribal Council[13]

The Executive Director's support represented a macro-level commitment to both me and the communities. To promote a research project with a non-Indigenous, amateur researcher on such a large scale, told me that we had established a strong trust in our relationship. Moreover, knowing what First Nation communities have previously experienced in "being researched to death" (Smith, 1999), I believe it took bravery and courage for Nokiiwin's Executive Director to fully support the concept of IPC Training in their affiliated communities.

At the meso or operational level, the Disabilities Coordinator was equally responsible for connecting me and the concept of IPC Training, to the Tribal Council and First Nation communities. In an email communication on October 16, 2016, the Coordinator emphasized: "The action research is so important to the communities and to your studies that I just want to

[13] Email communication and personal correspondence for reporting purposes were accepted in the REB approval and are being used with permission.

make sure that everything is aligned and on track". The Coordinator went above and beyond her respective duties because she had a strong trust in the value of IPC training in First Nation communities. This support continued throughout the pre-research phase, and is captured in an excerpt taken from an email communication, dated May 5, 2017, sent to community members for the Opening Action Research Conference on May 23, 2017:

> This is the opening workshop for the participatory action research. The workshop will cover the following topic: 1) Literature reviews supporting interprofessional collaboration as a means to improve access to healthcare services, and how it relates to Nokiiwin's needs assessment and web-maps of services, 2) Relationship between Nokiiwin and Lakehead University in the research action project (Interprofessional collaboration training), and 3) Community engagement towards improving access to healthcare services. Interprofessional collaboration has shown to improve team functioning in both healthcare and non-healthcare. Reduces staff-burnout, staff turnover, mortality rates, decreases suicide, reduces work-related injury and illness and increases job satisfaction.

What is not represented in this example, are the multiple responses from community members who challenged the Disabilities Coordinator on how the re-search would respect community values and support existing community goals. On several occasions, I heard about the Disabilities Coordinator's challenges with promoting the language of 'interprofessional collaboration' to community members who had never heard these words before (Field notes, June 21, 2017; July 7, 2017; August 10, 2017). For her, trust and bravery were needed to advance the re-search project. Despite an early departure from the team, her initial coordination efforts were the study's foundation.

After the Disability Coordinator's departure, the Mental Health Navigator played a significant role in assisting me with accessing community members for the purpose of facilitating engagement in IPC Training (i.e. micro-level involvement). She not only assisted logistically with networking in and between communities, but took part directly in the research

process by attending an IPC Training. In an email to the Executive Director early on in the data collection period, I reflect on having the Navigator as part of the IPC Training:

> It was fantastic having [the Mental Health Navigator] there and I look forward to working with her moving forward. I'm thinking that we should set up regularly meetings, at your convenience, to ensure that we stay on the same page with the communities and their needs. (J. Jecker, email communication, September 13, 2017)

She became a new voice for the re-search, in combination with the many professional development trainings for which she was responsible. In the process of transitioning to the former responsibilities of the Coordinator, the Navigator identified both the challenges with juggling the research commitment, and her dedication to the project:

> I apologize for not getting back to you sooner! It has been a busy week and I was away yesterday. We do not have any dates locked in but I am working on some training opportunities for our current Spirit Builders that you may want to join in on – I can let you know once those are solidified. (Navigator, email communication, September 20, 2017)

Within a couple of weeks of transitioning to the research team, the Navigator was sending out emails to the communities as the former Coordinator had done:

> Hello [Communities],
>
> We are touching base with you regarding a Lakehead University research initiative focused on building team collaboration which is currently under way. In order to participate in this opportunity, training will need to be completed by February 2018. This training involves a 6hr session focused on role clarification, communication, conflict resolution, team building, community goal design, and collaborative leadership. Justine Jecker is a trained occupational therapist and researcher who has focused on collaboration for the past 5 years and is available for any questions you may have. (Navigator, email communication, October 10, 2017)

The importance of both the Coordinator and the Navigator roles in supporting the research and acting as a bridge to inform the Executive Director, cannot be understated. Without a shared sense of trust and bravery, re-search involving the IPC Training would not have been initiated. It was only after delivering the IPC Training in the communities, that I realized the extent of

bravery needed by these three individuals, to convince the communities that this re-search would be helpful and not harmful.

With Nokiiwin's support in the IPC Training and community action research overall, it was equally as important for participants to feel that interprofessional collaboration could improve access to culturally-appropriate healthcare services in the community setting. According to the Administrator, the dilemma in understanding the potential impact of the re-search was not necessarily for the teams being targeted, but rather for those community members who did not work in the band office:

> When I think of the big picture, such as accessing care or services for our community, I feel that there is an *us against them* mentality. For some reason, members are "us" and the Council/Staff are "them". *We are those people.*

This statement represents bravery and trust as there are very few circumstances where 'us' and 'them' can be talked about in a safe setting. This discussion is an example of what may not be explicitly talked about in small communities, but is inherently felt by those who live there. This expression had a profound influence on how the re-search team decided to address the dilemma of improving access to healthcare services for those living in First Nation communities. The 'us' and 'them' discussion acted as a reminder, that not all divisions are created between Indigenous and non-Indigenous ways of knowing.

Part of the process in talking about the impact of the IPC Training, was not to over-sell the benefits of the IPC Training, but rather to build on existing knowledge with regards to access in each of the communities. For example, the Coordinator expressed: "there are a lot of areas in the current system where people can fall through the cracks. It becomes especially difficult when we lose important community engagement personnel"; while the Administrator acknowledged: "at the band office, we are entirely reliant on each other [to enhance healthcare access]… Our

work partners can be more than our family, even when we are not amicably close". These examples demonstrate that trust can be as strong or as fragile as the system which supports it.

Overall and in relation to the IPC Training, the Coordinator and Educator identified that they felt that this could be one mechanism to improve access to culturally-appropriate services, especially if the community members took part in the training. The Coordinator expressed, "as far as collaboration improving access to care, I think it is extremely important, if not the most important thing. This gives a voice to a lot of people and different situations, to ensure this [access] is achieved in an all-encompassing way"; while the Educator felt that, "better access to resources could be achieved once the community begins working together in sync". For the Spirit-Builder, she saw the IPC training as an opportunity to improve access to care because it highlighted what providers are doing in the communities, as well as what other staff are doing at Nokiiwin. Perhaps most poignantly, the Spirit-Builder expressed: "After teams experience this training, it is evident that more options are available regarding access…It is through this training that people can learn to be vulnerable because their voices can be heard without judgement". These personal reflections on potential impact of the IPC Training, not only became a part of the narratives identified in this dissertation, but were statements that communities began to use as testimonials to promote the IPC Training within and between communities. In essence, by experiencing the IPC Training first hand, interprofessional teams used their experiences to promote the re-search to community members.

This theme demonstrated examples of where bravery and trust were needed in the pre-research and research phases of the study. These Grandfather Teachings, *to do what is right for self and others* and *to have the confidence to speak up*, were reflected throughout the re-search process – i.e. in the preparation and planning phase, in the recruitment phase, and in the

engagement phase of the IPC Training. Without fully knowing what the outcomes would be, research participants placed their trust in me, and other members of Nokiiwin, to guide the communities in the process of re-searching collaboration in relation to improving access to service.

Theme 2: Humility and Truth. In this theme of humility and truth, concepts relating to the reality of implementing the IPC Training, examining research supports, working on communication, engaging in collaboration, evaluating research involvement, and addressing re-search setbacks are discussed. As defined by Nokiiwin's Seven Grandfather Teachings (Nokiiwin Tribal Council, 2016), *humility* is represented in illustrations that speak to the need for a welcoming workplace, where we treat each other with respect, dignity, and equality; while *truth* is captured in ways where we are able to accept our differences and speak to one another in a good way.

For participants who engaged in the interprofessional collaboration training, it was both a humbling and an "eye-opening experience" [Administrator]. The Administrator noted in her narrative, that: "a constant re-education of our roles with the [community] members is needed; this helps to showcase our work and to build relationships". She explained that this is a practice that should be further encouraged every year at the Annual General Meeting; something that requires community members from all levels to talk about who they are and what they do. In the context of the IPC Training, role clarification supported participants to evaluate and describe roles, which the Administrator felt was a humbling exercise given that people have worked together for decades. Similarly, for the Coordinator, she felt that the IPC Training allowed her to: "be humble about what I bring to the table", when considering the complexity of interprofessional collaboration. Specifically, this experience required her to reflect, and "to sit

back and listen in order to appreciate what others had to say". For someone who is in a position of needing to know large amounts of information, to best help the communities navigate their way through the healthcare system, the Coordinator demonstrated that the IPC Training was a reminder of what she still needed to learn.

One of the first questions that was asked of interviewees was: *What is the meaning of interprofessional collaboration?* What was humbling for participants responding to this question was that they needed to craft a response that not only represented their views, but also the views of their communities. Despite hesitation initially with using the term interprofessional collaboration, interview participants shared common ideas of what this meant:

i. [IPC] is when thoughts and ideas come together for the betterment or improvement of a situation (Coordinator)

ii. [IPC] is coming together as a team, working together, sharing ideas, sharing practices, and sharing strategies (Educator)

iii. [IPC] is something that requires all facets of the community – council, leaders, members, administration – to come together and work towards a common goal (Councillor)

With these responses, I reflect back to Maya Chacaby's Nanabush story, where she called upon the loons to step up as their community leaders. For each of these participants, responses were expressed in a way that was respectful, and directed at making sure that their communities stay true their values and their culture. Following the defining of interprofessional collaboration, participants acknowledged that IPC Training is needed for all members of their communities, if they are move forward and accomplish community goals. The Coordinator in particular expressed disappointment for those [particular leaders] who have not been able to engage in the IPC Training, while the Councillor suggested that the IPC Training will have limited meaning if leaders are not involved. For the Educator, IPC was happening in her community, but she could

see that the value of the value of formal training was needed. The act of talking about and reflecting on interprofessional collaboration in each of the communities, and within Nokiiwin Tribal Council, was an incredibly humbling experience for those who took part.

As humility was experienced for those participating in the IPC Training, it was also experienced and challenged by the research committee and I who engaged in difficult communication practices on a regular basis. The feeling of being disconnected, led to assuming that people were not interested in the research: "Given that [a research team member] has not taken part in the IPC training, I am attributing our disconnect to that" (Field notes, September 18, 2017). In another field note written on November 30, 2017, I acknowledge: "Communication with the [research team] has been frustrating to say the least", in relation to not receiving responses to communications over the course of several months. Additionally, there were times when meetings would be cancelled at the last minute, or gatherings would take place without everyone present, despite a collective commitment to the IPC Training (i.e. "We have seen that there are events that overshadow planned trainings" {Spirit-builder}).

For the research team, concerns were noted when emails were not read in their entirety; and at times, not read at all. This led to assumptions about how the research project was unfolding, and who was responsible for engaging in specific tasks. For example, it was not uncommon to hear: *I have no idea what's going on*, or, *the meeting was not in my calendar so unfortunately, I cannot attend*. As re-search lead, there was a need to address instances of disconnect with humility, and assume responsibility for the purpose of strengthening the team. This was especially true when decisions involving which communities to visit and when, could justifiably be supported or refuted on any given day by various leadership. It became a common understanding, that decisions often depended upon who was at the table, as well the current

climate in the community (i.e. politically, meteorologically, socially) [Field notes, November 30, 2017]. These common understandings not only required humility towards the existing decision-making processes in place, but also a recognition of the truths that informed our successes and challenges.

Decisions to contact specific community members to request engagement in the IPC Training needed to be carefully considered to ensure leadership protocols had not been overstepped. These important decision-making processes made it challenging at times, to meet the needs of the communities. Decision-making relied strongly on the research team to be aware of: internal community conflicts taking place, issues regarding elections, the impact of community funding allocations at certain times throughout the year, and most importantly, respecting the existing decision-making processes that were in place between Nokiiwin and the communities. One of the research team members "continually informed me that she had done everything possible to keep the door open to the communities: inviting [communities] to be a part of the IPC Workshop when the environment supported it" (Field notes, December 2, 2017).

When the IPC Training was cancelled due to legitimate reasons on several occasions, this created a sense of disappointment (Field Notes, January 19, 2018; February 9, 2018; March 23, 2018), as much work had gone into recruiting communities both prior to and during the research period. Rather than letting tensions brew or evolve into conflict, we learned how to make do with what were given (i.e. time, space, participants):

> There is always something to work with…for example, this month has marked a new beginning in the Action Research project for a number of reasons….we now have more interested participants, even if we do not yet have dates yet booked [for the IPC training] (Field notes, January 12, 2018).

As a team, we became aware that certain communities would not have the opportunity to engage in the IPC Training due to: competing initiatives, limited time, and challenges with accessing the

communities. Part of truly engaging in community action research, was knowing when to take a step back for other initiatives which were equally beneficial (e.g. Elder story-telling via videography, the creation of a mental health application, development of skills inventory database). Additionally, I was personally challenged in these moments to begin to honour the daily successes with humility, rather than focus on what had yet to be accomplished. In an example of a field note written on January 26, 2017, I began to live this concept of humility when following up with a community who had received the IPC training four months prior: "It was a very productive day which strongly focused on role clarification, communication/conflict, and community-centred care". Rather than focusing on what we did not have (i.e. more communities involved in the IPC Training), I focused on what we did have (i.e. multiple visits to the same community who received the IPC Training).

In the process of recognizing and engaging in humility, our re-search committee began to uncover 'universal truths' about our processes, as well as the impact of the IPC Training. At Nokiiwin's Annual General Meeting in March 2017 (i.e. three quarters of the way through data collection), the research committee identified three truths: 1) that the re-search team remained committed to the success of the project regardless of which communities participated, 2) that engaging in re-search with a self-identified non-political organization such as Nokiiwin, did not remove politics from the re-search environment, and 3) research-related conflicts strengthened our ongoing work. It was important for our team to identify these re-search related truths, as we knew by the end of March 2017, that we would likely not have any more communities participate in the IPC Training during the REB research timelines. By recognizing these truths,

we were better able to work with people with differing agendas and personalities, to ensure that IPC Training could be provided in the post-research phase (Field Notes, April 13, 2018)[14].

Theme 3: Respect and Love. *Respect* or *act in a way you would expect to be treated by acknowledging individual opinions* (Nokiiwin Tribal Council, 2016), for one another and for the re-search, was experienced in the most unplanned and uncoordinated periods of time. Some of the most meaningful communication took place serendipitously at the Nokiiwin Tribal Council office or when catching a last-minute ride to one of the communities. It was the travel or being on the road that brought us together as teammates which allowed for many honest conversations to unfold, both personally and professionally. Despite all of the hardships, challenges, and important milestones that were experienced throughout the data collection period, a lot of positive verbal and written feedback was provided following each IPC Training session. This overwhelming support for what we were collectively trying to achieve, created opportunities for *love* or *walking together to find balance and take care of one another towards common goals,* as defined by the Seven Grandfather Teachings (Nokiiwin Tribal Council, 2016). Without knowing what could happen from one day to the next, there was a reliance on respect and love for each other that kept us on the right track.

In this study, participants spanned a variety of occupational backgrounds, some of which included: community developer, forestry technician, service management, social worker, administrator, Chief, councillor, educator, ECE teacher, educational assistant, secretary, mental health worker, psychology student, recreation worker, and wellness worker. What was unique in the assembly of individuals was that participants felt that they knew each other well before the

[14] NB: Currently in the post-research phase, we have had 50 participants take part in the IPC Training as of January 31st, 2019 with an expected 50 more participants to engage by the summer of 2019.

IPC Training. However, throughout the interviews and follow-up discussions that transformed the narratives, participants felt that IPC Training had brought participants' understanding of others to the next level:

i. I saw some very introverted and shy people share more than they would typically do; the shyness was being shed….Increased guidance from individual community members created a wealth of information for the larger group. (Coordinator)

ii. I wasn't expecting to make any new connections in the IPC Training. However, I found that everyone I knew was lighter and more engaging with one another during the IPC Training. I can see how when dedicating time to understand one's role, even with those whom I have great relationships, access to services can be improved. (Spirit-Builder)

These reflections support the notion of *love* or *walking together to find balance* because they represent that if we are not given the opportunity to come together in safe space, we may not have the opportunity to truly get to know and respect one another in new ways. Notably, the Councillor identified that physical presence is a paramount in demonstrating respect: "Physical presence is incredibly important to be seen and to belong. In the future, training needs to be made mandatory for everyone to ensure that we can all be on the same page". Through physical presence, the Councillor felt that accountability becomes transparent, symbolizing a form of respect that shows how we are interconnected in ways we may not appreciate.

Daily individual and community challenges identified by interviewees described the difficulties for some participants and communities to embrace IPC Training within the research timeframe. There was a sense from the research committee throughout the data collection period, that some communities did not 'get it' or respect the benefits that this training could have for community members (Field notes, March 17, 2019). For most communities, there was a dependence and expectation on leadership to drive the concept of interprofessional collaboration (i.e. top-down approach). This meant that even if community members had identified that they

wanted to participate in the IPC Training, either at the Action Research Orientation workshop or by contacting me directly, there were cultural protocols that needed to be followed in order for a community to commit to engage in the re-search. To examine an example from the narratives, the Coordinator acknowledged:

> … [that the] loss of an opportunity made it challenging for Nokiiwin workers to know what exactly was happening in the community – In the beginning, this explains why the project may have been viewed as 'siloed'.

Additionally, the existing social context in which the re-search took place did not readily support IPC on a community level. The Councillor identified that "there is a lack of respect towards collaborative goals; the focus is on individual goals", and while the Administrator expressed that "people always think the grass is greener on the other side, and that other First Nation communities are doing better that we are". Moreover, the Coordinator identified: "we have seen that there are events that overshadow planned trainings, such as a death in the community, or there can be resistance from different people who are resistant and fearful of change". What was important for the research committee and me to recognize as we examined the concept of respect, was that logistical considerations (e.g. staff turnover, personal communications, other professional development trainings, resistance from those fearful of change, or deaths in the communities) did impact the implementation of IPC Training; however, this should not be representative of how the IPC Training was viewed itself. An important consideration that supports this idea in the post-research phase, is that we have had an additional two communities including 50 people, take part in the IPC Training as of January 31st, 2019. Thus, this concept of respect has extended beyond the re-search period demonstrating its relational aspect that is, respect is something earned and experienced over time and in relation to the other Teachings.

The Teaching of Love is seen to be what we are collectively trying to achieve, and builds on all of the other Grandfather Teachings. For the re-search, the concept of *love* relates to the goal of interprofessional collaboration, as both concepts are seen at the centre of their models – at the core of The Seven Grandfather Teachings, and at the core of the National Interprofessional Health Collaborative Framework (CIHC, 2010). This teaching acknowledges that we are walking together to find balance and take care of one another toward common goals; in the case of the re-search, this would be accessing culturally-appropriate healthcare services. In this re-search there were varying views on what this meant. The Councillor believed that services were everywhere; "I think we have phenomenal services"; however, many community members were not familiar with their existence. It was an assumption of this study that healthcare services were available and affordable, which aligned well with the Councillor's narrative. The Councillor further explained that, "sometimes it is as simple as knowing what is available [that is culturally-acceptable]….to change how services are accessed". This belief in having phenomenal services locally, in conjunction with the goal to create a culturally-appropriate healthcare service repository (identified in the IPC Training), laid the foundation for creating the Community Resource Guide.

This concept of culturally-appropriate services in community was further supported by the Educator who identified that ample healthcare services are currently available in the school (e.g. counselling, speech-language pathology, occupational therapy). She explained that: "when it comes to access to services, I don't see services expanding any more at this point in time" (i.e. given the current abundance of services). Notably however, the Educator identified that there is no Ojibwe language teacher. The identification of what was not present, was as important as identifying what was, as this absent knowledge was identified in the Community Resource

Guide. The creation of this tool is not only a collective goal that has identified where services are located but has also attempted to demystify who can access what. In reflecting on the words of the Administrator, that "we are those people", the resource guide reflects culturally-acceptable services available to all community members; it is a resource that does not continue to promote an "us against them mentality".

Therefore, Love is best represented in the Community Resource Guide as it has created a transparent roadmap to local services that anyone in any of the communities can access. The knowledge has been translated into a mechanism that is accessible by anyone – Chief and Council, Band Administration, and Community Membership. There is no 'us' and 'them' in this resource guide, it is simply 'we', and look at the services 'we have access to'. The guide represents much more than a resource guide; it reflects the power of sharing knowledge at the community level with a common goal of making community members aware of the tools in their toolbox. It represents *individual points of view* (respect) and *working towards common goals* (love).

Theme 4: Wisdom. The theme of *wisdom* challenges us to *consider our words and how they can affect others*. By examining community interactions, reflective research practices, and traditional practices, this theme is focused on changing the narrative through what we have collectively learned about ourselves in this journey. In this study, there was an underlying assumption that most participants had a moderate to high-level of interprofessional competency. This was evident for two reasons: 1) given their responses on the AITCS survey instrument which indicated that participants felt they worked on effective interprofessional teams, and 2) their collective experiences facilitating access to healthcare services. Thus, it is important to acknowledge that there was an existing knowledge or understanding of interprofessional

collaboration. Even with those who considered themselves knowledgeable on the skills needed to collaborate, a reflection from the Coordinator highlights the fact that competency attainment is an ongoing work in progress:

> I would like to believe that I had a lot of these [interprofessional] skills already, especially given the background that I have in health and education. But, I really appreciated watching the other people evolve with this [training]; watching their thought processes, their minds open up, gaining a better understanding of themselves, and watching other people's strengths to see what they bring to the table.

For the Administrator, a strong satisfaction of already working on a high-functioning team was shared. Despite knowing fellow staff members very well due to familial ties, the Administrator felt that engaging in the role clarification exercises (i.e. the Talking Wall and True Colours) was very important in personally acknowledging and appreciating one other. This interviewee shared that from the learning, came the realization that one cannot take communication for granted:

> Following the collaboration workshop, I noticed that there were more opportunities for people to truly learn about one another. One of our members was called 'the traveler' because everyone thought that's all he did. The training gave him a voice and gave others a strong understanding of why he needs to travel so much for work…Practicing people skills and spending time with one another in a meaningful way was very important

For the Spirit-Builder, a fellow facilitator of professional development sessions, this competency training provided many insights. This interviewee learned about the importance of giving people the opportunity to talk and share in a safe space. She realized that it was in this safe space that opportunities for finding resolutions can be found:

> Since the training, I've made it a point in my own training to engage participants without fear of having them share their stories. I have learned that I cannot be afraid of the direction of the conversation and know that I need to let certain conversations be had. (Spirit-Builder)

Additionally, the Educator shared that it is important to have ongoing professional development days that are focused on bringing teams together: "having days like this needs to

happen more often. I can absolutely apply this learning to everyday life". This IPC Training, similar to other professional development trainings discussed in the literature review in Chapter 2, allowed space for knowledge to be shared, discussed, acquired, and internalized. It supported concepts from both healthcare knowledge management and Indigenous ways of knowing, as knowledge translation happened in the communities, in the places in which people work and live (i.e. on First Nation land). In their home environments, interviews reflected on the open discussions that took place during the IPC Trainings. For example, participants were at times shocked to be engaging with a leader or colleague in a manner in which they never had, during previous years of work. In the Councillor's experience, the presence of the Chief at the IPC Training was pivotal in bringing community members together:

> The training allowed for building team skills by understanding what everyone does and appreciating the level of their work [in the presence of the Chief]. The session also allowed for better respect of everyone in the room and to listen to one another's contributions; it was an opportunity to be friendly and build trust.

As a reflection on the overall wisdom shared in the narratives, there was consensus in that: "true and ongoing collaboration is an important piece to ensure that we get to where we want to and need to be" (Spirit-Builder). Some of the following reflections act as a driving force to address and overcome interprofessional collaboration training implementation challenges:

i. I do believe that relationships were strengthened, and the appreciation following the training for our individual skillsets was better. Overall, I feel that I became stronger with the community and on an individual basis. (Coordinator)

ii. What was really special was that all participants had the chance to experience the full day from beginning to end, completing many group tasks that were focused on strengthening relationships. (Administrator)

iii. Regardless of what the evaluations say about this training, I have heard voluntarily a lot of positive comments and feedback; this has been a major turning point for the community. The excitement voice by the two communities who have engaged, is creating positive energy at Nokiiwin and in other communities. (Spirit-Builder)

The long-term sustainability of incorporating IPC Training into Nokiiwin's First Nation communities is only possible if traditional day-to-day practices are recognized and acknowledged. For those not belonging to a First Nation, there may be limited understanding that those belonging to Chief and Council or Band Administration, "can never be band members" (Administrator). These 'members' are predominantly represented in their occupational role and may only feel like 'community members' during election time when their votes are cast in private (Administrator). Certain individuals are exceptional in their roles and focus on serving the community as a whole (e.g. working with multiple community member during the annual Aboriginal Day festivities) (Councillor & Administrator); however, very few people are aware of what others do for the community outside of their job title. Additionally, the Councillor identified:

> community members have varying ties to the community – some are more tied to the lake rather than familial ties – so focusing on finding a communal identity and engaging in cultural practices (e.g. language, land-based teachings) is very important. We need to work together to achieve the same goal and be on the same page. It is only then that services can be better accessed. (Councillor)

Varying ties to the communities, reflects different understandings of wisdom or how our knowledge impacts others. The Spirit-Builder and Administrator reminded us, that the IPC Training acts as a window to communication and provides a platform to begin discussions. The Training does not necessarily solve all community problems, but provides the tools and wisdom through relationship-building, to move forward as community.

By identifying collective goals through collective wisdom, communities worked on implementing additional community goals, involving policy development. In one community, it was identified that it was not uncommon for people to be walking in the mall in Thunder Bay and have numerous community members attempt to engage their representatives in work

discussions while they were on family time. A code of conduct was particularly needed to protect councilors and administration staff when they were off work time. The IPC Training led to policy development and implementation focused on appropriate communication practices both inside and outside of the office: "[the IPC Training] has strengthened our working relationships and has increased our appreciation and respect for one another" (Administrator). The creation of this policy inspired policy development in another community, focusing on how to address conflict in the workplace, after bullying was identified as a habitual issue that was not being addressed. These examples further demonstrate *the impact of considering our words and how they affect others*.

Personally, I have come full circle with the learning and wisdom acquired in this re-search journey, when I think back to the Journey to Wellness session led by Maya Chacaby at the beginning of the data collection period. It was following this presentation that four specific Calls to Action (TRC, 2015) were identified and included in the re-search. It was agreed upon by the research team, that by re-searching knowledge with and for First Nation communities, we could be one step closer to reconciliation between Indigenous and non-Indigenous peoples. This commitment to change and reconciliation did not come without hardship, as I experienced few moments of stability or predictability throughout the year. I learned that commitment to re-search meant: changing directions at a moment's notice and transforming plans into something else entirely.

Some of the following excerpts from field notes over the course of data collection capture this concept of change: "I will need to engage in a new strategy" (Field notes, September 20, 2017); "It is important to constantly reinvent ourselves if we are to be successful in achieving our goals" (Field notes, November 2, 2018); "I'm moving forward with whatever seems to be thrown

at me" (Field notes, December 3, 2018); "there have been substantial changes in a 5-day period" (Field notes, January 11, 2018); and "lately, I feel as though I am busy with a thousand things and yet I also feel, that nothing is moving forward" (February 7, 2018). It was in these emotional and changing times, that I grew stronger by reminding myself of how my words and actions were affecting others. Through these moments of learning, I feel a wisdom was generated in me that taught me to focus on the process; to know that the outcome will follow, and that re-search is not about a means to an end. Re-search is modestly and unassumingly about the means, about the process of relationship-building, about honouring two-ways of knowing, and about being true to ourselves.

Qualitative question. *What are the experiences of service providers after introducing interprofessional collaboration training for the purpose of improving healthcare access?*

Five service providers were interviewed: a coordinator, an educator, an administrator, a councillor, and a spirit-builder. Based on four interview questions, the narratives conveyed individual experiences following the IPC, also reflective of existing community collaboration processes. To summarize the narratives and themes generated, the following collective experiences or understandings were recognized. First, communities already have interprofessional skills and engage in collaborative practices, but often do not take time to discuss these skills, or appreciate that others are in different stages of working on these skills. The training was unique in that it provided an opportunity for people to get to know one another outside of the day-to-day work setting. Interviewees felt that the learning could be applied to any role (e.g. mother, worker, leader) in any setting (e.g. work, home, community).

Overall, participants recognized that it is important to allow others to take the lead, so that lessons can be learned from community members with alternative perspectives; those whose voices are not often heard. In this way, respect can be developed more deeply and trust can be built more strongly with all community members seen as equals. Collectively, participants expressed that professional development training, such as interprofessional collaboration training, is valued and desired more frequently with both care providers and community members at the same time. This is because space is needed for community members to focus on relationship-building across niches (i.e. band administration, Chief and Council, community membership). In the space created for this research, participants felt that collaboration training was able to unite interprofessional teams to identify specific solutions to increase access to culturally-appropriate healthcare and wellness services.

Mixed Method Action Research Findings

Community action research portrait. In Figure 19, each quadrant of the portrait represents one year of the re-search project. In 2015 - 2016 (Year 1), *seeing the vision* involved building relationships which were foundational in pre-research activities such as the needs assessment (Nokiiwin Tribal Council, 2016), and web-mapping process. In 2016 - 2017 (Year 2), *realizing the vision* involved community engagement through student placements, reviewing both Western and Indigenous scholarship, applying for funding, and reviewing local and national policies impacting Indigenous healthcare access. From an evidence-based perspective, the reviews of diverse bodies of literature, in conjunction with the needs assessment and web-mapping, laid the foundation for research to formally take place in the third year of the project. In 2017 - 2018 (Year 3), *figuring out the vision* involved participants engaging in the IPC Training, working on community action-oriented goals, collecting and analyzing data, and

reconnecting with participants on knowledge uncovered. In the final year, 2018 - 2019 (Year 4), *doing the vision* involved formally documenting achievements and disseminating results; training Nokiiwin staff to continue to deliver the IPC Training within communities; and moving towards publishing knowledge using a two-eyed seeing approach with community members.

The illustrative component of the portrait is represented in both the earth elements and the stages of life. The elements bring the portrait to life: tobacco in the east, sage in the south, cedar in the west, and sweetgrass in the north. The tobacco and sage represent the smudging that would take place before each major re-search gathering, while the cedar and sweetgrass were represented in the physical geography of each community that took part in the re-search. Metaphorically represented, the stages of change capture how I grew from Year 1 to Year 4, from naivety as an entry-level PhD student through to achieving some wisdom as a soon-to-be Doctor of Philosophy. Upon completing the portrait, a more detailed visual analysis was created to further speak to the *credibility* of the re-search.

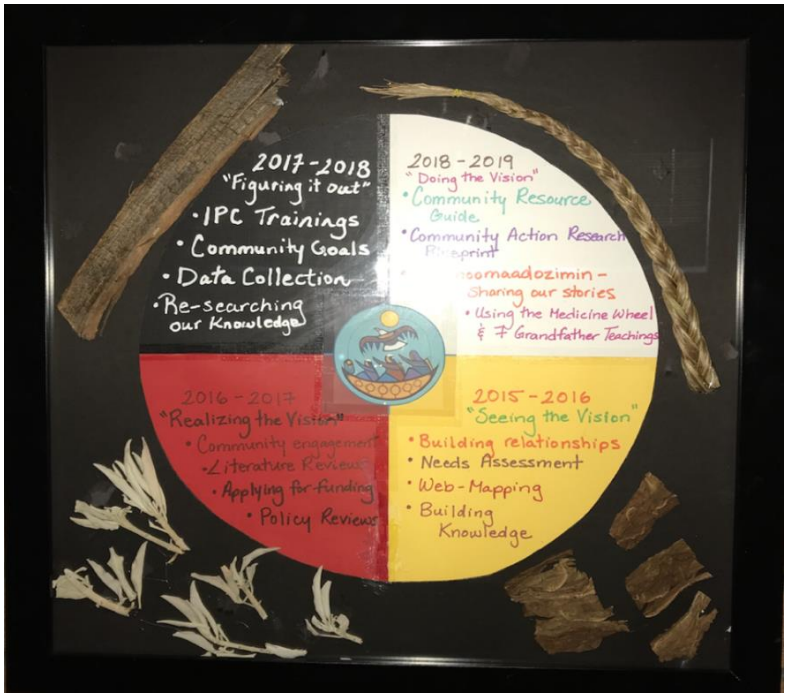


Figure 19: *Portrait of a Re-search Journey*

Community action research blueprint. To see a large-scale version of the community action research blueprint, go to: https://www.sencia.ca/download/blueprint_poster.pdf. It will make it easier to follow the rationale supporting the credibility of the re-search in the following section. Before getting into the content of the blueprint, its features will be described. Firstly, similar to the portrait, each year of the re-search study is represented by a switchback in the river, also reflecting the colours of the medicine wheel. Specifically, the yellow river flow represents the rising sun in the east and spiritual wellness needed to begin a re-search journey; the red river flow represents the southern heat and emotional wellness needed to build relationships; the black river flow represents the west and the physical wellness needed to travel to and engage with communities throughout the data collection period; and the white river flow represents the northern climate and mental wellness needed to translate the re-search journey into a dissertation.

I am represented in the canoe at four different points along the river, to metaphorically represent my growth in knowledge: from infancy, to childhood, to adulthood, to elder, over this four-year timeframe. Realistically, I still feel best represented in the third growth phase as an adult, as I am still learning on a daily basis about how this re-search study is impacting Nokiiwin's communities. On the base of the canoe are six circles, representing the six communities who were a part of the journey from the beginning. Bell's (2014) vision statements have been chosen as subtitles for each year, which were initially identified in the re-search portrait. If you look closely, each year is further broken down into four seasons represented by the following icons: leaf for fall, snowflake for winter, flower for spring, and sun for summer. Thus, sixteen seasonal changes are represented over the course of the blueprint, which ultimately reflect the major milestones of the community action re-search project.

Figure 20: *Community Action Research Blueprint*. (J. Jecker)

Community resource guide. As part of the IPC Training, community teams developed action-oriented goals for the purpose of increasing access to healthcare services. Three goals in particular were achieved: 1) policy creation targeting occupational health and safety (NB: these policies have not been included due to confidentiality reasons); 2) improved communications to ensure the consistent delivery of professional development trainings (i.e. Mental Health First Aid, Spirit-Builder Training, Lateral Violence Workshops, IPC Training, and monthly Community Gathering Circles); and 3) the development of a Community Resource Guide (CRG). The development of the CRG, which is a mixed methods action-oriented goal that was achieved with, and on behalf of, all community members, will be further discussed. This achievement speaks to the reach of this re-search, and answers the questions: Is it alive? Is it in current use? Can it be transmitted? (Simonds & Christopher, 2013).

Once the collective need to develop an online resource guide was identified, members from the six communities were invited to talk about the design of the resource guide. Even though only two communities took part in the quantitative and qualitative data collection processes, there was an agreed upon understanding by the communities and me that any overall or mixed method outcomes would or could be beneficial to all 5990 Nokiiwin Tribal Council members. Thus, at the start of the post re-search phase in the summer of 2018, six formal community gatherings were arranged between June and September (Appendix M), and visits were made by me and the research team to gather feedback on the development of the Community Resource Guide in each community. Research funding was used from Indigenous and Northern Affairs Canada to hire an assistant to input all of the recommended details. These community gatherings provided an additional opportunity for me to stay connected with communities and to further discuss re-search results.

All possible internal and external community healthcare services were reviewed with tens of hundreds of community members in individual and group discussions. The term 'wellness services' was decided upon as a reference to healthcare services, so that education, spirituality-related, and traditionally-focused services could be included. Even though the web-maps provided a basis of existing services, we soon realized that these maps were far from being representative of what the communities were offering. It became evident that traditional services of all kinds were being offered out of people's homes, of which very few people had knowledge. This was due to several reasons: 1) some people lived between multiple homes in and outside of the community and did not know about local services; 2) some people assumed that there were no services of a certain type available (e.g. traditional healing, translation, spiritual therapy); and 3) some people had limited trust or faith in healthcare or education services, and were therefore not interested in knowing about whether they were being delivered or not. These follow-up community gatherings allowed the research team the opportunity to uncover more about 'access', and why some people had little knowledge of what was potentially next door to them.

To summarize a year's worth of feedback, the communities felt strongly that four essential features needed to be incorporated in the Community Resource Guide (CRG): 1) there needed to be more visuals than words; 2) health services needed to be represented in the medicine wheel's four descriptions of well-being: emotional, physical, spiritual, and mental; 3) there needed to be only three 'clicks' to access a phone number; and 4) there needed to be minimal writing and it should be comprehensible at an elementary school level. Using INAC funding dedicated to the re-search study, a local tech company was hired to create the guide based on this and other community feedback. The technology company was informed that ongoing adjustments and negotiations would take months in order achieve the optimal

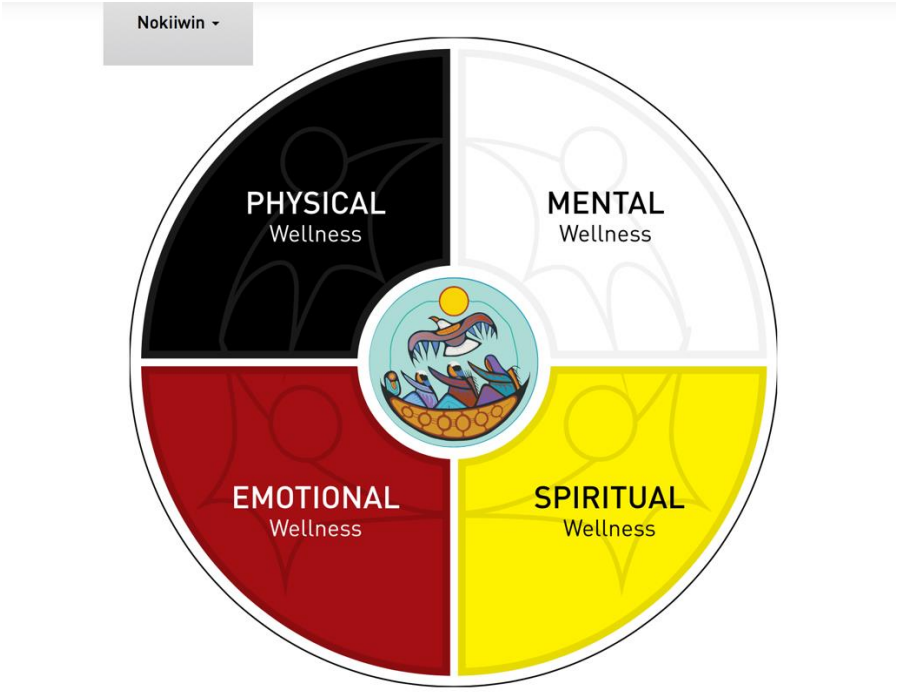
Community Resource Guide; therefore, weekly meetings were required to ensure that all feedback could be incorporated. From the day the CRG was first conceptualized in October 2017, it took one year to launch the web link.

A breakdown of how to use the guide is as follows:

> Step 1: Go to website (http://www.nokiiwin.com/crg) and identify from which **community** you are looking to obtain services. Each community is represented in yellow; Nokiiwin Tribal Council is represented in red and lists all services.

Figure 21: *Community Resource Guide – First Webpage*

Step 2: Identify which **area of service provision** (physical, mental, emotional, spiritual) is needed based on the four types of wellness highlighted in the medicine wheel. Descriptions below provide a more detailed account of which services are housed within each quadrant.



Physical Wellness

These resources focus on rehabilitation services, holistic wellness, walk-in clinics, victim services, family health teams, telehealth, emergency health services, diabetic foot care, medical device loans, public health units, hospitals, therapy services, dental programs, crisis response, NIHB services, assisted living, family care/support services, pharmacy, brain injury services, cancer services, disabilities services, pain management programs, wheelchair recycling, optometry services, renal services, spinal cord injury services, stroke clinics, lung associations, and hearing and vision programs.

Mental Wellness

These resources focus on holistic care, traditional and non-traditional counselling services, mental health services, family services, victim crisis services, healing lodges, addictions support groups, addictions treatment services, mental health hotlines, health benefits coverage, emergency services, women's services, police services, clinic services, legal services, community health services, telehealth, First Nation organizations, psychiatric services, and pharmacy locations.

Emotional Wellness

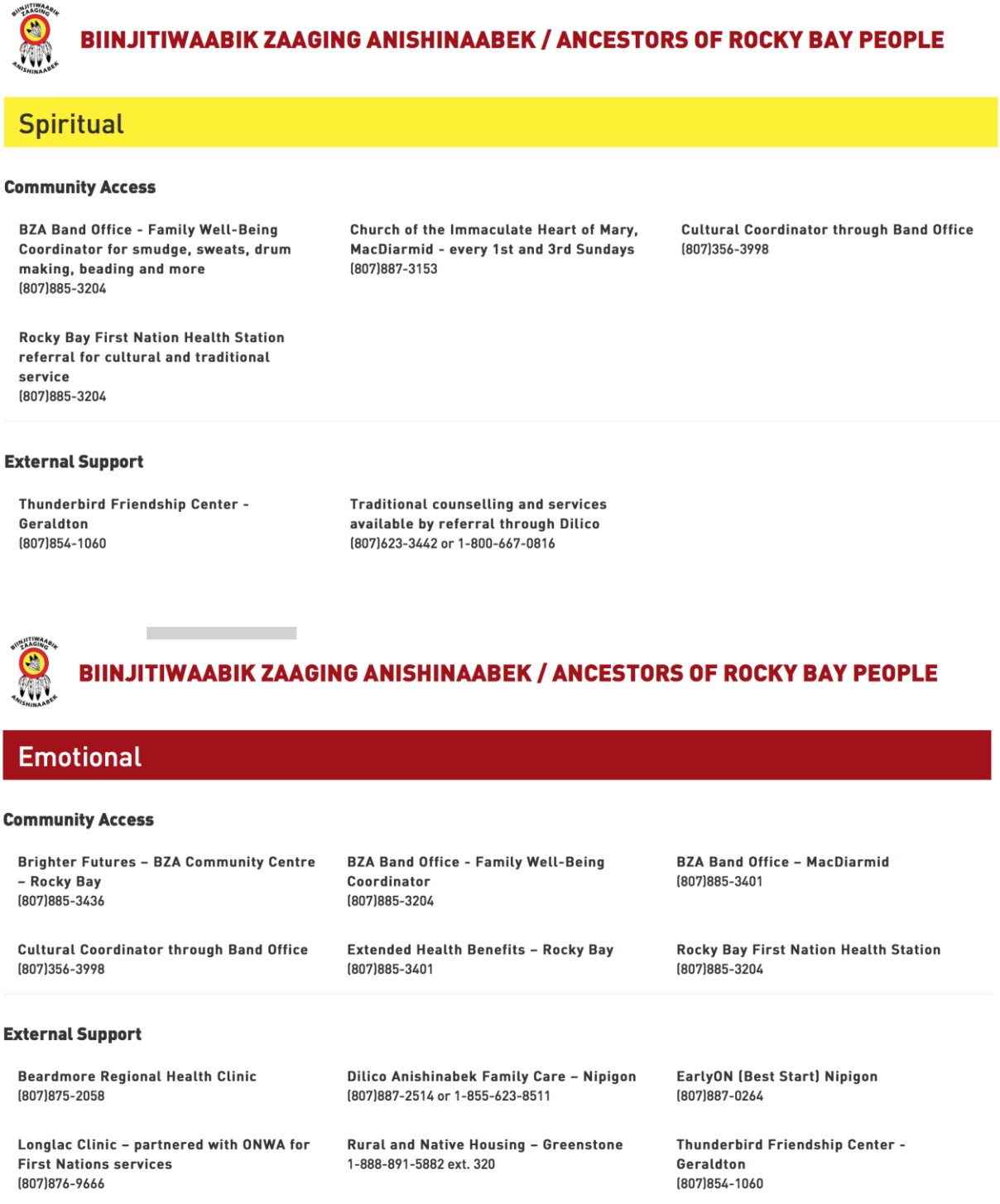
These resources focus on family care, holistic care, violence prevention, legal services, advocacy, education services, children's services, food banks/services, housing, community development, public health, recreation services, justice services, assisted living services, palliative care services, government support services, First Nation organizations, transport services, health organizations, shelter services, and respite care.

Spiritual Wellness

These resources focus on spiritual, traditional, religious, cultural, counselling and land-based practices. They can be accessed to address existing spiritual challenges or to engage in spiritual practices.

Figure 22: *Community Resource Guide – Second Webpage*

Step 3: Select **service**, either within the community (i.e. community access) or outside of the community (i.e. external support) and click on the hyper-linked phone number.



BIINJITIWAABIK ZAAGING ANISHINAABEK / ANCESTORS OF ROCKY BAY PEOPLE

Spiritual

Community Access

BZA Band Office - Family Well-Being Coordinator for smudge, sweats, drum making, beading and more
(807)885-3204

Church of the Immaculate Heart of Mary, MacDiarmid - every 1st and 3rd Sundays
(807)887-3153

Cultural Coordinator through Band Office
(807)356-3998

Rocky Bay First Nation Health Station referral for cultural and traditional service
(807)885-3204

External Support

Thunderbird Friendship Center - Geraldton
(807)854-1060

Traditional counselling and services available by referral through Dilico
(807)623-3442 or 1-800-667-0816

BIINJITIWAABIK ZAAGING ANISHINAABEK / ANCESTORS OF ROCKY BAY PEOPLE

Emotional

Community Access

Brighter Futures – BZA Community Centre – Rocky Bay
(807)885-3436

BZA Band Office - Family Well-Being Coordinator
(807)885-3204

BZA Band Office – MacDiarmid
(807)885-3401

Cultural Coordinator through Band Office
(807)356-3998

Extended Health Benefits – Rocky Bay
(807)885-3401

Rocky Bay First Nation Health Station
(807)885-3204

External Support

Beardmore Regional Health Clinic
(807)875-2058

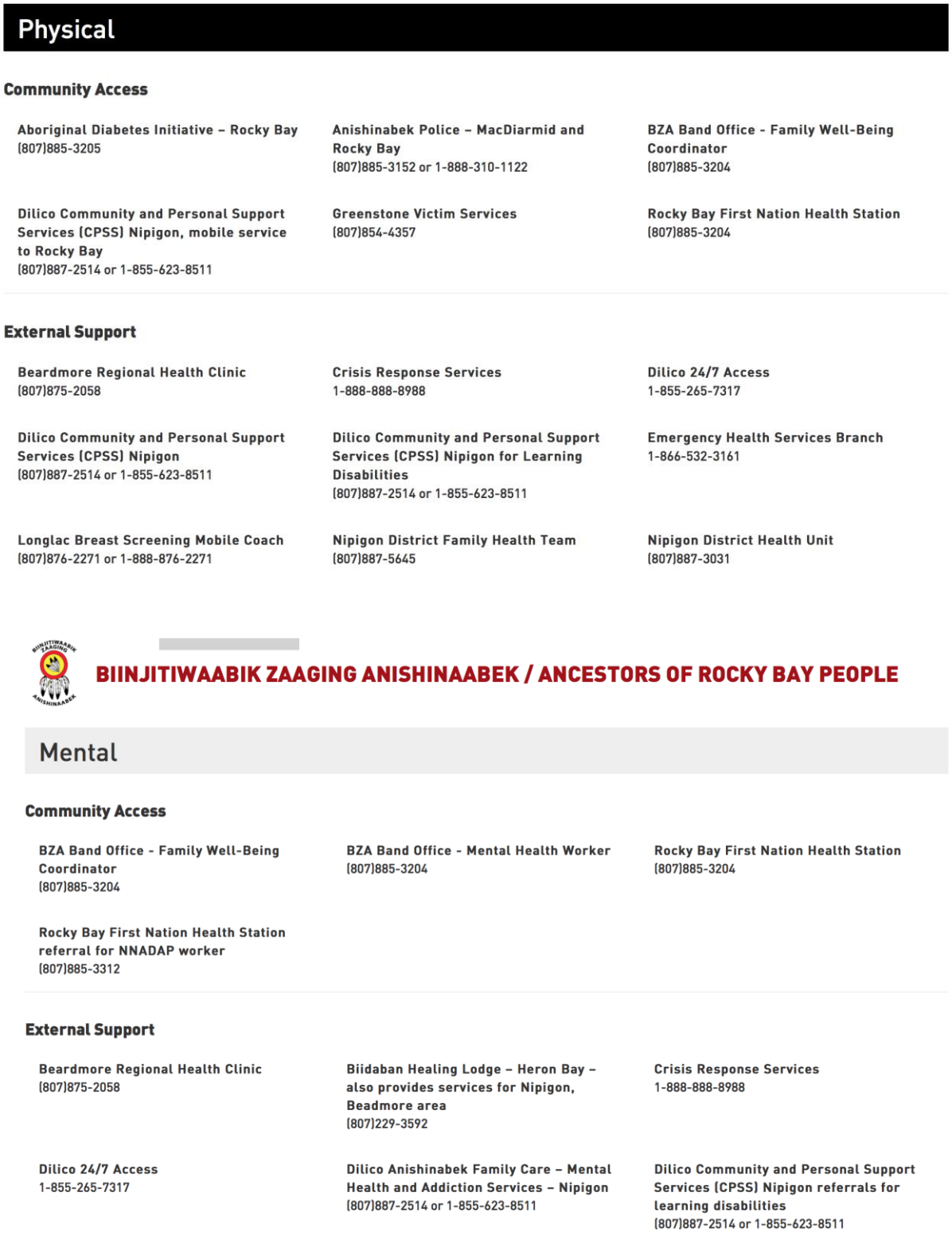
Dilico Anishinabek Family Care – Nipigon
(807)887-2514 or 1-855-623-8511

EarlyON (Best Start) Nipigon
(807)887-0264

Longlac Clinic – partnered with ONWA for First Nations services
(807)876-9666

Rural and Native Housing – Greenstone
1-888-891-5882 ext. 320

Thunderbird Friendship Center - Geraldton
(807)854-1060



Physical

Community Access

Aboriginal Diabetes Initiative – Rocky Bay
(807)885-3205

Anishinabek Police – MacDiarmid and Rocky Bay
(807)885-3152 or 1-888-310-1122

BZA Band Office - Family Well-Being Coordinator
(807)885-3204

Dilico Community and Personal Support Services (CPSS) Nipigon, mobile service to Rocky Bay
(807)887-2514 or 1-855-623-8511

Greenstone Victim Services
(807)854-4357

Rocky Bay First Nation Health Station
(807)885-3204

External Support

Beardmore Regional Health Clinic
(807)875-2058

Crisis Response Services
1-888-888-8988

Dilico 24/7 Access
1-855-265-7317

Dilico Community and Personal Support Services (CPSS) Nipigon
(807)887-2514 or 1-855-623-8511

Dilico Community and Personal Support Services (CPSS) Nipigon for Learning Disabilities
(807)887-2514 or 1-855-623-8511

Emergency Health Services Branch
1-866-532-3161

Longlac Breast Screening Mobile Coach
(807)876-2271 or 1-888-876-2271

Nipigon District Family Health Team
(807)887-5645

Nipigon District Health Unit
(807)887-3031

BIINJITIWAABIK ZAAGING ANISHINAABEK / ANCESTORS OF ROCKY BAY PEOPLE

Mental

Community Access

BZA Band Office - Family Well-Being Coordinator
(807)885-3204

BZA Band Office - Mental Health Worker
(807)885-3204

Rocky Bay First Nation Health Station
(807)885-3204

Rocky Bay First Nation Health Station referral for NNADAP worker
(807)885-3312

External Support

Beardmore Regional Health Clinic
(807)875-2058

Biidaban Healing Lodge – Heron Bay – also provides services for Nipigon, Beadmore area
(807)229-3592

Crisis Response Services
1-888-888-8988

Dilico 24/7 Access
1-855-265-7317

Dilico Anishinabek Family Care – Mental Health and Addiction Services – Nipigon
(807)887-2514 or 1-855-623-8511

Dilico Community and Personal Support Services (CPSS) Nipigon referrals for learning disabilities
(807)887-2514 or 1-855-623-8511

Figure 23: *Community Resource Guide – Third Webpage*

Mixed question.

As a result of the IPC Training, can improved access to healthcare services be achieved for Nokiiwin Tribal Council?

Initially yes, but further evaluation on 'access' leading to increased service provision is needed. McIntyre, Thiede, and Birch's (2009) access framework was used to identify the re-search problem and to define the term 'access' in the context of this re-search study. In order to avoid being overwhelmed with this term, we accepted the notion that available and affordable healthcare is being provided in northern Ontario, despite what the reality may be. Instead, we focused on the idea of 'acceptable' access corresponding with the term 'culturally-appropriate' access. This is because, at the root causes of ensuring acceptable access, lies the issues of power relations, training, and professionalism. With this as a foundation, the IPC Training was offered to address these root causes.

Prior to this training, there was limited knowledge on services available to Nokiiwin's rural and remote communities both by service providers and users. The two communities who participated in this re-search study, identified the need to create this guide as a first-step solution to identifying where and what the services are that can be accessed both within and outside of their communities. The term 'healthcare' was extended in this study to include the idea of 'wellness', which now refers to any service benefiting the community. This means in theory, that all resources in the community could be identified in the CRG. In its current form, the CRG's entire purpose is to increase recognition of, and access to, healthcare services for the six First Nation member communities affiliated with Nokiiwin. By involving the communities in the identification of local services during the creation of the CRG, we were able to pinpoint culturally-acceptable healthcare services locally.

Particularly in this re-search, we have been able to link community members to: healers, elders, spiritual guidance counsellors, translators, language teachers, healthcare providers funded by both the provincial and federal governments, and policy-makers, to name a few. The list of available services is changing on a daily basis, as Nokiiwin receives feedback from communities on which services they would like to see added. From a clinical utility perspective, the website is compatible with all cell phones so that information can be accessed in seconds. Phone numbers are intentionally hyperlinked so that providers can be accessed in a three-click sequence, as per the communities' request. For those who travel beyond internet reception areas, all resources can be downloaded into a PDF and saved on either a phone or computer to be used in remote locations. This was particularly important for communities who are considered to be off grid.

With this said, there are two additional measures that Nokiiwin Tribal Council is currently putting in place in the post-research phase to further evaluate the impact of 'access'. Foremost, one of Nokiiwin's staff is working to implement a metric-system to track: 1) how many people access the website daily, 2) which wellness quadrants are specifically being tapped into (i.e. spiritual, emotional, physical, and mental well-being), and 3) which wellness services are specifically being accessed through the phone number hyperlinks, attached to the website and the web application. Secondly, Dr. Brian Dunn, is continuing to work with the communities indefinitely at this point, to increase the utility and presence of the CRG [NB: Dr. Dunn has been hired on as the Wellness Coordinator to replace the former Disabilities Coordinator based on his contributions to this re-search project]. Moreover, Dr. Dunn will be evaluating how the metric-system leads to better service provision overall. That is, is a phone call to the appropriate care provider sufficient to increase access to appropriate healthcare services? There are many opportunities that lay ahead to further support the answer to this question.

Chapter 6: Discussion and New Directions – Truth and Reconciliation

Figure 24: *Calls to Action: 18, 19, 22, 23.* (Wheeler & Daniels, 2016)

In this Chapter, we reflect on coming full circle through the Seven Grandfather Teachings and Medicine Wheel Teachings that helped us to make sense of the findings in this re-search study. It is through the lens of the two-eyed seeing approach, that we begin to discuss what this re-search project means reflecting on the knowledges that were shared, created, and rediscovered. Particularly, this chapter will summarize our accomplishments and put them into the context of four Calls to Action identified in the Truth and Reconciliation Commission of Canada (2015). We will revisit the concept of knowledge decolonization and how interprofessional collaboration training has created new opportunities for knowledge generation in First Nation communities. We will also summarize how this re-search study has led to the beginning of improving access to healthcare services, because we now know which services are in existence. Finally, research limitations and recommendations will be presented to future research teams, so that they may learn from our knowledge, and can continue the process of finding truth and engaging in community reconciliation.

Discussion

It was expected that by improving interprofessional collaboration for healthcare providers servicing northwestern Ontario First Nation communities, that issues regarding culturally-acceptable access to healthcare would be mitigated (CIHC, 2010; Frenk et al., 2010; HealthForceOntario, 2007; WHO, 2010). This study went beyond the scope of improving collaboration only for healthcare providers; it included any community member contributing to the health and well-being of the community, which essentially included anyone. Positive changes due to the IPC Training were anticipated (Adams et al., 2014; Bain et al., 2014; Baker & Fowler Durham, 2013; Treadwell et al., 2015), and positive changes resulted. Participants identified having developed their interprofessional skills as a result of the training (i.e. role clarification,

conflict resolution, team functioning, interprofessional communication, community-centred care, and collaborative leadership). Moreover, narratives identified additional qualities that were developed, including: respect, shared decision-making, and accountability.

Re-search expectations identified in the Nokiiwin Tribal Council needs assessment (2016), were also attempted in this study: 1) that an interprofessional approach could enhance access to healthcare services, 2) that this study could extend the concept of health and wellness beyond the individual to include the community, and 3) that cultural competence could be considered in the delivery of interprofessional collaboration training. These expectations were founded on the recommendations of others (Health Canada, 2005, 2015; Lavoie & Gervais, 2012; Minore & Boone, 2002; Minore et al., 2004; Purden, 2005; Rukholm, Carter & Newton-Mathur, 2009). It is because of the research team and the community-chosen re-search methods, that we were able to ensure these expectations became a reality. We can now say that this study has strengthened Nokiiwin Tribal Council's local capacity and its endeavour to improve access to services, as we have helped empower communities with their own knowledge.

Four main deliverables resulted from this community action research project: the Community Resource Guide, the Community Action Research Blueprint, the portraits of the re-search journey, and knowledge creation (i.e. narratives, policy resources, and this dissertation). Each of these deliverables has a specific and intended purpose benefitting those involved, and even those not involved, in the re-search. Lavoie and Gervais (2012) recommended that we build on the ideas of the community knowing that they are the constant; and so, we worked within existing system limitations to realize the following deliverables.

Deliverables. The online Community Resource Guide (http://www.nokiiwin.com/crg) is meant for the community members belonging to the First Nation communities of Nokiiwin Tribal Council. In the post-research phase, we have seen the interest in this guide go beyond the Robinson-Superior Treaty Territory, and expand into Nishnawbe Aski Nation through Wesway health and respite services, northwest of Thunder Bay (K. Maki, personal communication, December 6, 2018). This resource may be new for Nokiiwin Tribal Council and others interested in its contents; however, its substance represents the collective knowledge of many community members interested in ensuring acceptable access (McIntyre et al., 2009) to services within and around their communities. This knowledge of where and how service providers can be contacted was not new on its own, but when brought together by the community for the community in the shape of the CRG, represents Wilson's (2008) concept of engaging in re-search and rediscovery. This culmination of knowledge, representing Indigenous and non-Indigenous services, evolved out of the community action-oriented goals that were identified in the IPC Training interventions for two communities.

The Community Action Research Blueprint was primarily intended for Nokiiwin Tribal Council, to assist in developing a research framework within the organization post-research. Incidentally, this blueprint also provides an example for the academic and scientific community, of systematic and rigorous community action research project that was completed at a doctoral level [NB: it should not go without saying that the contributions of the INAC grant, as well as my position as an educator were contributing factors to its success]. In the sequence of re-search events, this blueprint was created directly as a result of the re-search portrait. It was after creating the portrait that I realized a blueprint was needed to go beyond the confines of this dissertation, so that other researchers could benefit from its procedural knowledge. Today, this complex re-

search may now be understood by a larger audience who does not have time to read a 250-word dissertation. On reflection, I believe this blueprint was also created as a result of countless emails to my PhD committee, who avidly attempted to follow the complex processes that unfolded over a four-year period. With committee members changing mid-way through my PhD journey, it became necessary to convey large amounts of knowledge in a meaningful a condensed manner. What I am most proud of with this work, is that this blueprint honours both Indigenous and non-Indigenous ways of knowing; it combines both literal and metaphorical concepts of knowledge and how it was applied in relation to the environment and its changing seasons.

Two portraits of the re-search journey were created; one created by me and my understanding of the re-search process, and the other by local artist Kevin Belmore, *A Gathering of Wellness Portrait* (Appendix N). Kevin's original work—*G'minoomaadozimin vision* as the basis of Chapter 4*,* laid the foundation for the re-search design and inspired the incorporation of the medicine wheel into mixed method findings in Chapter 5. For me, my portrait will always be a reminder of what was experienced in this study, through the snapshot of a four-year journey. The experience alone of creating the portrait brought me back to my early days of elementary school, when we best learn to express ourselves through the use of paper and scissors, and glue and markers. There was something very powerful about this experience as it forced me to use skills that I had not used in quite some time, to make sense of my current reality. For those working at Nokiiwin's head office, *A Gathering of Wellness Portrait* will act as a reminder of: 1) value of community-focused action research, and 2) what communities can do when they come to together with a shared purpose. In fact, fifty years down the road, this portrait may be the only remaining evidence that this re-search project took place. For me this is bold reminder,

that Indigenous ways of knowing have and do outlive non-Indigenous ways of knowing in many circumstances.

Knowledge creation may be the most rewarding deliverable for those who intimately took part in the re-search process. Firstly, the translation of the narratives into Ojibwe has created a whole new understanding of what this re-search means locally. Through the power of language, we have created two ways of knowing and understanding the same concept, interprofessional collaboration. These works can now be used by anyone wanting to learn Ojibwe as a resource, and will also share the prevailing understanding of collaboration during this re-search timeframe. Secondly, the occupational health and safety policies that were designed in the re-search timeframe but not included in this dissertation, are currently being enacted. The creation of these documents has created safe spaces for people not to feel bullied, and to avoid unnecessary miscommunications in the workplace. Finally, components of this dissertation will be used for future publication which is valuable to me and those choosing to engage in the publication process. We have a big story to tell, and many possibilities in which to transmit this knowledge.

Phase 5: Answering TRC's Calls to Action & Literature Contributions

For Nokiiwin, uncovering the truth and reconciling with Indigenous peoples of Canada is a process that non-Anishinaabek are responsible for while Anishinaabek people are responsible for regaining their culture and land-based practices (Maya Chacaby, personal communication, November 6, 2017). On behalf of Nokiiwin Tribal Council, Maya challenged its six First Nation member communities, and non-Anishinaabek affiliates to directly address the Truth and Reconciliation Commission of Canada report (2015) by giving back community bundles, inclusive of knowledge, to the First Nation communities. As a non-Anishnabek person, I heard the call loud and clear, and felt that it was my responsibility to incorporate Calls to Action (TRC,

2015) that would authentically attempt to enact a decolonizing approach to the re-search purpose in this study.

The following four Calls to Action were included: No. 18 – the need to acknowledge that previous health policy is responsible for the current state of Indigenous health and to implement Indigenous healthcare rights under law; No. 19 – the need to publish reports identifying the availability of appropriate health services; No. 22 – the need to recognize and support the value of Indigenous medical practices with healers and elders; and No. 23 – the need to provide culturally-appropriate competency training for healthcare professionals. These Calls to Action were simplified using language that would be meaningful to the research team, given that the original language in the TRC (2015) speaks to the federal, provincial, and territorial governments as well as the healthcare system in general. The following sub-sections will specifically examine how these calls were met with action.

No. 18 - acknowledge previous policy's role in the current state of Indigenous health. The first three chapters of this dissertation demonstrate evidence derived from multiple literature reviews which speak to historical events that directly led to the current state of Indigenous Health. Prior to Canada becoming a nation, the Gradual Civilizations Act of 1857 laid the foundation of how Indigenous peoples were forced to transform their ways of living and being. The Indian Act of 1867 followed by the federal government's acknowledgment of the Indian Problem in 1887, created the blueprint and supported infrastructure to remove human rights, practices, culture, language, and ultimately, family, health, and well-being from status and non-status Indians, for the purpose of extermination. These policies unfolded uninterrupted, for over a hundred years, until the generation of the Hawthorne Report (1967), which specifically identified the Indian Act's impact on the marginalization and mistreatment of Indigenous peoples across

Canada. No matter, in 1969, publication of the White Paper called for the ongoing assimilation practices and stronger implementation of the Indian Act than previously enacted.

Over two decades would pass before Canadians would begin to see new policy and new government documents which opposed previous oppressive policies: the (1991) Royal Commission on Aboriginal Peoples and the (1994) Aboriginal Health and Wellness Strategy. Still, it would take another two decades before the following policies would be taken seriously outside of predominantly First Nation or Indigenous contexts: the (2015) Report from the Auditor General of Canada, and the (2015) Truth and Reconciliation Commission of Canada report. In this decade, there are numerous publications that recognize the role of previous policy and its impact on Indigenous Health (e.g. Allan & Smylie, 2015; Bourassa & Peach, 2009; Daschuk, 2013; Kulig & Williams, 2012; Maar et al., 2009; Purden, 2005; Smith, 2012), and it was therefore an important part of this re-search, to formally acknowledge how previous policy led to the 're-search problem' and subsequent 're-search purpose' focused on how to increase access to healthcare services through interprofessional collaboration.

No. 19 – publish reports identifying the availability of appropriate health services. Identifying availability of appropriate health services began four years ago at the outset of this community action research project. After completing a needs assessment on available and appropriate health services within the Nokiiwin communities (Nokiiwin Tribal Council, 2016), we began a process of web-mapping which acted as a tool to tell us 'who' was available 'where' and 'what' services were being provided throughout the year. It was through McIntyre, Thiede, and Birch's (2009) Access Model that we were able to fundamentally recognize that access is more than availability and affordability. Appropriate access to services also requires acceptability of services; in other words, culturally-appropriate service provision.

Through the establishment of community goals in the research project, it was decided that the web-maps needed to be converted into an online community resource guide inclusive of all services deemed necessary by Nokiiwin Tribal Council community members. The guide took about one year to design, as it required the input of hundreds of community members. It is now available online at: http://www.nokiiwin.com/crg. The creation of this resource guide has been published in Nokiiwin Tribal Council newsletters and AGM reports, and in funding reports to Indigenous and Northern Affairs Canada. Following the acceptance of this dissertation, there will be further opportunities to publish about the Community Resource Guide in peer-reviewed journal articles and potentially in a book.

No. 22 – support the value of Indigenous health practices with healers and Elders.

The value of Indigenous medicine and working with Elders was experienced throughout the re-search. This occurred during engagement of pre-research activities, development of re-search findings, the development of the Community Resource Guide, and the design of the Community Action Research Blueprint. Notably, Elder Tony (Lazar) DePerry guided this re-search from the very beginning, encouraging our team to focus on incorporating a two-eyed seeing approach (Bartlett, Marshall, & Marshall, 2012; Martin, 2012) when working with First Nation communities. This guidance had a profound impact on the way that 'healthcare teams' came to be understood within the communities. Prior to truly recognizing the two-eyed seeing approach, healthcare teams were considered eligible for research, using a relatively Western lens of what constituted a healthcare provider: nursing, medicine, physiotherapy, social work, etc. (Purden, 2005). After meeting with the Elders and Chiefs of the communities, our definition of healthcare team expanded to include anyone in the community contributing to health and well-being (e.g. educators, administrators, councillors, spirit-builders, coordinators, parents, grandparents). This

experience confirms Purden's (2005) findings that the definition of a 'healthcare team' in Indigenous settings is much broader, and includes individuals focused on both health and wellness.

As part of Indigenous health practice, numerous Indigenous models were recognized in this project. Firstly, Dr. Lana Ray's (2016) Tree of Research Ethics for Indigenous Education (TREIE) created the metaphorical and literal boundaries in which the re-search took place. Moreover, the student research model focusing on Indigenous healthcare access (Radassao et al., 2017) was used to better understand the results of the needs assessment (Nokiiwin Tribal Council, 2016) as well as current practices impacting healthcare access at Nokiiwin Tribal Council. Perhaps most importantly, the Seven Grandfather Teachings were used to help us understand the qualitative findings in a way that makes sense for those for whom the re-search is intended. With regards to specific health practices, the research team did learn that there are an array of individuals and services within each First Nation that need to be recognized. The resource guide has given these people a voice, and is therefore supporting the value of Indigenous health practices.

No. 23 – provide culturally-appropriate competency training for health providers. The literature review in Chapter 2 demonstrated that it would be inadequate to discuss interprofessional collaboration training, without focusing on culturally-competent practice (Fisher et al., 2015; Hooper et al., 2007; Maar et al., 2009; Oelke et al., 2013; Purden, 2005; Rukhom et al., 2009; Salvatori et al., 2007; Truong et al., 2014). In this dissertation, cultural competency has referred specifically to understanding and incorporating Indigenous ways of knowing (e.g. cultural beliefs, values, religions) into the IPC Training activities. Specifically, cultural competency was considered in conjunction with the research committee, in the teaching

of: role clarification, interprofessional collaboration, team functioning, and conflict resolution. This process was critical as non-Indigenous service providers are represented in all of Nokiiwin's communities.

During the Talking Wall exercise focusing on role clarification, we talked about the different professions that exist within First Nation communities and how many of these leadership positions are either funded annually by the government, or are elected positions through Chief and Council. Understanding how people are employed, was an important part of understanding job security and allowed for appreciation of why people do their jobs in a certain way (e.g. why the 'traveler' is always traveling). These frank discussions allowed teams to build trust amongst one another at the very beginning of the training, thereby creating a culturally safe space to better understand one another. Additionally, we discussed roles that are typically not seen outside of First Nation communities (e.g. band administration, forestry and mining roles, Chief and council roles, spirit-builders, elders). This discussion allowed for acknowledgment of cultural diversity in Indigenous communities, as the titles of leaders in First Nations look quite different than those found at a regional hospital. In these activities, a shared cultural understanding was needed by both Indigenous and non-Indigenous participants, which echoed the findings of Truong et al. (2013).

The case study created for the interprofessional communication competency was revised from its original version to allow for a culturally reflective case-based scenario. The revised vignette included 43-year-old Jasmine who lives in a rural First Nation community, experiencing chronic pain in conjunction with an opioid addiction. In order to make this vignette culturally appropriate, Jasmine's family history was adjusted to reflect multiple family generations and community members involved in her care, as this would be the case in one of Nokiiwin's

communities. Specific changes included: addition of a family wellness worker, English as a second language, her role as a grandmother supporting the entire family, and attending traditional circles to support her spirituality. These adjustments allowed participants to engage in meaningful conversations surrounding how they could help someone like Jasmine in their current role, using a variety of communication techniques. If this vignette had remained unchanged, it would not have been a culturally-appropriate tool to use for the purpose of increasing interprofessional communication. Participants would not have been able to relate to Jasmine's worldview, which was originally reflective of a privileged White woman unable to cope with pain. They would have read a vignette about a settler who does not know the impact of colonization, who has had the full support of the healthcare system throughout her life, and whose biggest challenge is an addiction that she can afford to fuel. The decision to revise this vignette is an example in this study of how the intervention itself supported a culturally-competent and decolonizing approach.

Teaching of the team functioning and conflict resolution competencies were delivered in tandem, due to the interconnected nature of these competencies. A unique cultural consideration that arose from engaging in the Marshmallow Challenge and conflict resolution discussions, was that health and wellness teams in First Nation communities are almost always comprised of family members either related by blood or through marriage. This means that it is almost impossible to take a sick day or leave of absence without everyone on the team being aware of the reason. Many participants acknowledged that there were very few boundaries between conflict at home and conflict at work, and that lateral violence amongst First Nation families and communities is prevalent. This familial connection to the workplace/community, therefore adds another degree of complexity. Thus, the IPC Training was able to assist participants in

highlighting precipitating factors of conflict that are typically not experienced by non-Indigenous wellness or healthcare teams. This revelation adds to our understanding of IPC Training with First Nation communities.

Additionally, this exercise gave participants the opportunity to generate solutions (e.g. policy generation) that could be applied in both the home and work environment. For example, in one community, bullying which was also referred to as lateral violence, was evident throughout the community and school setting. Examples were provided between parents and educators, and between community members and the healthcare team. Given that these issues required further discussion, an additional three-hour facilitated session focused on developing conflict resolution strategies; it was delivered by me following the initial training. Without taking a culturally-competent approach in the delivery of team functioning and conflict resolution modules, discussions about community functioning outside of the workplace environment, would likely not have happened. This experience was not identified by previous researchers, and so adds to our current understanding of IPC Training in First Nation communities. Finally, by supporting culturally-focused interprofessional discussions to take place over the course of the day, community action-oriented goals were developed with these discussions as their foundation. I feel that this re-search achieved the call to action purpose, of providing culturally-appropriate competency training for health and wellness professionals.

Decolonizing Knowledge

This study has brought the re-search team on a unique journey, which began with realizing and understanding concepts of healthcare knowledge management and translation (Abidi, 2008; Bordoloi & Islam, 2012; Frost, 2014; Gowen et al., 2009; Guptill, 2005; Hislop, 2013; Razzaque & Karolak, 2011; Stauss et al., 2009) and Indigenous knowledges practices

(Alfred, 2009; Archibald, 2008; Dei et al., 2000; Kenny & Fraser, 2012; King, 2012; Lawrence-Lightfoot & Davis, 1997; People's Knowledge Editorial Collective, 2016; Simpson, 2008; Smith, 1999, 2012; Talaga, 2017, 2018; Wilson, 2008). We went a step further, and examined how researchers developed knowledge locally using community-based methods that were respective of the people, land and histories (Agbo, 2001; Boone et al., 1997; Maar et al., 2009; Walker et al., 2010). Most prominently, I (and we the research committee) were challenged to examine whether the knowledge I (we) have created contributes to the oppression and colonization of Indigenous peoples (Smith, 1999); and, in our case, whether our re-search findings which examined IPC Training and healthcare access for Indigenous persons, may or may not contribute to colonization.

At the core of this re-search was IPC Training, based on six competencies highlighted in the National Interprofessional Collaborative Framework (CIHC, 2010). This framework was chosen because of its ability to support both Indigenous and non-Indigenous ways of knowing. Kovach (2009) supports that binary conceptual frameworks can contribute to decolonization, as they help to mitigate methodological inconsistencies that arise when Indigenous and Western ways of knowing are integrated. Based on the recommendations of others (Ball, 2005; Frenk et al., 2010; Health Canada, 2005, 2015; HealthForceOntario, 2009; Maar et al., 2009; WHO, 2010), clinicians were brought together for the purpose of improving interprofessional collaboration. Three specific analyses were used to re-find or re-search existing knowledge: quantitative, qualitative, and mixed methods analyses. This was achieved with the understanding of a two-eyed seeing approach (Bartlett et al., 2012; Martin, 2012) that supported the need for an ethical space of engagement (Ermine, 2007; Ray, 2016).

So, we ask ourselves, have I (we) contributed to the colonization of knowledge? Another way of asking this question is, have I (we) made the same mistakes made in the past? (Menzies, 2004). Prior to conducting re-search, this question of knowledge utility was paramount for me. I met with Dr. Paul Berger and Dr. Richard Matthews on two occasions to talk about the work of Menzies (2004), and how I could ensure that I was not harming Indigenous peoples through this re-search process. In order to really answer this question, I was asked to reflect on the ethical framework (Ray, 2016) guiding the re-search. It was in this process that I, and we as a research team, identified the White-walled labyrinth that we are currently living in (e.g. worldviews, language, beliefs, educational background), and took a critical look at how research and different kinds of knowledge were co-produced (Bartlett et al., 2012; PKEC, 2016).

This collective understanding allowed our research team to choose a methodological orientation that supported Indigenous ways of knowing and being. It was necessary that within our re-search processes, we acknowledged that we were an integral part of the community (Boone et al., 1997) and remained community-focused over the course of a four-year re-search project. By choosing an ethical framework (Ray, 2010) created by a local Indigenous scholar, that literally and figuratively represented the communities in which the re-search took place, we created a space for genuine dialogue (e.g. IPC Training, community gatherings, day-to-day interactions), and allowed for spontaneous goal development to occur in a culturally-appropriate and unrestricted re-search environment (PKEC, 2016).

As recommended by Smith (1999), understanding how this re-search knowledge will be used is one of the most important ways of determining whether knowledge is contributing to colonization or decolonization. In general terms, the quantitative results can be used by Nokiiwin Tribal Council in future funding proposals to continue to support collaborative professional

development training in its communities. With the permission of the communities and Nokiiwin, the academic community and/or government agencies could use these quantitative findings to support the need for IPC Training to improve collaborative functioning in First Nation communities. In the case of the qualitative findings, they can be used as an example in mainstream scholarship of how Indigenous models and ways of knowing can be incorporated into the re-search process (e.g. TREIE Framework, the Seven Grandfather Teachings, the Medicine Wheel, translated narratives). Additionally, the mixed methods findings represented in various deliverables can be used by community members (i.e. Community Resource Guide), researchers (Community Action Research Blueprint), and academics (publications), intended for both Indigenous and non-Indigenous persons. In reflecting on these ways that this research knowledge can or will be used, it is my hope that this re-search project has not contributed to the colonization of Indigenous peoples, and has in fact contributed to the process of knowledge decolonization.

Perhaps the knowledge that will be used the most is found in the Community Resource Guide, a central hub, where healthcare service information was centralized for the purpose of increasing access to services. Maar & Shawande (2010) support that hubs facilitate Indigenous ways of knowing, as knowledge is easily exchanged in a community platform that welcomes everyone. In this way, we have kept knowledge alive (PKEC, 2016), in the day-to-day practices of our communities, and have already succeeded in knowledge sharing outside of the scope of this dissertation. Finally, we have engaged in the process of knowledge recovery and utilization as a way to decolonize existing ideas of Indigenous knowledge (TRC, 2015). We have had these successes because we learned from each other as well as from the mistakes of others (Menzies, 2004). With the many positive learning experiences that were had in this re-search journey, I will

now share our oversights so that others may learn from our mistakes, and continue the journey of decolonizing knowledge.

Limitations. Prior to initiating this re-search, limitations were considered pertaining to the methodology of community action research as well as the implementation and evaluation of research using mixed methods. Available time and researcher capacity were daily challenges (i.e. in a non-Indigenous sense referring to REB timelines), which prevented the IPC Training from being delivered in more than two communities. I see this as a non-Indigenous limitation, because in Western ways of knowing we are governed by deadlines, that impact the knowledges we gather. In an Indigenous or Anishnaabe sense, this may not be seen as a limitation given that the IPC Training continues to be delivered in the post-research phase, and has currently been provided in two additional communities as of January 31, 2019. Nokiiwin Tribal Council has been trained to deliver this IPC Training and now has the ability to build on this re-search study; thus, it is arguable in an Indigenous sense, things are happening when they are meant to happen. For those communities who could not participate but had the intention to, many real-life challenges persisted. For instance, two of our most interested communities experienced: multiple community deaths, the impact of community bi-annual elections, changes in the community political landscape, and miscoordination of dates and times to deliver the IPC Training.

A second challenge involved team turnover. The Disabilities Coordinator from 2015 - 2017 was heavily involved in the start-up of the community action research project, as her position connected me to community and healthcare partnerships within the First Nation communities. When this position was unexpectedly removed three months into the data collection period, those on the research committee were challenged to operationally support the project, without having the same background knowledge as the former Coordinator. Over the

course of eight months, there were times that I was expected to fill in as the Disabilities Coordinator. It was a weekly struggle to reorient the research committee to the purpose and parameters of the research, in a respectful and non-avoidance way. Daily field note documentation on the potential for scope creep, as well as ongoing reflection and feedback from the research team, allowed me to work through this unique challenge, which may have otherwise jeopardized the integrity of the re-search. This challenge is considered a limitation in a non-Indigenous sense, because energy was diverted away from booking IPC Trainings in communities (i.e. completing tasks) and invested in relationship-building (process components).

Thirdly, being an 'outsider' (i.e. University-based PhD student) to Nokiiwin's communities presented unique challenges that may not have been experienced if I were an 'insider' (i.e. Nokiiwin employee or First Nation community member). The Tribal Council itself did not have a previously established research framework; thus, the action research in many ways trail-blazed through non-existent policies, in a historical context that was and is deeply impacted by colonialism. For example, my Whiteness, academic privilege, student status, and female make-up, were challenged often in explicit and non-explicit ways, by different Indigenous and non-Indigenous affiliates of Nokiiwin. In the beginning, my Whiteness appeared to be more of an issue when the concept of community action research was developing. At one meeting, I was assertively asked how I would know anything about living "on a reserve", and or how I would know anything about addressing "Nish problems". I realized in this moment and moments like this that followed, that I was not being asked to literally answer a question, I was being asked to listen.

Additionally, academic privilege was evident each time I introduced myself as a PhD student from Lakehead University, with an affiliation at the Northern Ontario School of

Medicine. This information was given for transparency and accountability; however, this introduction alone acted as a limitation because it could shut down conversations and create awkward silences, where people felt that a line had been drawn between them and me. When possible, I avoided introducing myself with titles and letters. I learned to say, "Hello, I'm Justine and I live in Thunder Bay; I'm not originally from here, but I've been living here for ten years….tell me about you". Notably, there were several non-Indigenous PhD affiliates already involved with Nokiiwin Tribal Council, and so the fact that I was a 'student', meant being in no one's land—not a community member and not an academic professional. It took some time, but I realized that I enjoyed this place of being the 'learner'—it actually enabled me to do my job as a re-searcher ally.

Due to the forethought given during the creation of the research's methodology, many anticipated limitations were addressed early on or ameliorated (Menzies, 2004). For example, by securing a three-year funding award with Indigenous and Northern Affairs Canada, there was limited concern over ensuring that there was enough money to cover the projected costs of the project. Moreover, I took the time needed to gain beginning competence in multiple methods, and to begin to appreciate Indigenous approaches to research in an attempt to avoid repeating the mistakes of past researchers working with First Nation communities (Menzies, 2004). Despite not having all communities engage in the study, equitable access to the re-search was promoted through community newsletters, Chief and Council, Board of Directors, research conferences, and on the website. Equity continues to be a challenge for First Nation communities, and so it was a strong goal of the research team to ensure that an equal invitation was given to each of the six communities. It should be noted, that all research committee representatives remained committed to the re-search process even if their communities were unable to participate directly

in the IPC Training. Lastly, the proximal and distal needs of the First Nation communities involved in the research (e.g. immediate need for access to healthcare services, and long-term sustainability of research action-oriented goals) were planned for using existing resources available at Nokiiwin.

In reflecting on the re-search process, Smith (1999, 2012) states that the very nature of conducting research is a colonial practice, thereby potentially making the re-search itself a limitation. I say 'potentially' for several reasons. By using Wilson's (2008) definition of re-search in this study, we did not 'conduct research' as understood in colonial Western ways of knowing. For instance, outside of this dissertation and PhD journey, it is possible that my name may never be associated with the knowledge that was re-discovered. One of the strongest examples of this is when I now hear communities say, "look at the resource guide we created, isn't it great?" or "wow, we are really starting to develop our own research framework at Nokiiwin". The OCAP principles which have guided me as strongly as Ray's (2016) TREIE Framework, have allowed me to learn about re-search with an incredible population. I believe that this is reward enough for me, and I have realized that I have no need or desire to benefit further from this re-search process personally (e.g. through publications, compilations, presentations, etc.). With this said, it would be an honour to share this information with other First Nation communities, academics, and learners, in the ways that Nokiiwin and communities would best like to do so.

Conversely, what is important to acknowledge regarding research or re-search being a limitation, is that those who contributed to this work will not be receiving a PhD for their knowledge. The future Dr. Justine Jecker will be, only because I was able to bring together people and their knowledge through committed Indigenous leaders representing communities

belonging to the Robinson-Superior Treaty Territory. I do believe the communities involved with Nokiiwin Tribal Council, have benefitted from this process; but, to say 'we' have equally benefitted, is not something I can definitively say. What I do know, is that after engaging in collaborative community action research involving non-Indigenous and Indigenous ways of knowing, methods and practices, my standpoint on research/re-search being a harmful process between Indigenous and non-Indigenous peoples, has changed. It has been because of this re-search that we have had the opportunity to challenge colonial practices identified in the Truth and Reconciliation Commission of Canada (2015). And, it is because of this process that we have been able to empower individuals and communities to make change that is meaningful and sustainable (i.e. as seen in the narratives and deliverables). Finally, this re-search has shown me that Indigenous and non-Indigenous partnerships are needed to continue to overcome research limitations, by re-finding or re-searching knowledges that may not otherwise come together.

Moving Forward

Agreements of support from Chief and Council representing Nokiiwin Tribal Council's First Nation member communities supported the implementation of IPC Training which has had an impact on its member communities. Dozens of community members formally committed to involvement in this community action research project either as research committee members, research participants, or research team members (e.g. Elder, translator, bioethicist). Commitments ranged from: engaging in the one-day IPC Training session; to participating in the development of action-oriented goals; to the design, implementation, and evaluation of the re-search; to the creation of re-search deliverables. Our united belief in interprofessional collaborative practices was the foundation of our union, which built on the recommendations of Bruce Minore, Mae Katt, Margaret Boone and Peggy Kinch in the early 1990's.

This study's results have substantiated support for IPC Training in communities with teams who already consider themselves to be interprofessional. In response to other IPC Training participants and populations listed in Chapter 2, this re-search project is the first to identify a two-eyed seeing focus that respects both Indigenous and non-Indigenous ways of knowing, supported in the context of an Indigenous ethical framework. Additionally, the action-oriented goals that were developed as a result of the IPC Training, led to the creation of deliverables focused on increasing access to healthcare and wellness services. Taking these processes and outcomes into consideration, this re-search study contributes to the existing literature in three specific ways: 1) this research responds to previous research recommendations which identified collaboration as a means to increase healthcare access; 2) this study demonstrates how four Calls to Action identified by the Truth and Reconciliation Commission of Canada (TRC, 2015), were incorporated into a community action research framework, and 3) the deliverables achieved throughout this project can have an influential impact on other First Nation communities looking to drive change.

The People's Knowledge Editorial collective (2016) reminds us that "we need to understand our own realities in order to connect to our communities, and then to connect ourselves to the wider world" (p. 69). This re-search brought all of us on a journey of discovery, of understanding our own realities and reaching out to our communities in old and new ways. We were challenged to try to understand ourselves, each other, and the bigger world in order to engage authentically with one another (Reason, 2006). By documenting the effects of the IPC Training and its resulting benefits, communities can now cite this research project as an example of how change can be initiated and achieved with and by First Nation communities. The creation of the action research blueprint has given us a common understanding and language that can be

shared with others, whereas the Community Resource Guide symbolizes what can be achieved when people come together with a common purpose.

This community action research project allowed for community goals to be collaboratively identified, engaged upon, completed, and evaluated. As of January 2019, research results are in the process of being disseminated at conferences and workshops within Nokiiwin's member communities, and for academic audiences at Lakehead University and the Northern Ontario School of Medicine. In reflecting on the knowledge practices of both Indigenous and Western worldviews, publishing this knowledge is the next step in moving forward. Bordeaux et al. (2007) provide guidelines for writing community-based manuscripts, and identify that community health partnerships may face challenges with having research published. It is suggested that a publication/dissemination committee composed of academic/community partners could be formed to help with the writing (Bordeaux et al., 2017). Therefore, the publication process will begin with those interested who took part in the re-search.

New Directions: Recommendations

i. Nokiiwin Tribal Council. The findings suggest that Nokiiwin Tribal Council and its member communities need to create safe spaces for community members to come together to work on and engage in collaboration. This concept of safe space supports Ermine's (2007) and Ray's (2006) concepts of creating ethical space to share ideas in a safe and culturally-appropriate environment. Professional development opportunities have been specifically suggested as a means to increase community engagement in health and wellness-related discussions. This recommendation supports other research that encourages professional development as a way to improve communication and collaboration within specific groups (Evans, 2001; Hislop, 2013; McWilliam, 2007).

Secondly, in this re-search, second-order narratives were used to convey individual and collective experiences, rather than traditional story-telling. When possible, story-telling can be used as a means to collect and disseminate knowledge within and between communities (Archibald, 2008). There are different ways in which stories can be told (Archibald, 2008; Lawrence-Lightfoot & Davis, 1997), and so other methods should be considered for future research. Lastly, other methodologies outside of narratives and story-telling, could be employed in future research undertaken within Nokiiwin's communities. For example, sharing circles and Anishnaabe symbol-based reflections (Lavalee, 2009) are examples of locally-based Indigenous research methodologies that are culturally-relevant. Additionally, photovoice which has been informed by Freire's theory of critical consciousness, can be used to convey knowledge in a way that words cannot (Mitchell, 2018). By using a variety of community-based Indigenous methodologies, community collaborations can continue to improve as members develop a stronger understanding of their shared knowledges.

ii. Nokiiwin Tribal Council. As a result of the community action research, Nokiiwin Tribal Council identified the need to generate a research framework. The research blueprint is one building block that can contribute towards how Nokiiwin engages in research moving forward. There are some additional elements that can be included which were not reflected in the chosen methodologies. Brant-Castellano (2000) identifies that Indigenous knowledge encompasses three processes: empirical observation, traditional teachings, and revelation. A focus on teachings passed down through generations, is a technique widely supported in Indigenous scholarship (Smith, 1999) and can be incorporated into a future framework. Additionally, knowledge acquired and examined through revelation such as dreams, visions, and intuition; or through thoughts, beliefs and actions that are conveyed from one's ancestors through

blood, is considered to reflect spiritual ways of knowing (Brant-Castellano, 2000). Perhaps most aligned to local Anishinaabek ways of knowing, would be the inclusion of research ceremonies as the basis of a research framework, such as Fasting or Sweat Lodge ceremonies (Cormier, 2016). Any of these and other Anishnaabek or Indigenous ways of knowing would most definitely benefit from the inclusion of Elders from different backgrounds to support the quality and depth of the framework (Auger, 1994; Cormier, 2016).

Furthermore, Smith (1999) and Absolon (2011) suggests that Indigenous frameworks involve re-writing, re-righting, and re-storying the histories of Indigenous peoples. In this dissertation, a general overview of the historical injustices inflicted upon Indigenous and First Nation peoples of Canada was provided. However, with a location-specific Indigenous framework, local histories could be the focus. Elements such as the Medicine Wheel (Marsh et al., 2015), Seven Grandfather Teachings (Peterson et al., 2016), and cultural life beliefs and practices (Ray, 2016) could also be incorporated, as they were in this re-search study. Lastly, ethical guidelines and models that reflect the beliefs of the local people can and should be included. This may mean introducing the need for healing medicines, smudging ceremonies, or Elder prayers to be directly incorporated into each research gathering as a means of unifying purpose and presence. In the time that I have been writing this dissertation, another important document was published focusing on practical guidelines for ethical research with Indigenous communities in Canada (Riddell et al., 2017). This article examine key principles for conducting research with different groups of Indigenous Peoples, and should be considered in the establishment of an Indigenous Research Framework for Nokiiwin.

iii. Lakehead University & PhD Education Program. I was grateful to uncover articles by other graduate-level action researchers (Baker Collin; 2005; Cormier, 2016; Cullen, 2008; Mitchell, 2016; Mock, 1999; Paradise, 2009) pursuing PhD's, who provided hope and encouragement that this could be achieved within a four-year timeframe. The key ingredient to these former studies as well as this re-search, was having well-established relationships with the community of interest either prior to or directly at the beginning of the PhD journey. The recommendation to Lakehead University is twofold. First, given the incredible community opportunities that exist in Thunder Bay and within our northern communities, there should be an established community inventory of previously identified research needs where graduate students can be in a position to choose a socially accountable research project that directly serves the needs of a local community. It is puzzling that any graduate student could be struggling to identify a worthy research question [NB: I witnessed numerous examples of this in my first and second year Directed Study courses], when our country is in the midst of Truth-telling and Reconciling the atrocities of what happened to Indigenous Peoples in Canada (TRC, 2015). To support this recommendation as a non-Indigenous student, Indigenous scholars support the allying of non-Indigenous students with Indigenous communities as this allows for ethnically diverse research teams that can advocate for Indigenous rights (Mihesuah & Wilson, 2004).

Secondly, PhD courses should be provided in the first and second year of the program that specifically focus on: 1) mixed methods research, 2) action research, and/or 3) Indigenous methodologies. With this said, I do not believe that any courses should be removed, rather I feel it is necessary to add to the existing program. Throughout the course of my studies, there was one session offered on mixed methods in a quantitative course. During this session, I co-presented with colleagues in a case study format, on how to critically examine a mixed method

article. This was the extent of my mixed methods training in the classroom. With regards to action research, it has been predominantly because of my healthcare background as an occupational therapist and social advocate, that this methodological framework could be incorporated. As Hodgkinson (1957) identified, action research began in the classroom, and so it should not be the exception that an action research dissertation is being defended in a PhD in the Educational Leadership and Policy Studies field.

In closing, van der Meulen (2011) wrote that if more PhD students were engaged in meaningful action-oriented research, there may be less attrition in PhD programs across Canada. With regards to mandating a course on Indigenous methodologies, this would not come as a surprise to students enrolled in a PhD of Education program in northern Ontario. If we are to truly decolonize knowledge, a collective understanding of Indigenous worldviews, beliefs, practices, and histories is the first step (Smith, 1999); therefore, a mandated course on Indigenous methodologies would ensure that doctoral students are educated on the basic histories and knowledges of Indigenous Peoples of Canada before engaging in research (TRC, 2015).

Final Thoughts

Very few of us are in a position to engage in action research either as a participant or as a researcher. As researchers, we therefore have a responsibility to ask ourselves what we could be doing to help facilitate hearing the voices of Indigenous and non-Indigenous citizens that may never be heard. This re-search directly involved hundreds of people over the course of four years, and based on our findings and deliverables, should continue to impact hundreds more for years to come. The quintessence of community engaged action-oriented research is that communities can be impacted by the voices, beliefs, and actions of their leaders. It is because of the coordinators, administrators, councillors, spirit-builders, and educators, that this study had the opportunity to examine interprofessional collaboration and access to healthcare services. Members were able to individually engage in a one-day training session that has created a long-lasting impact on their communities. I am honoured to have met so many loons like Shingibiz, ones who were willing to challenge themselves and the status quo for the betterment of the community. It did take great courage for our story-tellers and participants, to trustfully engage in a re-search project that had never before been undertaken, and to share their stories of collaboration.

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Appendices

Appendix A: Community Letters of Support

Biinjitiwaabik Zaaging Anishinaabek

501 Spirit Bay
Road Rocky Bay Reserve
MacDiarmid ON P0T 2B0

Office of the Chief and Council
Phone 807-885-3401
Fax 807 885-1218

January 22, 2016
Geraldine Cullingham, Senior Officer, Social Programs
Education and Social Programs Directorate
Indigenous and Norther Affairs Canada
100 Anemki Place, Suite 101
Fort William First Nation, ON P7J 1A5

Dear Ms. Cullingham,

RE: Letter of Community/Band Support- Disabilities Initiative Program

On behalf of Biinjitiwaabik Zaaging Anishinaabek, we are writing this letter to indicate our support for Nokiiwin's proposed initiative under the Disabilities Initiative Program. We look forward to participating fully in every aspect of this program.

Biinjitiwaabik Zaaging Anishinaabek is a small community by has a relatively high number of members experiencing difficulties due to disabilities. This program will identify the service gaps and needs of those with disabilities living in the community. Furthermore, we support the development of a community specific web based alternative care model that would help people stay in the community longer. By working with Nokiiwin, we take advantage of economies of scale which will allow us to create a more effective and broad-based program than we could on our own.

We understand that Nokiiwin agrees to administer the funds, run the program, and ensure that program guidelines are followed. We agree to provide Nokiiwin with the data it needs for program planning and reporting.

Please contact us if you have any other questions.
Sincerely,

Ray Nobis
Acting Director of Health, Biinjitiwaabik Zaaging Anishinaabek

BINGWI NEYAASHI ANISHINAABEK

146 Court Street South, Thunder Bay, Ontario P7B 2X6
Phone: (807) 623-2724 Fax: (807) 623-2764

January 22, 2016

Geraldine Cullingham, Senior Officer, Social Programs
Education and Social Programs Directorate
Indigenous and Norther Affairs Canada
100 Anemki Place, Suite 101
Fort William First Nation, ON P7J 1A5

Dear Ms. Cullingham,

RE: Letter of Community/Band Support- Disabilities Initiative Program

On behalf of Bingwi Neyaashi Anishinaabek, we are writing this letter to indicate our support for Nokiiwin's proposed initiative under the Disabilities Initiative Program. We look forward to participating fully in every aspect of this program.

Bingwi Neyaashi Anishinaabek, is a small community by has a relatively high number of members experiencing difficulties due to disabilities. Our community is not funded in full or in part by any other disability initiative. This program will identify the service gaps and needs of those with disabilities living in the community. Furthermore, we support the development of a community specific web based alternative care model that would help people stay in the community longer. By working with Nokiiwin, we take advantage of economies of scale which will allow us to create a more effective and broad-based program than we could on our own.

We understand that Nokiiwin agrees to administer the funds, run the program, and ensure that program guidelines are followed. We agree to provide Nokiiwin with the data it needs for program planning and reporting.

Please contact us if you have any other questions.
Sincerely,

Jessica Wilhelm
Director of Health and Social Services

Netamisakomik Centre for Education

P. O. Box 615, Pic Mobert First Nation, Ontario P0M 2J0
Phone: (807) 822-2011 Fax: (807) 822-2710

January 22, 2016

Geraldine Cullingham, Senior Officer, Social Programs
Education and Social Programs Directorate
Indigenous and Norther Affairs Canada
100 Anemki Place, Suite 101
Fort William First Nation, ON P7J 1A5

Dear Ms. Cullingham,

RE: Letter of Community/Band Support- Disabilities Initiative Program

On behalf of Pic Mobert First Nation, we are writing this letter to indicate our support for Nokiiwin's proposed initiative under the Disabilities Initiative Program. We look forward to participating fully in every aspect of this program.

Pic Mobert is a small community by has a relatively high number of members experiencing difficulties due to disabilities. This program will identify the service gaps and needs of those with disabilities living in the community. Furthermore, we support the development of a community specific web based alternative care model that would help people stay in the community longer. By working with Nokiiwin, we take advantage of economies of scale which will allow us to create a more effective and broad-based program than we could on our own.

We understand that Nokiiwin agrees to administer the funds, run the program, and ensure that program guidelines are followed. We agree to provide Nokiiwin with the data it needs for program planning and reporting.

Please contact us if you have any other questions.
Sincerely,

Jacky Craig
Principal

Animbiigoo Zaagi'igan Anishinaabek
204 Main Street, PO Box 120, Beardmore, ON P0T 1G0
P: 807 875-2785
F: (807) 875-2786

January 22, 2016

Geraldine Cullingham, Senior Officer, Social Programs
Education and Social Programs Directorate
Indigenous and Norther Affairs Canada
100 Anemki Place, Suite 101
Fort William First Nation, ON P7J 1A5

Dear Ms. Cullingham,

RE: Letter of Community/Band Support- Disabilities Initiative Program

On behalf of Animbiigoo Zaagi'igan Anishinaabek, we are writing this letter to indicate our support for Nokiiwin's proposed initiative under the Disabilities Initiative Program. We look forward to participating fully in every aspect of this program.

Animbiigoo Zaagi'igan Anishinaabek is a small community with a relatively high number of Members experiencing difficulties due to disabilities. This program will identify the service gaps and needs of those with disabilities living in the community. Furthermore, we support the development of a community specific web based alternative care model that would help people stay at home in the community longer. By working with Nokiiwin, we take advantage of economies of scale which will allow us to create a more effective and broad-based program than we could on our own.

We understand that Nokiiwin agrees to administer the funds, run the program, and ensure that program guidelines are followed. We agree to provide Nokiiwin with the data it needs for program planning and reporting, and any other support they may require to ensure this initiative is successful.

Please contact us if you have any other questions.
Sincerely,

Priscilla Graham
Band Administrator
Animbiigoo Zaagi'igan Anishinaabek

FORT WILLIAM FIRST NATION

January 28, 2016

Geraldine Cullingham, Senior Officer, Social Programs
Education and Social Programs Directorate
Indigenous and Norther Affairs Canada
100 Anemki Place, Suite 101
Fort William First Nation, ON P7J 1A5

Dear Ms. Cullingham,

RE: Letter of Community/Band Support- Disabilities Initiative Program

On behalf of Fort William First Nation, we are writing this letter to indicate our support for Nokiiwin's proposed initiative under the Disabilities Initiative Program. We look forward to participating fully in every aspect of this program.

Fort William First Nation has a relatively high number of members experiencing difficulties due to disabilities. This program will identify the service gaps and needs of those with disabilities living in the community. Furthermore, we support the development of a community specific web based alternative care model that would help people stay in the community longer. By working with Nokiiwin, we take advantage of economies of scale which will allow us to create a more effective and broad-based program than we could on our own.

We understand that Nokiiwin agrees to administer the funds, run the program, and ensure that program guidelines are followed. We agree to provide Nokiiwin with the data it needs for program planning and reporting.

Please contact us if you have any other questions.

Sincerely,

Chief Peter Collins
Fort William First Nation

90 ANEMKI DRIVE, SUITE 200 • FORT WILLIAM FIRST NATION, ON • P7J 1L3
PHONE: (807) 623-9543 • FAX: (807) 623-5190

Appendix B: Research Cover Letter and Consent Form

Dear Potential Participant:

Re: Improving Interprofessional Collaboration for Indigenous Access to Health-Care Services

My name is Justine Jecker, PhD Candidate at Lakehead University in Thunder Bay. In collaboration with Nokiiwin Tribal Council of Superior Robinson Treaty Territory and its six First Nation Member communities: Animbiigoo Zaagi'igan Anishinaabek (Lake Nipigon Ojibway); Biinjitiwaabik Zaaging Anishinaabek (Rocky Bay First Nation); Bingwi Neyaashi Anishinaabek (Sandpoint First Nation); Kiashke Zaaging Anishnaabek (Gull Bay First Nation); Pic Mobert First Nation; and Fort William First Nation, we are engaging in community action research based on Nokiiwin's Disability Initiative to improve access to health-care services. Specifically, this research will be targeting interprofessional communication and collaboration practices of health-care teams that service these reserves. The funder of this research study is Indigenous and Northern Affairs Canada (INAC). My dissertation supervisor, Dr. Seth Agbo will be supervising this research project.

The purpose of this study is to examine how the introduction of interprofessional education competencies to health-care teams servicing northern Ontario reserves can enhance interprofessional collaboration and Indigenous health-care access. The National Interprofessional Competency Framework (CIHC, 2010) is the basis for two surveys and interview questions that will be used in this research study. Data gathered from participants representing the six member First Nation communities will address existing policy and research recommendations which support interprofessional collaboration as a mechanism to improve access to health-care services for those living on-reserve in northern Ontario.

The study as a whole has potential benefits for participants and the participating institutions. First, the results of the study will help to determine the best ways of providing healthcare access to the inhabitants of on-reserve communities in northern Ontario. Secondly, as the literature has demonstrated that existing access to health care for Indigenous persons is unacceptable (Boone, Minore, Katt, Kinch, 1994; Duckett, 2009; Dunn, 2016; Health Canada, 2005, 2007, 2015), this study will explore how interprofessional collaboration (IPC) amongst health-care providers servicing northwestern Ontario reserves will help improve general access by finding ways of minimizing inherent problems in the current system of health-care provision to the communities (CIHC, 2010; Frenk et al., 2010; HealthForceOntario, 2007; WHO, 2010). Finally, it is known from the literature that IPC improves health outcomes (CIHC, 2010; Frenk et al., 2010; WHO, 2010). Thus, while participants would benefit by having access to health-care services, the participating institutions would become aware of the best ways to provide effective health-care services. The funders of this research and the

participating institutions do not perceive any conflict of interest in carrying out the project as all those involved stand equally to benefit from it.

We are kindly inviting you and other members of your community to participate in this study. We deem your participation important because your viewpoints, opinions and suggestions would help us to understand how to improve health-care services on First Nations reserves. Please note that your participation in this project is voluntary and you may terminate your participation at any point of the study. You may withdraw from the study at any time; and you may also request that data collected from you may be withdrawn from the study. Furthermore, you may decline to answer any question that you do not wish to answer.

For the purpose of this study, the research procedures will involve a study in which you will be invited, first to participate in a one-day interprofessional collaboration competency training opportunity which will signal the beginning of a four-month research period to be completed prior to the end of 2017. Community members are being contacted based on Nokiiwin Tribal Council's healthcare web-maps and based on interest in this research project identified at a Nokiiwin Tribal Council community workshop scheduled prior to this letter. The one-day interprofessional collaborative competency training for participants will be based on the National Interprofessional Competency Framework (CIHC, 2010) (i.e. the intervention) in their respective Nokiiwin Tribal Council community. The competencies that would be taught include the following: role clarification (1hr), interprofessional communication (1hr), conflict resolution (1hr), team functioning (1hr), and patient-centred care and collaborative leadership (1.5hrs). Interactive learning taking into account adult learning principles and transformative learning strategies, will involve role-play, teach-back opportunities, review of vignettes, and reflection exercises will take place.

Data collection will start at the commencement of the training. Referrals to health-care providers will be accepted to ensure that as many people as possible have the opportunity to participate in this research study. Participants will have the opportunity to fill out two separate surveys at the three points in time. Additionally, four to six participants will be interviewed based on interest identified following the baseline survey. Interviews will be audiotaped and transcribed for accuracy. To ensure appropriate storage of data, an electronic password protected filing system will be created with back-up information stored on an external hard drive stored in a locked cabinet. High quality tapes will be used for audio recording to ensure information is not lost in the storage process. A master list of information sources will be developed for quick reference to finding collected materials.

All information collected in this project is for research purposes only. To ensure confidentiality no real names of individuals will be used in this report or release of this information. Researchers will not seek any private, family or sensitive information in this study. Participants' contribution will remain confidential and anonymous with pseudonyms being used in transcriptions or other forms of data collected as well as the final report. This study will comply with Lakehead University's policy that all research data will be securely stored for 5 years in the Principal Investigator, Dr. Seth Agbo's

office at Lakehead University. Results will be shared with participants following data analysis (Spring 2018).

There are no foreseeable risks to participants of this study. However, risks identified by previous researchers (Wilson-Forsberg & Easley, 2012) working with Indigenous peoples include: 1) the impact of disseminating research results without considering existing rivalries in Indigenous communities, 2) the challenge with confidentiality and anonymity in small communities given that there is often one person who matches a given description, and 3) the impact of overlapping roles and relationships of health-care providers as research participants. This study will take precautions to ensure minimum risk and provide maximum anonymity for participants. Furthermore, measures will be taken to ensure that in reporting the results of this study, none of the participants will be identifiable. Nevertheless, for the purpose of this study we are making provisions for anyone in need of counseling due to emotional distress to be referred to a trained Disabilities Coordinator, at Nokiiwin Tribal Council.

All travel costs and other expenses related to participation in the project are being supported by INAC. All the participants will therefore be reimbursed for such costs by the Nokiiwin Tribal Council.

We intend to present the results of this study at local, regional and international conferences such as: the Northern Interprofessional Collaborative on Health Education (NICHE), the Northern Health Research Conference (NHRC), Collaborating Across Borders (CAB), and workshops and conferences put on by Nokiiwin Tribal Council. We also intend to publish our findings in the *International Journal of Indigenous Health* by which the general audience and participants of this study will be able to access the findings. We also intend to disseminate our findings by making presentations in each of the participating communities. In disseminating our findings, participants and sites would not directly or indirectly be identified. Only the researcher and her supervisor Dr. Seth Agbo and the Nokiiwin Tribal Council of Superior Robinson Treaty Territory and its six First Nation Member communities will have access to information collected for this project. If at any time you wish to address any possible ethical issues in the research you may contact Lakehead University Research Ethics Office by email at research.ethics@lakeheadu.ca or by phone at +1(807) 343-8283.

We will, along with this letter send a consent form that you may sign to indicate your willingness to participate in the study. Correspondence regarding this letter may be sent by e-mail to jjecker@lakeheadu.ca or I may be reached by telephone at (807) 766-7469.

Yours sincerely:

Justine Jecker, Ph.D. Candidate

CONSENT FORM

I have read and I understand the provided information and have had the opportunity to ask questions about the research project: **Improving Interprofessional Collaboration for Indigenous Access to Health-Care Services.**

The research study is consistent with *Ethics Procedures and Guidelines for Humans Subject Research.*

- Participants will be asked to participate in a one-day competency training workshop; those unable to attend but interested in participating in research will be given a one-hour tutorial on what was covered in the workshop and will be used as a control group.
- For those chosen to engage in interviews based on voluntary interest, interviews will be audio recorded and transcribed by the primary researcher. Participants who complete the interview may request to have their interview removed from the sample at any time.
- I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason and without cost.
- I understand the potential risks and benefits of this study.
- Data will be stored at Lakehead University for a minimum of five years following this research study. I understand that I will be given a copy of this consent form. I voluntarily agree to take part in this study.
- Research findings will be available to all participants

☐I Do ☐Do not

Consent to my participation in the study (Please, check one and sign only if you consent to participation)

Participant's signature _____ Date _____

Investigator's signature _____ Date _____

Page **1** of **1**

Appendix C: Interprofessional Collaborative Competency Indicators

Based on the National Interprofessional Competency Framework (CIHC, 2010), participants learned about the six interprofessional collaborative competencies in a facilitated workshop, and were able to engage in and/or demonstrate indicators listed in the accompanying right column following the intervention.

Role Clarification: Learners/practitioners understand their own role and the roles of those in other professions, and use this knowledge appropriately to establish and meet client/ family and community goals.	• Explores own professional ethical considerations, role and scope of practice • Explores team members roles and scopes of practice • Identifies relevant professional roles in a given context, and identifies potential gaps in team membership • Explores professional role overlap; how are we all related/unique • Explores patient's role as an IP team member • Seeks information on personal skill sets of all team members • Identifies professional requirements for self-reflection
Communication: Learners/practitioners from varying professions communicate with each other in a collaborative, responsive and responsible manner.	• Identifies the impact of communication on interprofessional care • Explores the level and mode of communication preferred by team members (i.e. patient, family, community, health professionals) • Identifies and demonstrates skills for effective verbal and non-verbal communication • Identifies and demonstrates skills/behaviours for active listening • Understands and constructs feedback for those on the IP team • Identifies legislation, policies and procedures related to confidentiality
Conflict Resolution: Learners/practitioners actively engage self and others, including the patient/ client/family, in dealing effectively with IP conflict.	• Acknowledges perceived power imbalances, and the stereotypes/historical hierarchies on which they rest • Identifies own conflict styles and those of team members • Identifies appropriate conflict management models • Identifies and explores social/professional/organizational opportunities and barriers to collaboration
Patient/Family-Centred Care: Learners/practitioners seek out, integrate and value, as a partner, the input and engagement of the client in designing and implementing care/services.	• Explores patient's role as an IP team member • Explores own view of patient centeredness within context related to current literature • Explores expectations of patients as members of the care team (PATs); prepares patient as a team member • Explores the level and mode of communication preferred by patient/family • Identifies legislation, policies and procedures related to confidentiality
Collaborative Leadership: Learners/practitioners work together with all participants to formulate, implement and evaluate care/services to enhance health outcomes.	• Identifies and employs appropriate technologies to facilitate collaboration • Identifies strategies and seeks guidance to address weaknesses and capitalize on strengths

(Northern Ontario School of Medicine, 2015)

Appendix D: Talking Wall Exercise

'Talking Walls' as a Technique to Enhance Interprofessional Learning

Resource Type: Small interprofessional group activity to improve the knowledge of roles and responsibilities of other professions.

Talking Walls was first described by Parsell, Gibbs and Bligh in 1998. The paper is entitled 'Three Visual Techniques to enhance interprofessional learning' and can be accessed via PubMedCentral. The following information comes from this paper.

Talking walls is a simple technique adapted from commercial situations of exploring issues, analyzing problems or developing action plans. It is used in this case to encourage students to explore the roles of other professions and start discussions with members of professions they will work closely with in future, but have little contact with during their separate educations.

The technique has been used by several studies, including the following;

- Parsell, Spalding and Bligh (1998) in their 'Evaluation of a multiprofessional course for undergraduate students'
- Coster et al. (2008) in their paper 'Interprofessional attitudes amongst undergraduate students in the health professions: A longitudinal questionnaire survey'
- Heath et al. (2008) in their paper 'Building interprofessional primary care capacity in mental health services in rural communities in Newfoundland and Labrador: An innovative training model'
- The Quality Improvement and Innovation Partnership (2009) for 'Supporting Ontario's family health teams' in the module 'Clarifying roles and expectations'

3

Appendix E: True Colours Exercise

True Colors is a model of personality identification that is easy to understand, remember, and apply. Essentially the model stems from the work of Isabel Brigs- Myers, Katherine Briggs and David Keirsey. A student of David Keirsey, Don Lowry, developed the True Colors system to facilitate a deeper understanding of people's communication styles. His hope was to produce positive self-worth and self-esteem.

The True Colors System was designed to promote a mental, emotional, and spiritual model that would increase the understanding of the SELF and others, which in turn would reduce the conflict. The idea is that once you learn your color and the color of your co-workers or people you relate to on a daily basis, you will have a better understanding of how others may see you, and also why they behave the way they do.

With the colors of Blue, Gold, Green and Orange –True Colors distills the elaborate concepts of personality theory into a user friendly, practical tool for fostering healthy productive relationships. True Colors has been utilized throughout corporations, education and therapeutical settings for over 25 years as a tool that improves communication, relationships, team-building, leadership, morale, and conflict resolution skills.

By taking this test you will:

- Learn how to create and sustain better relationships
- Learn to appreciate the differences in others and respect them
- Learn how to create instant rapport with the opposite sex
- Learn to respond to others more appropriately, consciously, and compassionately
- Maximize relationships through use of the True Color Personality Assessment Quiz

  Each color is associated with certain personality traits or behaviors. Everyone has some degree of each color, but one color is predominant. The following quiz will identify your color spectrum. Print out the following five pages. Follow the directions carefully and transfer your score to the score sheet. If you have two colors with the same score, you pick which one you think more accurately describes you.

How to Use the True Colors Personality Quiz

Describe Yourself: In the boxes below are groups of word clusters printed **horizontally** in rows. Look at all the choices in the first box (A,B,C,D). Read the words and **decide which of the four-letter choices is most like you**. Give that a "4". Then rank order the next three letter choices from 3-1 in descending preference. You will end up with a box of four-letter choices, ranked from "4" (most like you) to "1" (least like you). Continue this process with the remaining four boxes until each have a 4, 3, 2, and 1.

BLUE

I need to feel unique and authentic
Enthusiastic, Sympathetic, Personal
I look for meaning and significance in life
Warm, Communicative, Compassionate
I need to contribute, to encourage, and to care
Idealistic, Spiritual, Sincere
I value integrity and unity in relationships
Peaceful, Flexible, Imaginative
I am a natural romantic, a poet, a nurturer

- I was extremely imaginative and found it difficult to fit into the structure of school life.
- I reacted with great sensitivity to discordance or rejection and sought recognition.
- I responded to encouragement rather than competition**.**

In relationships...

- I seek harmonious relationships.
- I am a true romantic and believe in drama, warmth, and empathy to all relationships.
- I enjoy the symbols of romance such as flowers, candlelight, and music and
- cherish the small gestures of affection.

At work...

- I have a strong desire to influence others so they may lead more significant lives.
- I often work in the arts, communication, education, and helping professions.
- I am adept at motivating and interacting with others.

Leadership Style...

- Expects others to express views
- Assumes “family spirit”
- Works to develop others’ potential
- Individuals oriented
- Democratic, unstructured approach
- Encourages change VIA human potential
- Change time allows for sense of security
- Expects people to develop their potential

Symptoms of a Bad day...

- Attention-getting misbehaving
- Lying to save face
- Withdrawal
- Fantasy, day-dreaming, and going into a trance

- Crying and depression
- Passive resistance

GOLD

I need to follow rules and respect authority ***Loyal, Dependable, Prepared***
I have a strong sense of what is right and wrong in life ***Thorough, Sensible, Punctual***
I need to be useful and belong
Faithful, Stable, Organized
I value home, family, and tradition
Caring, Concerned, Concrete
I am a natural preserver, a parent, a helper

In childhood...

- I wanted to follow the rules and regulations of the school.
- I understood and respected authority and was comfortable with academic routine.
- I was the easiest of all types of children to adapt to the education system.

In relationships...

- I am serious and tend to have traditional, conservative views of both love and marriage.
- I enjoy others who can work along with me, building secure, predictable relationships together.
- I demonstrate admiration through the practical things I do for the ones I love.

At work...

- I provide stability and can maintain organization.
- My ability to handle details and to work hard makes me the backbone of many organizations.
- I believe that work comes before play, even if I must work overtime to complete the task.

Leadership Style...

- Expects punctuality, order, loyalty
- Assumes “right” way to do things
- Seldom questions tradition
- Rules oriented
- Detailed/thorough approach - threatened by change
- Prolonged time to initiate any change
- Expects people to “play” their roles

Symptoms of a Bad day...

- Complaining and self-pity

- Anxiety and worry
- Depression and fatigue
- Psychosomatic problems
- Malicious judgments about yourself or others
- Herd mentality exhibited in blind following of leaders
- Authoritarianism and phobic reactions

ORANGE

I act on a moment's notice ***Witty, Charming, Spontaneous*** *I*
consider life a game, here and now ***Impulsive, Generous, Impactful***
I need fun, variety, stimulation, and excitement ***Optimistic, Eager, Bold***
I value skill, resourcefulness, and courage ***Physical, Immediate, Fraternal***
I am a natural trouble-shooter, a performer, a competitor

In childhood...

- Of all types of children, I had the most difficult time fitting into academic routine.
- I learned by doing and experiencing rather than by listening and reading.
- I needed physical involvement in the learning process and was motivated by my own natural competitive nature and sense of fun.

In relationships...

- I seek a relationship with shared activities and interests.
- I like to explore new ways to energize the relationship.
- In a relationship, I need to be bold and thrive on physical contact.
- I enjoy giving extravagant gifts that bring obvious pleasure to special people in my life.

At work...

- I am bored and restless with jobs that are routine and structured.
- I am satisfied in careers that allow me independence and freedom, while utilizing my physical coordination and my love of tools.
- I view any kind of tool as an extension of myself.
- I am a natural performer.

Leadership Style...

- Expects quick action
- Works in the here and now
- Performance oriented
- Flexible approach
- Welcomes change

- Expects people to “make it fun”

Symptoms of a Bad day...

- Rudeness and defiance
- Breaking the rules intentionally
- Running away and dropping out
- Use of stimulants
- Acting out boisterously
- Lying and cheating
- Physical aggressiveness

GREEN

I seek knowledge and understanding
Analytical, Global, Conceptual
I live by my own standards
Cool, Calm, Collected
I need explanation and answers
Inventive, Logical, Perfectionist
I value intelligence, insight, fairness, and justice
Abstract, Hypothetical, Investigative
I am a natural non-conformist, a visionary, a problem solver

In childhood...

- I appeared to be older than my years and focused on my greater interests, achieving in subjects that were mentally stimulating.
- I was impatient with drill and routine, questioned authority, and found it necessary to respect teachers before I could learn from them.

In relationships...

- I prefer to let my head rule my heart.
- I dislike repetition, so it is difficult for me to continuously express feeling. I believe that once feelings are stated, they are obvious to others.
- I am uneasy when my emotions control me; I want to establish a relationship, leave it to maintain itself, and turn my energies to my studies, work or other interests.

At work...

- I am conceptual and an independent thinker. For me, work is play.
- I am drawn to constant challenge in careers, and like to develop models, explore ideas, or build systems to satisfy my need to deal with innovation.
- Once I have perfected an idea, I prefer to move on, leaving the project to be maintained and supported by others**.**

Leadership Style...

- Expects intelligence and competence
- Assumes task relevancy
- Seeks ways to improve systems
- Visionary
- Analytical

Symptoms of a Bad day...

- Indecisiveness
- Refusal to comply or cooperate; the silent treatment
- Extreme aloofness and withdrawal
- Snobbish, put-down remarks, and sarcasm

Appendix F: Revised TOSCE Case Scenario

Interprofessional Communication

Jasmine's Experiences with Chronic Pain

1. Review the information provided regarding Jasmine.
2. Discuss as a team, how to help Jasmine and write this down.

Jasmine is a 43-year-old woman who has been identified by her community due to increasing opioid medication use. Jasmine has a history of pain which is not diagnosed, and her family wellness worker has noticed she has been experiencing increasing pain in the past two months. As a result, she is very tearful and seems sad. Her family wellness worker is concerned that she may be taking too much medication because Jasmine is very vague when asked how much she is taking.

When you see Jasmine, she walks slow, and looks sad and uncomfortable. Her spoken English is good but she sometimes has difficulty understanding health-care providers and asks them to repeat themselves. She works part-time doing labour work, where she stands most of the day. This increases her pain and she has had to take some sick time recently. She is worried about losing her job and doesn't want to complain. Both pain and worry are keeping her awake at night, as she needs to continue working to support her family.

She has three children living at home, and two grandchildren that she takes care of as her daughter is struggling with addictions. Her husband knows that she has occasional back pain and takes pills to help, but she doesn't want to bother him. He spends a lot of time outside of the home hunting or fishing, and her grandchildren are "always out". She feels like she is alone much of the time caring for her young grandchildren, who having been missing a lot of school as of late. Besides that, she has little time for herself between work and caring for the family.

Jasmine's traditional spiritual community is very important to her and she attends circles each week. Lately, she is too tired and sore to get up and go with friends to these circles. She has frequent headaches and is feeling exhausted. Some days she has to take many tablets to help control her pain but even then, on "bad days", she doesn't seem to get much pain control.

Appendix G: Assessment of Interprofessional Team Collaboration Scale (AITCS)

Assessment of Interprofessional Team Collaboration Scale (AITCS)
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The AITCS is a diagnostic instrument that is designed to measure the interprofessional collaboration among team members. It consists of 37 statements considered characteristic of interprofessional collaboration (how team works and acts). Scale items represent four elements that are considered to be key to collaborative practice. These subscales are: (1) Partnership/shared Decision Making —19 items, (2) Cooperation--11 items, and (3) Coordination—7 items.

Scoring AITCS
Respondents indicate their general level of agreement with items on a 5-point rating scale that ranges from 1 = "Never"; 2 = "Rarely"; 3 = "Occasionally"; 4 = "Most of the time"; to 5 = "Always". These ratings produce scores from 37 to 185. It takes approximately 15 minutes to complete.

Demographic Information

Please enter the last four digits of your employee ID number in these boxes: ☐☐☐☐

Please check ☐ the category you belong to:

Gender: ☐ Male ☐ Female **Age:** ____years

Employment Status: ☐ FT ☐ PT ☐ Casual

Educational Preparation
- ☐ Certificate
- ☐ Diploma
- ☐ Other (specify): _____
- ☐ Bachelor Degree
- ☐ Masters Degree

Please check one of the following discipline categories:
- ☐ Audiologist
- ☐ Clinical Kinesiologist
- ☐ Clinical Psychologist
- ☐ Dental Assistant
- ☐ Dentist
- ☐ Dietary Aid
- ☐ Dietitian (Nutritionist)
- ☐ Imaging Technologist
- ☐ Laboratory Technologist
- ☐ Nursing: Registered Nurse
- ☐ Nursing: Practical Nurse
- ☐ Occupational Therapist
- ☐ Physical Therapist (Physiotherapist)
- ☐ Pharmacy
- ☐ Paramedics
- ☐ Physician (Medicine)
- ☐ Personal Support Worker
- ☐ Speech Language Pathologist
- ☐ Social Worker
- ☐ Spiritual/Pastoral Care
- ☐ Recreational Therapist
- ☐ Respiratory Therapist
- ☐ Therapy Assistant
- ☐ Other (please specify) _____

Please indicate:
Years in practice (*since achieving license to practice*):_____; Years with your current team: _____

Assessment of Interprofessional Team Collaboration Scale

Instructions:

Note: Several terms are used for the person who is the recipient of health and social services. For the purpose of this assessment, the term 'patient' will be used. While acknowledging other terms such as 'client' 'consumer' and 'service user' are preferred in some disciplines/jurisdictions.

*Please read over each statement and **circle the value** which best reflects how you currently feel your team and you, as a member of the team, work or act within the team.*

1	2	3	4	5
Never	Rarely	Occasionally	Most of the time	Always

Section 1: PARTNERSHIP/SHARED DECISION MAKING[1]

When we are working as a **team**[2] all of my team members…..

1	establish agreements on goals for each patient we care for	1	2	3	4	5
2.	are committed to the goals set out by the team	1	2	3	4	5
3	include patients in setting goals for their care	1	2	3	4	5
4	listen to the wishes of their patients when determining the process of care chosen by the team	1	2	3	4	5
5.	meet and discuss patient care on a regular basis	1	2	3	4	5
6.	would agree that there is support from the organization for teamwork	1	2	3	4	5
7.	coordinate health and social services (e.g. financial, occupation, housing, connections with community, spiritual) based upon patient care needs	1	2	3	4	5
8.	use a variety of communication means (e.g. written messages, email, electronic patient records, phone, informal discussion etc.)	1	2	3	4	5
9.	use consistent communication with team members to discuss patient care	1	2	3	4	5
10.	are involved in goal setting for each patient	1	2	3	4	5

[1] Orchard & Curran "A partnership between a team of health professionals and a client in a participatory collaborative and coordinated approach to shared decision-making around health and social issues" (2003)

[2] A team can be defined as any interactions between one or more health professionals on a regular basis for the purposes of providing patient care.

11.	listen to and consider other members' voices and opinions/views in regard to deciding on individual care planning processes	1 2 3 4 5
12.	would agree when care decisions are made, the leader strives to obtain consensus on planned processes from all parties	1 2 3 4 5
13.	feel a sense of belonging to the group	1 2 3 4 5
14.	establish deadlines for steps and outcome markers in regards to patient care	1 2 3 4 5
15.	jointly agree to communicate plans for patient care	1 2 3 4 5
16.	consider alternative approaches to achieve shared goals	1 2 3 4 5
17.	encourage each other and patients and their families to use the knowledge and skills that each of us can bring in developing plans of care	1 2 3 4 5
18.	focus of our teamwork is consistently the patient	1 2 3 4 5
19.	work with the patient and his/her relatives in adjusting care plans	1 2 3 4 5

Section 2: COOPERATION

When we are working as a **team** all of my team members…..

20.	share power with each other	1 2 3 4 5
21	help and support each other	1 2 3 4 5
22.	respect and trust each other	1 2 3 4 5
23.	are open and honest with each other	1 2 3 4 5
24.	make changes to their team functioning based on reflective reviews	1 2 3 4 5
25.	strive to achieve mutually satisfying resolution for differences of opinions	1 2 3 4 5
26.	understand the boundaries of what each other can do	1 2 3 4 5
27.	understand that there are shared knowledge and skills between health providers on the team	1 2 3 4 5
28.	exhibit a high priority for gaining insight from patients about their wishes/desires	1 2 3 4 5

29.	create a cooperative atmosphere among the members when addressing patient situations, interventions and goals	1 2 3 4 5
30.	establish a sense of trust among the team members	1 2 3 4 5

Section 3: COORDINATION

When we are working as a **team** all of my team members…..

31.	apply a unique definition of ***Interprofessional collaborative practice*** to the practice setting	1 2 3 4 5
32.	equally divide agreed upon goals amongst the team	1 2 3 4 5
33.	encourage and support open communication, including the patients and their relatives during team meetings	1 2 3 4 5
34.	use an agreed upon process to resolve conflicts	1 2 3 4 5
35.	support the leader for the team varying depending on the needs of our patients	1 2 3 4 5
36.	together select the leader for our team	1 2 3 4 5
37.	openly support inclusion of the patient in our team meetings	1 2 3 4 5

Revised version June 28, 2011

Thank you for completion of this questionnaire!

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Appendix H: Interprofessional Collaborative Competencies Attainment Survey (ICCAS)

ICCAS – Interprofessional Collaborative Competencies Attainment Survey

For your unique anonymous participant code, please provide your mother's first name initial, the day and month of her birthday: __ - __ __ __ __
Please indicate your profession: _____
Please indicate if you are: a student _____ year of program _____ or practitioner _____

Please answer the following questions by filling in the circle that most accurately reflects your opinion about the following interprofessional collaboration statements:
1= strongly disagree; 2= moderately disagree; 3=slightly disagree; 4= neutral; 5=slightly agree; 6=moderately agree; 7= strongly agree; na= not applicable

Please rate your ability for each of the following statements:

	Before participating in the learning activities I was able to:								**After** participating in the learning activities I am able to:							
Communication	1	2	3	4	5	6	7	na	1	2	3	4	5	6	7	na
1. Promote effective communication among members of an interprofessional (IP) team*	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
2. Actively listen to IP team members' ideas and concerns	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
3. Express my ideas and concerns without being judgmental	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
4. Provide constructive feedback to IP team members	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
5. Express my ideas and concerns in a clear, concise manner	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Collaboration																
6. Seek out IP team members to address issues	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
7. Work effectively with IP team members to enhance care	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
8. Learn with, from and about IP team members to enhance care	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Roles and Responsibilities																
9. Identify and describe my abilities and contributions to the IP team	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
10. Be accountable for my contributions to the IP team	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
11. Understand the abilities and contributions of IP team members	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
12. Recognize how others' skills and knowledge complement and overlap with my own	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Collaborative Patient/Family-Centred Approach																
13. Use an IP team approach with the patient** to assess the health situation	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
14. Use an IP team approach with the patient to provide whole person care	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
15. Include the patient/family in decision-making	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Conflict Management/Resolution																
16. Actively listen to the perspectives of IP team members	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
17. Take into account the ideas of IP team members	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
18. Address team conflict in a respectful manner	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Team Functioning																
19. Develop an effective care*** plan with IP team members	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
20. Negotiate responsibilities within overlapping scopes of practice	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

*The patient's family or significant other, when appropriate, are part of the IP team.
**The word "patient" has been employed to represent client, resident, and service users.
***The term "care" includes intervention, treatment, therapy, evaluation, etc.
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Appendix I: Field Notes Codebook

Code	Description
Challenges	Examples of reality that were in contrast to the research expectations
Change or Movement	The will to change direction when needed and continue to move forward despite challenges or unexpected change
Colonialism	Examples of where the research project was impacted by colonialism
Communication	Examples of where and how communication was or was not effective
Concerns	Examples of when the researcher thought that the research project could be impacted by external factors
Conferences or Gatherings	Opportunities that showcased the IPC Training and community action research project
Connectedness	Examples that represent where connections were strong or non-existent
Director's Role	Director's role in supporting the research project
Disabilities Coordinator	Coordinator's role in the research project
Disappointment	Examples of where I felt let down by either people or situations
Disconnect	Examples showing a disconnect for participants or the researcher between Nokiiwin's goals and community goals
Emotion or Energy	Examples of emotion that were exceptional in the context of this research
Ethical Conduct	Examples of where ethical dilemmas or experiences challenged the research process
Exclusion	Examples of where people felt excluded from the research process
Grant Funding	Examples of where funding support was key to the research project

IPC Training	Value or impact statements reflecting the IPC training
Lack of access	Examples where access to people, resources or communities was prohibited
Leadership	Examples where leadership was promoted or needed
Mental Health Navigator	Role of the mental health navigator in the research project
Nokiiwin Tribal Council & Communities	Examples of where Nokiiwin represented the communities values and beliefs
Optimism	Examples of maintaining a positive attitude
Other Research	Examples of where other research projects indirectly influenced involvement in the IPC Training
Politics	The hidden or obvious political environment that impacted the day-to-day workings of the research project
Positionality	Examples of where the researcher's positionality was considered and reflected upon in the research process
Progress	Examples of where individual or community progress following the IPC training was evident throughout the research project
Recruitment	Examples of recruitment for community participation in the IPC Training (e.g. newsletters, emails, phone calls)
Reflections	Researcher's weekly reflections of the research process contrasting pre-determined ideas of how the research would unfold
Resources	Resources required to ensure the success of the project (e.g. physical space, presentations, incentives, support staff, time)
Role Clarification	Examples of where ongoing role clarification was needed to ensure understanding of the research team members
Supports	People who played a key role in supporting the data collection and data analysis
Timelines	Specific timeframes or deadlines alluded to throughout the data collection process
Travel	Traveling to communities and/or the concept of being on the road

Appendix J: Narratives Codebook

Access to Services	Comments shared on access to services without mentioning IPC; focus is on acceptable access to services
Availability of Health Services	Availability of health and social care services in the community
Competency Training	Comments made regarding the impact, effectiveness, and outcomes of the interprofessional collaboration competency training
Connections and/or team functioning	Examples where improved connections with team members were made as a result of IPC
IPC Implementation	Examples demonstrating where IPC competencies or community goals developed from the training were or could be implemented
IPC and Access	Examples of where IPC improves or can improve acceptable access to healthcare services
IPC Meaning	Definitions or interpretations of interprofessional collaboration
Policy	Examples of policy creation or implementation
Research experience	Comments pertaining to one's involvement or experience in the overall research project
Traditional practices	Comments pertaining to current or past traditional practices (e.g. health, land, culture, language)

Appendix K: Our Respectful Community – The Seven Grandfather Teachings

Appendix L: Ojibwe Translations of 5 Narratives

COORDINATOR – Role Clarification

Interprofessional collaboration for me is when thoughts and ideas come together for the betterment or improvement of a situation, a direction, a project, or whatever it may be.

Kakina anookiiʼininiwag kaawiitanokimitiwaj gaakakwe ishjiikenaniwan. Kekonan keminosekin, kekishjiikatekin kaye.

With everything, everyone brings different strengths and gifts to the table—as far as collaboration, improving access to care, I think it is extremely important, if not the most important thing.

Kawiitanokimitiwaj opiitoonawaa kekonan jionjiminosek. Ga anookiikajikatetekin maawaaj iwe ekjiinentaakok kakina awiyek jiwiitanookimitiwaj.

This gives a voice to a lot of people and different situations, to ensure this is achieved in an all-encompassing way.

Miiowe kiiwiitanokiimitmaaniwan eshi noontawaakaniiwaj awiyak Anishinabek aaniin igo eshisewaj jianokiikaataanowaj anokiiwin idash jiktishjikaate.

I think there are too many times that we get caught in our own perspectives and belief systems that we miss out on a whole area that is imperative.

Nindinentaan oshaam paatiinawaa ushise kaa inentamang kaishitebwetamaang kitishjiikemin. Kaawiin paakaan awiyaa kaa inentang kaishitebwetang Kaawiin kipisintaawaasiimin kaawiin kekitishjikesiimin miisa eshi waniseʼ kaaishi kaakweanookikanjitatek.

I would like to believe that I had a lot of these [interprofessional skills] already, especially given the background that I have in health and education.

Miisa eshitebwetamaan ashaa eayayanan ineniwan kashkjiikewinan onjiandowewin kaye kikinooamakewin kikenjikewinan aniish ashaa ningii pianooki imaa tonokan anookiiwinan.

But, I really appreciated watching the other people evolve with this; watching their thought processes, their minds open up, gaining a better understand of themselves, and watching other peopleʼs strengths to see what they bring to the table.

Miiwe ekiiwaapaadaamaan gakiiʼishkikinooʼamaakoyang ekiiwaabamakwaa kotak awiyaag kashinaanaakataawentamowaj kashiniisiitootaamoowaj ekiionji awashiime kitkenimiitisiiwaj kaye dash kaapiitoowaj otinentamowininiwaa.

The communication was so interesting… I noticed that it is so essential to allow other people to take the lead.

Kiijtakanoontiitnaaniwang wiinke kijiinentaakong awiyaag jiminaakaniwaj jiniikaaniwaj.

Everyone was involved rather than one person taking the lead - they took turns sharing, feeling valued in the group, and all had something special to contribute.

Memeshkoj Kakinaa kiinitkaaniiwag. Kiikaakitowag kakinaa idash kekon okiipiitoonawaa keapajiikaateg.

I saw some very introverted and shy people share more than they would typically do; the shyness was being shed.

Ningii waapaamag kanepewisiiwaj ekaktowaj piinish kaawiin giinepewisisiiwag.

The whole experience was extremely positive—I could see the community members becoming excited as they engaged in the True Colours exercise.

Maawaj ekiininwashiing owe kiikinooamaakewin. Gidanishinabeminagnik wiikeʼgii-minwendamog gii ishjikewaj I twe True Colors ishjikewin.

This exercise showed people that they are similar in ways they could not have imagined (i.e. a sense of shared ownership evolved from each colour).

Egiiwaapamitisiiwaj kaawiin epakaanishiwaj. Maamoo piko peshikwan giitishiaamin.

This session allowed me to see these competencies at the forefront and be humble about what I bring to the table.

Ningii waapaataanan mashkawisiwinan kaye ningii tapasemin kenin kagii-piitooyaanan nindineniinoowinan.

The experience made me reflect and listen.

Wiinke ningii-wiijiʼkonan kaakiiʼshjiikeyaang. Nindonji kijinanaakataawendan kaye episiintaweyan.

Sometimes it was better to sit back and listen in order to appreciate what other had to say.

Koting ishise jimijipisintamang ekitoj awiya.

I realized that we always try to comprehend why things are the way they are, despite the complexity beyond our comprehension.

Nindonji kikendan kaye ekakwe kikenendamang kekonen wejiʼisisekin kekonan anakii sanakendaakokin.

a. Coordinator

Interprofessional collaboration for me is when thoughts and ideas come together for the betterment or improvement of a situation, a direction, a project, or whatever it may be.

Kaakina anookii'ininiwag kaawiitanokimitiwaj kaakakwe ishijikenaniwan. Kekonan keminosekin, kekishijikaatekin kaye.

With everything, everyone brings different strengths and gifts to the table—as far as collaboration, improving access to care, I think it is extremely important, if not the most important thing.

Kawiitanokimitiwaj opiitoonawaa kekonenan jionjiminosek. Ka anookiikajikaatekin maawaaj iwe ekijiinentaatok kaakinaa awiyek jiwiitanookiimitiwaj

This gives a voice to a lot of people and different situations, to ensure this is achieved in an all-encompassing way.

Miiowe kiiwiitaanokiimitimaaniwan eshi noontawaakaniiwaj awiyak Anishinaabek aaniin igo eshisewaj jianokiikaataamowaj anokiiwin idash jikiishijikaate

I think there are too many times that we get caught in our own perspectives and belief systems that we miss out on a whole area that is imperative.

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I would like to believe that I had a lot of these [interprofessional skills] already, especially given the background that I have in health and education.

Miisa eshitebwetamaan ashaa eayaayaanan ineniwan kashkijikewinan ojiandowewin kaye kikinooamakewin kikenjikewinan aniish ashaa ningii pianooki imaa tonokan anookiiwin.

But, I really appreciated watching the other people evolve with this; watching their thought processes, their minds open up, gaining a better understand of themselves, and watching other people's strengths to see what they bring to the table.

Miiwe ekiiwaapaadaaman kakii'ishikikinoo'amaakoyaang ekiiwaabaamakwaa kotak awiyaag ka'shinaanaakatawentamowaj ka'shiniisiitootaamoowaj ekiionji awahshime kiikeniimitisiiwaj kaye dash kaapiitoowaj otinentamowininiwaa

The communication was so interesting… I noticed that it is so essential to allow other people to take the lead.

Kiijkakanooniitinaaniwang wiinke kichinenaakon awiyaag jimiinaakaniwaj jiniikaaniiwaj

Everyone was involved rather than one person taking the lead - they took turns sharing, feeling valued in the group, and all had something special to contribute.

Memeshkoj Kakinaa kiiniikaaniiwag. Kiikaakitowag kakinaa idash kekon okiipiitoonnawaa keapajijikaateg

I saw some very introverted and shy people share more than they would typically do; the shyness was being shed.

Ningii waapaamag kanepewiisiiwaj ekakitowaj piinish kaawiin giinepewiisisiiwag

The whole experience was extremely positive—I could see the community members becoming excited as they engaged in the True Colours exercise.

Maawaj ekiiminwaashiing oowe kikinooamaakewin. Gidanishinabnemiaanik wiike gii-minwendamog gii'ishijikewaji I'iwe True Colors ishijikewin.

This exercise showed people that they are similar in ways they could not have imagined (i.e. a sense of shared ownership evolved from each colour).

Egiiwaapamitisiwaj kaawiin epakaanishiwaj. Maamoo piko peshikwan giitishiaamin

This session allowed me to see these competencies at the forefront and be humble about what I bring to the table.

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Sometimes it was better to sit back and listen in order to appreciate what other had to say.

Goting ishise jimijipisintamang jinootamang eikitoj awiya

I realized that we always try to comprehend why things are the way they are, despite the complexity beyond our comprehension.

Nindonji kikendan kaye ekakwe kikenendamang kekonen wejji'isisekin kekonan anakii sanakendaalokin

I do believe that the relationships were strengthened, and the appreciation following the training for our individual skillsets, was better.

Wiinke nintebwetaan minowiijiiwitiwin onjimashkawisiimakanoon aanjike idash kikitemimitimin

Overall, I feel that I became stronger with the community and on an individual basis.

Ningii onjimashkawikaabow nipimaadiziwining kaye nindi'shkonikaning

The training created an awareness that everyone on the team has different skills.

Kigii onji waapaadaamin kaye pepakan izhijikewinan eshi kashkitooyang

We were able to identify different resources directly in the community that can be accessed.

Wiijii'wewinan I'maa ishkonikaning kaye ningii oshitoomin keapajijikaatekin

Increased guidance from individual community members created a wealth of information for the larger group.

Aaniinda kiiwiiji'wewag ewiindaamoowaj kekonen keonji apaajijikaatenkin

I think another area that was a concern, which needed to be identified on a larger scale, was people experiencing mental health issues (e.g. individuals not transitioning back to community with supports).

Miinawaa kekon gagiiwaapaanjikaateg awiyaag omitaanentimowin ka'naapinej jionji katwe wiijiakaniwij ishkon'kaning.

There are a lot of areas in the current system where people can fall through the cracks.

Noonkom gayaayan kaawiin anokiisesiimakan.

It becomes especially difficult when we lose important community engagement personnel whose job it is to connect people to appropriate resources.

Miinawaa eshi majiseg gii-ishkwa anookiij awiyaa ga'nanookiij jiwiji'wej

The communities quite often do not have regulated healthcare providers; however, their qualified workers need to access sensitive information.

Ishkonikanan ishisemakanoon kaawiin andawewining anookiiwininiwag kaawiin mooshaag anookiisiiwag. Miidash kotak anookiiwininiwag onaandaawendaanawaa kaamanaa wiinjikaatekin oshipii'kanan.

Most of the time this is not possible, as when clients are discharged from the hospital, there is not release of personal information to the families.

Mooshaag kaawiin ishisesinoon jiondinikaatekin kaamana wiinjikaatekin oshipii'kanan giipakitinaakaniwij jikiiwej aakosiiwikamigong. Kaawiin kekon oshipii'kanan ayaamakasinoon jionji kikenimaakaniwij aaniin eshisej

This directly impacts community access as they do not know how to support members with health issues in the community.

Mii'wedash kaawiin kikenimaakaniwisiin keishiwiijiyaakaniwij kiikiiwej o'tishkonikaning

In closing, I will say that one thing that was frustrating for me, is that the whole of Nokiiwin did not engage in the training.

Ishwaaj niwii'kid ningii onji manendan kaawiin kakina Nokiiwin ga ishianookiiwaj giitakwiisiiwag gakii kikinoamaakoyang

This loss of an opportunity made it challenging for Nokiiwin workers to know what exactly was happening in the community.

Gapanisewaj Nokiiwin anookiiwininiwag kaawiin mayaa okikendasiiwaa eshiseyang.

In the beginning, this explains why the project may have been viewed as siloed.

Miiwe enetakon epeshiikog

The training itself, unveiled pre-existing and new forms of conflict that it was intended to address.

Gakiikikinoamaakooyang giionji naakanoon weshkaaj majisewinan kaye nonkom majisewinan kekii-anookiikanjikatekin

I see possibilities for this training to reach new heights with all members of the Nokiiwin communities.

Niwaapaaadaan owe kikinoamaatiiwin kaakinaa Nokiiwin ishkonikanan jiwiijisekin.

b. Educator

EDUCATOR – Interprofessional Communication

Collaboration to me is coming together as a team, working together, sharing ideas, sharing practices, and sharing strategies.

Gawiidanokimitinaaniwan nindinedan kiwiji'iminmaannoo jiiwiidanookiimitiyaan gaye kiitoonjiminosemin gaishi anookiyang.

Collaboration to me means unification – be become unified.

Gamaamoowiidanookimitinaaniwan nindineda ekidoomakeg jimaamoosekin kakina anokiwinan jionji wiijiitiiyang.

This is absolutely needed if we are going to access services as we cannot run a school otherwise.

Miiowe enaataawentaakok jiipiniwidoyaang kiikinooamaadiwigamig.

Our collaboration with Nokiiwin has been very strong, as well as with APS, Dilico, Chief and Council, and parents.

Giiwiitaanookiimaankiitaaw Nokiiwin kotak paamisiwinan APS, Dilico gaye okiimakanak, gaye onikigoog giitoojimaashkaa kaapawiimin.

But Collaboration can also mean not just with other services externally, but within the school – the staff collaborate very well with each other and the students.

Kaawiin eta kotag paamisiwinan taaonji minosesiin kiimaamoo wiitanookimitinganiwan kiiminowiitanookimitiiwaaj shaa omaa kiikinooamatiiwigamigong kaye ga-anookiiwaj kikinoamatiiwigamigong miiwe keishi minoseg.

When it comes to building connections with parents, I see that we need to work 'with' each other not just 'for' each other.

Jigakwe wiitanookiimaakaniwaj nikigoog niwaapatan jikakwe wiitokotatiyaan kaawiin eta jianookiyang.

With regards to the Interprofessional Collaboration training, I don't remember much about the training in June as I had school issues to address.

Kaawiin apajii ningiwichiitagsiin gegii izhi kikinooamaakoyaan ningii odaamii. Ka'ani ishwaasek kikino'amaakosiwin izhikonikaaning.

Because of these pressing concerns, it did not allow me to have the full experience.

Miisa ka ishi paani soayaan ka kii ishi kikinoo'amaakoyang.

With that said, today's session [follow-up Conflict Resolution session] has been awesome; what a beautiful day!

Nongom gakishigaak gaishigii kikino'amaa koyaan weweni gananajikaateg maajisewinan inke kii onjiminokiishikan wiinke mino kikinoo'amaakewin iwe.

How liberal and free everyone is to speak—they don't hold back, they have opinions and they express them.

Ka kina awiiyag idashkiikakidowag ga wii ikidowag igo. Gainendanoowaaj gii'kidowag.

Having days like this needs to happen more often.

Ga gii apiiji mino sek maamoopiwin mooshak tagi'ishi seban.

I can absolutely apply this learning to everyday life – work in the school, work with admin, work with each other.

Ga kii ishi kikinoo amaakoyang ninga apaajiitoon taaso gii shiik ka ichi anookiyana kaye kawiitaanookiimikwaa.

These PD trainings help me to connect, relax, and talk about issues that we usually don't have time to talk about.

Oneniwan ka gi kinooamaakoyang niwiiji'ikonan. Gaawiin ako kiitishesiimin jiitaashintaamang ga naaki naakishkaataamang.

Next week people will come and talk about what was learned during the conflict resolution training.

Awiiyak kiga gakwejiiminkonanik wekonen ga kii kikinooamaakoyang iiwe weweni kaanaaichikaatek maajisewinan.

What's great about PD in general is that its like going to a conference; you're not sure what you're going to get out of it, but you know its going to be worthwhile.

Gii aado kikino'amaakoyang gawiin kikikendaasiimin wegonen ke kikino'amaakoyang ki ki kendamin jii minagshin.

One thing I would like to acknowledge is that circumstances are changing. When it comes to access to services, I don't see services expanding any more at this point in time.

Miisa nindikid ka kinakekon anianjisewan. Kaawiin nongom niin waapedasiin jii anikooseskin wiijii wewinan.

Dilico is here visiting on a regular basis, we have a school councillor, an SLP who is here 4/5 days, an OT once every 3 months, and Creative Therapy services from Thunder Bay three times a year to assess students and help teachers.

Dilico mooshak piishawek, kikinoo'amaatiiwin kaanooshiwewinini ayaa imaa kikinoo'amaatowigamigong, kotaak awiiyag kiwiijikonanek, SLP, OT kaye Creative Therapy.

Where we are short is with Ojibway language teaching.

Kawiin apijii kitaayaasiimin Ojibwemowin kikinoo'amaatiiwin.

In our community, we have always received 100% support from the Band Manager, Chief and Council, and others serving the school.

Nindishkonikanaanig maawaj niiwiigikonanek Ogimaakanak kaye o taanokiimaa kannaag. Imaa kikinoo'amaatiiwigamigong.

Collaboration to me is coming together as a team, working together, sharing ideas, sharing practices, and sharing strategies.

Gawiidanokimitinaaniwan nindinedan kiwiiji'timmaanoo jiiwiidanookiimitiyaan gaye kiitoonjiminosemin gaishi anookiyang

Collaboration to me means unification – be become unified.

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This is absolutely needed if we are going to access services as we cannot run a school otherwise.

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But Collaboration can also mean not just with other services externally, but within the school – the staff collaborate very well with each other and the students.

Kaawiin eta kotaak paamisiwinan taaonji minosesiin kiiminowiitanookiimitiiwaaj shaa omaa kiikinooamatiiwigamigong kaye ga-anookiiwaj kikinoamatiiwigamigong miiwe keishi minoseg

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Kiigakwe wiitanookiimaakaniwaj nikikoog niwaapatan jikakwe wiitokotatimin kaawiin eta jianookiyang.

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Kaawiin apajii ninwiiwiichiitawsiin gagii izhi kishkinooamaakoyaan ningii odaamii. Ka'ani ishwaasek kikino'amaakosiiwin izhikonikaaning.

Because of these pressing concerns, it did not allow me to have the full experience.

Miisa ka ishii paani soayaan ka kii ishi kikinoo'amaakoyek

With that said, today's session [follow-up Conflict Resolution session] has been awesome; what a beautiful day!

Nongom gakiishigaak gaishwe kikino'amaa koyaana meewani gananaijiikaatek maajisewinan iikeye kii mino kiishika

How liberal and free everyone is to speak—they don't hold back, they have opinions and they express them.

Ka kina okiikakidowag ga wii ikidowag

Having days like this needs to happen more often.

Ga gii apiiji mino sek maamoopiwin mooshak tagii'ishi seban

I can absolutely apply this learning to everyday life – work in the school, work with admin, work with each other.

Ga kii ishi kikinoo amaakoyang ninga apaajiitoon taaso gii shiik ka ichi anookiyana kaye kawiitaanookiimikwaa

These PD trainings help me to connect, relax, and talk about issues that we usually don't have time to talk about.

Ka ki kinooamaakoyang niwiijii'ikonan. Gaawiin ako kiitishisesiimin jiitaashitaamang ga naaki

Next week people will come and talk about what was learned during the conflict resolution training.

Awiiyak kiaa aakweiiminkonaniik wekonen ga kii kikinooamaakoyang iiwe weweni aananaichikaatek maajisewinan

What's great about PD in general is that it's like going to a conference; you're not sure what you're going to get out of it, but you know it's going to be worthwhile.

Gii aado kikino'amaakoyang gawiin kikikendaasiimin wegonen ke kikino'amaakoyang ki kendamin jii minawshin

One thing I would like to acknowledge is that circumstances are changing.

Miisa nindikid ka kinakekon enianjisek…Kaawiin nongom niin waapedasiin jii anikoo sekin wiijii' we winan

When it comes to access to services, I don't see services expanding any more at this point in time. Dilico is here visiting on a regular basis, we have a school councillor, an SLP who is here

4/5 days, an OT once every 3 months, and Creative Therapy services from Thunder Bay three times a year to assess students and help teachers.

Dilico mooshak piishawek, kikinoo'amaatiiwin kaanooshiwesinini awaa imaa kikinoo'amaatowigamigong, kotaak awiiwaa kiwiijiikonanek, SLP, OT kaye Creative Therapy

Where we are short is with Ojibway language teaching.

Kawwin apijii kitaayaasiimin Ojibwemowin kikinoo'amaatiiwin

In our community, we have always received 100% support from the Band Manager, Chief and Council, and others serving the school.

Nindo ishkoniikanaanin maawaj niiwiigiik nanek Okimaakanak kaye o taawokimaa kaniwag. Awiijiikooyaaang imaa kikinoo'amaatiiwigamigon

c. Councillor

COUNCILLOR – Conflict Resolution

Interprofessional collaboration is something that requires all facets of the community – council, leaders, members, administration- to come together and work towards a common goal.

Maamoo kaakina anookiiwiniiwag kawiidanokimitiwaj gaichikaateg. Antawedaakosiwag ogiimaag. anookiiwiniiwag gaye ishkinikaning ka daawaj ji wiitanokimmitiwaj jikiishitoowaj kakon jikiishjikaateg.

Collaboration can become greatly impeded when:

Wiidaanookimitiiwin damaajise kiishpin:

1. There are particular individuals who are not collaborative and harm the process for others.
2. When all team members are not present (i.e. physically or figuratively) for the collaborative process, and
3. When a common identity is missing that can unite the collaborative process.

Currently, there are tremendous resources in the community, however the mechanism to identify those resources such as a resource booklet, is not available.

Nongom nipiwaa ayaamakanoon wiichi'iwewinan shakoj gaawiin ayaamakasinoon andi ke ochii mikikaatekin.

Better access to resources could be achieved once the community begins working together in sync.

Aniwiidanokiimitiiyang taani miinose keonjii miikikaatekin wiijii'iwewinan.

Despite the importance of resource acknowledgment and utilization, this takes a back seat when the community itself is struggling with cultural identity and vision.

Gitchi inwedaakanoon wiijii'iwewinan pinamaa dash Dakii anookikanjiikate weneniwiyangi dash aawin kenitotamang aniish kaawiin mashi tebwe ki kikenta siinmin.

Following the Interprofessional Collaboration session where occupational health and safety issues were identified such as bullying in the workplace, community members have begun working on a Code of Conduct policy to be put in place that will pertain to everyone (Council, Administration, Membership), and hopefully implemented by next spring.

Ka'ishkaa taashinjikaatek maamoo anookiiwiniiwag kawiidonokimitiwag anookiiwining Kiitaashinjikaatewan maachiisewinan. Mekwaa anokiikaikaatewan ke pisminisha kaateg oshipii'kanan awiyaa ga maaneni-maakaniwij gaishi anookiij. Jikii shijikateg miinawaa siikwang.

Collaboration can be achieved when inter-council and leadership continue to work towards building a better rapport with one another in a team-based environment.

Maamoowiijii'itiwin taaminose kakina wiitaanokimiwitiwaj.

With new people joining the team and others having belonged for decades, it is inevitable that conflict will be experienced.

Oshki anookiiwiniiwag kaye kapii anokiiwaj okanaakishaanawaa maajisewinan.

Sessions like the Interprofessional Collaboration training should include the presence of Chief and Council to enhance the overall benefits to the community.

Ogiimaakanag kewinawaa jitakwiiwag … kiikinkioomaakeyang jionji ani minosekiin ishkonikanan.

Certain individuals are exceptional in their roles and really focus on serving the community as a whole.

Andaa gaanookiiwaj wiinka okaashkitoonawan odaanookiiwiniwaa jiwiidokewaj ishonikaaning.

With this said, community members have varying ties to the community – some are more tied to the lake rather than familial ties – so focusing on finding a communal identity and engaging in cultural practices (e.g. language, land based teachings) is very important.

Pepakan kidishisemin kiiayayang kidishkonikanaaning apiiji kiijinedakon… kakinaa kadaawang ishonikaaning ji kakwe wii ji toowa kaishi pinaadisiyang.

We need to work together to achieve the same goal and be on the same page.

Maamoo wiijii'itiyang miisa kekashkitooyang kekonan ji anookimagakin.

It is only them that services can be better accessed.

Miisa etako wiijii'iwewinan keondinamang.

As a councillor, I have gained different perspectives regarding access issues and community needs.

Ki okimakanensiyaan niwaapadan piinji iskonikaning kaanoondesekin wiijii'iwewinan.

The location of where the community will be built is an important discussion piece as there's a disconnect between where the community has come from, and where the community is going to be built.

Wiike kitchi'nen daakon jidaashinchikaate aandi keichi oshiijikaatek iskonikan. Kaawin kiki'endasiimin aandi kaaonjimagaak kaaonjimaajisek kido ishkonikaniminan gaye aandi ishi ayaamaakag.

It will take a community to build a community, so our inclusion of membership is strongly needed.

Miidash kakiina katiipentaakozhi iskonikaning aantaawedaakozi jiiwiijitaj.

There is a desire for progress to happen here and now which can create a disconnect with membership, given that the challenges involved in getting funds are not well understood.

Miisawendakon awashime wiijiiwewinan anookiiwinan jiayaamaakaaken ishkonikaning gaawiin dash aapiiji kikendaagosi noon epiiji saanaakan shooniyaa kiigakwe ondinaakaahiwij.

An important step is the need to unroll our Community Plan to move things forward.

Maanoodash jimaaji anookikadamang kaawii'ishi jikeyang ji ozhi tooyaang kidishkonikaaninaan.

Following the IPC session, I found that it was a very beneficial session that allowed us to be engaged in a round table discussion.

Kaa ishwaa kikinooamaakoyang wiijise weweni kii kaanoonitiyang.

Interprofessional collaboration is something that requires all facets of the community – council, leaders, members, administration- to come together and work towards a common goal.

O'owe maamookaakina anookiiwinininiwag kawiidanokiwitiwaj gaichikae Angwedakosiwag ogiimaag, anookiwinininiwag gaye ishkinikaning ka daawach chii wiitanokimmitiwach.

Collaboration can become greatly impeded when:

Wiidaanookimmitiiwin damaachese kiishpin

1. There are particular individuals who are not collaborative and harm the process for others,
2. When all team members are not present (i.e. physically or figuratively) for the collaborative process, and
3. When a common identity is missing that can unite the collaborative process.

1. **awiiyag gaawiin ka wiiwiijii'iwewach**
2. **awiiyag kaapaanisewach**
3. **Kiishpiin kekoon awaamaakishinok keonjiiminosek maamo anookiiwitiwin**

Currently, there are tremendous resources in the community, however the mechanism to identify those resources, such as a resource booklet, is not available.

Nongom niipiwaa ayaamakainoon wiichi'iwewinan shakoj gaawiin ayaamakasiinoon andi kaye ochii mikikaatekin

Better access to resources could be achieved once the community begins working together in sync.

Aniiwiidanokiimitiiyang taani miinose keonjii miikikaatekin wiijii'iwewinan

Despite the importance of resource acknowledgment and utilization, this takes a back seat when the community itself is struggling with cultural identity and vision.

Gitchi inwedaakanon wiijii'iwewinan pinamaa?? Da anookikanjiikate wenenniwiyangidash aandin kenitotamang aniish kaawiin mashi tebwe ki kiketa siinmin

Following the Interprofessional Collaboration session where occupational health and safety issues were identified such as bullying in the workplace, community members have begun working on a Code of Conduct policy to be put in place that will pertain to everyone (Council, Administration, Membership), and hopefully implemented by next spring.
Ka'ishwaa taashinjikaatek maa anookiiwinininiwag kawiidonokimitiwag anookiiwining. Kiitaashinchikaatewan maachiisewinan gaishi mekwaa anokiikachikaatewan ke pisminishe anookiiwiniwa

Collaboration can be achieved when inter-council and leadership continue to work towards building a better rapport with one another in a team-based environment.

Maamoowiijii'itiwin taaminose aakimaa wiitaanokimiwitiwag

With new people joining the team and others having belonged for decades, it is inevitable that conflict will be experienced.

Oshki anookiwiniwag kaye kapii anokiiwag okanaakishaa nawaa miigisewin

Sessions like the Interprofessional Collaboration training should include the presence of Chief and Council to enhance the overall benefits to the community.

Ogimaakanag Kawinawaa chitakwiiwag … kikinooamaakewin

Certain individuals are exceptional in their roles and really focus on serving the community as a whole.

Andaa kaanookiwag wiinka okaashkitoonawag odaanookiwiniwaa jiwiidokewag iishonikaaning

With this said, community members have varying ties to the community – some are more tied to the lake rather than familial ties – so focusing on finding a communal identity and engaging in cultural practices (e.g. language, land-based teachings) is very important.

Kishiinedakong… kaakinaa kadaawaag ishonikaaning chii kakwe wii chi toowag kaishi pimaadisiyang

We need to work together to achieve the same goal and be on the same page.

Maamoo wiichii'itiyang miisa mekashtooyang gekonan chii anookimaagakin

It is only them that services can be better accessed.

Miisa etako wiichii'iwewinan kaondinamang

As a councillor, I have gained different perspectives regarding access issues and community needs.

Ki okimakanensiwiyaan niwaapadan piinchi iskonikaning kaanoondesekin wiichiiwaawinan

The location of where the community will be built is an important discussion piece as there's a disconnect between where the community has come from, and where the community is going to be built.

Wiinke kitchi'nen daakon chidaashinchikaatek… Aandi ke… oshichikaatek iskonikan. Kaawin kikiendasiimin aandi kaaonjimaagaak kaaonjimaachisek kido iskoniminan gaye aandi kaye ishi awaamaaka

It will take a community to build a community, so our inclusion of membership is strongly needed.

Miidash kakiin katiipentaakozhji iskonikaning aantaawedaakozi jiiwiichitawj ki oshichi kaadek

There is a desire for progress to happen here and now which can create a disconnect with membership, given that the challenges involved in getting funds are not well understood.

Miisawndakom jiianookiikaanjikadek gaawiin dash aapiiji kikendaagosi noon wene… weji tiipiindaakoji ishkonikaaning si ondinaakaniwiig shooniyaa

An important step is the need to unroll our Community Plan to move things forward.

Maanoodash jimaaji anookiikadamang kaawii'ishi chikeyang chi ozhi tooyaang kidishkonikaaninaan.

Following the IPC session, I found that it was a very beneficial session that allowed us to be engaged in a round table discussion.

Kaa ishwaa kikinooamaakoyang wiijise weweni kii kaanoonitiyang

As a council member, this was the first time that the Chief was heard in quite some time and was beneficial to those who were present.

Ki okimaakanensi wiyaan, kakiikikinooama… miiwe paayaash ekiipisiintawaakamiwwch ogimaakaan…

It is important to understand what everyone does even though the disconnect may be specific to one person.

Aantaawentakon kaakiina awiiwaa giniisiitoonaan aniientootang otanookiiwining anokiiwininiwag

Currently, there is a lack of respect towards collaborative goals; the focus is on individual goals.

Noongaom, gaawiin kichiinendaakasinoon mamo kakweiishichiikewinan, peshig etah iishichiikewin anokiikaachikaangde
With this said, there is a strong connection between team members - most of us are open to listening to each other.

Shaakoj ayaamakan wiitaanokiimitewin. Maamoo chiwiiji'itiiyang

Staff do not feel that they have support for all of council which is something we need to build on to avoid disconnect.

Shaakoj kaye aaniida anookiiwinininiwag inentaa moo wag… kaawiin owiichiikosiiwan ogimaaganak. Jii anookiimitayang idash kaawin anookiwin ji onjimachii sek.

When council members or the Chief are not present, this can lead to issues with the administrative staff feeling disrespected.

Ogimaaganak kaawin miijitaw wach (kiayaawach) miiwe eschi inendamowach anookiiwinininiwag kaawiin ninkichinenimiikosiinmin

Physical presence is incredibly important to be seen and to belong.

Kii ayaawach kaye kii wii too kewach ogimaakana kichinentaakon.

In the future, training needs to be made mandatory for everyone to ensure that we can all be on the same page.

Kaakinaa anookiiwiinininwag… Peshigong anooki gikikendaamoowag… Niikan, chii ona chii kaa tek…

Through this communication, we will be able to achieve community goals.

Kiiwiin daamaadiyang, paatiiinkekonan kaawii kaye gikaanooniitiiwang … shi chii keying kakashkiioomin kaye kakiishi toomi

The training allowed for building team skills by understanding what everyone does and appreciating the level of their work.

Kaakii kikinooamaakoyang kiitoonji nisitooyanmiin kaye ki toonji ki kentaamin aanin entootaamiwin annokiik…

The session also allowed for better respect of everyone in the room and to listen to one another's contributions; it was an opportunity to be friendly and build trust.

Gigii onji mino wiijiiwitimin kaye gigiionji kichiiinenimitiiwmin

For myself, I try to practice this regularly.

Niin kaa ishi peshigoyanng minkaakwetootgang I'ikwe
Recently, I sent out a nice email to ensure ongoing communication; it allows for professional and personal relationships to be strengthened.

Noongomiike ningiioshipii'amoowag aanookiik awaashiime jiiminowiitanoki mitiiyang

Observations that I have made regarding negative email communications, tell me that examples need to be set; respect can only be gained if projected.

Nis waapataanan oshpiikanan kaa maanechike minenjikewin ishipimooseyaan taamiinose

A booklet/resource guide is currently being put together.

Mekwaach oshi chi kaate mazineikan, kookinoa wiichi'itiwinan chi maanooipii'ikaatekin

With our AGM coming up in January/February, we need the community to be updated and informed on last year's progress and available programming.

Kitishookniikanananing ki tagii saakaakiipii'I kemin wekonen kakii' ishi chi keying, wekonenan kaye eyaayang piinchi ishoonikaning jibwe oskikisis maamoopiiw

Lastly, there are mental health and addictions concerns with cannabis becoming a legal drug being mixed with other prescription drugs.

Iskwaach dash miwii'ikid kaawii paakiitinikaadek maajimashkiki kaa saagaswaajikaatek, kaye maajimashkikin taa oji machisewag awiiyag o maamaa mitaanenjiwi

This is a universal concern for all First Nations which we need to be proactive about and aware of, especially when changes happen in policy.

Noongom idash ji aanookiikanjikaate kaye chitaashinji kaateg jibwe oshiseg inaakonikewining.

d. Administrator

ADMINISTRATOR – Team Functioning

The interprofessional collaboration training was very eye-opening.

This shows that ongoing collaborative group work ensures success of the overall event.

Maamoo anookiwining kawiidanokimitiwaj kikinoamakewin wiike minaashiin kaye minosek.

Miiwa enaakok gii maamoo wiidaanookiwitiyang kegoon minose.

I particularly liked the exercise where we needed to describe our roles; we do something similar at our AGM's where visuals of people are presented with their names to ensure that everyone knows who we are and what we do.

There is an underlying assumption by the community that, if you take an event, you take if from start to finish – that is, digging horse shoe holes if you have the horse shoe event.

Ningii minewendan kiiwiindamaatiyang aaniin endotamang gidanokiiwinaning.

Enentaakon kekoon gii'shijikaaniwan kiitinenimigo ji kiishtiooyang.

A constant re-education of our roles with the members is needed; this helps to showcase our work and to build relationships.

Although people know that they will be supported no matter what.

Kaye mooshaag jii widamang ishkonikaning ka'ayaawaj, ji kikendamoowag aniin endotaamaj kii aanookiyang, kaye minowiichiwitiwin ji onchimaakaag.

Awiyaak okikendaanawaa jiwiiji'akaniwij.

Despite these positive experiences, some of our staff may underestimate their value.

It is important to acknowledge work achieved as this will give us a better appreciation of our roles.

Anakii kichi anookij anookiwinini aaniida kaawiin minwendasiiwag.

Kijiinetaakon kaye naanaakomaakaniiwaaj aanookiwininiwag ga ishi kashkitowaaj otanookiwin.

At the AGM, some people shared to complain about the AA's behaviour without understanding that we all wear multiple hats.

At the band office, we are entirely reliant on each other.

Daasopiboon kitchi maamoopiwining bishishig awiiyaag omaanapantanawaa ka ishi ji kewaaj anookiwininiwag, yaa'ing AA kaawiin okikendasiinawaa mishiin anookiwin eshijikewaaj.

Ka ishi anookiyang ishisebiko ji wiichi'itiiyang.

What members do not often understand is that we can never be band members.

Some staff, for example, are able to jump into other roles when needed.

Iskonikaaning anishinabek kaadaawaj niinaawand dash taapishkoj kaawiin wiikaa nikaatipentaakosisiimin ishkonikaning.

Aandaa okashki toonawaa niishweg anookiiwin ji toodamoowaaj.

We are constantly represented in our occupational role, and the only power we have as a member is during election time when we cast our votes.

Our work partners can be more than our family, even when we are not amicably close, because we spend so much time together.

Miiwe eta eshi waabamikoyang enookiwininiyang. Baanimaa eta kii pitnjiwaapinikaaniwan.

This can be very challenging experience for staff as family tensions and rivalries will surface.

Ka ishi anookiiyang tabishkooj igo enawemitiyang minik tipaa'ikan ka wiijiiwitiiyang.

Saanaakendakon kii maajetinaaniwan kiimaajenmintisaaniwang.

It is known in our work space that we are not allowed to share political views or pick a side; Facebook can be a major instigator.

When new people come on, they can feel like an outsider, so we've learned to use each other's strengths and weaknesses to make the most of situations.

Kaishi anookiyang gawiin niipakitinikosiinmin ji wiijitaayang kaishi maanaapantinaaniwang.

Oshki anookiwininiwag kiimaataanokiiwaj taapishkooj epiiwiitewaj, miidash eshi wiiji akaaniwag.

To ensure safety, honest discussions are needed within the band office to allow people to speak freely.

For example, with Aboriginal Day there are all sorts of activities, teachings and cultural experiences taking place.

Kaishi maanoo anokiiyang antwetakon ji maamoo tashiinjikaatek maajisewinan.

Taapishkoj, Anishnabwe Kiishikan wiike paatiin ishi jikewinan kiiayaawan.

We are the only support system for each other, and we know that we cannot bring this home.

In the beginning, Council would lead us on how the day would unfold so that people had the opportunity to see where their strengths are.

Kaishi anookiyang niwiijiitinin, kaawin jikiiwewidosiiyang kaa ishiwebak nindanookiwininan.

Being able to leave here in a good space at the end of each day is paramount.

Niitam okimaakanak oginiikaanishkanaawag ishi ji kewinan ishijikewinan Piinitish kaagiiwijitawach awiiyag okiianikikendaanawaa aishi kashkijikewag.

Wiiji'waamakan kiinakaadaanang daanookiiwinan gaishi anookiiyang.

Nowadays, some people who have already participated in the past, take a head start, and so natural roles have been established.

Noongom idash okikendaanawaa keminosek.

The interprofessional collaboration training was very eye-opening.

Maamoo anookiiwininiwa kawiidanokimitiwaj kikino amakewin wiike minawshiin and minosek kaye

I particularly liked the exercise where we needed to describe our roles; we do something similar at our AGM's where visuals of people are presented with their names to ensure that everyone knows who we are and what we do.

Ningii minewendam kiiwiindamaatiyang aaniin endotanmang kiitaanokiiwininaning

A constant re-education of our roles with the members is needed; this helps to showcase our work and to build relationships.

Kaye mooshaag chii wiidamang ishkonikaning ka'ayaawaj, chi kikendamoowag aniin endotaaman kii aanookiiwang, kaye minowiichiiwitiwin chi onchimaaka

It is important to acknowledge work achieved as this will give us a better appreciation of our roles.

Kichiinetaakon kaye naanaakomaakaniiwaaj aanookiwininiwag ga ishi kashtowaj otanookiwin

At the band office, we are entirely reliant on each other.

Ka ishi anookiyang ishisebiko ji wiichi'itiiyang

Some staff, for example, are able to jump into other roles when needed.

Aandaa ke niishwek anookiiwin toodamoowa

Our work partners can be more than our family, even when we are not amicably close, because we spend so much time together.

Ka ishi anookiiwang tabishooj igo einowemitiya minik tipaa'ikan ka wiichiiwitiiyang

When new people come on, they can feel like an outsider, so we've learned to use each other's strengths and weaknesses to make the most of situations.

Oshki anookiiwininiwag kiimaataanokiiwag taapishke…? E piiwiitewaj, miidash eshi wiichi akaaniwag

For example, with Aboriginal Day there are all sorts of activities, teachings and cultural experiences taking place.

Taapishkoj, Anishnabwe Kiishikan wiike paatiin ishi chikewinan kiiayaawan

In the beginning, Council would lead us on how the day would unfold so that people had the opportunity to see where their strengths are.

Niitam okimaakanak ogiiniikaanishkanaawan ishi chi kewinan Piiniish kaagiiwiichitawach okiianiikiken kai shikashkijikewag

Nowadays, some people who have already participated in the past, take a head start, and so natural roles have been established.

Noongom idash okikendaanaawaa keminosek

This shows that ongoing collaborative group work ensures success of the overall event.

Miiwa enaakok gii maamod wiidaamookiwitiyang kegoon minose

There is an underlying assumption by the community that, if you take an event, you take if from start to finish – that is, digging horse shoe holes if you have the horse shoe event.

Kakoon ishijikewin kimaajisek ki maajitoyang kiishitoon

Although people know that they will be supported no matter what.

Awiyaak okikendaanaawaa chiwiichi'akani

Despite these positive experiences, some of our staff may underestimate their value.

Anakii kichi anookij anookiwinini aaniida kaawiin minwendasiiwag

At the AGM, some people shared to complain about the AA's behaviour without understanding that we all wear multiple hats.

Daasopiboon maamoopiwin aaniinda awiiyaag omaanaapantawaa ka ishi chi kej anookiiwinininj, kaawiin beshikwek ishi chi kesiin

What members do not often understand is that we can never be band members.

Iskonikaaning anishinaabek kaadaawaj niinaawand kaa anookiyang taapishkoj kaawiin mindaakoniikosiimin ji ishkonikaan anishinabeyang

We are constantly represented in our occupational role, and the only power we have as a member is during election time when we cast our votes.

Miiwe etaa eshi waabamikoyang e anookiwinininiyang. Baanimaa etaa kii piinjiwaapimikaaniwan

This can be very challenging experience for staff as family tensions and rivalries will surface.

Saanaakendakon kii maajetinaaniwan

It is known in our work space that we are not allowed to share political views or pick a side; Facebook can be a major instigator.

Kaaishi anookiyang koawiin niipakitimikosiin min ji wiijitaayang kaaishi maanaapantinaaniiwang

To ensure safety, honest discussions are needed within the band office to allow people to speak freely.

Kaishi maamoo anokiiyang antwetakon ji maamoo taa shiinjikaatek maajisewinan

We are the only support system for each other, and we know that we cannot bring this home.

Kaa ishi anookiyang niwi'itimin, kaawin wiindag e nikiiwewitoosiinmin kaa ishiwebak nind

Being able to leave here in a good space at the end of each day is paramount.

Wiiji ewaamakan kiinakaadaan odaanookwiiwin aa ishi anookii

At one time, we had a nurse here who wanted to give everyone sick notes (insert laughter).

Beshiwaa mashkikiwikwe niiwiimiikonaan oshipii'ikanan kaawiin ji anookiiyang

We realized that staff members were bringing work home regularly, making us question; where is the safe haven? What can we do for each other?

Aninda anookiiwininiwag okiiwewitonaawaa odaanokiiwiniwaa. Aniish kedootamang ke jiwiijiit yang

We were once told that we should not hire familial-related band members into the office; this is impossible!

Ningii inikoominaapan kaawiin kitaawiininaag Ji anookiwaj. Kaawiin dash taa kipitinikaate siinoon

We are all related either through bloodline or by marriage and so this is the daily reality that we need to work within.

Aaniish kitinaawaamitimin anindake wiitikewininiwing

Following the IPC training, I learned that communication is needed on an ongoing basis but is difficult to do when we are busy.

Maawaj saa chikaakwe kanoonitiyang mooshak, shaakoj saanakise kii ondamiij anookiwinim

We can fail to communicate because we have so much trust in one another --- oh, I thought you were doing that.

Ishise piko, kaawin kiikanonitiyang kiikikend mitiyang wiike kiiwii tanookimitiyang che'inentang genaakiin katoodaan

This can be a danger of being a high-functioning team, as it is easy to gloss over the small things.

Maachise osaam kiikikenimitiyang paaneshi oniikikaatekin andaa

We meet every Monday for group sharing, and to reflect on where we are all at.

Daso Oshkikiishikan nimaamoopiming, jiwiindamaatin yang aaniin eshichikeyang

Sometimes we get busy and rush through this meeting, so we need to be sure not to do this.

Ozaam kii ochaaniniziyang aajinaa eta nii maamoo piming

Another communication snafu that occurs is when people do not know where people are.

Ishise kaye kaawin kiikikenimaakaaniwaj aniin eshichikej awiiyaa kaye aniindi eyaaj

We have realized the importance of emailing a communication spreadsheet on our whereabouts rather than saying we don't know where people are.

Niin kikendamin emiinoseg kiiwiindaamaatiyan aaniiti awiiyaa eshi ayaaj, kaawiin memej chi'ikitoonaaniwan kaawin nikikentaasiin

This has been especially helpful to Council as we have worked hard to intentionally separate our working spaces into two different environments.

Ningi chi anookiikataamin weweni jiminosek anookiiwin

I was necessary to draw this line to ensure that both groups could be productive and successful in achieving their goals without people stepping on one another [figuratively and literally].

Weweni jikiishitoowaj kaa'anookikatamowaj kaawin ji onji maajisenaaniwan

This has strengthened our working relationships and has increased our appreciation and respect for one another.

Miisa eshi mashkaapowinmin kaye nindoji eshenitimin

We know that at the end of the day, what Council says goes, but we have much better channels of communication now.

Nikiketaamin Ogimaag kaaishi antawendamowin te ishi se, miisa eshi minosek kiikaanonitiyang

Following the collaboration workshop, I noticed that there were more opportunities for people to truly learn about one another.

Kaakii kikinoo amaako'yang ningii waabadaan anookiiwininwag wenji kikiikendomowaj anii eshi anookiiwaj

One of our members was called the 'traveler' because everyone thought that's all he did.

Beshig anookiiwinini kii ishinikaanaakanin kapapaamiyaaj miiwe kaa'inetamoowaj enaanokii

The training gave him a voice and gave others a strong understanding of why he needs to travel so much for work.

Kiiwiindam idash wekonen weji paapaami y ji kikendanowaj kawii tanokiimajin

Overall, appreciation was noticeable and staff members knew who to go to for when needing help for certain things.

Anookiig ikikentanaawaa wenen ke kakweji maakaniwij kewiiji'ikooj

Practicing people skills and spending time with one another in a meaningful way was very important.

Miinaawaa kaa onishishiin kiikikikendaana aniin eshi minosek awiyaa kaa'anookikadawich

What was really special was that all participants had the chance to experience the full day from beginning to end, completing many group tasks that were focused on strengthening relationships.

Kakinaa kakiikikino amaakoksij kiiwiijitwaa kaakinakekon kakii ishi chi kaaniwan… ki onji mashkaawisiimikan

When I think of the big picture, such as accessing care or services for our community, I feel that there is an us against them mentality.

Kiikaakwe ondi nitaat wiichiiwewinan taapishooj kaawiin ekakwe wiichi angkii niiwiichi anishinaabwek aaninda inendaanoowag

For some reason, members are “us” and the Council/staff are “them”.

Taapishooj wiinaawaa Ogimaakanak idash kiinaawaand idash anishinabeg

We are those people.

Kiinaawaand sa’ikweniwag

I think if we were physically settled in our community, that bringing the collaboration training at a wider level would really help us (i.e. groups for elders, youth, parents).

Kiishpin aasha ayaamakaag kitishkonikaanii nai owe kaakikenkinoamaakoyang tawiij se

Members for instance, would not forget that they have a role and that they are needed; they would be able to see what is happening behind the scenes.

Okakikendanaawaa aaniin keishichi kaaj awiyaa. Ogawaabaan daanaawag eshi we bag kaawiin kiwaapamaakaniwai anokiig edasotootaan

For the members, the physical visuals are very important.

Anishinabwe imaa ishkoniikaming ka onji tipaantaakosij okichiinendaanaawaa kiwaapadang waj… anookiwin eshi seg

It is not sufficient to say “I did the following” without visual proof.

Jiwaapadamaowaaj ekianookiikajikaateg kekon

It’s not that people intentionally dislike band council or staff, it’s just that only one side of the story is available.

Owiiwwapadanaawaa sago anookiiwin e anookikatamooawaj. Kaawin omajenimaasiiwaa anookiig kaye Ogimaag

The other issue is that everyone questions the finances.

Kotaag kawii kikenjikaateg shooniyaa inaapikinikewin

Our Financial Manager is always available for this conversation; however, no one takes these offers up as they see It as not their responsibility.

Shooniya Sakakipii’ikewinini ayaa jiwiintamaakej enaapikiniikej ishkonikan

We have always talked about having a “true and honest” finance meeting; those not in the know always see the worst despite an annual audit presentation.

Biishishiig ninkaakwe wiitaamin eshisej shooniyaa awiyaag kaawiin kakikendamowaaj pakaan inentamoowag

When we say “we’ve spent 3 million dollars”, this can shut down a conversations before it starts.

Kii’ikidoyaang niipiiwa shooniya ninkiiapaji…? Kaawiin kekon ikidosiiwag

High salaries are made known to the public which can also cause conflict.

Kii wiinjikaateg aaniin minikog awiyaa kaa Ontisij kaye onji maajise

The bottom line is how do we get from A to B when people always think the grass is greener on the other side, and that First Nation communities are doing better than “we are”.

Aniish ke ishiji keyaang awiyaa kii’inentamoowaaj maawaaj kiinaawaand kiminosemin

Moving forward, we know that community engagement is needed.

Antawentaakon maamoo wiiji’itiwin ji aayaamakaag ishkonekaning

Also, policy generation is needed to protect council, staff and members when they are both on and off of work time (e.g. walking in the mall and being stopped to explain work matters).

Anookii inaakoniikewin jioshijikaateg kepiminisha’ikaateg

True and ongoing collaboration is an important piece to ensure that we get to where we want to and need to be.

Maamoo wiijii’itiwin antaawenjikaate jikashki tooyang kaawii’ishijikenaaniwang

e. Spirit – Builder

SPIRIT-BUILDER – Collaborative Leadership

Following the training, I can say that I see this as an opportunity to bring co- workers together, which can be a challenging thing to do logistically, geographically and personally.

Ningiiawapadaan jisanakiseg mooshaag jikakwe maamooshkikaayang aniish isiwe kitayaamin.

We have seen that there are events that overshadow planned trainings, such as a death in the community, or there can be resistance from different people who are resistant and fearful of change.

Paatiin kekonan kitishisemin wenji kipijisekiin maanoopiwinan.

I see the collaboration training as an opportunity to improve access to care because we become aware of what others are doing.

Kakiikikino'amaakooyang taonji minose jitepinamang wiiji'iwewinan kaye kitoojikikendaamin wenen canokiikatang.

Specifically, we learn to piggyback other trainings, such as the kid ness training and sweet grass teachings so that we can expand to more members in the communities.

Kotag kikinooamakewinan jitaakonikaatekin kewinaawaa kiiwiij Anishinabek ji otaapinamoowaj.

This also allows us to see what is happening within Nokiiwin, and to translate programming in a meaningful way to the communities.

Jionji kikendagmang aniin eshijikewaj Nokiiwin kaye jioshipii'ikaatekin ishijikewinan kakina jikikendamowaj.

Nokiiwin's role as an advisor and neutral facilitator helps communities with identifying supports.

Nokiiwin kiwiij'iwewaj kitishkosninaanan wiiji semaakan.

I see that Nokiiwin is making changes every day, and in some ways, is leaps and bound ahead with regards to embracing change.

Nokiiwin otooshitoonaawaa kishaatapiiwag jiangitoowaaj kekon.

From the IPC training, I learned that it's important to give people the opportunity to talk and share in a safe space.

Kagikikinooamaakoyang ningii ojikikendang awiyaag jikaakiitowag wewenі kaawin jikotaajiwaj.

In order for true sharing to happen, a safe space is needed; this also allows opportunities for finding resolutions to identified problems.

Kiiwiintamaatiyang kekonan kaawiin awiyaa jikotaaji jiishi kakitoj igo miiweke wenji mikikaateg minosewin.

Since the training, I've made it a point in my own training [facilitating] to engage participants without fear of having them share their stories.

Apii Gaakikikinooamaakeyang awiyaag jitiitpaajimnoowaj igo kaawin jikotaaji kaawiin tawiinjikaatesinoon otiipaajimowin.

I have learned that I cannot be afraid of the direction of the conversation and know that I need to let certain conversations be had.

Jingikenendaan kaye jigakidooj igo awiyaag ekonen tiipaajimoowin wa'ikitooj.

At four months post-training, I feel that the experiences and learning have stuck, and that I can carry them forward me as part of what I do on a day-to-day basis.

Ashaa niiwo kisis apii gakiikikinooamaakoyang paatiin kekonen nindapaajitoonan kaishi anookiiyaang.

I wasn't expecting to make any new connections in the IPC Training.

Kaawin ningii incndaasiin paatiin awiyaag jionji kikenimakwaa.

However, I found that everyone I knew was lighter and more engaging with one another during the IPC training.

Wiike kakinaa kionji naakentaamowag kakii ishi kikinooamakoyang.

With two of the leaders in particular, I had a solid working relationship, but the training still helped to improve these relationships.

Niishin kakiinikaaniiwag niiminoo wiianokemag wiinke idash awaashime niinigrowiitanookimitmin.

With regards to Council, it was because of this session that I realized that they had full-time jobs on top of being Council members.

Ningii onji kikendaan Ogimaag e anookiwaj kaye e Ogimaawiwaj. Niipiwaa anookiwin ishijikewag.

This recognition gave me an overall appreciation and understanding of what the days and responsibilities might look like.

Miisa weji gii nishitootaamaan minikog anookiwin kaye paamisiwin eshijikewaj.

I can see how when dedicating time to understand one's role, even with those whom I have great relationships, access to services can be improved.

Jiwiitookawakawiwij minose kiikikendamang kaishijikej awiyaa odaanookiwinining kaye jionji wenjiseg wiiji'iwewinaning.

Also, working with a researcher who has similar values as I do, allows for progress to be made with community members.

Minose kaye kiiwiitanokiimaakaniwij kanaantokikenjikej beshikon kainendang miiwe wenji maajoamakakin ga anookiikaadekin.

After teams experience this training, it is evident that more options are available regarding access.

Wiinke onji minose kekonan kidaanookiwininaning.

By collectively sharing our skillsets, we learn better how to connect with other people and share information.

Awaashime minose kekon kiwiijiitiyaang.

Going forward we no longer need to work in silos as we feel comfortable working with others.

Miidash kaawin awashme kikaabeshiko anookiisiimin.

It is through this training that people can learn to be vulnerable because their voices can be heard without judgement.

Gakiikikinooamaakooyang kaawin memej jiseksisj awiyaa kekon wii ikidoj.

Regardless of what the evaluations say about this training, I have heard voluntarily a lot of positive comments and feedback; this had been a major turning point for the community.

Aanin igo keinendamowang awiyaag gakiikikino amaakoyang nipiwa ojii miinwendaanawaa ekii miinwashing kikinooamaakowin maawaj ganinosemin kiki shkonikananing.

The excitement voiced by the two communities who have engaged, is creating positive energy for us at Nokiiwin and in other communities.

Wiinke kiiminwendamoog niishiin ishikonikanan anishinabeg gakiiʻishawaj wiike idash nindojiminwendami ninawend Nokiiwin ga ishi anookiiyang kaye kotag ishkonikaning.

Following the training, I can say that I see this as an opportunity to bring co-workers together, which can be a challenging thing to do logistically, geographically and personally.

Niwawpadaan jisanakiseg mooshaag jikakwa maamoo shiikaayang aniish isiwe kitayaami

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Paatiin kekonan kitishisemin wenji kipijisekiin maamoopiwinan

I see the collaboration training as an opportunity to improve access to care because we become aware of what others are doing.

Kakikikino'amaakooyang ta onji minose jitepinamang wiigi'iwewinan kaye kitoojikikendaamin wenen eanokiikataang

Specifically, we learn to piggyback other trainings, such as the kid ness training and sweet grass teachings so that we can expand to more members in the communities.

Kotaag kikinooamaakewinan jitaakonikaatekin kewiinaawaa kiiwiiji Anishinaabek ji otaapinamoowaj

This also allows us to see what is happening within Nokiiwin, and to translate programming in a meaningful way to the communities.

Ji onji kikendaomang aniin eshijikesaj dokiiwin kaye ji oshipii'ikaatekin ishijikewinan kakina jikikendamowaj

Nokiiwin's role as an advisor and neutral facilitator helps communities with identifying supports.

Nokiiwin kiwiiji'iwewaj kitishkosninaanan wiiji semaakanoon

I see that Nokiiwin is making changes every day, and in some ways, is leaps and bound ahead with regards to embracing change.

Nokiiwin otooshitoonaawaa ekishaatapisek kekonan ajisewinan

From the IPC training, I learned that it's important to give people the opportunity to talk and share in a safe space.

Kagiikikinooamaakoyang ningii ojikikendang awiyaag jikaakiitowag weweni kaawin jikotaajiwaj

In order for true sharing to happen, a safe space is needed; this also allows opportunities for finding resolutions to identified problems.

Kiiwiintamaatiyang kekonan kaawiin awiyaa jikotaagi ji'ishi kakitoj igo miiweke wenji miki'kaateg minosewin

Since the training, I've made it a point in my own training [facilitating] to engage participants without fear of having them share their stories.

Kiikikinooamaakeyan awiyaag jitiipaajimoowaaj igo kaawin jikotaaji kaawiin tawiinjikaatesinoon otiipaajijmowin

I have learned that I cannot be afraid of the direction of the conversation and know that I need to let certain conversations be had.

Jigakidooj igo awiyaag ekonen tiipaajimoowin wa'ikitooj

At four months post-training, I feel that the experiences and learning have stuck, and that I can carry them forward me as part of what I do on a day-to-day basis.

Ashaa niiwo kisis apii kakiikikinooamaakoyang paatiin kekonen nindapaajitoonan nindanookiiwining

I wasn't expecting to make any new connections in the IPC Training.

Kaawin ningii inendaasiin paatiin awiyaag jionji

However, I found that everyone I knew was lighter and moe engaging with one another during the IPC training.

Wiike kaakinaa kionji naaketaamowag kaaki'ishi kikinooamaakoyang

With two of the leaders in particular, I had a solid working relationship, but the training still helped to improve these relationships.

Niishin kakiinii kaaniiwag niimiinoo wiitinikemag wiinkeidash awaashime nimiinowiitanoo kimitimin

With regards to Council, it was because of this session that I realized that they had full-time jobs on top of being Council members.

Miinonaake ningii onji kikendaan Ogimaag e anookiwaaj kaye e Ogimaawiwaj. Niipiwaa anookiwin ishijikewag

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I can see how when dedicating time to understand one's role, even with those whom I have great relationships, access to services can be improved.

Minose kiikikendamang kaishijikej awiyaa odaanookiwinining kaye jionji wenjiseg kaye wiiji'iwewinan

Also, working with a researcher who has similar values as I do, allows for progress to be made with community members.

Minose kaye kiiwiitanokiimaakaniwij kananantokikenjikej beshikon kainendang

After teams experience this training, it is evident that more options are available regarding access.

Wiinke onji minose kekonan kitaanookiwininaning

By collectively sharing our skillsets, we learn better how to connect with other people and share information.

Awaashime minose kekon kiwiijiitiiyaang

Going forward we no longer need to work in silos as we feel comfortable working with others.

Miidash kaawin awashme kikaabeshiko anookiisiimin

It is through this training that people can learn to be vulnerable because their voices can be heard without judgement.

Kakiikikinooamaakooyang kaawiin memej jisekishij awiyaa kekon wii ikidoj

Regardless of what the evaluations say about this training, I have heard voluntarily a lot of positive comments and feedback; this had been a major turning point for the community.

Wiinke minwaashiin kakii'ishi kikinooamaakooyang pakanisewaan kekonan

The excitement voiced by the two communities who have engaged, is creating positive energy for us at Nokiiwin and in other communities.

Wiinke kiiminwendoamoog niishiin ishi koniikanan anishinabeg gakii'ishawaj wiike idash nindoji minwendamin

Appendix M: Community Gatherings

Appendix N: "A Gathering of Wellness" Portrait

“A Gathering of Wellness” by Kevin Belmore

Kevin Belmore is a woodland artist from Kiashke Zaaging Anishinaabek, now based in Thunder Bay. Kevin also painted the original vision and logo for our G’minoomaadozimin ‘We Are Living Well’ initiative. As a sequel, “A Gathering of Wellness” represents a four-year journey. The birch bark canoe coming from the East gathers knowledge, medicines, and wisdom for community wellness – spiritual, emotional, physical, and mental wellness. Each of the seasons represented on the medicine wheel has contributed to our journey of re-search, story-telling, and knowledge gathering. The birch bark canoe leaves open the opportunity for other communities to join in Nokiiwin’s journey. Our collective knowledge is now represented in the Community Resource Guide and Action Research framework.