First Nations Parenting and Child Reunification: Identifying Strengths, Barriers, and

Community Needs

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Abstract

First Nations children are overrepresented in the child welfare system in Canada (Blackstock, 2003). First Nations communities are seeking to improve current service delivery models and create alternative evidence-based strategies. A First Nations child welfare organization has identified priority areas related to reunification and parenting, identify successes and barriers to reunification, and examine service needs. These priorities were addressed with a community-based, participatory model, and guided by a community Research Advisory. Results were analyzed using a blend of grounded theory and thematic analysis techniques. Participants identified the need to place children with extended family or within home communities to facilitate best child outcomes. Improving parental and community capacity was recognized to promote positive reunifications. Successes identified within communities included available supports, such as those that increased empowerment and community capacity. Identified barriers within communities were the lack of culturally appropriate parenting services, hesitancy to obtain available support due to fears of child welfare intervention, and mental health difficulties of community members. Results of this study will be disseminated to communities and used to develop a culturally appropriate parenting program.

First Nations Parenting and Child Reunification: Identifying Strengths, Barriers, and

Community Needs Within the Child Welfare System

There is a high demand for culturally appropriate child welfare services for First

Nations children that are self-governed by First Nations community agencies

(Blackstock, Brown, & Bennett, 2007).   First Nations communities have indicated the

need for evidence based, alternative pathways of care that move away from government

controlled child welfare services to those that are self-governed by First Nations agencies

(Blackstock et al., 2007). This study examined community perspectives of child welfare

program related to both child reunification and parenting practices in First Nations

communities. Using a community-based, participatory approach, successful outcomes

and barriers related to child reunification and parenting within communities were

explored. The current status of First Nations children in care will be reviewed, with

particular attention to the high prevalence rates of children in care, current mental health

outcomes of children in care, and the systematic barriers that exacerbate these outcomes.

By furthering the understanding of First Nations perspectives of the child welfare system,

evidence based solutions can be generated for families that require these services.

Historical Cultural Assimilation, Marginalization and Colonization

Policies and practices that regulate the welfare of First Nations children in Canada

have perpetuated cultural assimilation, marginalization, and discrimination (Fournier &

Crey, 1997). Discriminatory practices experienced by First Nations children prevail

within current detrimental government policies related to funding allocation, cultural

assimilation of services, and institutional racism within the child welfare system

(Blackstock, Prakask, Loxley, & Wien, 2005). Systemic funding disparities for

Aboriginal child welfare services exist; for example, on-reserve Aboriginal children receive 20% less federal child welfare funding per child for services than non-Aboriginal children (Blackstock et al., 2005). Discriminatory policies related to assimilation practices within residential schools (Menzies, 2010) and excessive child apprehension (Sinclair, 2007) have created a history of systematic oppression that must be considered when comparing Aboriginal and non-Aboriginal family child welfare outcomes.

First Nations child welfare outcomes cannot be examined without considering the influence of these policies on generations of families (Blackstock, 2003). Intergenerational trauma, specifically attributed to historical traumas of residential schools, has been identified to contribute to homelessness (Menzies, 2010), adverse mental health outcomes (Kirmayer, Gone, & Moses, 2014; McQuaid, Bombay, McInnis, Matheson, & Anisman, 2014), lower socio-economic status (Raphael, Rainer, & Layton, 2011) and poor child welfare (Tait, Henry, & Walker, 2013) within First Nations families. This history of trauma combined with ongoing disparities of services perpetuates the continuation of intergenerational trauma for First Nations children today (Sinclair, 2007).

The trauma endured by residential school survivors resulted in ongoing negative outcomes for generations of Aboriginal Canadians (The Truth and Reconciliation Commission of Canada, 2015; Menzies, 2010). Caregivers in many of these institutions did not provide fundamental needs of food, medical care, education, and safety for the children living in residential facilities (TRC, 2015). Children consistently felt despair, hopelessness, and shame, resulting in some children attempting or committing suicide (TRC, 2015). Assimilation practices (including stifling native language use, cultural

identity, and spirituality) created negative mental health outcomes for children who attended residential school (King, Smith, & Gracey, 2009). Survivors of residential schools have indicated difficulty sharing traditional knowledge and values with newer generations due to forced assimilation (TRC, 2015).

The abuse and neglect experienced during residential school have influenced residential school survivors' own parenting behaviours and quality of family life for their children. Residential school survivors were denied access to traditional family structures, parent-child attachment behaviours, and learned parenting skills (TRC, 2015). This has influenced the way that survivors approach parenting and care for their own children (LeFrance & Collins, 2003). Survivors have indicated parenting difficulties related to showing affection to children, sufficient use of discipline or punishment, and modeling positive attachment to children (LeFrance & Collins, 2003).

The "Sixties Scoop" also led to intergenerational trauma and continued family disruption experienced by First Nations families. This term describes the vast number of Aboriginal children apprehended from families during the 1960s and placed within non-Aboriginal environments (Sinclair, 2007; TRC, 2015). Official counts of the number of children apprehended in the Sixties Scoop are not valid due to the exclusion of Métis and non-status children (Fornier & Crey, 1997). By end of 1960s, it was estimated that approximately 30 to 40% of children in the welfare system were Aboriginal, even though they represented 4% of the national population at the time (Fornier & Crey, 1997). In the next fifteen years, estimates of Aboriginal children in care in some provinces were even higher, with Aboriginal children representing 60% of all children in care in Manitoba, 50% in Alberta, and as high as 70% in Saskatchewan (McKenzie & Hudson, 1985).

Many First Nations families were disrupted as a result of the Sixties Scoop not only due to the high numbers of children initially placed in care but also to the difficulty of reunifying children with families (Bennett & Cyr, 2000). Once apprehended, children were rarely returned to their biological families or home communities. Separation of children from their families was a distressing experience, as families did not know when or if they would be reunified with their children. When reunification was attempted, it was proven to be a difficult endeavor, as many adoption records were missing, incomplete, or falsified to obstruct children from reconnecting with their biological families (Bennett & Cyr, 2000).

Many families experienced distressing psychological outcomes due to the Sixties Scoop. For parents who lost their children throughout these years, they experienced a range of adverse mental health effects related to low self esteem, alcoholism, somatic disorders, depression, violence, and other symptoms of psychological distress (Fournier & Crey, 1997). Community members, particularly Elders, felt a diminished sense of purpose, and could not educate youth or teach cultural practices within communities without children present (Bennett & Cyr, 2000). Parents were often residential school survivors, and may have experienced effects of multiple personal traumas such as physical, mental, and sexual abuse, experienced while attending residential schools (Fournier & Crey, 1997). Within First Nations communities, the Sixties Scoop resulted in high substance use, incarceration rates, and deaths for First Nations youth during this era (RCAP, 1996; The Truth and Reconciliation Commission of Canada, 2015).

Current Status of First Nations Children in Care

First Nations children are currently overrepresented in the child welfare system in Canada, with three times the number of children placed in care than at the height of the residential school era (Blackstock, 2003). Within Ontario, Aboriginal children represent 3% of the child population, although within the Ontario child welfare system (consisting of approximately 9 000 children), 21% are Aboriginal (Ontario Ministry of Children and Youth Services, 2010a). In 2011, 3.6% (14,225) of First Nations children aged 14 and under were in foster care, compared with 0.3% (15,345) of non-Aboriginal children (Statistics Canada, 2011). On-reserve First Nations children are eight times more likely to be in care than majority culture children. Informal placements, such as placing the child with grandparents or other kin, were more than three times higher for Aboriginal children (Gough, Trocmé, Brown, Knoke, & Blackstock, 2005). Including children whose placement has yet to be decided, a total of 25% of Aboriginal children were removed or under consideration for removal, from their families. This placement rate is approximately 15% higher than the placement of non-Aboriginal children (Gough et al., 2005).

Disparities between Aboriginal and non-Aboriginal families that result in higher placement rates of Aboriginal children have been examined. Primarily, children are placed in care due to neglect, which can be an expression of social factors related to poverty or the inaccessibility of appropriate health care (Sinha et al., 2011). Over half of Aboriginal cases of substantiated or suspected maltreatment (61%) involved some form of neglect, which is double the rate for non-Aboriginal children (Blackstock & Trocmé, 2005). Compared to non-Aboriginal families, Aboriginal families were four times more likely to be investigated for neglect or emotional maltreatment (Trocmé, Knoke, &

Blackstock, 2004). The higher placement rate of Aboriginal children may occur at the

agency level due to lack of resources or increased monitoring of Aboriginal families

(Fluke, Chabot, Fallon, MacLaurin, & Blackstock, 2010).

There is a disproportionate presence of risk factors experienced by First Nations

families that can significantly contribute to deciding to place a child in care due to

neglect (Sinha et al., 2011). These risk factors (often related to social determinants of

health of a child) are statistically more prevalent for Aboriginal families. These risk

factors include instability of housing, higher rates of substance abuse, more parents who

were maltreated as children, younger parents, and more use of social assistance (Trocmé

et al., 2004). Historically, this trend has continued since the Sixties Scoop, when children

were apprehended due to uncontrollable, systemic factors typically related to being

Aboriginal and in poverty at the time (McKenzie & Hudson, 1985). Inability to access

adequate medical services is still a reason why Aboriginal children continue to be placed

in care (Tiechroeb, 1997).

Family poverty can result in higher investigation rates by child services of First

Nations families and therefore, increased apprehension of First Nations children (Trocmé

et al., 2004). Failing to meet fundamental childcare needs due to social determinants of

health, such as poverty, indicate that apprehension of First Nations children may not

exclusively be due to poor parenting behaviours. Family poverty is considered to be a

significant risk factor for negative outcomes for children and neglect issues related to

poverty can be more systemic rather than related individualized parenting practices

(Bennet, Blackstock & De La Ronde, 2005). Physical neglect as a result of poverty, poor

housing and substance abuse is a key factor in child apprehension (Trocmé et al, 2008).

Within Canada, Aboriginal children have significantly higher rates of poverty than non-Aboriginal children. In 2006, 18% of children lived in poverty, but for children with Aboriginal identity, that rate was 36% (MacDonald & Wilson, 2013). As of 2010, one in four First Nations children lived in poverty as compared to one in six for non-Aboriginal children (Macdonald & Wilson, 2013). Approximately 40% of off-reserve Aboriginal children live in poverty (Macdonald & Wilson, 2013).

The effects of family poverty on developmental outcomes for Aboriginal children are further exacerbated by disparities in social determinants of health (Richmond & Ross, 2009). Intersecting social disparities (such as poverty, unstable housing, or food insecurity) for children who are placed in care result in more adverse outcomes for First Nations children than for those who are not Indigenous. This difference has indicated that involvement with the child welfare system should be considered a social determinant of health for First Nations and Métis children due to the significant influence of child welfare intervention on child health outcomes (Tait et al., 2013). This has been attributed to the higher rates of child welfare intervention for First Nations and Métis children, the number of children raised outside of their cultures or communities within foster and adoption places, and the lived experiences of First Nations children in foster care.

Child welfare intervention is increased due to additional health disparities within First Nations populations. First Nations children living in poverty are three times more likely to live in a house that requires major repairs compared to the non-Indigenous children of families with similar income levels and five times more likely to live in an overcrowded house (Status Report of the Auditor General of Canada, 2011). There are additional nutritional challenges for some First Nations communities due not only to a

lack of income, but also due to the loss of traditional sources of food combined with the

high cost of importing foods to remote or northern communities (Public Health Agency

of Canada, 2011). As well, more than half of all water systems on First Nation reserves

pose a public health risk (Status Report of the Auditor General of Canada, 2011).

Current Funding Disparities

Current provincial funding does not meet the needs of Aboriginal communities in

Canada (Auditor General's Report, 2008). Despite the increasing numbers of Aboriginal

children in care, federal funding allocation has remained the same. Funding in Canada is

not based on actual costs of service delivery but uses a formula from 1988 that is applied

nationwide, without consideration of individual, provincial, or community needs. The

formula assumes that each First Nations child welfare agency has only 6% of on-reserve

children in care. Although this number matches some reserve statistics, it is considered

to highly underestimate the needs of many communities. For example, in 2007, the

actual range of on reserve children in care varied from 0 to 28% in five provinces (British

Columbia, Manitoba, Ontario, Saskatchewan and Alberta). By using the existing funding

allocation formula, funding disparities for First Nations child welfare services are

maintained within provinces (Auditor General's Report, 2008).

The provision of First Nations services has been an ongoing point of contention

within federal, provincial, and community agencies. The paternalistic and discriminatory

Indian Act has continued to impose upon and assimilate First Nations' actions, identity,

and autonomy. Challenges to the *Act*, including colonial assumptions embedded in

governmental distribution of education and health funding are ongoing, but have been

met with limited results. First Nations communities continue to dispute such

discriminatory policies to reduce disparities for their children. To provide services for

First Nations children, many of whom have complex medical needs (Young, 2003;

Adelson, 2005), often involves the collaboration of municipal, provincial and federal

government bodies (Auditor General's Report, 2008). Agency disputes regarding

funding jurisdiction for these expenses can result in disruptions or delays in service

delivery. To ensure adequate service delivery that does not deny services to the child in

question due to funding disputes, Jordan's Principle was created. Jordan's Principle states

that the government agency that has initial contact with the child fund the required

services and then resolve the question of jurisdictional obligation. Although enacted to

reduce the number of children waiting for essential services, Jordan's Principle has

remained aspirational rather than obligatory in many agencies. It has not been fully

implemented within provincial or federal government departments (First Nations Child

and Family Caring Society of Canada, 2015; Auditor General's Report, 2008).

Funding concerns identified in the Auditor General's Report for First Nations

Children and Families (2008) were obtained through informal discussion with First

Nations peoples (populations not further described) in Canada. Although the report did

not allude to the number of people or demographical information of those interviewed,

current challenges as a result of underfunding were identified. Those interviewed stated

that First Nations individuals have limited input into child welfare legislation, making it

difficult to provide culturally appropriate services that align with some provincial funding

standards and policies.

Participants interviewed for the Auditor General's Report (2008) expressed

concerns about the program design of child welfare funding. Due to inflexible funding,

there can be a higher motivation to place children in care so they can receive essential

program services they would not have access to otherwise. Additionally, access to

required services is difficult in rural and remote communities, with high travel costs that

are not considered within the current funding allocation formula. It is difficult to recruit

and retain competent staff in these areas due to an inability to offer competitive

compensation. Additional concerns arose regarding the increase in substance addictions

amongst children. As a result, there is a need for specialized services that address socio-

economic conditions present in many child welfare cases that the current system cannot

provide.

Need for Aboriginal Directed Culturally Appropriate Child Welfare Services

Child welfare services delivered to Aboriginal peoples continue to be

predominantly mandated through federal and provincial statutes (Association of Native

Child and Family Services Agencies of Ontario, 2001). Currently over 125 Aboriginal

controlled agencies exist in Canada (Auditor General's Report, 2008). Many of these

agencies aim to move services from provincial jurisdiction to a community based model

of care in an attempt to provide more culturally appropriate services for Aboriginal

children in care. These services must be designed using the best available research

relevant to First Nations populations (Kirmayer, Simpson, & Cargo, 2003), however

there is minimal literature on First Nations family outcomes related to the child welfare

system. With consideration of historical colonizing practices, it is essential that First

Nations peoples are the directors of their own research and services (Adelson, 2005).

Current parenting literature and evidence based practices may not be appropriate

for First Nations peoples. Using a westernized lens when observing First Nations

parenting is problematic and it often results in negative appraisal of child development (Okpik, 2005). Rather than recognizing existing cultural differences associated with parenting, First Nations children are deemed to be disadvantaged. Neckoway, Brownlee, and Castellan (2007) have argued that popular psychological theories related to parenting, specifically those related to attachment between mother and infant, may not accurately assess First Nations parenting capacity. For example, the First Nations conceptualization of family is more encompassing than the westernized "nuclear family" and can include Elders, other family members, or even entire communities (Okpik, 2005). Attachment theory does not appropriately capture the influence of these multiple relationships within a child's development, and instead labels this style of parenting as problematic (Neckoway et al., 2007).

It is critical that culturally appropriate parenting practices be implemented in First Nations parenting interventions. These interventions must be those that promote First Nations' self-identity, are evidence-based for such populations using knowledge that is valued and credible to communities, and meet expressed community expectations and needs. Traditional practices of First Nations peoples can be used to create interventions that are useful to First Nations families. Current cultural approaches could include incorporating healing or talking circles and including Elders and other community leaders as teachers of cultural information. Within this process, communities may be at varying levels of reclaiming culture or re-traditionalizing services, thus creating individual community needs. Diverse and culturally appropriate service design, implementation, and evaluation must be completed within the communities intending to use these services.

Child Reunification with Families

As per the United Nation Convention on the Rights of a Child, all children have the right to be with families without governmental interference, in a nurturing and safe environment (UNICEF, 1989). A child's family is recognized as the natural mechanism for growth and support, and therefore, the family structure for a child should be preserved when appropriate. In cases where removal from the family is necessary due to abuse or neglect, the least disruptive means is critical to reducing potential harm to the child (Shangreau, 2004). Reunification has been defined by placing a child that was previously in out of home care back with their family of origin. This was determined by westernized child welfare systems to be best-practice solutions for families, and is not necessarily how First Nations communities conceptualize best-practice solutions for their children.

Child reunification practices have demonstrated a longstanding history of discriminatory government imposed conceptualization of best practices within the child welfare system. These practices that result in higher rates of child apprehension of Aboriginal children result in systemic institutionalization of these children, comparable to practices used within the Sixties Scoop or residential schools (Tait et al., 2013). Western values of foster placements, adoptions, and family reunification practices, have entirely overshadowed expressed needs and values of First Nations communities in regards to care of their children.

Imposed Western definitions of the nuclear family (two-parent households with children) do not necessarily encompass the broader family definition of many First Nations communities. This definition of family can include additional family members (grandparents, uncles, or aunts for example), and other unrelated community members

that are significant to the child (Tam, Findlay, & Kohen, 2016). Family has been

conceptualized within Indigenous families as being influenced by social relations,

language, childrearing practices, and location of residence (Tam et al., 2016). With such a

disparity within the defined concept of a family, it is impossible for western values of

reunification with family to adequately capture a First Nations child's needs. When

placement of a First Nations child is with a non-biological community member, or

kinship relative that is considered by the child to be within their definition of family, this

may be considered to be reunification.

Due to the broader notion of family, care of a child can extend to other family

members and can be shared for long amounts of time. Within many families, it can be

determined for a child can be "placed" with another family member, without any type of

institutional intervention (Tam et al., 2016). This type of family care, as a self-selected

process for families, has minimal institutional intervention, and can result in less

stigmatization for families as they avoid formalized apprehension. Despite the benefits

of this act of "placement", it is not currently recognized by formalized child welfare

systems, and as a result, such family members do not receive any supports, financial or

otherwise, typically provided to mainstream foster families. Through these policies,

mainstream welfare practices continue to be privileged and prioritized over practices that

work better within an Indigenous framework.

Specifically for First Nations children undergoing reunification, best practices that

result in positive child outcomes for these children that have been identified within many

families and communities but have yet to be documented or shared between

communities. It has not been determined if reunification with the primary caregiver,

kinship care, or simply within the community is the best practice for First Nations

families. At this time, no studies exist that identify factors associated with positive

outcomes related to parenting within reunified families. Critical reviews of the current

reunification strategies, specifically from First Nations families and communities, need to

be collected to identify barriers and successes within the child reunification process. Due

to the positive outcomes associated with keeping families together, evidence based

strategies need to be created and maintained to ensure First Nations child well being.

Study Purpose

Currently, there is limited understanding of the psychosocial, mental, physical and

spiritual outcomes of First Nations children within the child welfare system. There are

few studies that specifically examine First Nations perspectives related to parenting and

positive child reunification. Due to the high prevalence of First Nations children within

child welfare programs, further information about First Nations perspectives of and

experiences in the child welfare system are needed. It is essential that First Nations child

welfare research be conducted in a culturally and contextually appropriate manner.

This study attempted to increase the understanding of the pathways and barriers to

reunification of children with their primary caregivers in First Nations communities using

a community-based participation approach. First Nations perspectives on positive child

reunification and associated strengths and difficulties with this process within

communities were examined. Additional information regarding culturally relevant

parenting values, skills and services associated with perceived positive outcomes for First

Nations children was collected.

Given the exploratory nature of this study, hypotheses were not developed; however, there were three general expectations of study results. First, it was expected that community definitions for the concepts of "positive child reunification" and "positive parenting practices" would be obtained. Second, it was expected that barriers and success for First Nations parents would be obtained related to general parenting practices and child reunification. Third, it was expected that available supports and requested resources or programs in the community would be identified.

Method

Research Partnership

This research began as a partnership with Dilico Anishinabek Family Care (Dilico) through a CIHR-funded team grant entitled "Understanding health risks and promoting resilience in male youth with sexual violence experience." The Dilico agency is a partnership between 13 First Nation communities in the Robinson Superior Treaty Area[1]. Dilico provides holistic mental health and child welfare services to these communities as a self-governed agency committed to providing community-based services that enhance the wellbeing of children, families, and communities. Dilico aims to provide evidence-based and culturally safe health services through ongoing partnerships with these First Nations communities.

This Research Advisory partnership is a four-tiered organizational team that collaborates to ensure research goals are aligned with expressed community needs, and expectations of the project. This partnership is depicted in Figure 1. The partnering

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[1] These First Nation communities include Animbigoo Zaagi'igan Anishinaabek, Bilnjitiwaabik Zaaging Anishinaabek, Bingwi Neyaashi Anishinaabek, Fort William, Ginoogaming, Kiashke Zaaging Anishinaabek, Long Lake #58, Michipicoten, Pays Plat, Pic Mobert, Pic River, Red Rock, and Whitesand.

communities provided permission and feedback to guide directions of the research

project. Individual community members also participated in other levels of Research

Advisory, or as study participants. The second level of the Research Advisory is the

board of directors at Dilico. This board of directors is the formal leadership and

representation of the partnering communities. Many board members are band counselors,

or chiefs in their communities. Board members formally represent partnering

communities, to oversee and approve all research activities. It was at this level of the

research partnership that the research priorities were identified based on the expressed

needs of the partnering communities. The third level of the Research Advisory is the

organizational leadership at Dilico. This leadership guides direct project activities such a

question development, method development, participant recruitment, and disseminating

results back to partnering communities. This level of the Research Advisory works to

champion the project to communities and ensure that day-to-day project activities are

completed. The final level is the research team completes all project activities, such as

data collection, data analysis, and visiting communities to disseminate information.

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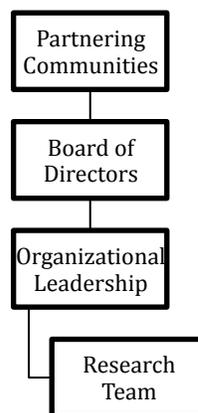
Figure 1. Structure of Research Advisory partnership.

The Research Advisory is a collaborative endeavor that aims to ensure research is being completed in a way that is aligned with community values and expectations of the project. The intention of this partnership was to ensure that the project remained guided by communities, and to facilitate communication between all invested stakeholders. Embedded organizational structures to increase communication such as holding re-occurring local Research Advisory meetings were beneficial. Additional endeavors to facilitate communication about the project included presentations at board of director meetings, attendance at community-events, and other gatherings requested by partnering communities.

Participants

Research Advisory Organizational Leadership. The Research Advisory was established through Dilico and consisted of members who resided within the service area and had high expertise in research and service implementation with First Nations families. For the purposes of this study, the Research Advisory was asked to identify key individuals who resided in each of the Robinson Superior Area Treaty communities. Community contacts were considered to be knowledgeable of best practices associated with logistical concerns of the research project, such as community gatherings and expectations of research projects within individual communities. These individuals were asked to aid in the organization and execution of key study activities such as recruitment and other activities associated with completing focus groups and interviews in these communities.

Study Participants. Study participants were First Nations individuals, adult (18 years or older) who resided in a Robinson Superior Treaty Area community where

interviews were conducted. Interviews were conducted in communities that provided

letters of support for the project (Appendix A), and indicated they would like to

participate. Individual interviews and focus groups were completed with 26 people from

seven different First Nation communities. To participate in a focus group or interview,

no prior experience with Dilico was required.

Seventeen individual interviews were completed with community members.

Some of these members chose to complete an individual interview due to confidentiality

concerns or unavailability at the time of focus groups. Individual interviews were

completed with community organizations or representative groups in community that are

involved with child mental health, wellbeing or welfare. These people (such as Elders,

chiefs, program managers or administrators) were able to offer valuable insight but did

not wish to participate in a group.

Measures

A semi-structured interview, developed in collaboration with the Research

Advisory (Appendix B) was used to guide discussion in both the focus groups and

individual interviews. The interview guide consisted of 12 questions (for the focus

groups) with an additional five questions (for individual interviews only) that asked about

child reunification, parenting and child wellbeing. These questions were originally

designed by the research team based upon foundational discussion with the Research

Advisory, and then were reviewed and revised to ensure questions accurately assessed the

desired concepts. The final questions asked participants to define concepts related to

child wellbeing, reunification, and parenting, to identify successes and barriers associated

with these concepts and to identify other needed resources in their communities. These

questions asked participants to identify indicators of successful reunification within their community, best practices of successful reunification for children, positive parenting supports and required parenting services within communities.

Procedure

Pre-Study Project Development. This project was approved by the Lakehead University Research Ethics Board. The Research Advisory and the study investigators collaborated to develop the study goals, procedures, and questions. This was completed in collaboration with all levels of the research partnership. The board of directors determined the research question and scope of the project based on identified needs of partnering communities. The organizational leadership enacted the development of strategies to answer this research question, by determining the study methods and designing interview questions. Letters were sent to each community that described the project in detail, and to ask if they would like to participate in the project. Interested communities were asked to provide permission to be contacted by a member of the research team. Of those communities that indicated interest, community leadership was contacted, and a community contact was established based upon their recommendation.

Recruitment. Potential participants were contacted primarily by a contact within the community in which they resided. Recruitment was through word of mouth, emails, posters and announcements in the community. Potential participants who indicated interest were provided with more information about the study.

Individual Interviews. Two senior graduate students completed the individual interviews. Most interviews were completed with both students present; however, some were completed with only one. When interviews were completed with both students, one

student would take notes, while the other would ask interview questions. Interviews

lasted approximately forty-five minutes. Interviews were recorded and transcribed.

Interview participants were given a copy of the interview questions and the consent forms

in advance if desired. Participants were able to omit questions they did not want to

answer.

        Focus Groups. Two senior graduate students conducted the focus groups. The

groups were held within participating communities in accordance with local norms and

customs. The groups were completed in English, and a translator was offered if required.

Focus groups lasted approximately two hours, and depended on the number of

participants and amount of group discussion. As a token of appreciation for participating

in the focus group, a lunch was provided to participants.

        During the focus groups, participants were seated at a table with the study

investigators. Decisions regarding the format of the focus group were established by

group consensus. These decisions included guidelines for group discussion and how the

group would be facilitated. The most common suggestions included reducing any

formalized aspects of the group by completing questions over lunch, having the

researcher read the questions, and to have a flexible nature of participation, with

participants coming and going as desired. A few participants wished to sit and listen to

discussion rather than engaging with group conversation, which was accommodated.

Before group discussion occurred, it was important to create a safe space in which

participants could openly discuss personal opinions and experiences. Interview questions

and consent forms were distributed to group members prior to the group.

Group facilitation was as non-directive as possible to allow participants full opportunity to express themselves. Prompting occurred by group facilitators when participants were unclear about their points, the question warranted further elaboration or discussion was inaudible. Focus groups were audio recorded (with group consent) and later transcribed, although one group opted not to record their discussion. For this group, the study investigators took handwritten notes. The study's principal investigator or the community contact was available to address any concerns. Participants were given a debriefing form (Appendix E) with contact information at the end of the individual interview or focus group.

Consent. All participants were given a letter of consent that reviewed study activities, purpose, and information about confidentiality. The letter was read aloud by a member of the research team. Participants either verbally consented or checked a box on a consent form (Appendix C) to signify participation in the study. Participants were asked if they wished to be contacted for the second portion of the study, and were asked to provide contact information if so.

The letter of consent to participants (Appendix D) informed participants about their right to cease participation and decline the use of their data at any time of the study. The processes used to protect participants confidentiality and the limits to such confidentiality were reviewed. Expected harms or benefits of participation in the study were discussed.

The efforts made by the research team to preserve participant confidentiality were discussed in the consent process for both focus groups and individual interviews. Given that the communities where interviews and focus groups were conducted at times in rural,

and lower populated areas, confidentiality considerations differ from more populated areas. Care was taken to ensure that identifying information (such as names, ages, towns, and details associated with specific people, places, or events in communities) were omitted when results were reported. Within focus groups, the importance of participants in maintaining the confidentiality of the groups was addressed. Although efforts were made by study investigators to preserve participant confidentiality in reporting study results, it was essential to ensure that participants understand they must also keep content expressed in the groups confidential.

Theme Validation. Verification and feedback of study results have been obtained from project stakeholders, in an ongoing process throughout the project. As an ongoing process, interested community members currently have the opportunity to complete a second session that lasts approximately 30 minutes to provide any additional feedback or clarification about study results. In these secondary interviews and groups, participants are asked validate the data that was obtained through the study. Participants review the emerging themes and report on the accuracy of these themes. Upon completion of these interviews, themes will be re-evaluated based on participant feedback and provided to the Research Advisory.

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Data Management and Analysis

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Data Management

All study data (including recordings, transcripts and affiliated forms or documents) is stored at Dilico Anishinabek Family Care or at Lakehead University. Data will be stored for five years, and in a manner that is consistent with both professional and institutional policies, determined by the Lakehead University Research Ethics Board.

Data Analysis

This project used a blended approach of techniques related to thematic analysis and oriented to the framework of grounded theory. Due to the exploratory nature of the study, it was important to conceptualize this process using a grounded theory epistemological framework. Specific techniques related to thematic analysis were incorporated to correct for limitations of this approach within this study. Thematic analysis is a foundational method of qualitative analyses (Braun & Clarke, 2006), and thus it was an important tool to further understanding the obtained data. Analysis within these techniques is recognized as an ongoing and iterative process, with constant comparison of obtained themes and results.

Multiple techniques were chosen to facilitate inductive data analysis. This type of framework perpetuates the understanding that knowledge is gathered from a study, rather than previously imposed from an existing framework. Given the high degree of institutional marginalization and discrimination experienced historically by First Nations peoples, a grounded theory approach can facilitate a more culturally appropriate framework of analysis. Themes and theory emerge from immersion in the obtained data, rather than based on pre-existing notions or literature. Grounded theory aligns well with a community based participatory approach (Braun & Clark, 2006), and was therefore consistent with the values of the study. Given concerns about prior research relating to First Nations research activities, a grounded theory framework can reduce potential colonialist biases that may be present within data analysis. Ongoing reflection is encouraged within grounded theory, through the identification of researcher social location and other potential implicit biases that occurred.

Codes were generated before overall themes to align with the inductive nature of the project and further limited researcher bias within the analysis. The generation of codes, concepts and finally, larger and more encompassing categories was completed. Firstly, themes were obtained using open coding procedures. Open coding facilitates familiarization with raw data and can reduce data into more manageable codes. Open coding is a preliminary step in qualitative data analysis that creates initial codes, or key words. Generation of these codes can be completed in a variety of ways. For example, codes can summarize each line of the document or could be obtained by counting the most re-occurring words, ideas or phrases within the data. It can be completed using computer programs such as NVivo or more traditionally using a manual, pen and paper approach.

It was not feasible for this study to remain entirely inductive, or to align with "pure" forms of "true grounded theory". Such forms tend to ignore prior knowledge generation, such as community knowledge, or literature reviews, in the pursuit of answering research questions. By having no prior knowledge or understanding of study concepts, it is theorized to reduce bias of results. These approaches strongly discourage literature reviews, generation of research questions, or even specific interview questions (Bruan & Clarke, 2006), and thus were not feasible for the current study. Given the emphasis placed on community knowledge of needs, and the understanding of current situational demands present within the Research Advisory and the research team, this study is not entirely inductive.

Additional techniques were also used for analyzing data, such as the use of thematic analyses. Techniques were chosen that complied with rigorous and systematic

methods employed for thematic qualitative data analysis. Thematic analyses aim to

identify, analyze, report and interpret data sets in rich detail, although there is no clear

agreement on exact methods to this approach (Braun & Clarke, 2006). Themes obtained

through these methods are first documented through open coding procedures and can

vary significantly in simple steps, though all encourage the same key concepts related to

grounded theory. The key components of this study's thematic analysis relate to

Marshall and Rossman's (1999) six phases of data analysis. These phases include 1)

organization of data, 2) generation of categories or themes, 3) coding the data, 4) testing

emergent themes within the data, 5) searching for alternate explanations within the data,

and 6) writing results of data analysis.

Data analysis for this study involved breaking the data into a specific data set.

Given that interviews and focus group questions targeted multiple research questions

across projects, it was important to manage feasibility of the data set. Participants often

varied significantly in how they answered questions, and moved between concepts while

answering a question. It was not feasible to simply eliminate all irrelevant research

questions. Instead, any information provided by participants that was not intended to

answer the study hypotheses was screened out, and thus not included in this data set.

Coding

Both a computer program (NVivo) and a manual method were used to code the

data. Although computer programs offer a faster, often more consistent method to

obtaining word frequencies of themes, there are some limitations to relying only on this

method. Potential limitations include lost data by misuse of key search words, inability

to analyze individual themes or create larger sub-themes and difficulties associated with

becoming proficient with the technology. By using two methods of data analysis, some of these potential limitations of using a computer program were addressed (Welsh, 2002).

Broad Categorizations. Initial review of the data set, through the initial reading of all transcripts over three times each, determined how the data would initially be categorized. These consisted of concepts such as strengths, parenting, and reunification, which generally represented participant answers to similar topical research questions.

Codes. Codes were generated to provide representation of individual ideas and concepts provided by participants within the data set. These were created using an open coding approach, which consisted of reviewing the data line by line, with at least 1 code assigned per 2 lines of the transcribed data, but sometimes as many as 3 or 4. A coding manual was created to assign these labels upon reading of the first 3 transcripts. Codes were primarily generated upon the analyses of the first three interview transcripts, but the coding manual was continuously modified throughout the process. A second coder used this manual to re-code data to assess for bias of initial codes and to determine accuracy between raters.

These codes were then amalgamated into concepts and are categorized as groupings of codes that are similar in content. These concepts are often considered the "themes" of the data analysis. Finally, upon review of these concepts, general categories were created from the data. For example, themes can be categorized into more generalized concepts, such as barriers of care or overall strengths of parents. These steps were completed by two senior graduate students and were reviewed by the principal investigator.

Results

Results of this analysis are divided into six subject areas that were related to the topics of the interview questions. These subject areas were as follows:

1. Removal of children from parents

2. Support for families during placement of child

3. Reunification with parent

4. Identified supports in communities

5. Identified barriers in communities

6. Requested services and supports

Participants discussed required resources for children, families, and communities throughout the child welfare process, from preventative strategies against removal, to support for families and children, including caregivers and foster families during removal, and services for families after successful reunification. Participants related these concepts to broader parenting and mental health service needs within communities. Additional barriers and further supports were discussed by participants.

1. Removal of Children from Parents

"Children shouldn't be apprehended unless they absolutely have to be. Um, and in our communities, I think that we have enough strength in our communities where we can rely on other community members and extended family members that these things don't need to occur; they don't have to happen."

Removal of children from their primary caregiver or parent(s) was considered by participants to be a last resort to promoting child wellbeing within challenging contexts or turbulent home environments. It was expressed by the majority of participants that placement of a child within the child welfare system was a final measure after applying

numerous preventative and secondary strategies to address children's health needs within their family environments. Removal of children was considered to be a challenging situation for all families involved, with often no ideal placement or for the child upon removal. A participant summarized this difficulty as, "I don't think you could follow one guideline. I think every situation is unique, and I think a lot of thought needs to put into it."

Participants described types of placement strategies that can influence the outcomes of children placed in care. The location of the placement (remaining within the child's initial community or being removed from home communities) was described as being an important consideration for placement of the child. Removing the child from the community was cited as the most detrimental outcome for the child due to the disruption felt, separation from familiar people and places, and the lack of community connection. When placed outside of the community, there were concerns about the child not being able to engage in cultural traditions, or community supports.

Some participants expressed that placement within the community better facilitated goals of possible reunification with the child's parent(s) and allowed parents to have frequent access to the child when possible. Placing a child with another family was cited as decreasing responsibility from the original parent, and reducing the ability of parents to practice important parenting skills. Facilitating more visitation, and allowing parents to practice ongoing parenting skills could provide parents with increased responsibility, empowerment, and confidence with parenting. As almost all participants expressed the need for parents to change parenting behaviours, and address their own

mental health issues (primarily addictions and trauma), this was provided as a way to help facilitate this.

The environment where the child is placed was also considered by participants to affect the likelihood of better outcomes for the child and the potential for a successful reunification. As stated by a participant, " it's not going to fix it just to put a child with a family member that's not, and… and the family too has to be committed, loving, all those things." Placement with extended family (including aunties, uncles, grandparents, and other relatives) was often expressed as the best option if these people resided close to the child's original home community. Families expressed concerns that foster families that were not First Nations would not engage in cultural practices or traditions with the child. The stability of these placement environments, including the ease of transition from home to placement environment, was considered to be beneficial to facilitating child mental health. One participant phrased this concern as, "healing takes a long time, and especially with kids. I think if there's a lot of back and forth, then it becomes an issue later, like in their teenage years where they're going to say, well, my mom does this, she's not going to change; I'm just going to do it too, kind of thing."

2. Support for Families During Placement of Child

"How are you going to learn to be a good parent if your child is not there…?"

Participants expressed the need for parents to maintain contact with the child and to continue to practice parenting where possible throughout the course of placements. This is facilitated through community organizations that provide supervised visits when necessary, but also through informal processes such as visitation with the family and child. This was summarized by a participant as, ""think of being a child and you're only

seeing your parents once a month, as opposed to maybe you can see them once a week or twice a week in your own community." Participants discussed how difficult it can be to improve parenting skills without children present, and stressed the need for parents to develop parenting skills that aim to improve parenting capacity. Participants discussed the need for parents to change individual behaviours, increase personal mental health (such as addictions or trauma), and modify current parenting skills to provide better care for their children.

Addressing mental health concerns throughout the placement process for families, non-relational placement caregivers, and communities involved with placement of a child was an identified limitation within current placements. Positive mental health was identified by participants to be important both for biological and non-relational caregivers. Addressing biological parents' own mental health concerns, specifically addictions and trauma during placement of their child was discussed by many participants.   This was phrased by one participant as, "(it is) not just parenting courses, they (parents) need like, um, treatment in not only addictions, but, um, trauma, um, uh, abandonment, stuff like that. Because a lot of parents… and just growing up with a parent like that." Addressing the mental health and wellbeing of children in the welfare system was discussed, with one participant stating, "they (children in care) carry a lot of anger and resentment to… to their parents. I mean, it's not new news that, um, our children, a lot of them have lived within homes where both their parents were addicts." Another participant mentioned resentment felt by children placed in care, as stated as, "They were in care; and when they came back, they, uh… you know, they were bitter; they were bitter toward their parent." Providing support for non-relational and extended

families providing care to children was expressed. Extended family members are often not provided the same financial support as foster families, despite kinship care being identified by some participants as the best option for many placements. Participants expressed the need to provide this support for extended families. For both non-relational and extended families, mental health and parenting support should also be provided.

3. Child Reunification

"Like there was no bond with family. Like she knows who her relatives are but she still communicates with them, but she said she'd never want to live in… she'd rather live where she was raised."

Reunification of a child with their original parent was seen as the primary goal of the child welfare system, and expressed to be a positive outcome for families. Some participants noted that although the intention of reuniting parents with their children is positive, they have personally witnessed limited success with reunification in their own communities. One participant expressed the inherent desire for children to be with their families, despite struggles in that environment as, "They don't care about what… what the problem is unless they're like older teens, then they would probably will say something; but most of them just want to be with their mom and dad." Reunifying children with their parents was phrased as the primary goal of the child welfare agency, as stated by one participant, "because it's not about closing files. I know I… you know, I read a lot what's going on and some of the strategies, that we want to bring these kids home."

Bringing the child "home" as a goal of reunification was not limited to placing a child back with their original parents or caregivers. Keeping a child with the family was

reported as beneficial when parental placement could not be obtained. Participants

recognized the possibility that reunifying a child with their biological parent is not always

characteristic of a successful reunification. Placing a child with extended family or with

the community was determined as possible options for reunification, as summarized by

one participant:

> I don't necessarily think that reunification has to be where it's mom and dad or
>
> grandma and grandpa, um, I… if it's… or if it's an extended, um, family. What I
>
> do believe is that no matter where the child goes is that they have some
>
> connection to who they are, that they have opportunities to attend functions, so
>
> that they at least feel a part of that community.

Maintaining familiar connections and prioritizing positive routines for reunified children

was identified to be beneficial. Stability of a child after reunification was a concern for

some participants. Constant removal and movement of the child within the system was

expressed as a concern for child wellbeing. Participants stated that they felt that multiple

placements, with different families, in different communities, were related to increased

difficulties for the child. Participants expressed that placements should remain as stable

as possible and care should be taken to ensure that parents are ready and able to resume

responsibility for their child.

Participants identified mental health concerns for children after reunification due

to instability of placements. Children's resentment, confusion, and fear of removal again

were barriers to positive reunification with their parent. Promoting stability and ensuring

that the removal of the child from their reunified environment did not occur was reported

to be a goal for reunification processes. One participant stated this as, "I think going

back into the home with trust and feeling safe, like you said, um, and just knowing that whatever reason it was that you were taken out of the home, that that's not going to happen again…"

Parent mental health difficulties and community issues related to addiction, poverty, mental health, and available resources were reported to be detrimental to successful reunifications. Participants reported that parents with reunified children sometimes felt increased anxiety or fear of future child welfare intervention or possible removal of the child from their care again. This was theorized to influence the way parents engaged in community parenting services and programs. One participant described their own personal experience as, "I've seen it where a person has lost their child for five, six or ten years and they do weekend visits, they do daily visits and whatnot, and then they're placed back in the home; and then they're… they're in panic; (thinking) I'm going to give the baby back."

4. Identified Supports in Communities

"You know, utilizing resources that we have in the community. You know, yes, there's not a lot of, um, extracurricular activities; but we have the bush, you know, we have the water, you know, uh, we have ceremonies. You know, there's these things that the parents can access which is free. We have a public library, free. You can bring your child down there to read a book, right."

Participants identified existing programs and services that supported community, parent, and child mental health. These supports included services provided by mental health professionals, ongoing early intervention programs, friendship centers, libraries, band offices, health offices, victim services, men's groups, and community centers.

Community events such as Aboriginal Day, pow wows, ceremonies, community feasts, and other celebrations were identified to be valuable community supports. Supports were identified to be more helpful if they were administered by First Nations people, incorporated traditional or cultural elements, and were located within the community. Supports that aimed to empower or support those who accessed them through a non-judgmental stance within program administration also promoted people engaging in these programs.

Communities of people, such as families, band leadership, Elders, and other groups were also identified as being important supports for parenting and child reunification. Participants identified the positive supports within the community, such as the community network of care that aids in the positive growth and care of children. Child-care and the promotion of positive development was reported to be shared among families, neighbours, teachers, Elders, and other adults within communities. Due to this network of adults influencing the positive wellbeing of a child, the necessity of healthy communities and individual community members' own personal wellbeing was suggested to influence children's mental health outcomes. The continued improvement of communities was supported by many participants, and summarized by one, stating, "Anishinaabe people are growing, and our circles of healthy people and, uh, people working for a better life is getting better and better, and I see it."

5. Identified Barriers in Communities

"A lot of times the parents are separated from the child for too long a period, and it's almost like they think that they can't do it and they give up."

Although many participants recognized the programs and services available in communities, barriers to accessing these services exist. Barriers to accessing services included the availability of required services, the accessibility of current programs, and the disjointed nature of some services. Participants identified that the availability of services could be limited, particularly due to the location of services in relation to other communities. Difficulty accessing health, recreation, spiritual, educational, or other resources was reported as a barrier to promoting positive child wellbeing and reunifications. Within the available programs, some failed to incorporate traditional values, local needs, or cultural components. Some participants reported traveling long distances for services.

The disjointed nature of programs due to stability of funding was a concern of participants. One participant spoke about how programs in her community could be inconsistent, with new programs being brought to the community rather than funding programs that were popular and used. This was reported to limit the participation or engagement in new programs, as community members were not consulted about their needs before development.

Raising children in communities with high rates of addictions, violence, and trauma were also identified as barriers to promoting positive mental health, reducing placement of children in care, and promoting positive parenting practices. Community substance addictions negatively influence individual community members. One participant shared, "it's like we're being consumed by addiction." Mental health difficulties from substance use were identified as barriers to increasing the mental health

of children in the community, and contributing to child welfare intervention within families.

Accessing addiction services was difficult for many community members, as many addiction programs and services required the individual to leave their community. For parents experiencing addictions, leaving their child(ren), families, and available community support networks was reported to be a limitation to successful reunification of children. Participants identified that if parents had access to their children but were seeking care for their own individual needs outside of their home community, the parent-child relationship was negatively influenced. The lack of available parent mental health, addiction, and trauma services within communities was a barrier to maintaining relationships between parents and their families. Leaving communities to seek mental health services was also expressed to be problematic, as these existing supports built in communities could not be accessed. Facilitating access to local mental health services, regardless of community location, was reported to reduce these barriers. One participant phrased this as, "I'm picturing it as like these little mini treatment centers right in the middle of the communities, or even like here with the surrounding area."

Many participants reported that difficulties parenting (such as lack of structure, enforcement of rules, and presence of parents) were barriers to successful reunification of families. Consistent parenting, within consistent home environments with reliable access to food, housing, clean water, and love was reported as difficult for some community members. Showing love and affection, as stated by one participant "these kids that… that are so hungry… so hungry for… not just food, but so hungry for love, so hungry for respect, so hungry for attention," was reported to be limited in some families.

The absence of parents (mostly attributed to parental mental health issues) increased the likelihood of child welfare intervention, as it resulted in "kids raising kids," as expressed by one participant.

Hesitancy to obtain help from mental health service providers due to a fear of future intervention by child welfare services was a commonly reported barrier to accessing services. As stated by one participant, "they're struggling with parenting skills, maybe they're afraid to say anything because they don't want, you know, these child welfare agencies kind of involved, right." Many parents were reported to live with a fear of their child(ren) being removed from their care, and thus avoided seeking mental health or parenting services. Stigma associated with accessing services, particularly in small communities was reported, and "cliques" within available programs reduced participation in available supports. Participants reported that at times, they felt unwelcome in programs in communities, and were therefore uncomfortable with accessing supports. One participant spoke about how parenting programs, such as Triple P, when available, were often court mandated. She stated that these types of programs could be intimidating for parents seeking more preventative care.

6. Requested Services and Supports

"We really need support groups out there. We need to have a place for our parents to come and, you know, this sucks, and to be able to say that."

Participants reported a desire for additional mental health services and parenting supports for their communities. There was recognition by participants that multiple services were required. One participant stated that by "surrounding the parent with these supports I think and access, like, almost like an umbrella, you know, to protect that mom,

to help her learn these skills." Participants requested "more First Nations people working with First Nations people", child care options to facilitate parent employment, and better organization of service plans to help families.

Parenting programs were also a commonly requested support. Participants stressed the importance of incorporating local traditions and culture into such programs. Preventative parenting programs, rather than punitive ones, were also requested, to provide support without fear of child welfare intervention. Follow up support after program completion, particularly for parents reunified with their children was identified as a need. Due to many family members providing parenting support, it was requested that programs be open to people involved with the child other than parents. Support for foster families, prior to, during placement, and after removal of the child was an identified area for program support. Long-term follow up with families, including parenting skills, mental health counselling services, and other additional resources were requested by participants.

Community groups that would provide general support, community outreach, and that facilitated shared experiences among community members were requested. Participants suggested community circles, women's groups, and peer led counselling services. Support groups that reduced stigma and were open to all community members were seen as valuable additions to communities. These groups were requested to be peer-led, and community-guided, with community members in charge of the creation, content, and facilitation of such endeavors.

Overall Themes

Major themes that encompassed all of these subject areas were obtained from discussion of parenting, the child welfare system, and children's mental health within First Nations communities. These three themes are as follows:

1. Healing the Community to Help the Child

2. Empowerment/Self-Efficacy

3. Culture, Traditions, and Spirituality.

1. Healing the Community to Help the Child. The wellbeing of communities was described to be a support to improving mental health of children within these communities. The current status of community health was reported to affect parenting and child welfare intervention within families. This was stated as, ""in order for something to be solid, you have to fix the foundation" by one participant. Participants referred to addictions, domestic violence, personal trauma, intergenerational trauma and other mental health concerns as factors that influence community wellbeing.

To improve the mental health of children, prevent child welfare intervention, and to promote reunification with families, parents must address their own mental health difficulties first. Services that target parent mental health within communities, such as addictions or parenting concerns, were suggested to improve the wellbeing of parents and overall communities. One participant phrased this as, "that's how we're going to support the children is by building our… our adults to be healthy first, right, our communities to be healthy first. Without that, I don't think we're ever going to be able to have these children supported mentally and physically." Parent struggles were expressed to negatively influence their own parenting abilities, and thus, by healing the adults caring for the children, positive influences to the child's mental health were expected. One

participant referred to how mental health challenges impede positive parenting

behaviours, stating,

> "if you want to have a good life… um, Mino-Bimaadiziwin… that's good life,
>
> good living… you have to… you have to start walking on that healing path and
>
> acknowledge that, yes, we did go through some kind of abuses or… which is the
>
> result of the addictions, which is a result of poor parenting, which is a result of I
>
> have lack of skills of cooking, um, reading to my child, like, um, taking the
>
> energy of when your child comes home from school…"

By seeking help and supporting community mental health for all families, participants

reported that children's mental health would also be improved.

Many participants expressed how difficult it was to remain in communities with

high mental health difficulties. Even if an individual is not experiencing these concerns,

remaining in a community where so many people are, was reported to be problematic for

promoting positive outcomes for their child. Intergenerational trauma, often affiliated

with parents or grandparents enduring residential schools, discrimination, and

marginalization by majority culture, was reported to negatively influence children and

families. As one participant stated, "like one program, if you're having a 12-week session

or something; that's three generations that you're reaching and so… which is less work

for us then in the field and, uh… because we're all… they're all struggling, and if one

struggles, we… we all get pulled down, right, and get stuck."

2. Empowerment and Self-Efficacy. Participants spoke about the importance of

helping themselves and increasing self-efficacy to address current community concerns.

Participants reported the need for First Nations people to be designing and implementing

programs within communities. Participants stated that children should remain in communities due to the importance of community involvement in a child's life.

Consequently, when community members do not feel empowered or they feel that services are punitive, participants stated they would be less likely to engage or access services. Participants reported that difficulty for parents accessing parenting programs or seeking child mental health services for fear of child welfare intervention was partially caused by parental disempowerment. One participant phrased this as, "when they… they have that courage to walk up into those buildings and then they get judged, they… they don't want to because they feel like there's something wrong with them". Empowering parents and having other community members provide support for them was reported by participants to increase hope. A participant stated that, "it's all about empowerment, you know, telling those moms that you could do it, you're… you know, you're… you're on the right path, you're making the right choices." Another said that, "empower young parents to be good parents and you're teaching them, you know, to take the right… right road, they're going to learn something." By creating a support network, it was stated that, "if you can find a place of comfort where they can actually support each other, but a lot of it is if they (community members) heal together."

Some participants spoke of peer groups, or community services that were preventative that were taught by other community members that could help others. One participant recognized the diversity of their community, and said, "we have so many great resources, and we have a lot of survivors, a lot of like recovered people who have recovered, and they're just amazing people and they want to help, they want to share that with others." Contributing to community development was recognized to be easier if

community collaboration occurred, as one participant stated, "we have to come together as groups because that will relieve some of the manpower, right." This would increase the self-efficacy of parents in the community, and participants noted the absence of these resources.

3. Culture, Spirituality, and Tradition. Culture, spirituality, and traditional teachings were frequently associated with positive outcomes for parents, children, and communities. The benefits of children reunified or remaining in communities with family members were often associated with upholding cultural or spiritual beliefs. Participants stated that remaining connected to spiritual traditions was a way to increase empowerment and healing within communities. This was facilitated by remaining connected with community events, such as feasts, pow wows, traditional events, or other celebrations. Cultural and spiritual connections were also maintained through commonly practiced activities such as hunting, fishing, trapping, sewing, regalia making, and drumming. Those who are experts in such activities were often community members.

Remaining connected to values and beliefs embedded within communities were identified as positive influences in promoting children's mental health, and successful reunifications. One participant stated, "so it's an incorporation of, um, family values, parenting, while incorporating the traditional-based activities; so having them heal together, have them attend ceremony together." These values were identified to be passed on by family members or others within the community, and thus, if children were removed from communities, participants stated they might not have access to these learning opportunities. One participant described the importance of maintaining values and beliefs, stating that, "you still have to maintain your values or your… your culture

and your traditions from what, uh, your parents and your grandparents have taught you or have… have learned."

Participants identified the need for children to incorporate culture, spirituality, and traditional teachings into their lives, and associated these with fundamental rights of their children. One participant stated that, "I believe that first and foremost a child deserves to be physically, mentally, emotionally and spiritually, um, protected." Many participants associated this need with keeping a child in their community as access to such cultural supports could be easily facilitated.

Discussion

This study aimed to describe how First Nations communities in Northwestern Ontario conceptualize parenting and child reunification practices, in relation to strengths and barriers within communities. Communities identified supports and resources needed to improve current parenting and child welfare practices in their communities. The themes obtained offered valuable information about how First Nations communities understand these concepts.

Placement of the Child

Kinship care, or placing the child with another willing family member, was identified by many participants as being a viable solution for children being placed in care. Placing a child with an external family member is considered to be a minimal disruption strategy that reduces consequences associated with removing children from their families (Wright, 2006). Three fundamental principles guide kinship care placement in an attempt to provide increased stability for the child. These principles state that the placements should be within the child's initial community, are based on kin ties

and are community sanctioned (Wright, 2006). Kinship care is associated with higher reunification rates for children with primary caregivers than children in foster care, even with consideration of child age and maltreatment types. If a child in foster care has increasing behavioural or emotional problems, the likelihood of reunification with families significantly decreases however this is not true for children in kinship care (Landsverk, Davis, Ganger, Newton, & Johnson, 1996). When children in foster care are reunified with their primary caregivers, they are more likely to be placed in out of home care again compared to children previously in kinship care (Perry, Daly, & Kotler, 2012).

Participants identified that placing a child in kinship care facilitated the connection between the child and their family, but also the child and their community. For many First Nations children in kinship care, creating a link to families and community associated with culture and traditions is important. Kinship care allows families to remain together in communities. It may reduce negative consequences on biological parents, as it may be easier for parents to accept relatives caring for their children. In some circumstances, kinship care can also facilitate increased biological parent access to their children (Wright, 2006).

Using a strategy such as kinship care placements that creates minimal disruption for the child is critical. Maintaining bonds with family creates opportunities for better outcomes for a child outside of the child welfare system. If children remain with siblings, reunification with parents is more likely (Fernandez & Lee, 2013). Preserving the relationship between the child and their biological mother is also important, as it has been associated with successful reunification (Leathers, Falconnier, & Spielfogel, 2010). Minimizing the amount of placements within the child welfare system is another way to

reduce child disruption. An increase in kinship or foster care placements has been associated with less successful family reunifications children (Connell, Katz, Saunders, & Tebes, 2006). Additional disruptions to a child's daily life, or factors that create potentially unsafe environments, such as family substance use, addictions, poor parental mental health or domestic violence has been negatively associated with reunification rates (Ferandez & Lee, 2011).

Healing the Community to Help the Child

Many First Nations communities experience high rates of poverty, inadequate housing, unavailable nutrition, and decreased access to health services, compared to majority culture communities in Canada. For these communities, it remains difficult to support parents and children when the overall environment does not promote positive community health and wellbeing. Many participants spoke about the need to leave communities to receive mental health services, and the barriers that are created to engage in such supports. Participants stated it was difficult to maintain progress obtained from such programs when returning to an unhealthy environment. It seems that if more services were available within communities, it would help facilitate better community health.

Poor parenting is not always the causal agent of child welfare service intervention within many families. Intervention by child welfare organizations can be influenced by many other social determinants of health, such a poverty or unstable housing. Lower socio-economic status does not equate with lower parenting skills, or love for a child, but rather acts as a barrier to parenting effectively. Many interventions primarily target parenting; however, few target systematic disparities such as poverty. Despite this, child

welfare services target families and can place blame on individualized parent behaviours. Given that many social determinants of health affect child wellbeing, placement of blame onto the individualized parent for poor child wellbeing is unfair.

Child welfare intervention can increase stigma associated with accessing parenting supports. Internalizing such blame for parents or the fear of such blame does not facilitate access to local parenting programs. Parenting programs and child welfare services act as institutional authorities and the gatekeepers to parenting knowledge, with the constant threat of intervention when necessary. This contains remnants of historical colonization practices such as the Sixties Scoop and residential schooling. With so many First Nations children currently placed within the child welfare system, reducing stigma within available services should occur. If local service providers are unwilling or incapable of targeting larger social determinants of health, parenting programs remain a feasible solution.

Intersectionality of Gender

The intersectionality of gender raises questions about existing differences of Indigenous women and Indigenous men when examining health inequalities. Participants in this study were primarily women, and many identified as mothers. Many spoke of their personal lived experiences in communities, and therefore it is likely that results of the study targeted women's lived experiences. Scholars have argued that women experience colonization differently than men. Gender discriminatory practices embedded in mainstream societal norms have transcended into Indigenous culture. Despite historical equality of gender in many First Nations communities, colonization facilitated the development of western social inequalities not present before settler contact.

Indigenous women face layers of discrimination, marginalization, and social inequality due to this colonization, the effects of which are present today.

Results of the study reflected the perception of inequality within child welfare practices, but also documented positive change in communities. A few participants expressed the need for gender specific programs, such as men and women's groups in communities. The need for the promotion of empowerment, hope, and strengths of community members was expressed.

When race or ethnicity is compounded with other social disadvantages, it can be difficult for Indigenous mothers to advocate for their children within colonial institutions. Given that single parent families are primarily single mothers, for both First Nations communities and majority culture, considerations for such intersectionality must be made. Participants expressed challenges advocating for their child within the school system, such as during parent-teacher interviews. Some expressed discrimination present or fears of retribution for engaging in parenting programs or seeking parenting support. Although initial investigation may not yield direct removal from the home, the more times a family is investigated by child welfare services, the more likely a child will eventually be placed in care (Fallon et al., 2015). By avoiding seeking parenting support, it is likely that these parents hoped to avoid parenting intervention services, and child welfare interference. Despite more children being removed from more single mother homes, a gendered approach to parenting has not been established within communities.

Empowering Parents. Some participants spoke about the need to empower women to parent and advocate for their children. Participants spoke about how they felt disadvantaged by the system. They perceived stigma associated with accessing and

participating in some child and family services was impeding benefits of such services.

Given the emphasis placed by participants for the parent to modify their own

individualized behaviour, and less emphasis on the social determinants or systematic

concerns related to parenting difficulties, blame is transferred directly to the parent, and

their individualized behaviour. As this parent is more likely to be a single mother, this

systematic assumption of negative parenting creating child apprehension, must be

corrected to reduce institutional stigma. Recognizing systematic factors present that lead

to child apprehension, and, at times, the limited capacity of parents due to the existence

of such concerns, could reduce the stigma associated with accessing initial parenting

supports, and increase the likelihood of community members engaging in preventative

care. Participants identified a need for services that empower them to heal, and to support

one another within the community. Services that promote a holistic understanding of

parenting and family care could better meet the needs of mothers in First Nations

communities.

Participants discussed the reluctance of some parents within communities to

access parenting services. This was partially attributed to fear of child welfare

intervention upon seeking services from professionals. This barrier can prevent access to

mental health services by increasing stigma associated with obtaining parenting services.

Mental health organizations have the responsibility to disseminate information about

confidentiality of client information, the limits of such confidentiality and other practices

related to informed consent to address these concerns. Helping communities understand

the existing processes of sharing client information, the structure of child welfare

intervention, and the limitations of such intervention could reduce such concerns.

Sharing information in communities that clarifies client rights can facilitate self-efficacy associated with addressing one's individual health needs.

The Influence of Culture, Spirituality, and Tradition

Adherence to cultural, spiritual, or traditional activities varied greatly between participants and within communities. Incorporating local beliefs and values into programming, such as using a medicine wheel framework, the Grandfather teachings, and "the good life" was recommended. These values are passed down throughout generations, often by grandparents and parents. Given that one role of parenting is teaching family values to children, parenting programs could incorporate such local beliefs and values.

Including such beliefs was identified as a need of local programs, and a potential way to increase use and benefit of services. Service providers should be invested in such programs and be knowledgeable of local community culture. First Nations community members creating and disseminating these programs was recommended as the cultural knowledge of community members was established from local norms and customs. Cultural competence is often cited as a necessary skill for mental health professionals (Sue, Zane, Nagayama, Hall, & Berger, 2009), although the term continues to be vaguely and inconsistently defined (Kirmayer, 2012). Kirmayer (2012) has stated that the definition of cultural competence must be broadened within mental health settings to ensure true service diversification for clients. Culturally appropriate traditional healing and interventions should continue to be included in mental health practices; however, these practices must align with professional values related to efficacy of treatment (Kirmayer, 2012). The need for culturally appropriate services is supported by results of

the current study, by local community members knowledgeable of local culture and customs.

It was recognized that communities are at different stages of cultural reclamation and not all community members engage in traditional beliefs. The assumption that incorporating cultural beliefs into local community services would benefit all community members is not valid; however, providing the option, and facilitating understanding of local community culture is necessary. Recognizing the diversity of communities when incorporating cultural knowledge is one step towards culturally appropriate practices for local service delivery (Kirmayer, 2012). In an attempt to create evidence-based practices for child welfare service provision reform, Alaska Native communities have documented the development of a local child welfare model (Johnson, Walters, & Armstrong, 2015). Improved tribal-state relations, shared vision, community engagement, and culturally defined evaluation were key themes obtained through interviews with participants related to developing a community based welfare model in five Alaskan communities. Key community stakeholders aimed to implement a community-defined approach to child welfare practices, identify local culturally based supports, and establish working relationships between the community and state partners. Mediated discussions of truth, reconciliation, self-determination, discrimination, decolonization, have established relationships between the community and state partners (Johnson et al., 2015). Community-based research, using community-endorsed methods and cultural understanding, builds evidence-based practices for diverse cultural groups.

Research Method Reflection

Throughout this project, care was taken to recognize the intersection of colonialism with the research methods used. Qualitative research is often considered to be an Indigenous research method, particularly when compared with quantitative approaches. Although many qualitative methods can be Indigenous, it is often the intention and practices embedded throughout, as decreed by the Indigenous population engaged in the approach, that makes such methods truly Indigenous (Kovach, 2010). Modifying common research practices (both qualitative and quantitative) to meet the needs of the communities engaged in projects was essential to the success of this study. The Research Advisory that provided research guidance and community expertise ensured that the research methods used were aligned with community values and project expectations. Consideration of Indigenous methods, with respect and reflection to my own social location as a non-Aboriginal researcher not residing in any of the interviewed communities, was an integral part of this process.

Qualitative methods have been commonly described as "giving a voice to" or "emerging" existing knowledge that is deemed to be embedded within existing data sets. This approach is problematic when using such methods with First Nations peoples and researchers must be aware of these concerns. As a Caucasian researcher completing data collection and analyses, it was important to be aware of these types of colonistic biases when engaging in these processes. By no means does the interpretation provided aim to speak for the First Nations participants engaged in these discussions, and this study does not attempt to suggest that data obtained is an accurate representation of even the entire seven First Nations communities interviewed. First Nations peoples have their own voices, opinions, and knowledge, much like every other population in Canada. It is not

within researcher's duties to "find", "expand", or "give" representation to participants' knowledge, but rather to represent and attempt to find commonalities in what was obtained. Within this study, a careful balance of assigning meaning and truly representing participants' knowledge occurred.

Searching for alternative explanations of the interpretations provided is the final step within Marshall and Rossman's (1999) thematic analysis process. This step was completed with caution in our study, and with the aid of community members engaged in the process. Returning to communities with analyses will explore alternative explanations to meet this requirement. Asking participants to provide their own understanding and assign meaning to the results can provide further clarity and potential correction of the described themes.

Limitations

To preserve confidentiality within communities, results were not described with consideration of geographical location or specific communities. Given the individualized needs of various communities involved with this study, it is likely that not all results are generalizable to even all of the participating First Nations communities involved with this study, let alone all communities in Northwestern Ontario. Results will continue to be disseminated to First Nations communities to be validated, however it is likely that not all themes will be applicable to every community. The obtained data may not accurately reflect true opinions of participants, and could warrant alternative explanations of the study results. Returning to communities will allow participants to provide alternative answers and explanations for the results that were obtained.

As this study was championed primarily through a local child welfare organization, there may be a participation bias in those who self-selected to be interviewed about parenting and child welfare practices within the community. Although some participants expressed concern about how child welfare services were delivered in communities, it is likely that some people did not participate due to discomfort with the subject matter, possibly with the service organization, or even the research process in general.

Future Directions

Results of this study will be returned to communities to be used at their discretion. The Research Advisory will determine how results are used and disseminated. This may consist of organizational reports, academic presentations and manuscripts, and presentations to local community groups. Results will also be presented within local communities if they indicate they wish to receive results from this study. If individual participants indicated interest, and provided contact information, they will also be emailed or mailed study results.

Results will be used to inform local service delivery of child welfare and parenting services. Many parents requested additional parenting resources and culturally appropriate parenting services that are designed by and directed to First Nations families. Study results will be used to inform the development of a new Aboriginal parenting program that will be delivered as a form of distance-therapy to these communities.

This study results can be used to inform evidence-based strategies of care to provide effective support for First Nations children in care and those seeking reunification with their families. Future studies should systematically seek to understand

foster families, primary care-givers, maternal, and youth experiences of the child welfare system. Although concerns arose for all three of these groups within the current study, further efforts about these needs should be explored. Additionally, a review of needs and barriers to seeking mental health and parenting services for these families could be completed.

Conclusion

This study represents a necessary step to understanding barriers, successes and overall concepts related to both First Nations parenting and child reunification with families. Themes will be disseminated to communities to use at their discretion. It is hoped that the data obtained from this work can be used to improve service delivery to families within First Nations communities. Further, this study offers the potential for the creation of evidence-based strategies of care to provide effective support for First Nations children in care and those seeking reunification with their families.

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Appendix A: Letter Requesting Community Support

Dilico
Anishinabek Family Care
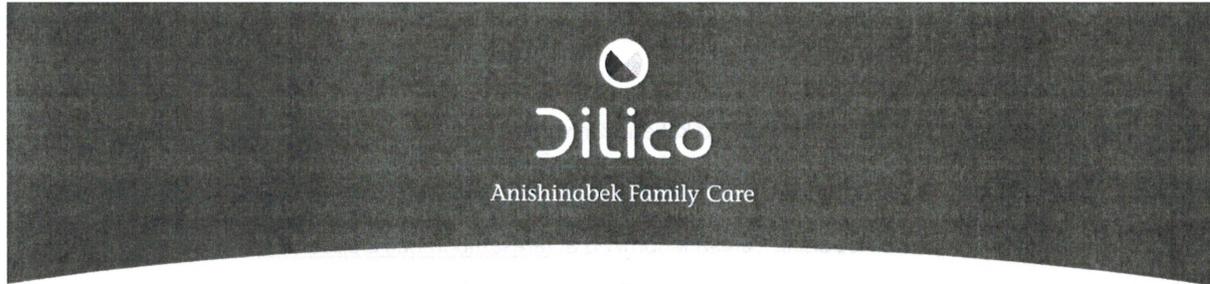
April 27, 2015

Dear Chief and Council:

RE: FIRST NATIONS CHILD MENTAL WELLBEING PROJECT

Dilico Anishinabek Family Care is collaborating with Dr. Christopher Mushquash and his students, Ms. Alexandra Kruse and Ms. Elaine Toombs, on a project looking at First Nations child mental wellbeing. As you know, the vision of Dilico Anishinabek Family Care is to provide services that bring about balance and enhance wellbeing for Anishinabek children, families and communities. We have identified child mental wellbeing as a priority area and are working to create a culturally appropriate tool to assist Dilico and your community in determining appropriate supports.

This project has been presented to the Dilico Board of Directors, which includes a representative from your community. On December 11, 2014 the Board passed a motion to support this project (see attached Board Resolution).

We would like to have permission from you to participate in the project and speak to members of your community about this important issue. If given permission, we would host 2 meetings in your community where we would invite people to participate in a group discussion, and also speak one-on-one to 2 or 3 community members. In the first meeting, we will ask questions that focus broadly on child mental wellbeing, child welfare and reunification, and parenting. We hope this meeting can happen prior to July 2015. A second meeting with interviewees and focus group participants will be held in Fall 2015 to provide community members with the opportunity to correct or clarify what was found in the first set of interviews prior to the creation of the measurement tool. Refinements will be made according to comments from community members. Once the tool has been created, Dilico Anishinabek Family Care will begin using the tool to see how it works.

We would like to ensure that all adult (18 years+) community members have the opportunity to participate if they wish. We believe that involvement from community leadership is key for guaranteeing that all interested individuals are made aware of the focus group and the information we collect is useful and correct. Any adults who live in your community are eligible - they do not need to be involved in services with Dilico Anishinabek Family Care in order to participate.

As this project is in collaboration with Lakehead University, we require a letter of support from leadership to bring this exciting project to your community.

If you are in agreement to this project, letters of support can be forwarded to the Mental Health & Addictions Executive Assistant, Teresa Moorhead at teresamoorhead@dilico.com.

If you have any questions or want further clarification regarding the project, you can contact Dr. Christopher Mushquash at (807) 343-8239 or via email at chris.mushquash@lakeheadu.ca

Respectfully,

John Dixon,
Director Mental Health & Addictions Services

CC: Darcia Borg, Executive Director
        Dilico Board of Directors

Appendix B: Interview and Focus Group Questionnaire

1. Tell me about children in your community
   a. What kinds of things do they like to do?
   b. What are their strengths/what are they good at?
   c. What areas do you think they may have challenges in/need help in?

2. What does reunification mean to you/your community?
   a. If a child is placed back with their family, what does that look like?

3. In your opinion, what does a successful reunification look like?
   a. A child is placed back with parent(s)?
   b. Grandparent(s) or aunt(s)/uncles(s)?
   c. Within their home community?

4. Are there any skills in your community that parents could benefit from learning?
   a. Do parents in your community need any help?

5. Where can they learn those skills/get that help?

6. What kind of supports does the community need?

7. What does mental wellbeing mean to you?
   a. What makes a healthy child?

8. What does your community do to promote child mental wellbeing/mentally healthy children?

9. Are there any barriers in your community to mental wellbeing for children?

10. What are signs that a child is:
    a. spiritually healthy?
    b. emotionally healthy?
    c. physically healthy?
    d. mentally healthy?

11. How can a child achieve balance/health in:
    a. the spiritual domain?
    b. the emotional domain?
    c. the physical domain?
    d. the mental domain?

12. What values are important for children to have in the community?
    a. Where do they get/learn these values?"

Additional Questions for Interviews:

13. What are some barriers to reunification in your community?
    a. How could the reunification process be improved for First Nations peoples?
    b. How can the reunification process meet the needs of people in the community?

14. Does the reunification process meet the needs of First Nations families? Why or why not?
    a. If not addressed, ask specifically about children and/or parents.

15. In your opinion, what does a successful reunification look like?
    a. What are the key factors/most important things to make a reunification successful?   Why?

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

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

Appendix C: Consent Form

Department of Psychology
t: (807) 343-8239 f: (807) 346-7734
e: chris.mushquash@lakeheadu.ca

CONSENT FORM: Child mental wellbeing in First Nations communities

Agreement to Participate

1)   Introductory Statement: My name is _____ and I work with Dr. Christopher Mushquash in the Department of Psychology at Lakehead University. We would like to talk you about child mental wellbeing.

2)   Purpose of the Study: In collaboration with Dilico Anishinabek Family Care, we are doing this study with communities in the Dilico partnership to better understand child mental wellbeing. We want to talk to community members, along with local leaders, health care providers, educators, and Elders. We also would like to listen to everyone's ideas about how to define child mental wellbeing.

3)   Participation: We are inviting people to volunteer for an individual interview or focus group about their thoughts on child mental wellbeing. You will also have opportunities to share your thoughts about how to improve child mental wellbeing. You can answer the questions any way that you want, skip questions, or ask us to stop asking questions at any time. If you decide later on that you do not want your answers used, that is okay, too. Your decision to take part or not to take part in this interview now, or to drop out of our study at a later time, will never affect your access to services or supports.

4)   Confidentiality: All information given is private and we will not share your answers with anyone outside the research team. Please keep in mind; if you choose to participate in a focus group, other people in the focus group will know that you have participated just as you will know that they participated. We will ask everyone to keep information shared in the focus group confidential, but cannot guarantee this. With your permission, we will take notes and audio record the interviews; the notes and recordings will be kept in locked cabinets at Dilico Anishinabek Family Care offices in Thunder Bay for 5 years, and then destroyed. All information that you provide will be combined with information from all the other people interviewed, so no one will know what you said specifically. We will never put your name on the tapes, or notes, or use your name in our reports or presentations.

5)   Benefits and Risks: While there are no direct benefits to people who take part in the interviews or focus groups, your ideas could help Dilico Anishinabek Family Care in delivering effective child mental health services. Because we are asking you to share your thoughts and experiences, however, we know there is a slight risk you might feel uncomfortable talking about some topics. If you do feel uncomfortable and need a break, just let me know and I will take a break. If you would like to continue, we can proceed when you feel comfortable. If you would like a worker from Dilico to follow-up with you, we will help connect you.

6)   Reporting: When our study is complete, we will prepare a summary of findings, along with recommendations on how the findings might best be applied. We will also prepare a final report that can be shared with your community and other First Nations to help them in measuring child mental wellbeing. We also will make a brief written summary of results that will be distributed to the communities at the end of the project. You will also be able to request a summary of results by contacting the research team. In collaboration with the project advisory, we may prepare additional reports for publication in order to share the information for the benefit of others working in First Nations child mental wellbeing. Again, as a participant in the interview or focus group, we will never include your name – your confidentiality and privacy will always be respected.

7)   Further Information: If you have questions about the study after the interview or focus group, or wish to receive a copy of the study results, you can contact Dr. Christopher Mushquash by telephone at (807) 343-8239. If you wish to speak to someone other than a researcher about the study, you may call the Lakehead University Research Ethics Board at (807) 343-8283. After the interview or focus group, we will mail you a letter that sums up the study procedures, tells you how to contact these people and what to do if you change your mind and do not want your answers used.

8)   Confirmation of Agreement to Participate: Remember, you can decide to be in this study or not and your decision to take part, or not take part, will never affect the services or supports that your community receives from Dilico Anishinabek Family Care.

      a)   Do you volunteer to take part in the interview?

              _____ Yes   _____ No

      b)   Do you agree to let the researchers audio record the interview?

              _____ Yes   _____ No

9)   Statement of Interviewer: I certify that I have reviewed the contents of this form with the participant being interviewed. I have explained the purposes of the study, its known benefits and risks of the research and other procedures, and it is my opinion that the subject understood the explanation.

Interviewer's Name: _____

Signature: _____

Date of Interview: _____

For mailing study summary:

Participant Name: _____

Mailing (or email) Address: _____

_____

Appendix D: Informational Participant Letter

Department of Psychology
t: (807) 343-8239 f: (807) 346-7734
e: chris.mushquash@lakeheadu.ca

Title of the Research Study: Child mental wellbeing in First Nations communities

Principal Investigator: Dr. Christopher Mushquash, Lakehead University
Email: chris.mushquash@lakeheadu.ca
Phone: (807) 343-8239
Student Investigators: Alexandra Kruse and Elaine Toombs, Lakehead University
Email: askruse@lakeheadu.ca, etoombs@lakeheadu.ca

Introduction
We invite you to take part in a research study being conducted by Dr.
Christopher Mushquash, Alexandra Kruse, and Elaine Toombs in partnership
with Dilico Anishinabek Family Care. Your participation in this study is voluntary
and you may withdraw from this study at any time. You should discuss any
questions you have about this study with Dr. Mushquash, Alexandra or Elaine.

Purpose of this study
The main purpose of this study is to better understand Anishinabek child mental
wellbeing.

Study design
This study involves two parts, which are described in detail below. Individuals
from all 13 communities that Dilico Anishinabek Family Care serves will be asked
to participate.

Who can participate in this study?
You must be a resident of one of the 13 First Nations communities that Dilico
Anishinabek Family Care serves.

Who will be conducting the research?
Dr. Christopher Mushquash, Alexandra Kruse, and Elaine Toombs will be
conducting the research.

What YOU will be asked to do: This study involves two parts. The total time
required for all parts of the proposed study will be approximately 2-3 hours.

Part 1 - You will take part in a focus group with other community members and/or
a one-on-one interview. We will be asking questions about parents and children

in your community and their mental health in relation to wellbeing. Part 1 will take approximately 1.5 hours to complete and will be conducted your community.

Part 2 - Part 2 will occur approximately 3-4 months after Part 1. For the second part of the study, we will ask original participants to return for a second session to verify the information we gathered and put together in Part 1. We want to ensure that what we have concluded based on your answers reflects exactly what you meant. Part 2 will take approximately 1 hour to complete and will be conducted in your community.

Possible risks and discomforts

There is a possibility that answering some of the questions asked in this study may make you feel upset. If you begin to feel upset during or after your participation in this study, please contact Dr. Mushquash by phone at (807) 343-8239 or by email at chris.mushquash@lakeheadu.ca. He will speak with you and help to connect you with appropriate services to help deal with any feelings you might experience. This study is voluntary. You are free to withdraw from the study at any time, and free to remove your answers from the study, up until the point at which the study is complete.

Possible benefits

A direct benefit of participation in this study is enhancing the understanding of child mental wellbeing from the perspective of community members in order to better provide services to the community in a manner that is appropriate. You will have an opportunity to learn about the results of this study at the completion of the project. If you are interested in learning more about the results of this study, please contact Dr. Mushquash. He will arrange for you to receive a written summary of the results of the study. No individual results will be provided. All results will be presented in aggregate form only. This means that all answers provided from your community will be combined together so that no one can find what was said by each person. This summary will describe the results of the study and potential implications of the findings in a non-technical format. This study will also provide indirect benefits by increasing our knowledge of child mental wellbeing in First Nations communities.

Confidentiality and anonymity

Anonymity: Your individual data will not be identified in any reports or publications. All data will be presented in aggregated form only. Several steps have also been taken to protect your confidentiality (see below).

Confidentiality: All information obtained is strictly confidential. You will not be identified in any audio or written recording of the focus groups/interviews.

Please keep in mind; if you choose to participate in a focus group, other people in the focus group will know that you have participated just as you will know that they participated.

Consistent with Lakehead University's policy on research data integrity, paper copies of data will be securely maintained for 5 years after the completion of the study. Electronic versions of the data will be retained for an indefinite period of time and will be kept in a password-protected computer in Dr. Mushquash's locked laboratory. Electronic versions of the data will never include your name or contact information but will contain the following information about you: age, sex, ethnicity (i.e., self-reported ethnicity and country of birth), occupation, and nature of employment (e.g., full-time, part-time, etc.).

Questions
If you have any questions about this study or your participation, you may contact Dr. Mushquash by emailing chris.mushquash@lakeheadu.ca

Problems or concerns
If you have any difficulties with, or wish to voice concern about, any aspect of your participation in this study, you may contact Lakehead University's Research Ethics Board for assistance at (807) 343-8934.

Appendix E: Debriefing Form

Department of Psychology
t: (807) 343-8239 f: (807) 346-7734
e: chris.mushquash@lakeheadu.ca

Debriefing Form

Title of Research Study: Child mental wellbeing in First Nations communities

Thank you for participating in our study. The main objective of the study was to better understand First Nations child mental wellbeing. We will be looking at your responses from today and then coming back once we've compiled them, so you have an opportunity to make sure that we understood everything you said properly.

If you chose to receive a summary of our results, it will be sent to you upon the completion of the study. If you or someone you know requires additional supports, please contact:

Dilico Anishinabek Family Care
200 Anemki Place
Fort William First Nation, ON
P7J 1L6
Phone: (807) 623-8511
Fax: (807) 626-7999
Toll-Free: 1-855-623-8511
Toll-Free Fax: 1-855-626-7999

For emergencies, please go to your nearest Emergency Department.