

MENTAL HEALTH OF RURAL MI'KMAW YOUTH: COMMUNITY BASED
PARTICIPATORY RESEARCH

by

Adele Ruth Vukic

Submitted in partial fulfillment of the requirements for the degree in Doctor of
Philosophy

at

Dalhousie University
Halifax, Nova Scotia
June 2014

DEDICATION PAGE

This work is dedicated to my mother and father: Stasys and Ruth Pakulis, and to Wes and Ann Charter.

Table of Contents

List of Tables.....	ix
List of Figures.....	x
Abstract.....	xi
List of Abbreviations Used.....	xii
Acknowledgements.....	xiii
Chapter1 Introduction.....	1
Introduction to the Study	1
Mental Health Issues and Aborginal Youth.....	3
Defining Mental Health	5
Proxy Indicators of Mi'kmaw Youth Mental Health.....	6
Programs and Interventions to Promote Mi'kmaw Youth Mental Health	14
Purpose of the Study	15
Resarch Questions.....	16
Significance of the Study	16
Chapter2 Literature Review.....	19
Introduction.....	19
Adolescent Development	19
Health Promotion	23
The Place of Communtiy in Health Promotion.....	27
Mental Health Promotion	32
Conceptions of Mental Health and Illness	37
Tensions in Aborginal and Western Understandings of Mental Health and Illness	39
Summary	40
Chapter 3 Theoretical Perspectives.....	41
Introduction	41
Indigenous Knowledge	41
Two-eyed Seeing and Ethical Space	45
Aboriginal Understandings of Mental Health and Illness	48

Western Psychiatric Understandings of Mental Health and Illness	52
Western Psychological Understandings of Mental Health and Illness.....	56
Common Understandings.....	60
Determinants of Health.....	60
Best Practice Models.....	62
Six Nations Reserve Mental Health Services	63
Traditional Pathways to Health Project (TPTH)	64
Promoting Cultural Identity.....	65
Summary.....	66
Chapter 4 Methodology.....	68
Introduction.....	68
Situating the Inquirer	68
Community Based Participatory Research (CBPR)	70
Ownership, Control, Access and Possession (OCAP) Principles	74
Critical Indigenous Qualitative Inquiry	76
The Setting	80
Establishing and Building Relationships	81
Establishing and Working with a Community Advisory Committee (CAC).....	82
Overview of Data Collection Methods	86
Individual Storytelling Sample, Recruitment and Data Collection.....	88
Description of Participants in Individual Storytelling Sessions	90
Talking Circle Sample, Recruitment and Data Collection	92
Open Forum, Recruitment and Data Collection.....	95
Ethical Considerations for Storytelling, and Talking Circle Sessions, and Open Forum	96
Participant Observation	98
Field notes	100
Data Analysis	100
Trustworthiness and Rigour	102
Credibility of Findings	102
Dependability of Findings	103

Confirmability of Findings.....	103
Transferability of Findings.....	104
Summary.....	104
Chapter 5 Living My Life Well; Msit no’kmaq (all my relations).....	107
Introduction.....	107
Self-Reflecting, Knowing More Anout Oneself and Taking Action	111
Bad Feelings Letting Go and Moving On.....	116
Integrating Physical and Mental Health.....	119
Living Mental Health in Relationships	123
Community Connections: “Security Blanket, One Big Family, Celebrating Culture”.....	124
Families; “ The Higher Generations Matter”	127
Friends and Peers: “Making Connections”	131
Summary.....	134
Chapter 6 Adults’ Understanding of Mi’kmaw Youth Mental Health; Wholistic and Relational.....	136
Introduction.....	136
Emotions and Mental Health	137
Being Proud of Who They Are	141
Spirituality and Mental Health.....	149
Community: “The Connection of Everybody Here”	152
Family: “They Start and End Their Day at Home”	159
“Youth Helping Youth”	162
Summary.....	163
Chapter 7 Navigating Negotiating and Creating a Sense of Self.....	165
Introduction.....	165
The Complexity of a Trusted Listener	165
Youths’ Perspectives; “Opening up to Someone Else”	166
Youths’ Perspectives; “Someone I Know and Trust”	167
Youths’ Perspectives; “ There Should Be An Option There”	172
Adults’ Perspectives; “ It Really Does Help”	176

Adults’ Perspectives; “ Someone Who Would Not Judge and Can Relate”	178
Supportive/Unsupportive Relations and Role Models.....	181
Youths’ Perspectives; Supportive/ Unsupportive Relations and Role Models	182
Adults’ Perspectives; Supportive/Unsupportive Relations and Role Models	186
Community Events.....	188
Youths’ Perspectives of Community Events.....	189
Adults’ Perspectives of Community Events.....	192
Leaving the Community	194
Youths’ Perspectives of Leaving the Community.....	194
Adults’ Perspectives of Leaving the Community.....	196
Becoming Side-tracked with Drugs and Alcohol	199
Youths’ Perspectives of Substance Abuse	199
Adults’ Perspectives of Substance Abuse	204
Youth and Suicide.....	208
Youths’ Perspectives of Youth and Suicide	208
Adults’ Perspectives of Youth and Suicide.....	209
Summary.....	211
Chapter 8 Discussion of the Findings.....	213
Introduction.....	213
Living My Life Well; Msit no’kmaq, (All My Relations).....	213
Youths’ Understanding of Living my Life Well.....	216
Youths’ Understanding of Msit no’kmaq, (All My Relations)	220
Adults’ Wholistic Understanding of Rural Mi’kmaw Youth Mental Health	224
Spirituality and Mental health	228
Trusted Listener	231
Summary.....	233

Chapter 9 Co-creation of an Action Plan to Promote Mi'kmaw Youth Mental Health in Mimikey¹	234
Introduction.....	234
Actions with Youth.....	235
Enhancing Workshops and Programs.....	235
Connecting With Elders and Mi'kmaw culture	238
Creating a Drop-in Center	240
Addressing Addictions	243
Broader Community Action Plan.....	245
Promoting Community Involvement.....	245
Collaboration Amongst Existing Services.....	248
Supporting Parents.....	256
Discussion About The Action Plan.....	258
Summary.....	262
Chapter 10 Conclusion.....	264
Introduction.....	264
Research Implications.....	264
Decolonizing Research: Theoretical Implications	265
Practice Implications.....	273
Youth Involvement	274
Integration of Services	274
Education Implications	275
Policy Implications	277
Limitations of the Research	278
A Reflexive Account About the Research	279
Plans for Dissemination	284
Concluding Remarks	285

¹ Mimikey is a pseudonym for this community to maintain confidentiality and is pronounced *mid ga deg jij* which means butterfly and was chosen by a respected member of the community

Appendix A, Wholistic Policy and Planning Model.....	287
Appendix B, Permission from Chief and Council	288
Appendix C, Terms of Reference for Community Advisory Committee.....	290
Appendix D, Script to Invite Potential Participants for Storytelling Sessions	292
Appendix E, Guide For Individual Storytelling.....	293
Appendix F, Recruitment Poster for Participation in Talking Circle	294
Appendix G, Guide for Talking Circle	295
Appendix H, Community Open Forum Invitation.....	296
Appendix I, Guide for Open Forum.....	297
Appendix J, Consent Form For Individual Storytelling.....	298
Appendix K, Consent Form for Talking Circle	304
Appendix L, Confidentiality Agreement for Transcriber	310
Appendix M, Permission Letter for the Wholistic Policy and Planning Model.....	311
Reference List.....	312

List of Tables

Table 1 Individual Storytelling Participants.....	89
Table 2 Individual Storytelling Demographics of Youth Participants.....	91
Table 3 Summary of Findings.....	212

List of Figures

Figure 1	The Integrative Processes of Data Collection Methods and Analysis	88
Figure 2	Image of Rural Mi'kmaw Youths' Understanding of Mental Health	110
Figure 3	Resource Planning Model for Action Plan to Promote Rural Mi'kmaw Youth Mental Health in Mimikeyj.....	263
Figure 4	Ermine's Model of Research.....	271

Abstract

Background: Some Aboriginal scholars explain mental health as a balance of the mental, physical, emotional and spiritual wellbeing of an individual in connection with families, communities and the land. A critical analysis of the literature identifies that mental health issues faced by Aboriginal youth are associated with the historical legacies of residential schools, the determinants of health, and intergenerational trauma. However, rural Mi'kmaw youth mental health is not clearly understood.

Purpose: To explore understandings of mental health among rural Mi'kmaw youth and identify potential actions that promote the mental health of youth aged 14 to 19.

Methodology: A critical qualitative inquiry informed by community based participatory research (CBPR), and the theoretical constructs of two-eyed seeing, and ethical space, were employed. The research process was developed in partnership with a Community Advisory Committee (CAC) composed of youth and adults. Data collection consisted of individual storytelling with youth, service providers, parents, teachers, and Elders, talking circles, a community forum, participant observation and field notes which enhanced the credibility and trustworthiness of the study. To ensure confidentiality, all data were collected by the principal investigator; anonymized data were analyzed with the assistance of the CAC. The CAC's participation in the analysis strengthened the dependability of the findings as common patterns and themes were identified. Atlas ti was utilized to manage data. Youth voices were dominant in the study

Findings: The three major themes are; 1) *Living my Life Well; Msit no 'kmaq, (All My Relations)*, 2) *Adults' Understanding of Rural Mi'kmaw Youth Mental Health; Wholistic and Relational*, 3) *Navigating, Negotiating and Creating a Sense of Self*. An action plan was co-created with participants, and the CAC which includes the active involvement of Mi'kmaw youth in promoting their mental health.

Conclusion: Mental health among rural Mi'kmaw youth is understood in relation to how Mi'kmaw youth strive to live their life well. Their lives are intrinsically interwoven within the community, rooted in historical, socio-economic and political inequities which cannot be addressed by a bio-medical model alone. Findings support the relevance of listening to, and engaging youth in the community regarding the promotion of their mental health.

List of Abbreviations Used

- AHF Aboriginal Healing Foundation
- CAC Community Advisory Committee
- CBPR Community Based Participatory Research
- IRS Indian Residential School
- NAHO National Aboriginal Health Organization
- OCAP Ownership Control Access and Possession

ACKNOWLEDGEMENTS

Most importantly, this study would not have originated or have been possible without the Community Advisory Committee in Mimikey. Although I cannot identify them individually because of the concern for confidentiality, each of them know who they are, and will receive the final version of this work. Our meetings were not only productive but fun, and although we took pictures to remember our relationship in this work I cannot share them here. Also, I wish to acknowledge the many leaders, formal and informal, and community members, including Elders who supported this work in the community. For the youth and adult participants who gave their time and shared their knowledge so openly and genuinely, I cannot thank you enough. Notably, I want to acknowledge the two thesis co-supervisors of this dissertation; Dr Ruth Martin-Misener and Dr David Gregory, for their countless hours of reading, emailing and skyping. They never failed in offering their guidance, support and wisdom, from the inception to the completion of this research. Although they both concurred it was their job, I believe they invested a lot of energy, commitment and patience that extended well above and beyond their job, for which I am so grateful. Their insights and challenging questions have resulted in a dissertation that will support knowledge development in the field of Indigenous youth mental health. Dr Frederic Wien and Dr Josephine Etowa played a large role in this work; larger than they can imagine. Dr Wien for his infinite wisdom of Aboriginal youth health and the social determinants of health locally and nationally, and Dr Etowa with her expertise in research with marginalized populations, and community based participatory research.

I also acknowledge the endless support from my partner in life Jim Lecky, who I can now hopefully give the attention he deserves, and our four daughters Andrea, Erin, Jessica, and Jamie, and granddaughter Ella who inspired me with their humor, laughter and passion for life. Most importantly, I extend my ongoing appreciation to Doug Knockwood, an Elder in Mi'kmaw territory. He planted the seed for this study to do research with Mi'kmaw youth, and supported and encouraged me with countless cups of Tim Hortons' coffee over the years. For him, I am most indebted.

Last, but not least, this research was made possible from the following funding agencies, scholarships, professorships, and awards:

Atlantic Aboriginal Health Research Program, funded by the Canadian Institutes of Health Research, the Institute of Aboriginal Peoples Health

The Dalhousie University School of Nursing Graduate Program Entrance Scholarship

The Dalhousie University School of Nursing Research Fund

Graduate Studies, Dalhousie University

The Astra Zeneca Canada Rural Scholarship, Canadian Nurses Foundation

The Ruby Blois Award, The Izaak Walton Killam Hospital

The Margaret Cragg Award, Faculty of Health Professions, School of Nursing, Dalhousie University;

The Alexandra Hirth Award, Graduate School of Nursing, Dalhousie University

The Electa McLellan Scholarship, Graduate School of Nursing, Dalhousie University

The E.B. Eddy (Bennett) Professorship, School of Nursing, Faculty of Health Professions, Dalhousie University.

Chapter 1 Introduction

Concerns about the mental health of Aboriginal² youth exist at all levels.

Aboriginal organizations such as the Aboriginal Healing Foundation (AHF), the National Aboriginal Health Organization (NAHO); past organizations which no longer receive funding, the Regional Health Survey (RHS) and the Royal Commission of Aboriginal Peoples (RCAP) have identified that promoting the mental health of Aboriginal youth is a priority. This concern has led to the implementation of Aboriginal youth mental health programs (Adelson & Lipinski, 2008; Dell & Hopkins, 2011; Jacano & Jacano, 2008; Kirmayer, Whitley, & Faurus, 2010; McCormick, 2009; White & Joidin, 2007). The importance accorded to Aboriginal youth mental health and responding to their mental health issues is also supported by the results and recommendations of several reports, current research and studies (Mussel, Cardiff, & White, 2004; Katz, Elias, O'Neill, Enns, Cox, Belik & Sareen, 2006; Suicide Prevention Advisory Group, 2002; Vukic, Rudderham, & Martin-Misener, 2009; Walls, Hautula, & Hurley, 2014). At a more local level, research is raising concerns about the mental health of Mi'kmaw youth (Musquash & Bova, 2007; Zahradnik, Stewart, Stevens, & Wekerle, 2009; Vukic et al., 2009). However, little research has been done to understand Mi'kmaw youth mental health or to

² The term Aboriginal refers generally to the Indigenous peoples of Canada, including First Nations, Inuit and Métis. The Royal Commission of Aboriginal Peoples of Canada (RCAP) stresses that the term Aboriginal peoples refers to organic political and cultural entities that stem historically from the original peoples of North America, rather than collections of individuals united by so called racial characteristics. The term First Nations replaces Indian and the term Inuit replaces the term Eskimo. However, Indian and Eskimo continue to be used for example, "The Indian Act". Native also continues to be used, for example "The Canadian Native Mental Health Association". For the purpose of this dissertation I refer to Aboriginal when including First Nations, Inuit and Métis, and refer more specifically to First Nations and /or Mi'kmaq depending on the context and the literature referenced. I also refer to Indigenous which recently has been used most extensively in the literature. The Canadian Institutes of Health Research, Institute of Aboriginal Peoples' Health are considering to change the use of the word Aboriginal to Indigenous stating Indigenous is more uniting globally and is a "less colonizing" term.

determine what can be done to promote the mental health of Mi'kmaw youth. Mental health and illness covers a broad landscape that encompasses personal growth and wellbeing, everyday problems in living, common disorders such as anxiety and depression, and severe mental disorders such as schizophrenia or manic-depressive illness (Kirmayer, Tait, & Simpson, 2009). This wide range of conditions is currently situated in a predominantly Euro-centric Western paradigm for diagnosis and treatment, and these conditions are often managed with mental health programs and interventions that do not necessarily recognize, or meet the health needs of Aboriginal peoples, particularly if such programs ignore cultural, historical, social, political and economic contexts (Dell et al., 2011; Smye, 2004; Vukic et al., 2009). Although there are some programs that include Indigenous knowledge the need to address Mi'kmaw youth mental health warrants further investigation.

This thesis has 10 chapters. In this chapter, I begin with the current literature on Aboriginal youth mental health in general, and then address proxy indicators of Mi'kmaw youth mental health specifically. The literature on Aboriginal youth mental health emphasizes community factors for understanding Aboriginal youth mental health and substantiates a community-based approach for this research. In chapter 2, I provide a description of adolescent development and include literature supporting the need to make a distinction between conceptions of mental health and illness from Aboriginal and Western³ understandings. The literature on health promotion relevant to Aboriginal youth mental health is also presented in Chapter 2, as health promotion was the focus of this research. In Chapter 3, I explain two-eyed seeing and ethical space, the Indigenous

³ For the purpose of this research I refer to Western as the dominant society in Canada which includes European, British and American worldviews and practices.

theoretical perspective that guided this study. Distinctions between conceptions of Aboriginal and Western mental health are shared in this chapter and reinforce the importance of applying two-eyed seeing. As a non-Aboriginal, I present how the inclusion of ethical space with two-eyed seeing can be used to co-create knowledge that is responsible, respectful, and relevant to Indigenous knowledge and conceptions of Aboriginal mental health and Western understandings. In Chapter 4, I describe the principles of ownership, control, access and possession (OCAP), and community based participatory research (CBPR); both methods for conducting decolonizing research. I explain the qualitative data collection methods used in this study; storytelling, talking circles, the open forum, participant observation, and field notes. I also present how the Community Advisory Committee (CAC) was involved throughout the study. In chapters 5, 6, and 7, I present the findings related to rural Mi'kmaw youth mental health. In Chapter 8, I interpret and discuss rural Mi'kmaw youth mental health findings and include the literature in this discussion. In Chapter 9, an action plan to promote rural Mi'kmaw youth mental health is provided based on youth and adults' perspectives. This plan was co-created with participants and in partnership with the CAC. In Chapter 10, I conclude by presenting implications for research, practice, education, and policy as well as the limitations of this study, some personal reflections, and plans for dissemination.

Mental Health Issues and Aboriginal Youth

In the following section I review literature related to the mental health issues Aboriginal youth face in Canada. Understanding mental health issues in Aboriginal communities necessarily includes the context of the lives of Aboriginal youth. The health disparities in First Nations communities are associated with social, economic, cultural,

historical and political inequities, which lie outside the domain of health (Adelson, 2005; Canadian Institute of Health Information, 2004). Brant (1993), the first Aboriginal psychiatrist in Canada, specifically identified poverty, despair, poor housing and political alienation as the root causes for many of the traumatic mental health problems within Aboriginal communities. Mental health issues arising from these root causes include suicide, depression, substance abuse, and family violence. Health services designed from a Western biomedical model are often a poor fit with Aboriginal views of health and healing (Adelson, 2007; Smye & Browne, 2002). The Kirby Report (2006) claims jurisdictional difficulties are a main barrier for addressing mental health services in First Nations communities; specifically confusion about federal and provincial responsibilities for the provision of health services, and the blurred boundaries between the responsibilities of Indian and Northern Affairs of Canada, and Health Canada. As a result, mental health services are caught up in a web of complexity that is not effective in promoting the mental health of First Nations. Such difficulties are experienced by Mi'kmaw youth living in their communities.

Policies of forced assimilation under the guise of residential schools have affected First Nations at every level of experience, from individual identity and mental health to the structure and integrity of families, communities, bands and nations, which in turn affects First Nations youth through intergenerational trauma (AHF, 2006; Bombay, Matheson, & Anisman, 2011; Health Canada, 2003; Minde & Minde, 1995; Mitchell & Maracle, 2005; Mussell, 2004; RHS (Regional Health Survey), 2002/2003; Walls, Hautula, & Hurley, 2014). Colonial practices continue to affect services in the communities and although Canadians are in the process of negotiation and renewal to

redress past injustices, events from the past cannot be reconciled spontaneously. History cannot be undone. It is lived, experienced and becomes a part of the individual and collective consciousness. How the past events of forced assimilation, residential schooling and colonization relate to the mental health of Mi'kmaw youth needs to be explored.

Defining Mental Health

For the purpose of this research: “Mental health is a sign of balance, harmony and connectedness among the interior aspects of the human person (spirit, mind and body) and the world he or she lives in. It is a characteristic of families and communities, as well as individual human beings” (Native Mental Health Association of Canada, (NMHAC), 2007, p. 6). This balance and interconnectedness to family and community symbolizes an interconnected relationship of the individual with the world. Mental health based thusly focuses on the interconnectedness of an individual with family, community, the land and with spirituality. Although they do not tell the whole story of mental health, some proxy indicators of imbalance, disharmony and disconnectedness are identifiable, observable and measurable. Proxy indicators include suicide ideation, attempt or completion, drug and alcohol abuse, poor performance in school, physical, sexual and psychological abuse and violence, all of which present in the current literature of Aboriginal youth mental health. These proxy indicators identify imbalance as they relate to an individual and they do not necessarily represent an understanding of rural Mi'kmaw youth mental health.

Proxy Indicators of Mi'kmaw Youth Mental Health

Aboriginal youth and suicide. According to McCreary (2008), the best available indicator of mental health in general is having never made a suicide attempt. This indicator may not necessarily be the best indicator of mental health. Although mental health is not exclusively equated with suicide, McCreary employs this indicator to mental health issues with non-Aboriginal and Aboriginal youth in British Columbia. Published research, reports, manuals and the expert opinions of those working in the field of Aboriginal youth mental health focus on suicide and suicide prevention programs (Capp, Devine, & Lambert, 2001; Duhamel, 2003; Echohawk, 2006; Kirmayer, Boothroyd, Tanner, Adelson, & Robinson, 2000; LaFramboise, Medoff, Lee, & Harris, 2007; MacNeil, 2008). McNeil's (2008) epidemiological study identified an increasing trend of Aboriginal youth suicide in some First Nations communities. Literature on specific suicide prevention programs (Jacano & Jacano, 2008; Katz et al., 2006; Kirmayer, Fraser, Fauras, & Whitley 2009; Wexler, 2008) provide insight for understanding the individual who is at risk, and community-based programs that are primary and secondary prevention strategies targeted towards individual youth. This literature emphasizes individual risk management as opposed to health promotion in Aboriginal communities and provides some evidence of program effectiveness. Also there is some concern that school based programs alone do not reach youth who are not attending school (Assembly of First Nations, 2007; Kirby, & Keon, 2006). Nonetheless, the literature provides meaningful approaches for working with individual youth in the community.

Suicide is a predominant theme in the literature on Aboriginal youth mental health for many reasons. The Aboriginal Healing Foundation (AHF) reinforces that suicide is an

affliction of Aboriginal youth. Over a third of all deaths of Aboriginal youth aged 10 to 29 are attributed to suicide, and Aboriginal youth are 5 to 6 times more likely to die of suicide than their peers in the general Canadian population (AHF, 2007). Health Canada (2009) reported that suicide rates within the First Nations population are significantly higher than the Canadian population. “Among First Nations men between the ages of 15-24 years it was 126 per 100,000, compared to 24 per 100,000 for Canadian men of the same age group. Young women from First Nations registered a rate of 35 per 100,000 versus 5 per 100,000 for non-Aboriginal Canadian women” (Health Canada, 2009, p. 28). Health Canada’s statistics on suicide completion provide a national indicator of the high rates of suicide within the First Nations youth population. Skinner and McFaul (2012) conducted a retrospective analysis of suicide rates from Statistics Canada over the period of 1980 to 2008 which included Aboriginal youth. They found mortality rates for suicide with female youth aged 15 to 19 increased from 3.7 per 100,000 to 6.2 per 100,000, and male rates in the same age decreased from 19.8 per 100,000 to 12.1 per 100,000 for the general youth population in Canada. Kirmayer (2012) comments on these rates suggesting that Aboriginal youth are over represented as much as 25% in the above statistics given the trend in Aboriginal youth suicide. Kirmayer acknowledges that rates have declined in some Aboriginal communities, yet some communities continue to have higher rates than Skinner et al. (2012) present, and in some instances the rates may also be increasing during the timeframe of 1980 to 2008 (p. 1016).

Completed Aboriginal suicide is often cited as high in the Aboriginal population; however, on closer examination, as Kirmayer (2012) identified, the high rates are restricted to certain communities. The importance accorded to communities and

Aboriginal youth suicide is relevant; however, there is a need to consider community factors in a manner that does not stigmatize communities. Chandler and Lalonde (2008) have researched and written extensively about identifying “cultural continuity” of the community as having a strong negative correlation with suicide in First Nations youth in British Columbia (B.C.). Cultural continuity does not mean maintaining old traditional rights and rituals as culture is dynamic and fluid. Chandler and Lalonde (2008) refer to cultural continuity in the sense of understanding the values and beliefs of the past, as they relate to the present and influence the future. The authors have identified communities with no suicides at all and others which have more than 150 times the national average suicide rate. In their research, which stems over a period of ten years, Chandler and Lalonde (2008) identified that communities with zero cultural continuity factors have 130/100,000 youth suicides, communities with 3 cultural continuity factors have 80/100,000 youth suicides and communities with 5 factors have 20/100,000 suicides. The markers or factors within the community where cultural continuity can be attained or maintained were identified in their study as: the use of band-level measures of community control over the delivery of health; education and policing services; the achievement of a degree of self-governance; secure access to traditional lands; the construction of various facilities to promote culture; women in government; and control over child welfare.

Other scholars in the field of Aboriginal youth mental health focus on other community factors that influence Aboriginal youth suicide. Mignone and O’Neil (2005) provide the beginnings of a conceptual framework based on an ethnographic study. This study was conducted in a Manitoba First Nations community for the purpose of

developing policies and programs to address youth suicide in First Nations communities. These authors identified social capital as having three dimensions: bonding, which is within the community; bridging, which is between communities; and linkage, which includes relations with formal institutions. This is an interesting framework offering a preliminary approach to understand why some communities may have lower rates of completed suicide.

In another study, Hallet, Chandler, and Lalonde (2007) identified how youth suicide dropped to zero in communities where over 50% of the community had conversational knowledge of their own native language. This study also suggests a strong correlation between language in an Aboriginal community and suicide. Further, this research supports the importance of considering the relationship of culture and language to community development, positive youth development and cultural continuity.

Other critical issues related to suicide among Aboriginal youth are also identified in the literature. Walls et al. (2014) in their research with three First Nations communities in central Canada revealed how suicidal behaviors were described by community members largely as a problem with deep historical and contemporary structural roots, as opposed to being viewed as individualized pathology (p. 63). A study of child welfare data in three provinces noted that 1 in 10 First Nations children are in alternate care as compared to 1 in 200 non-Aboriginal children (Blackstock, Prakah Loxley, & Wien in AHF, 2008). Being in alternate care has been linked with a sense of cultural loss and is correlated with suicide risk among Aboriginal youth (Morris, 2007).

Suicide and Mi'kmaw youth. Examining suicide locally provides some insight into understanding Mi'kmaw youth suicide. There are no recent provincial statistics on

Mi'kmaw youth suicide completion; however, in a provincial survey of Mi'kmaw youth between 12 and 17 years of age (282/455, 62%), 90% of respondents reported never considering suicide, whereas 24% indicated they knew a friend or family member who had committed suicide (Loppie & Wien, 2007). In a more recent Nova Scotia Mi'kmaw Population survey conducted in the Mi'kmaw communities from 2008- 2010, 14.5% of male youth and 25.8% of female youth reported that they had thought about committing suicide; 6.5% male youth and 10.2% of the female youth population indicated they had attempted suicide (Union of Nova Scotia Indians, 2013). Hereafter the report will be identified as RHS (2013). The proportions of youth considering suicide is higher than in the 2007 report. The 2008-2010 statistics of witnessing suicide of a family member or friend remained stable at 24.6%. Further, although no statistics specific to Mi'kmaw youth suicide are available. While I was working with the community on this research (2012-2013) there was a completed suicide. I could not locate any literature on understanding community factors as they relate to Mi'kmaw youth and suicide.

Substance abuse and Mi'kmaw youth. Substance abuse among Aboriginal youth is mainly referred to in the literature as a risk factor for suicide (White & Joudin, 2007). In the Mi'kmaw population health survey, when asked about binge drinking (five drinks or more in a few hours), 10% of respondents indicated that they did this once a week and 24% once a month (Loppie & Wien, 2007). Overall, 54% of female youth and 36% of male youth reported that they engaged in heavy drinking at least once a month and 34% of the female youth and 43.6% of males reported taking mood altering drugs, without a prescription, at least once in the past 12 months. The RHS (2013) reported the percentage of males surveyed who have never engaged in heavy drinking declined from

37 % in 2002-2003 to 21% in 2008-2010. Increased frequency of drinking for males rose from 25.5% in 2002-2003 to 41.6% in 2008-2010. The female rates have remained around 32% for heavy drinking from 2002-03 to 2008-2010, and the frequency of drinking has declined from 41.2% in 2002-2003 to 31.0% in 2008-2010. These two surveys suggest the trend is that male Mi'kmaw youth are drinking less heavily but more frequently, and female youth are still drinking heavily but less frequently. These statistics do not portray the misuse of substance abuse and alcohol within the Mi'kmaw youth population; however, community members in the community where this research was conducted have expressed concern about the youth in the community misusing drugs and alcohol.

Depression. Studies examining the rates of depression and mental health in Aboriginal youth and Caucasian youth and between Aboriginal youth off-reserve⁴ and on-reserve, provide evidence of the concern for Aboriginal youth mental health in First Nations communities. Lemstra et al. (2008) compared depressed mood of off-reserve Aboriginal youth aged 10-15 years old and Caucasian youth. Using a validated tool with a sample size of 4,093 youth, the authors found that 8.9% of Caucasian youth had depressed mood in comparison to 21.6% off-reserve Aboriginal youth. In another study, Lemstra et al. (2011), using the Center for Epidemiological Studies of Depression Scale, found 25% of Aboriginal on-reserve youth had moderate depressive symptoms in seven First Nations Communities in Saskatchewan. The prevalence of moderate depression was

⁴ First Nations community is more acceptable than referring to communities as on reserve /off reserve which is found in the literature and discourse of Aboriginal Peoples. I refer to off reserve and on reserve as represented in the literature and refer to First Nations community in reference to this study and others. The terms are used interchangeably in this dissertation and do not stem from disrespect or lack of awareness of the appropriate designation of First Nations communities.

higher in on-reserve Aboriginal youth than off-reserve youth, which is also higher than non-Aboriginal youth.

The Chief Public Health Officer's Report on the State of Public Health in Canada (PHAC), (2011) supports an understanding of positive mental health that is more than the absence of mental illness. The Report asserts that positive mental health consists of attributes such as having a purpose in life, positive relations with others, experiencing personal growth, social acceptance, social coherence and making contributions to society. The PHAC (2011) report on youth mental health found 66% of off-reserve Aboriginal youth compared to 77% of Canadian youth and young adults rated their mental health as good to excellent. The RHS (2013), focussed on mental health of Aboriginal youth living on-reserve and found 65.6% of youth aged 12 to 18 reported a balance of their mental health (p.111), a little more than 10% lower than the PHAC report (2011). The RHS (2013) referred to balance of mental health as opposed to positive mental health, since, according to the RHS, "the idea of balance is important in First Nations' conceptions of health" (p. 110). The RHS (2013) findings on the balance of mental health in youth raises concerns about how mental health and mental illness are understood, and in particular, what mental health means for Aboriginal youth. Most importantly, these studies suggest depression may be higher for Aboriginal youth on-reserve. Also disconcerting is the rise in the numbers of youth feeling sad, blue or depressed for two or more weeks in the 12 months prior to the survey. The rate increased from 22.5% to 25.9% for male youth and 35% to 38.9% for female youth (RHS, 2013).

Violence and Mi'kmaw youth. Zahradnick's (2010) study in a Mi'kmaw community found that alcohol misuse was used to mediate post traumatic stress disorder

in youth experiencing violence. “This relationship held regardless of which exposure to violence we examined (physical abuse, sexual abuse, or emotional abuse/witnessing family violence)” (p. 46). The study was conducted across two schools with a total of 72 female and 55 male participants ranging in age from 14 to 18. The study was initiated because of community members’ concern of the growing number of disclosures of child abuse in the community. MacMillan (2010), in her study of family violence in Mi’kmaw communities, found that Mi’kmaw communities experience high rates of family violence, many accused of family violence have had at least one form of abuse in their own life, and family violence is one of the most important issues affecting the quality of life in Mi’kmaw territory.

Stress and Mi’kmaw youth. A study related to mental health among Mi’kmaw youth aged 12 to 18 applied a gender analysis of the stress experienced by young Mi’kmaw women (McIntyre et al., 2003). These researchers found gender differences in the types and responses to stressors. Most youth identified family problems, school stress and relationship issues as stressors. The young women distinguished violence and abuse as stressors which contrasted with the young men who claimed drug and alcohol use as stressors. Both genders in the study described their identity as Mi’kmaq and spoke of their background with pride.

The authors of the study acknowledged long-term socio-economic strategies are needed to address these stressors and the broader determinants of health are also implicated. The youth in the study advocated for more culturally-relevant education to reduce stressors and to recover from stressful experiences. The youth also recommended

improved school environments, less bullying, less racism, and more sensitive teachers. Counseling and having supports were also deemed necessary.

School performance and Mi'kmaw youth. Based on the Mi'kmaw population health survey (Loppie & Wien, 2007), 95.1% of the youth surveyed were attending school; 43% repeated a grade while 8% stated they skipped a grade. Community members where this study was conducted were concerned about youth completing their high school education; however, findings indicated that most students who participated in the survey reported that they enjoyed school and many hoped to go on to university education (Loppie, & Wien, 2007). The RHS (2013) reported an increase in the proportion of youths' self-reported problems with learning at school between the time periods 2002-2003 and 2008-2010 (40.9% to 49.5% for male youth and 42% to 44.9% for female youth). The female youth reported more trouble with math and the male youth reported more trouble with writing.

Programs and Interventions to Promote Mi'kmaw Youth Mental Health

Agencies such as Mi'kmaq Child and Family Services, as well as programs provided by First Nations Inuit Health (FNIH), provide services to Mi'kmaw youth. These programs include National Native Alcohol Drug and Addictions Program, Building Healthy Communities, Indian Residential School Residential Resolution (IRSRR), Brighter Futures, Youth Solvent Abuse and National Aboriginal Youth Suicide Prevention Programs. The schools, the health clinic, the band office, and churches also provide support for youth in some Mi'kmaw communities. The Confederacy of Mainland Mi'kmaq (CMM), a Tribal Council incorporated in 1986 as a not-for-profit organization, supports communities through programs and advisory services to actively promote

Mi'kmaw perspectives. Their mission statement best summarizes the objectives of the organization: "To proactively promote and assist Mi'kmaw communities' initiatives toward self-determination and enhancement of community" (www.cmmns.com). This organization serves seven Mi'kmaw communities in Nova Scotia including the community where this research took place. Currently their areas of concentration are on diabetes, tobacco, fetal alcohol spectrum disorder and health interpreter services, however, they continue to advocate and work with other organizations to enhance Mi'kmaw mental health services for the seven communities.

With respect to current regional mental health services, at a conference I attended, concern was expressed by Aboriginal youth health workers attending the conference that there are very few Mi'kmaw youth accessing regional mental health services. They expressed concern that these services do not address cultural understandings of Mi'kmaw youth (Building Bridges: Strengthening Outcomes for at Risk Youth Conference, Dartmouth, N.S. March 30-April 1, 2010).

Purpose of this Study

Promoting the mental health of Mi'kmaw youth is a priority for Mi'kmaw people of Nova Scotia (Vukic et al., 2009). It is clear that some services are available for Mi'kmaw youth in their communities. What is not clear is how Mi'kmaw youth mental health is understood in a rural Mi'kmaw community and how to best promote the mental health of Mi'kmaw youth. The purpose of this research was to engage a rural Mi'kmaw community in a collaborative partnership to explore understandings of Mi'kmaw youth mental health and identify potential plans for action to promote the mental health of Mi'kmaw youth living in a rural Mi'kmaw community.

Research Questions

1. How is the mental health of youth understood by youth and adults living in a rural Mi'kmaw community?
2. What actions are needed to support mental health promotion of Mi'kmaw youth living in a rural community?

Significance of the Study

Focusing on Mi'kmaw youth is justified given the Regional Health Survey's (RHS) (2002/03) recommendations to focus on Aboriginal youth. In addition, the Aboriginal Healing Foundations (AHF) (2006) noted concerns about the effects of residential schools and forced assimilation on Aboriginal youth. Nationally, regionally and locally Aboriginal Peoples support the need to direct and focus attention on youth. While the gender analysis on Mi'kmaw female youth stressors (McIntyre et al., 2003), the Mi'kmaw Population Health Survey (Loppie & Wien, 2007), and the RHS (2013) present information on Mi'kmaw youth mental health, the studies and reports do not provide Mi'kmaw youths' understandings of mental health or identify health promotion plans for promoting mental health with Mi'kmaw youth.

The First Nations Regional Health Survey (RHS) 2002/2003 (2005) data on population size reflect a growing Aboriginal population with a large proportion of the population younger than 20 years. Health Canada (2009) identifies that the proportion of the First Nations population under the age of 30 is 61.1% compared with 38.8% of the Canadian population. Further, some predict a steady increase in the migration of the Aboriginal population to urban centers (Wilson & Rosenberg, 2002; Canadian Institute of Health Information (CIHI), 2007). In Nova Scotia, persons of Aboriginal identity are

2.8% of the population, most live on the 13 reserves in the province, and they are not migrating to the urban centers (Statistics Canada, 2006). The majority population cohort in Mi'kmaw communities is rural Mi'kmaw youth (Statistics Canada, 2006). This research is a step toward understanding Mi'kmaw youth mental health in a rural community and to identify potential promising health promotion initiatives which stem from community members. Promoting the health of future generations of Aboriginal community members is a priority among Aboriginal Peoples (AHF, 2006; NMHAC, 2008; RHS, 2002/2003). However, Mi'kmaw youth mental health is not clearly understood in the literature. Exploring the understandings of mental health of Mi'kmaw youth by focusing on health promotion with the community is important. Health promotion fosters a wholistic⁵ ecological understanding that is in keeping with Aboriginal knowledge and traditions. Community-based participatory research (CBPR), guided by two-eyed seeing and ethical space offers an approach for understanding the community's conceptions of mental health and what health promotion actions arising from the community are needed. Two-eyed seeing respects Indigenous knowledge and Western knowledge, and ethical space ensures reciprocal, respectful dialogue (Longboat, 2008).

Understandings and plans for action learned from this study may be shared with the other Mi'kmaw communities in Nova Scotia, as well as other rural Aboriginal

⁵ Mi'kmaq use the term wholistic as opposed to holistic as the term wholistic is more in keeping with the traditions of entirety and captures the important link between individuals and the interconnectedness with the environment (Native Council of Nova Scotia, Union of Nova Scotia Indians & Confederacy of Mainland Micmacs 1997).

communities regionally and nationally, as they develop their priorities for promoting Aboriginal youth mental health. Mi'kmaw adults are raising concern about the mental health of Mi'kmaw youth (Vukic et al., 2009); however, there has been no systematic study to date to understand Mi'kmaw youths' perspectives on mental health or to determine what can be done to promote the health of Mi'kmaw youth from the community perspective, including Mi'kmaw youth themselves.

Chapter 2 Literature Review

In this chapter I review the literature relevant to Aboriginal youth mental health. I begin by providing a description of adolescent development in general and include the literature supporting the need to make a distinction between conceptions of mental health and illness from Aboriginal and Western understandings. The literature on health promotion relevant to Aboriginal mental health is provided in this chapter as health promotion is a focus for this research.

Adolescent Development

Adolescent development is a normal yet rapid transition from childhood to adulthood. The process involves changes in cognitive, physical, emotional, sexual and psychosocial development which begins at age 11 to 12 and ends between the ages of 18 to 21. Some have broken this development into three phases; pre-adolescence, mid-adolescence and late adolescence. For the purpose of this research, it is appropriate to examine the changes more broadly since adolescent development does not occur in slow step by step progression with clearly marked milestones but rather is a process that evolves. Erikson (1968), in Singleton (2007), described the developmental stages of this age group as identity versus role confusion, and intimacy versus isolation. Erikson's theories of childhood psychosocial development may not necessarily be congruent with Aboriginal youth development; however, this seminal work provides a framework for understanding the psychosocial tasks of this age group. The transitions youth experience cognitively, emotionally, physically, sexually and socially as they mature from child to adult are most important. Kaplan and Osborne-Love (n.d.) claim that adolescence is one of the physically healthiest periods in life. They believe the challenges are less about

physical diseases in this stage of development and more about accommodating the cognitive, emotional and psychosocial growth that influences the health of adolescents.

The cognitive development during adolescence is relevant for understanding youth. The move from concrete thinking to sophisticated abstract thinking skills is an important aspect of adolescents' cognitive development (Kaufman, 2006). Concrete thinkers tend to think in "black and white" and do not necessarily consider the consequences of their actions. "Concrete thinkers have difficulty generalizing rules to varying situations and also have a hard time figuring out rules or common themes from a variety of experiences" (Kaufman, 2006, p. 286). Abstract thinking is related to the development of the prefrontal cortex, which is responsible for abilities such as prioritizing tasks, organization, planning, and analyzing options. This development influences adolescent thought processes. As the prefrontal cortex develops, teens are in the midst of making decisions based on emotion more so than sound reasoning (Burns, Dunn, Brady, Starr, & Blasser, 2004; Dixon & Stein, 2006; Kaufman, 2006). Further research on the development of the prefrontal cortex is required; however, there is evidence to support the cognitive development of more complex methods of decision making in adolescence.

Along with cognitive development, the first signs of puberty begin in adolescence accompanied by changes in hormones that affect physical maturation and influence emotional changes. Certainly, gender differences are said to develop at an early age; however, as adolescents develop secondary sexual characteristics, they also further develop their sexual orientation. Some teens identify themselves as being gay, lesbian or bisexual, which is perceived negatively in some societies, and many teens are unsure of

their sexual orientation (Dixon & Stein, 2006). “In many Aboriginal communities, homosexuality remains a taboo topic and is highly stigmatized” (AHF, 2007, p.47). Support for youth at this time is critical. By mid-adolescence most teenagers engage in some form of sexual activity, which varies depending on the adolescent, the context and situations. By late adolescence, teenagers become more comfortable with their new bodies (Dixon, & Stein, 2006).

Teenage development does not follow a linear path. For example, a 14 year old can be physically mature but psychologically and socially immature. Along with cognitive development, physical, emotional and sexual development, psychosocially adolescents are learning their place in society. Youth may associate less with parents and be more with peers, and by late adolescence have a stronger sense of who they are as individuals (Burns et al., 2004; Dixon & Stein, 2006; Kaplan, & Osborne-Love, n.d).

According to Singleton (2007), the prevalence of mental health problems tends to peak in adolescence compared to the other life stages. Whether the incidence of mental health disorders is increasing is debatable. However, Briggs (2009) claims there is strong evidence of a high level of mental health difficulties among youth and that the predominance of assessment tools and emphasis on making fast diagnoses undermine working with youth from a developmental approach. The need to focus on positive youth development is being more widely accepted as another approach that focuses on youth mental health. There is empirical evidence that supports the influence families and communities have on promoting positive youth development (Morrisey & Werner-Wilson, 2005; Youngblade, Theokas, Schulenburg, Curry, Huang, & Novak, 2007). This influence results in increased social competence, engagement in health promoting

behaviours and improved self-esteem (Youngblade et al., 2007) or the development of pro-social behaviors (Morrisey et al., 2005). Pro-social behaviours demonstrate a caring attitude and engagement in activities that provide assistance to others (p. 68).

Problem-focused paradigms dominate current youth development research theory, and practice; however, the shift to a more positive view of youth development is gaining some recognition (Briggs, 2009; Hohenemser & Marshall, 2002; Morrisey et al., 2005; Youngblade et al., 2007). A more positive view of youth development means working with youth as resources rather than problems to be managed and is based on the idea that young people need support and attention from adults, who actively engage them, solicit their input and help them to develop skills and to make a difference in their communities (Hohenemser & Marshall, 2002). This research is aligned with a positive youth development focus. The emphasis is on including youth, family, groups and community organizations in a process to increase the understanding of mental health of Mi'kmaq youth in the community and to identify potential action plans for health promotion. The focus is to build on the strengths in the community in relation to this understanding and to view youth as resources to the community.

In summary, the literature on adolescent development is explained from Western understandings of adolescent development. Nonetheless, while the literature on Aboriginal youth development is limited, the literature presented in this section identifies descriptions and theories that help to understand adolescent development overall. Research focusing on positive youth development supports working with youth as resources, builds on their strengths, engages them in community action to make a

difference in the community and develops their skills. Positive youth development is the intent of this study.

Health Promotion

The literature on health promotion supports positive youth development and is explained in this section of the proposal. Health promotion with populations who are marginalized is a practice standard for community health nurses (Community Health Nursing Association of Canada (CHNAC), 2003). The emphasis in nursing literature has been to interpret health promotion as a means to address individual lifestyle change (Stirling & O'Neill, 2007). This is problematic insofar as health promotion is the process of enabling people to increase control over and improve their health (Ottawa Charter, 1986), which requires a paradigm shift from health education aimed at changing individual health habits to establishing a practice which examines the oppressive and constraining forces which do not enable people to have control over their health (Koch, & Kralik, 2006; Meagher-Stewart, Aston, Edwards, Young, & Smith, 2007; Sword, 1997; Wright, & Leahy, 2005). This paradigm shift requires public participation, collaboration, engagement and empowerment and a focus on social justice. Hancock, Lamont, and Edwards (1999) suggest the emphasis for practice should be on the determinants of population health as opposed to the determinants of health of individuals.

The Ottawa Charter was established at the first international health conference on health promotion held in Ottawa in 1986 sponsored by the World Health Organization, the Public Health Agency of Canada, and Health and Welfare Canada. Health promotion actions are directed at strengthening individual life skills, as well as responding to the factors influencing the health of individuals. The emphasis for health promotion includes

the health sector but goes beyond the health sector to include the multiple sectors influencing the health of individuals and communities (Epp, 1986). The international health conference was held to build on the World Health Organizations declaration in 1978, Health For all by the Year 2000. The Ottawa Charter has been instrumental in building on health promotion strategies, focusing on the pre-requisites needed for health, and prioritizing approaches for health promotion in Canada. The health priority actions include building healthy environments, strengthening community action, developing personal skills, reorienting health services and developing healthy public policy. Since then, the Djakarta Declaration in 1997 re-examined the basic strategies and priority actions identified in the Ottawa Charter and reinforced the value of the priority actions and basic strategies. The Djakarta conference emphasized poverty as a major deterrent to health and the need to include the private sector in intersectoral plans of action to promote health (O'Neill, Pederson, Duprère, & Rootman, 2007).

A population focus makes the development of identifying needs and indicators of success a complex process which warrants a comprehensive framework for analysis of interventions and measurement of health outcomes. In Canada, the development of an Integrated Model of Population Health and Health Promotion (IMPH&HP) was developed by Health Canada (Hamilton, & Bhatti, 1996). This model combines strategies for health promotion, with the determinants of health, and various levels of intervention including social change, and has been instrumental in influencing how community health nurses work with populations. In the model, the emphasis is on community development and capacity-building practices.

In conjunction with IMPH&HP, the socio-ecological approach to health has also influenced community health nursing practice. “The socio-ecological perspective highlights the interdependencies among social systems operating at different levels and shifts the focus beyond an individualistic approach to consider the influence of broader social, economic and political forces and how these are mediated through local community settings, norms and values” (Barry, Patel, Jane-Llopis, Raeburn, & Mittlemark, 2007, p. 69). This approach captures how community health nurses work with individuals, families and groups to address the socio-environmental constraints influencing the health of individuals, families groups and populations.

The challenge associated with identifying effective health outcomes specific to health promotion is what to measure and how. Raphael (2000) argues that health promoters should be explicit about the principles (for example, strength based, or problem-focused, self-determination) and values (for example, equity) behind their health promotion activities and consider how ideology, values, principles and data interact to produce evidence. Examining values and assumptions is the foundation of the IMPH&HP model. This foundation is important because health promotion strategies are driven by values and assumptions which need to be made explicit when deciding what to measure and how.

Mittlemark (2007) claims health promotion uses complex processes acting on complex social phenomena which are not readily evaluated by traditional experimental research methods. However, some scholars have chosen to measure process indicators such as public participation, capacity building and collaboration to determine success in health promotion (Abelson et al., 2004; Abelson et al., 2007; Collins, Abelson, & Eyles,

2007). Abelson's research is helpful in establishing guidelines and principles for public participation in large urban Eurocentric settings but the guidelines and principles have not been tested in small rural First Nations communities. Measuring participation, a process indicator and one of the principles of health promotion advocated by Abelson et al. is also evident in First Nations' research (Fisher & Ball, 2002; Garwick & Auger, 2003). Fisher and Ball (2002) examine participation as an outcome of health promotion which is problematic as participation then becomes associated as a health outcome and not a process needed to achieve a health outcome. The outcomes Fisher and Ball chose for community participation include perception of satisfaction with, and expectations for participation by the community. They claim that community participation becomes explicit and may be analyzed, further developed, and effectively applied to a range of public health issues in diverse community contexts; however, the indicators presented by Fisher and Ball, that is, perception of satisfaction with and expectations for participation do not provide evidence of specific health outcomes.

Hayward, Ciliska, DiCenso, Thomas, Underwood and Rafael (1996) claim that use of randomized controlled trials (RCTs), the gold standard for measuring the effectiveness of interventions, is a barrier to the evaluation of health promotion because the complex interaction of various systems, values and context of health promotion strategies are not necessarily measurable. However, Juneau, Jones, McQueen and Potvin, (2011) argue that evidence of interventions in health promotion can be taken into account. Juneau et al. (2011) analyzed 26 case studies and identified main outcomes that were categorized according to one of the five strategies in the Ottawa Charter. Scholars such as McQueen and Jones (2007) conclude that the given methodological approach is

mainly driven by the topic area and backgrounds of those searching for evidence. Measuring the effectiveness of health promotion is necessary as Aboriginal health research begins to focus on intervention research and evidence-based practice (King, 2011). Correspondingly, there is a concern that the recent public health reform model in Canada, with its emphasis on prevention of communicable diseases and lifestyle changes will erode the values of health promotion as interventions in these areas can be more readily identified and measured (Kirk, Tomm-Bonde, & Schreiber, 2014). Raphael (2000) argues that evaluation of health promotion activities needs to identify changes in the conditions that support health, for example, community characteristics, such as relations within the community, with formal institutions and with other communities. These relations may take considerable time to build and are crucial in health promotion practice.

The place of community in health promotion. According to Raeburn and Rootman (2007), since the Ottawa Charter, an emphasis on health promotion with populations that are marginalized is in the forefront. This paradigm shift includes empowerment. Raeburn and Rootman equate empowerment with capacity-building which is important for identifying and providing support for health promotion within First Nations communities. The emphasis in health promotion is on capacity-building and creating supportive environments that promote the strengths within the community, including the strengths of youth, adults and Elders alike. Further, “NAHO, as well as the Aboriginal community in general, recognizes that health promotion and disease prevention are cornerstones of wellness....with principles and approaches that are compatible with an Aboriginal world view” (National Aboriginal Health Organization (NAHO), 2002, p. 5). A commitment to advance the mental health of Aboriginal youth

by applying the principles of health promotion requires that participation by the community is a priority and supports the need for the community's involvement in identifying plans of action. Ultimately the community should be defining and driving the process.

The context of community becomes critical in the analysis of health promotion strategies. Dooris (2005) suggests there is a tendency in health promotion research to evaluate only discrete projects in settings that may not adequately capture the synergistic impact and outcomes of interventions which are dynamic, multifaceted and operating at many levels in complex systems. "To capture the added-value of an ecological whole-systems approach requires a framework capable of tracking and demonstrating the interrelationships and interdependencies between its component parts" (Barry, et al., 2008, p. 69). A framework presented by Reading et al., (2007), entitled the First Nations Wholistic Policy and Planning Model (Appendix A, p. 284) incorporates many of the systems and considerations for planning mental health promotion. I refer to the framework presented by Reading et al. here as it reinforces Barry et al.'s (2008) claim that a whole system approach is needed for tracking health promotion efforts. The model presented by Reading et al. (2007) identifies the component parts and the interrelationships and interdependencies to consider when planning within First Nations communities. Using a whole system framework has the potential to establish how systems work together to promote Mi'kmaw youth mental health. Application of the model does not have to include all of the systems outlined in the Wholistic Policy and Planning Model, only those relevant to the community in which the model is being applied. For example, Barry et al. (2008) demonstrated that effective mental health

promotion strategies involving multiple systems, similar to some of the systems identified in the Wholistic Policy and Planning model, such as education, community services and the justice system, as well as the health care system, contributed to a range of improved health and social outcomes. The outcomes included educational achievement, employment, reduced crime and delinquency, improved sexual health, better family and social relationships and reduced inequities.

Dennis Raphael, from York University, and Toba Bryant, from the University of Toronto, argue against neutral epidemiological approaches with large-scale studies that attempt to identify general determinants of health for the entire population and decontextualize the complex environments within which individuals, groups and communities are situated. “The data that result from these studies cannot consider individuals’ health in relation to local societal structures, nor do they consider the forces that influence how these structures are organized” (Raphael & Bryant, 2000, p.198). Raphael and Bryant (2000) verify that the economic, social and political conditions under which people live are major factors that determine whether individuals develop an illness or not. Hofrichter, a health policy analyst from the United States advocates that “without a perspective grounded in values of social justice, approaches to inequities in health will likely aim at symptoms, continuing to rely on cures, treatments, or individual interventions rather than transforming institutions that cause health inequities” (Hofrichter, 2003, p. 12). This study, with a Mi’kmaw community is grounded in the principles advocated by Raphael and Bryant. In other words, a central aim of this dissertation was to contextualize the promotion of Mi’kmaw youths’ mental health in

relation to their day- to-day experiences, and to involve the community in identifying potential actions for health promotion.

Aboriginal leaders are demanding change and requesting research to support the change required for health promotion and prevention (Smylie, Anderson, Ratina, Crengle, & Anderson, 2006). The Aboriginal Health and Human Resource Initiative (AHHRI) Draft Research Plan (2007) advocates for using research to inform best practices and is another model that considers the benefits of health promotion (National Aboriginal Health Organization, (NAHO), 2007). Determining the health human resources necessary to promote mental health in a community is important. One strategy to promote youth mental health is to increase the number of mental health workers in communities. For example, British Columbia hired 20 new mental health workers to work in First Nations communities (Aboriginal Nurses Association of Canada (ANAC), 2007). This approach is important; however, as scholars in the field of health promotion have identified, more comprehensive plans for health promotion within First Nations communities are also needed. Health promotion strategies should also consider the strengths within the community. Further, an understanding of Mi'kmaw youth mental health by the community is needed before health promotion action plans can be identified.

An integrative whole community approach to address Aboriginal youth mental health from a broader perspective is consistent with a health promotion framework. In such an approach, action plans are more extensive and include the social determinants of health and systems in the community as Barry et al. (2008) have demonstrated. Health promotion that focuses on outcomes, best practices and population health needs is consistent with NAHO and the AHHRI. “The framework (AHHRI) is designed to

facilitate the determination of health and human resource (HHR) requirements based on the health needs of a defined population in a manner that is responsive to communities, patient-centered, culturally appropriate, evidence-based, and outcomes directed” (Tomblin-Murphy & Maddalena, 2007, p.7). In order for Aboriginal leaders to make decisions about HHR allocation, research focusing on community members’ understanding of Mi’kmaw youth mental health and identification of health promotion strategies is needed.

An integrative whole system approach is also consistent with scholars such as Chandler and Lalonde (2008) and Mignone and O’Neil (2005), who advocate for understanding community factors that promote mental health. This approach supports a framework for health policy planning as suggested by Reading et al. (2007) in which the community is central to determining change. Health promotion champions (Barry et al., 2008; McQueen, & Jones, 2007; Raphael et al., 2000; Stirling, & O’Neill, 2007) also advocate for an ecological health promotion strategy that emphasizes a framework that captures the interrelationships and interdependencies of systems. The focus of such a strategy is not necessarily on individual behavioral changes.

As identified earlier, most Mi’kmaw youth continue to reside in their communities; hence, research with the community to understand Mi’kmaw youth mental health and to identify potential action plans to promote Mi’kmaw youth mental health requires a research framework that includes and examines understanding of the community. Mignone and O’Neil’s (2007) model of social capital presented earlier in this thesis in an attempt to understand Aboriginal youth suicide is important; however, this approach is too broad, and may not necessarily include the cultural and historical context of the community. The

authors suggest that it may be helpful to know how the socially-invested resources (SIR) of a community (physical, symbolic, financial and human) connect with the culture of trust, norms of reciprocity, collective action and participation and if the networks are inclusive, flexible and diverse in order to inform policy and programs. The culture of the community does not refer to Aboriginal culture but a culture of any community, Aboriginal or non-Aboriginal, with varying degrees of trust, reciprocity, collective action and participation. A broader understanding of health and social outcomes is possible by employing the Wholistic Policy and Planning Model, which is a more collaborative whole system integrated approach, inclusive of Mignone and O'Neil's model. Research with the community from a health promotion framework may enable the community to identify potential action plans. Exploring the understanding of Mi'kmaw youth mental health with Elders, adults and youth in the community may build knowledge and skills within the community to identify ways to promote Mi'kmaw youth mental health.

Mental health promotion. Mental health promotion focuses on improving the social, physical and economic environments that determine the mental health of individuals and populations. Incorporating the principles of mental health promotion in the community and addressing the determinants of health in a community is not unique to any one understanding of mental health and could, in fact, be a common ground for Aboriginal and non-Aboriginal health care providers and researchers. As Mussell, Director of the Native Mental Health Association of Canada (2008) states: "In recent years, holistic models for health and wellness have begun to emerge in mainstream thinking, such as the population health and determinants of health model. These are more congruent with Indigenous conceptions and we welcome these changes" (p.6). The

emphasis extends beyond the clinical and individual treatment focus of current mental health service delivery to address the influence of broader social and environmental factors on mental health.

Barry and Jenkins (2007), experts in the field of health promotion, describe mental health promotion in the community with the following principles based on their health promotion experience:

- Involves the populations as a whole in the context of their everyday life, rather than focusing on people at risk from specific mental disorders;
- Focuses on protective factors for enhancing wellbeing and quality of life;
- Addresses the social, physical and socioeconomic environments that determine the mental health of populations;
- Adopts complementary approaches and integrated strategies operating from the individual to socio-environmental levels;
- Involves intersectoral action extending beyond the health sector;
- Based on public participation, engagement and empowerment (p.15).

If the above principles were addressed in mental health promotion, the effects of historical trauma could be taken into account and strategies to address the issues would be forthcoming by the community. Stakeholders and community members could emphasize structural factors influencing mental health such as good living, environment, housing, employment, transportation and education, or community factors such as social support. Individual factors that promote healthy ways to deal with stressful events in everyday life can also be considered. Ensuring active participation and engagement of Aboriginal community members would elicit what is meaningful for the community to

promote mental health in the community given the historical legacy of residential schools and colonization. Imposition of health promotion strategies grounded in Western perspectives may only perpetuate a Western approach in the community and negate the significance of the community's understandings of social, cultural and historical determinants of mental health. Collaboration with community members is critical.

Including the principles outlined by Barry and Jenkins (2007) would privilege and promote Aboriginal understandings. Clearly participants must be meaningfully engaged not only in the social determinants of mental health but also the cultural and historical context relevant to the community.

The second principle for health promotion identified above by Barry and Jenkins (2007) is to focus on protective factors for enhancing wellbeing and quality of life. This principle emphasizes the enhancement of individual potential rather than the reduction of disorders. This approach is in keeping with scholars in the field of Aboriginal mental health who focus on the notion of resilience as opposed to identifying deficits. The National Network for Aboriginal Mental Health Research promotes the understanding of resilience in relation to mental health. Tait (2009) claims: "alarmist arguments that characterize Aboriginal communities as dysfunctional and pathologic ignore the historical resilience and resistance of Aboriginal peoples in the face of adversity brought on by European colonization" (p. 214). Understanding resilience within the context of youth mental health is congruent with a strengths-based approach to working with youth and is in keeping with Aboriginal ways. Resilience highlights how youth can and do promote their wellbeing despite adversity. A Lakota spiritual Elder, expressed how the concept of resilience is inherent in his tribal culture: "The closest translation of

‘resilience’ is a sacred word that means ‘resistance’ . . . resisting bad thoughts, bad behaviors. We accept what life gives us, good and bad, as gifts from the Creator. We try to get through hard times, stressful times, with a good heart. The gift [of adversity] is the lesson we learn from overcoming it” (James Clairmont in LaFramboise, Hoyt, Oliver, & Whitbeck, 2006, p.194).

Although evidence to substantiate the effectiveness of mental health promotion within Aboriginal communities is limited, advancing mental health promotion with the principles described holds promise for fostering positive mental health in ways that are relevant to the community’s understanding of mental health. Active participation with a community in the spirit of health promotion would enable creation of strategies that are in keeping with the community’s needs, strengths and understandings of what would promote positive Aboriginal youth mental health in their community. Programs promoting mental health that are oriented towards empowerment aim to restore positive mental health and a strong sense of cultural identity by giving youth an active role in designing and implementing programs that meet their needs (Kirmayer et al., 2009). “Mental health promotion needs to be incorporated into the wider health development agenda in order that the broader determinants of poor mental health such as poverty, social exclusion, exploitation and discrimination can be successfully addressed” (Barry et al., 2007, p. 27).

Mussell, Cardiff and White (2004) observe that: “Communities involved in the development of prevention and treatment strategies must understand that the problems facing Aboriginal communities are complex and involve multiple factors including individuals, families, peers, schools, communities, culture, society and environmental

factors” (p.19). Brant Castellano (2008) provides further insight into the need for broad community-led initiatives to address youth mental health. She claims, “community-led initiatives to restore balance and vitality to collective life operate on the margins of public programs put in place to support health, education, employment especially for youth, and safety” (p. 396). The marginalization of communities by imposing programs and policies that do not originate in the community are oppressive and do not lead toward self-determination and a vibrant community. Further, as Tait (2008) argues, these programs may be problematic ethically as they operate under time-limited funding and are not sustainable.

Focusing on the community for understanding Aboriginal youth mental health is consistent with some Aboriginal scholars. Little Bear (2000) explains: “Aboriginal mental health is relational; strength and security are derived from family and community. Aboriginal traditions, laws and customs are the practical application of the philosophy and values of the group. The values and wholeness speaks to the totality of creation; the group as opposed to the individual” (p. 100). Further, Chandler and Lalonde (2004) reinforce, Indigenous knowledge⁶ might be real knowledge, and the best way of helping those in need of help may be to help them help themselves” (p.119). Hence, research is needed that can focus on identifying potential actions for health promotion based on the community’s understanding of Mi’kmaw youth mental health, is spearheaded by

⁶ Indigenous knowledge is derived from Indigenous peoples. More than 5000 Indigenous peoples live in 70 countries with a world population of over 300 million. In each province in Canada, Aboriginal people represent tremendous diversity of peoples, languages, cultures, traditions beliefs and values. Such diversity at the world level has been difficult to capture within a working definition (Battiste, 2005). The International Labour Organization has defined Indigenous Peoples as tribal peoples in independent countries whose social, cultural and economic conditions distinguish them from other sections of the national community and whose status is regarded wholly or partially by their own customs or traditions or by special laws or regulations (ILO, 1989 in Battiste, 2005).

communities and does not impose programs that originate from outside the community. This approach is consistent with that of Brant Castellano (2008) and Tait (2008), who advocate that health promotion initiatives originating in communities are sustainable, are not oppressive and can lead to a more vibrant community.

Conceptions of Mental Health and Illness

This section of the literature review informs the foundation for the promotion of mental health with rural Mi'kmaw youth by first examining the literature that provides rationale for making distinctions between Western and Aboriginal understandings of mental health and illness. As identified in the introduction, mental health and illness covers a broad landscape that encompasses personal growth and wellbeing, everyday problems in living, common disorders such as anxiety and depression, and severe mental disorders such as schizophrenia or manic-depressive illness (Kirmayer, Tait, & Simpson, 2009). This wide range of conditions is currently understood and situated in a predominantly Euro-centric Western paradigm and these conditions are often managed with mental health programs and interventions that do not necessarily recognize, or meet the health needs of Aboriginal Peoples, particularly if such programs ignore cultural, historical and social political contexts (Smye, 2004; Vukic et al., 2009). Aboriginal mental health and illness understandings are different from Western understandings rooted in the traditional biomedical model. Further, Vukic, Gregory, Martin-Misener and Etowa, (2011) acknowledge that mainstream mental health services that accommodate cultural differences do not speak to the totality of Aboriginal understandings of mental health or to self-determination and self-reliance. Therefore, explicating differences and

commonalities may provide direction for mental health promotion that is in keeping with Aboriginal ways of knowing, and supporting a community's efforts in self-determination.

Distinguishing between Aboriginal and Western understandings can be problematic as it may foster the process of othering.⁷ For example, in their study on the pedagogy of nursing students' understandings of culture, Gregory, Harrowing, Lee, Doolittle, and O'Sullivan, (2010) identified how nursing students rely on essentialist understandings of culture, stereotype the "other" and assume culture to be static and inherited. Gregory et al.'s. (2010) findings clearly highlight how distinguishing between Aboriginal and Western understandings may perpetuate an essentialist understanding of Aboriginal culture. Othering has the potential of marginalizing Aboriginal Peoples or rendering Aboriginal knowledge as a commodity to exploit, appropriate, or, potentially, misinterpret. Distinctions between Aboriginal mental health and Western worldviews of mental health also run the risk of making generalizations about Aboriginal culture without considering individual and tribal differences or appreciating the dynamic nature of cultural worldviews, values, beliefs and understandings. Nevertheless, to ignore Aboriginal worldviews about mental health is also problematic as Aboriginal Peoples recover from the legacy of colonization to regain a sense of balance and harmony within their collective historical identities. Thus, knowledge of the distinguishing features of these two standpoints is important to appreciate the priority Aboriginal Peoples have given to mental health. Adapting services to be culturally and socially relevant is

⁷ This term has been used in the literature to explicate how the discourse of difference can promote racialization and an essentializing gaze on culture as static by categorizing a person as 'other' with fixed beliefs, not taking into account differences in class, gender, age, context, or location. Collins (2006), bell hooks (2006) Vukic and Keddy (2002) have written about the marginalization of othering.

important (American Psychiatric Association, 2000; Bernal & Sáez-Santiago, 2006), but insufficient because it does not speak to the totality of Aboriginal understandings of mental health or to the self-determination and self-reliance of Aboriginal Peoples.

Tensions in Aboriginal and Western Understandings of Mental Health and Illness

The notion of two distinct and essentialized cultures, the Aboriginal and the non-Aboriginal, dominates the Aboriginal mental health literature. The problematic nature of conceptualizing Aboriginal mental health in this manner is explained by Waldram (2009), a well-known medical anthropologist working with First Nations. Waldram (2009) argues some scholars have attempted to understand the cultural reality of Aboriginal peoples through a negative deficit approach such that Aboriginal peoples in distress are depicted as being caught between two worlds and experiencing acculturated stress. The inadequacy of the Aboriginal/non Aboriginal explanation and acculturated stress ideologies is evident in Aboriginal mental health practice and research. The Aboriginal/non Aboriginal distinction refers to cultural explanations as if there are discreet populations that can be accurately self-declared and known in the same way and to the same extent by each member, that there is a biological heritage associated with culture, and that community, nationality, and identity are synonymous with culture, and culture is a uniform fixed entity (Waldram, 2009). For example, Lemstra et al. (2008) isolated the variable culture from other covariates, such as socioeconomic status, to study depression in Aboriginal youth. Although culture did not influence depression, this study presents an essentialist notion of culture that Waldram cautions against when conducting Aboriginal mental health research.

The acculturated stress ideology leaves little room for human agency, neglects other aspects related to mental health such as the determinants of health and explains mental illness as a manifestation of culture (Waldram, 2009). “At present, the meaning of Aboriginality as a construct of both identity and culture, for an understanding of contemporary mental health issues, remains unclear” (Waldram, p.75). However, the justification for distinguishing between Aboriginal and Western conceptualizations of mental health is that it challenges established Western ideologies of mental health and illness, broadens the potential for decreasing a prescriptive Western approach to promoting mental health, and opens avenues for developing effective meaningful strategies that are derived from Aboriginal communities.

Summary

This chapter focused on adolescent development, health promotion as it relates to Mi'kmaq youth mental health promotion and the literature that provides a rationale for making a distinction between Western and Aboriginal conceptions of mental health and illness. The historical and social context of Aboriginal communities must also be considered. Cultural identity and resilience are two concepts that have been presented in the literature specific to Aboriginal youth mental health. This literature review supports the need for Aboriginal youth mental health promotion that is inclusive of Aboriginal and Western understandings of mental health, and identifies the potential role for Aboriginal communities in promoting positive youth mental health.

Chapter 3 Theoretical Perspectives

In this chapter, I explain how two-eyed seeing and ethical space informed this study. Distinctions between Aboriginal and Western conceptions of mental health and illness are presented to illuminate current understanding of mental health and illness under the umbrella of two-eyed seeing. Three best practice models are described to demonstrate how common understandings of mental health and illness can be successfully applied in the provision of mental health services.

Indigenous Knowledge

Battiste (2008), a world renowned Indigenous scholar from Mi'kmaw territory, whose discipline is in education, explains that Indigenous knowledge has been referred to as cross-cultural or multicultural understanding which is problematic in understanding Indigenous knowledge.

To date, Eurocentric scholars have taken three main approaches to Indigenous knowledge. First, they have tried to reduce it to taxonomic categories that are static over time. Second, they have tried to reduce it to its quantifiably observable empirical elements. And third, they have assumed that Indigenous knowledge has no validity except in the spiritual realm. None of these approaches, however, adequately explains the holistic nature of Indigenous knowledge or its fundamental importance to Aboriginal people. (p. 502)

The theoretical and epistemological frameworks underlying Western scientific and Indigenous knowledge systems may have fundamental differences, similarities or commensurabilities. I am not advocating a dichotomous framework of Western and Indigenous knowledge. The intent is to prevent Western hegemonic science coming to bear on the research, and the concept of Mi'kmaq youth mental health and wellbeing. Research must be specifically developed and evaluated from Indigenous knowledge and within the context of Aboriginal communities (Kovach, 2009; Native Mental Health Association, 2007; Smylie, Martin, Kaplan-Myrh, Steele, Tait, & Hogg, 2003). Further, Denzin and Lincoln (2008), in their *Introduction to Critical and Indigenous Methodologies*, claim the decade of critical Indigenous inquiry has arrived. The essence of this approach is not to essentialize Aboriginal ways of knowing, but to respect Aboriginal world views, and not to impose Western science in the process.

As a non-Aboriginal conducting research with Mi'kmaq, the necessity of critical inquiry informed by Indigenous knowledge is paramount. For example, postcolonial Indigenous thought rejects the use of any European postcolonial theory or its categories. "Indigenous thinkers" use the term postcolonial to describe a symbolic strategy for shaping a desirable future, not an existing reality" (Battiste, 2000, xix). Further, as Kincheloe and McLaren (2005) concur, "from a Western perspective there is a risk that uncovering colonialism and postcolonial structures of domination may in fact unintentionally validate and consolidate such structures as well as reassert liberal values through a type of covert ethnocentrism" (p. 325). In other words, taking a Eurocentric postcolonial stance may maintain the status quo. Postcolonial structures of Western domination may advocate accommodation for difference as opposed to developing action

plans for structural changes which includes Aboriginal ways of knowing (Vukic, Gregory, & Martin-Misener, 2012). Getty (2010) claims “the findings of a study using a postcolonial lens may reflect the values of the White researchers, such as focusing on individual health issues, rather than health challenges of the collective” (p. 9).

Indigenous scholars’ focus is to uncover the existing realities of current colonial practices to shape a desirable future. The potential to validate and consolidate colonial structures through Western notions of postcolonialism that may perpetuate the status quo and offer solutions based on accommodation for difference warrants a process of critical inquiry. As Kincheloe and McLaren (2005) warn, a postcolonial stance may assume colonialism is over, and research may focus on accommodating differences and perpetuating a colonial system. Postcolonialism may not respond to current colonial issues of oppression.

Although some scholars warn of the concerns of postcolonial theory other scholars such as Anderson et al. (2009) describe how a postcolonial feminist lens sets out to break down the structures perpetuating inequity in health and in access to health care. Browne, Smye, and Varcoe (2005) echo the concerns about a postcolonial stance in nursing and offer valuable insight into how postcolonial theories advance nursing research to address decolonizing research approaches for promoting health equity. While nursing scholars need to be mindful of the concerns about postcolonial perspectives, it is important that they recognize the strengths of postcolonial theoretical perspectives for decolonizing research. Browne et al. (2005) explicate how postcolonial theories draw attention to issues of partnership and voice in research, apply knowledge for social change, and consider continuities between past and present — that is, how socio-

historical conditions continue to shape health, healing, and access to health care. Postcolonial theories do not necessarily assume that colonial practices are past. As Browne et al. state, “By remaining cognizant of the distinctions between postcolonial theory and postcolonial Indigenous thinking we can use each to inform the other while resisting both imposition and appropriation” (p. 24). Postcolonial theory is valuable in conducting research with Aboriginal people; however, given the purpose and questions of this research, and the focus on understanding rural Mi’kmaw youth mental health, two-eyed seeing and ethical space provides a meaningful framework to guide this work.

Including Indigenous knowledge was possible in this research as the approach is community based participatory research (CBPR), and the principles of ownership control access and possession (OCAP) were included. Some Aboriginal scholars refer to this approach as decolonizing research (Walters & Simoni, 2009). Bartlett, Iwasaki, Gottlieb, Hall, and Mannell (2007) claim that, “not only does decolonizing research privilege Indigenous thought as the most rational approach to Indigenous research, but it also offers Indigenous cultural ways of conducting research for general population researchers” (p. 2376). These authors present the implementation of an Aboriginal-guided research approach to examine the lived experiences of Métis and First Nations peoples with diabetes in Winnipeg, Manitoba. Their approach included the following six processes: being Aboriginal guided, using participatory action, negotiating relationships, using Indigenous methods, using reciprocal capacity building, and crediting Indigenous Knowledge. All six of these processes were included in this research on Mi’kmaw youth mental health; however, framing research as decolonizing as Bartlett et al. (2007) claim may be misleading as no single research study could decolonize Aboriginal Peoples. That

said, the research process described by Bartlett et al. is in keeping with recognizing, respecting and crediting Indigenous knowledge that is less colonizing than some traditional Western research that may not advocate for Indigenous ways of knowing.

Archibald, Jovel, McCormick, Vedna, and Thira (2006) explain how they incorporate the principles of respect, relevance, reciprocity, and responsibility in their work on creating transformative Aboriginal health research. According to them, respect is demonstrated by valuing the diverse knowledge of health matters that contribute to Aboriginal community health and wellness (p.5). Having relevance with Indigenous ways of knowing and community is critical for the success of Aboriginal health research. Reciprocity is accomplished through a two-way process of learning and research exchange in which both community and university benefit from effective research relationships. Responsibility is fostered through active and rigorous engagement and participation. These principles support the notion of ethical space and two-eyed seeing, and were employed in this CBPR which is described in the subsequent chapter 4 on methodology.

Two –Eyed Seeing and Ethical Space

Two-eyed seeing refers to individuals learning to see from one eye with the strengths of Indigenous ways of knowing and from the other eye with the strengths of Western ways of knowing and to use both of these eyes together (Hatcher, Bartlett, & Marshal, 2009). In other words different perspectives are explored.

Two-eyed seeing is a principle that is grounded in the Integrative Science Program at Cape Breton University by Aboriginal and non-Aboriginal peoples (Dr. Cheryl Bartlett, personal communication, August 2008). Albert Marshall, the co-creator

of two-eyed seeing, is a respected Elder of the Mi'kmaq of Eastern Canada. He was an "inmate" of the Indian Residential School in Shubenacadie, Nova Scotia, for much of his childhood and teenage years and was profoundly affected by this experience. The residential experience has led him on a lifelong quest to connect with and understand both the culture he was removed from and the culture he was forced into and to help these two find ways to live in mutual respect of each other's strengths and ways (Hatcher et al., 2009). Two-eyed seeing may perpetuate an essentialist notion of culture as perspectives may be presented from an either/ or way of understanding, and may not consider multiple ways of knowing. However, awareness of this concept and discussion of two-eyed seeing does bring to the forefront different ways of knowing and understanding the world. "Two-eyed seeing adamantly, respectfully and passionately asks that we bring together our different ways of knowing to motivate people, Aboriginal and non-Aboriginal alike, to use all our understandings so we can leave the world a better place and not compromise the opportunities for our youth" (Iwama, Marshall, & Marshall, 2009, p. 5).

Ethical space presents a space where Indigenous inquiry and Indigenous knowledge along with Western knowledge can create the potential to generate knowledge that is meaningful and transferable to Indigenous communities. Ethical space provides a process that is respectful and mindful of different understandings and provides an avenue for creating knowledge that is beneficial to the community. Ermine (2005, 2007) acknowledges Western knowledge has always dominated the research process but participatory research that is conscious of "ethical space" is necessary in order to build meaningful partnerships between Mi'kmaq communities and universities embedded in

Western ways of knowing. Williams (2007) reinforces the need for ethical space for health promotion in Saskatchewan. She claims that by recognizing these knowledge systems, the dominant concepts pertaining to health become apparent as well as Indigenous concepts, and makes the practice of health promotion in Saskatchewan more democratic. Interacting meaningfully to create research and practice that is not oppressive, but is informed by Indigenous knowledge, prevents the ongoing imposition of Western ideologies that have ignored Aboriginal views of mental health and healing. Further, to produce knowledge that does not acknowledge Indigenous ways of knowing is unethical. To apply Western knowledge and adapt Indigenous knowledge into practice can be demoralizing, stigmatizing and detrimental to self-determination especially if there is no recognition of where this knowledge originated. To acknowledge Indigenous ways of knowing and appropriate this knowledge creates conditions for opportunistic research which is morally and ethically unacceptable.

Ethical space as outlined by Ermine (2005) means two worldviews can move from talking about one another, to talking together and co-creating understanding (Estey, Kmetc, & Reading, 2008; Stansfields & Browne, 2013; Tait, 2008; Warry, 2007). Estey et al. (2008) explain the difference between two-eyed seeing and ethical space. Two-eyed seeing is learning to see with the strength of Indigenous and Western ways of knowing for the benefit of all, whereas ethical space is about creating space for dialogue and discussion between two different worldviews.

Ethical space, as Ermine (2005) claims, can be a space for procreation of future possibilities. Conducting this research with Mi'kmaq, informed by two-eyed seeing and ethical space was important; two-eyed seeing enabled the cultural divide to be broken

down by acknowledging different world views, and ethical space enabled the creation and encouragement of a space for dialogue that was inclusive of Western and Indigenous ways for understanding Mi'kmaw mental health.

Ethical space and two-eyed seeing create a potential space where Indigenous inquiry and Indigenous knowledge along with Western knowledge can generate knowledge that is meaningful and relevant to Indigenous communities (Vukic et al., 2012). Ethical space requires a dialogue about intentions, values and assumptions throughout the research process (Canadian Institute of Health Research, 2008, p. 17). Ethical space in this dissertation was fundamental as I worked with the community to identify mental health understandings and action plans for Mi'kmaw youth mental health promotion.

What follows is an examination of the distinctions in the major Aboriginal and Western understandings of mental health and illness, their commonalities, and an analysis of three best practice models of promoting Aboriginal youth mental health that incorporate aspects of both understandings.

Aboriginal Understandings of Mental Health and Illness

There is great diversity among Aboriginal Peoples in Canada. This diversity influences worldviews, reinforcing there cannot be one uniform fixed collective Aboriginal identity. Similarly, how mental health and illness are understood by Aboriginal people is also not uniform. For example, some Indigenous people attribute depression to serotonin levels which is consistent with some Western understandings (Cohen, 2008). Depression is multifaceted and there is limited written knowledge of Aboriginal ways for addressing depression. The label depression itself becomes

problematic since many Aboriginal languages do not have a direct translation for the word. “In Indian language the terms of sadness are descriptive and fluid rather than diagnostic and rigid” (Cohen, 2008, p. 129). Furthermore, Aboriginal peoples’ experiences of living with depression remain largely unknown.

The Medicine Wheel⁸ is one model which has facilitated acknowledgement of the nature of Aboriginal ways of knowing and understanding mental health and is referred to by leaders in the field of Aboriginal mental health (McCormick, 2009; Mussell, 2004; Native Mental Health Association of Canada, 2008; Waldram, 2008). Although there are some regional variations, the overall principle of the Medicine Wheel is that all knowledge is contained in the circle. All things are interrelated (relatedness is a core value) and everything in the universe is part of a single whole. Everything in life is a part of the circle, which is different than understanding life as a continuum with a beginning and an end, or of excluding the natural world elements from the spiritual. The spiritual in this sense is not derivative of a God but refers to someone or something having spirit or soul and that we are all related. The circle represents the totality of existence, the interconnectedness of relations, and is symbolic of life.

The Medicine Wheel has been used by some Aboriginal scholars and Aboriginal organizations to present the wholistic nature of mental health or what Western science would label mental illness or disorder. To say that mental illness is an imbalance of an individual is too simplistic, and does not capture wholistic understandings as understood

⁸ Historically, the Medicine Wheel has been passed down orally from one generation to the next and is depicted as a circle with four quadrants balancing mental, physical, emotional and spiritual wellbeing of an individual as well as many understandings of the way of life. Although some communities have not adopted this model, the Medicine Wheel and its teachings have become widely available in many forms and can be readily accessed on the Internet.

by traditionalists or Elders. Although the Medicine Wheel as a framework for understanding mental health and illness needs is not universal for all Aboriginal Peoples, it provides some insight into Aboriginal understandings of this phenomenon and reinforces the interconnectedness of an individual to the universe.

Within the framework of the Medicine Wheel, mental illness is a condition that cannot be reduced to the presence of a physical disorder but rather a disturbance in the interconnectedness of mind, emotion, spirit and body (Mitchell, 2005). The expression, mental illness, perpetuates a mind-body dualism situated in Western biomedical ways of knowing and understanding mental illness. The interaction and balance of the mind, emotions, spirit and body and the interconnectedness with the environment is contrary to the individual mind/body dualism found in paradigms addressing mental illness as a biological entity. In contrast, Aboriginal wellness involves the physical, emotional, mental and spiritual aspects of a person in connection to extended family, community and the land. Adelson (2007), a Jewish scholar, maintains that a wholistic perspective on health that is consistent with cultural concepts of the interaction and balancing of the mind, emotions, spirit, and body in connection with family and community does not fit with a perspective of mental illness that focuses on a belief that the key to curing mental illness is to determine the underlying functions of the brain.

According to McCormick, a well-known Mohawk psychologist (2009), “Traditional cultural values provide Aboriginal people with teachings on how to attain and maintain connection with creation and many of the mental health problems experienced by Aboriginal people can be attributed to a disconnection from their culture” (p. 348). Aboriginal cultures have a rich tradition of healing ceremonies. The Aboriginal

Healing Foundation (AHF) (2008) spearheaded research of five healing programs across Canada in urban and rural communities. Although definitive best practices could not be mapped out, the case studies provide an understanding of the management and process of healing in Aboriginal communities in both urban and rural settings. Overall, the studies determined that an eclectic and flexible approach to healing is fundamental because there is an interchange of Traditional ways/knowledge and Western ways/knowledge. It is not a matter of an either or approach as there is not one singular Aboriginal identity or one singular Aboriginal approach (Waldram, 2008).

One of these five studies, conducted by Adelson and Lipinski (2008), focused on the Mi'kmaq Youth Initiative in New Brunswick. The initiative was structured as a youth drop-in center and included aspects of Western healing and Aboriginal approaches to healing. Youth were involved with many activities that fostered their individual development and wellbeing. When determining Aboriginal approaches to health and healing, the authors found that those interviewed acknowledged unique Aboriginal approaches which were more community oriented, spiritually-based and included sweats, talking circles, smudging and sun dance ceremonies (p. 28).

Although not every Aboriginal person believes in ceremonies or the traditional values of Aboriginal culture, Kirmayer, Brass and Tait (2000) claim, "The resurgence of interest in traditional practice is part of a more global movement to regenerate Aboriginal identity and explore the significance of an evolving tradition in the contemporary world" (p. 614). AHF (2005) defines culturally-based approaches to healing as wholistic that include a central role for Elders and Traditional people, use of the structure of the circle and outdoor physical setting, as well as traditional teachings and medicines, storytelling

and ceremony. AHF (2006) identified positive healing practices used in many programs across Canada. These programs included the above structures as well as sweats, pipe ceremonies, talking circles with talking sticks, songs, and drumming. Some programs also included Western practices of individual and group counseling and solution-focused cognitive behavioral therapy.

Standardized interventions by health professionals to address the mental health of Aboriginal peoples often do not take into account Aboriginal concepts of wholeness or the fundamental connections among all living things. Standardized approaches, although helpful, need to be more inclusive of Aboriginal understandings, while appreciating that there is no single approach that can effectively address the complexity of mental health, especially within diverse cultural contexts.

Western Psychiatric Understandings of Mental Health and Illness

Mental illness, as an underlying function of the brain, is predominant in the literature on the treatment of mental disorders in childhood (Walkup et al., 2008). Advances in neuroscience suggest childhood psychiatric disorders can be associated with abnormalities in neurotransmitters and/or structural or functional abnormalities of specific brain regions, and/or the circuitry that interconnect affected brain regions. Neurobiological explanations of childhood psychiatric disorders are often used to support the use of psychotropic medications for childhood psychiatric disorders (Walkup et al.) and support a mind/body relationship to understanding mental illness. Although advances in neuroscience increase knowledge of brain function, it is difficult to determine if these changes are a result of brain dysfunction or if feelings and thoughts affect brain function. A neurobiological explanation of mental disorders does not include

concepts of mind, body, emotion, and spirit and interconnectedness with family, land, and community and renders mental illness as a disorder of the brain. A neurological approach does not exclude other influences but emphasizes the need to address the dysfunctional brain disorder so that other influences can be addressed.

Advances in pharmacology are also changing how problems experienced during childhood are regarded. Children's 'troubles' are increasingly defined as disorders and access to services requires a diagnosis of a disorder (Harper, & Cetin, 2008). The use of medications to ameliorate the symptoms associated with mental illness in Western biomedical science is specific to the mental illness diagnosis and is advocated for use by psychiatrists. Early detection and treatment in childhood can decrease the seriousness of mental illness in later years. Kutcher, Murphy and Gardner (2008) discuss the essential pharmacological drugs for mental disorders in adolescents and support the development of a universal list by the World Health Organization for disorders such as depression, sleep disorders, anxiety disorders, psychosis, obsessive compulsive disorder and eating disorders. Kutcher et al. (2008) advocate for the use of culturally appropriate assessments and interventions that will enable effective pharmacotherapy. However, it is unclear how these assessments and interventions blend with Aboriginal understandings of symptoms and management of mental illness. Kutcher et al.'s (2008) work is locally and internationally known and has proven beneficial in the treatment of mental disorders by alleviating symptoms.

The *Diagnostic and Statistical Manual of Mental Disorders DSM-IV* of the American Psychiatric Association is the psychiatric diagnostic system in use in Canada and the United States. "In DSM-IV each of the mental disorders are conceptualized as a

clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress, or disability or with significantly increased risk of suffering, death, pain ,disability or an important loss of freedom” (American Psychiatric Association, 2000, p.xxxi). This manual has been developed and revised over the years based on health professionals’ input, consultation and analysis of research related to mental illness. DSM-IV recognizes cultural variations in clinical presentations, and culture bound syndromes and provides an outline to consider cultural differences in relationship to an individual’s culture (DSM-IV, p. 897). For example, the culture bound syndrome identified for Aboriginal Peoples is labeled “ghost spirits” (p. 897), which is not clearly defined, and excludes other descriptors of how some Aboriginal peoples understand mental illness. Labels may limit more fluid and more descriptive understandings of mental health and illness.

Mental health service providers are often challenged with conducting clinical assessments with culturally diverse clients when employing standard tests that do not take into consideration different understandings of mental health and illness (Mushquash et al., 2007). Empirical findings suggest that it is a challenge to assess Aboriginal clients in an unbiased manner because culture potentially plays a significant role in the assessment process (Mushquash et al.,2007). If a mental health care provider is unfamiliar with cultural norms such as emotional expression, mannerisms, and verbal style, he or she may misinterpret such expressions, which could affect the course of the treatment (Jackson, Schmutzer, Wenzel, & Tyler, 2006; Whitbeck, 2006). For this reason, health care providers and communities may hesitate to use standardized tests. For example, Zahradnik, Stewart, Stevens and Wekerle’s (2009) research with a rural Mi’kmaw

community highlighted the community's involvement, and commitment to deal with post traumatic stress disorder (PTSD). The tangible benefits were that the community became more aware of PTSD and more informed about the ways to work with community members who may be suffering from PTSD. Although a standardized PTSD screening tool was available, the community preferred to use an informal atmosphere to assess clients with PTSD. The reasons for this were not explored, leaving questions about whether the standardized tests for PTSD were seen as less culturally relevant or intrusive to building a therapeutic relationship. Other studies have shown that there is a need to adapt assessments to be more culturally relevant, and for those who do the assessment to be more aware of the historical, cultural understandings and language when conducting a psychiatric/psychological assessment (Vukic et al., 2009). Although cultural sensitivity and awareness of difference while doing standardized assessments is one approach, there is no evidence to substantiate the effectiveness of this approach. Not only can the assessment tools lack cultural relevance, the process of assessment could be perceived as intrusive, or assuming a stereotypical stance of all Aboriginal peoples. Further, if the cultural nuances of interpersonal communication are misread or dismissed, the assessment process may leave the individual who is seeking help feeling vulnerable or discriminated against (Browne, & Fiske, 2001). The risk of this happening is exacerbated by a recent trend toward using standard screening programs. As Kirby and Keon (2006) report, there is a trend towards quick assessments and diagnoses. Standard screening programs such as depression screening may increase awareness of the problem of depression, but often all it does is support the idea that depression is a singular biological entity. Screening may produce high rates or false positives if not validated with different

cultural or ethnic groups. This idea is highly promoted by the pharmaceutical industry but has no support in the literature (Kirby & Keon, 2006). Psychiatric billing plays a higher role in increased use of medication vs psychotherapy. This has shaped clinical practice in Canada significantly.

In summary, psychiatry as a field of study and discipline has advanced physiological understanding of mental illness. Standardized assessment and diagnostic processes and interventions often do not take into account Aboriginal ways of knowing and understandings of the wholistic nature of mental health and healing.

Western Psychological Understandings of Mental Health and Illness

Psychology is the scientific study of the mind to understand mental functions and human behavior. Psychologists are not necessarily trained in medicine although they may use the DSM-IV for diagnosis and some may prescribe medications. The emphasis for psychologists is on counseling by drawing on many schools of thought in psychology such as abnormal behavior, humanistic theory, behavioral theory and therapies like cognitive behavior therapy, and psychotherapy (Goldner, Jenkins, Palma, & Bilsker, 2011; Gordano, 2007; Leftwich, 2007). Clinical psychologists are trained in assessing and treating mental disorders and applying empirically supported theories developed by Western science and specific techniques to treat disorders. Whereas psychological based counseling is practiced by nurses, social workers, and mental health workers who are working with individuals experiencing mental health problems. There is a plethora of psychological theories, approaches and techniques for practitioners (Wheeler, 2008).

Counselors and other health professionals in Canada are aware of some culturally appropriate methods of assessment and counseling with Aboriginal youth and adults

(Stewart, 2008). Gone (2009), an American Native clinical psychologist, presents his concerns about culturally appropriate methods of assessment and counseling. He provides insight into different psychological approaches based on his background. He identifies the differences between Western and Aboriginal understandings including: individual egoistic enlightenment versus interpersonal relations or “life lived in a good way”; secular versus sacred therapeutic orientations; and the ascription of illness as endogenous rather than interpersonal. Gone (2009) identified these distinctions as paradoxes in Western understandings of the human mind, body and spirit, and his tribal culture. He is not adverse to scientific inquiry to explore insights into psychological approaches, yet supports the need to have Indigenous ways of knowing included in the scientific inquiry (Gone).

Other psychologists (Cohen, 2008; Jackson, Schmutzer, Wenzel, & Tyler, 2006; McCabe, 2008; McCormick, 2009) concur with Gone’s concern of different world views and how this impacts on assessment and treatment. Jackson et al. (2006), based on a preliminary empirical study, support the concern that cognitive behavioral therapy may need to be adapted for Northern Plains Indians. The world views of Northern Plains Indians suggest some of the underlying principles of cognitive therapy are not necessarily helpful. For example, a linear analysis of how thoughts cause feelings may be incongruent with attributing depressive symptoms based on a more wholistic understanding of mental health and illness (Jackson et al.). McCormick, (2009), asserts that the values of mainstream counseling such as, individuation, self-actualization, independence and self-expression may not be embraced by many Aboriginal clients. Clare Brant (1990), the first Aboriginal psychiatrist in Canada, who was Mohawk ,

stressed the importance of understanding Aboriginal worldviews and recognizing the impact Aboriginal values and beliefs have in therapeutic assessment and treatment. The core principles of Aboriginal worldviews he referred to were the ethics of noninterference, non-competitiveness, sharing and emotional restraint (Brant). McCabe (2008), another psychologist who has worked extensively in Aboriginal mental health, asserts that cognitive therapy abounds in today's society. He describes how cognitive therapy is a concern because mind, body, emotion and spirit conceptions common to Aboriginal understandings is far deeper than a cognitive awareness level which focuses exclusively on the mind. McCabe (2008) supports the use of traditional ceremonies, and teachings and spiritual integrity as essential components of traditional healing.

Stewart (2008) suggests that mental health services are under-used by Aboriginal peoples because of difference in understandings about mental health and illness. She claims, "research suggests that this is partly because most services are based on non-Indigenous conceptions of health and healing" (p. 49). Peters and Demairis (1997) claim large numbers of First Nations have a strong preference for native-owned and operated programs and for receiving services from native staff. In Nova Scotia access to specialized services in small rural communities is challenging. Schmidt (2000) concurs that it is not feasible to offer programs, such as life skills, employment mentoring, day programs, and supportive housing, which are offered in urban settings for healing or rehabilitation, in communities with small populations. He suggests there is a need to examine how these services could be modified or adapted or accommodated for small rural communities. Further, the presence of programs in a community does not necessarily mean that youth will access those programs. This was discussed in a local

conference on youth mental health (Building Bridges: Strengthening Outcomes for at Risk Youth Conference, Dartmouth, N.S. March 30-April 1, 2010). There was discussion of how few Mi'kmaw youth access the Life Choices Program offered by the Capital District Health Authority. Aboriginal participants at the conference remarked that the lack of visibility of Aboriginal culture in the programs, more so than transportation issues, was a likely explanation for why this was happening. Although access to current urban mental health services is problematic, more research is needed to substantiate the reasons for the under-utilization of Western mental health services by the Aboriginal population.

In summary, distinctions have been made in how mental health and illness is understood from Aboriginal and Western world views. Specifically, Aboriginal understandings of mental health and illness are based on a framework of wholism. Western understandings regard mental health and illness as individually situated. The distinction is made not to promote one over the other, but to acknowledge that Aboriginal mental health and illness cannot be addressed exclusively from Western understandings of mental health and illness. Western medicine has the power of the government, the law and medical system behind it (McCormick, 2009); however, Aboriginal understandings of mental health are necessary as Aboriginal peoples prioritize approaches to promoting mental health that are inclusive of Aboriginal understandings. While there is a recognition that Aboriginal understandings are important, what is actually known about these understandings is relatively little. Research framed by the lens of two-eyed seeing and ethical space will illuminate a broader understanding of these distinctions.

Common Understandings

Difference does not necessarily equate to the absence of common ground between these two perspectives. Actually, there are similarities between Aboriginal and Western understandings of mental health. These commonalities are the focus of the following section.

Determinants of health. There are many different ways in which social, environmental, psychological, and biological factors are thought to interact in the development of mental disorders (Kirby, & Keon, 2006). The Standing Committee Report stresses the importance of the social determinants of health in understanding mental illness and in fostering recovery from it. The Standing Committee on the Kirby Report was repeatedly told that factors such as income, access to adequate housing and employment, and participation in a social network of family and friends, play a much greater role in promoting mental health and recovery from mental illness than is the case with physical illness. With respect to Aboriginal peoples, most researchers support locating mental health and mental health care for Aboriginal peoples within these wider historical, social, political and economic contexts (Adelson, 2005; Gone, 2009; Kirmayer, Tait, & Simpson, 2009; McCormick, 2009; Stewart, 2008; Smye, 2004; Waldram, Herring, & Young, 2006; Wieman, 2009). Reading and Wien (2009) divide the social determinants of health for Aboriginal peoples into the following categories: (a) proximal, or those that directly influence health, such as health behaviors, and physical and social environments, employment and income, education, and food insecurity; (b) intermediate determinants, such as community infrastructures, resources, systems and capacities, including the health care system, educational system, environmental stewardship, and

cultural continuity; as well as (c) distal determinants, which include social, historical, political, and social contexts, such as colonialism, racism and social exclusion, and self-determination. Dividing the determinants into proximal, intermediate and distal categories is helpful in providing a broad understanding and situating mental health within a contextual framework. The interplay of these categories warrants consideration as well. For example, health behaviors, a proximal determinant is influenced by intermediate determinants such as the educational system, which is also influenced by racism a distal determinant.

Locating mental health contextually enables researchers and practitioners to view mental health beyond an individual biomedical problem. The emphasis on promoting the mental health of Aboriginal peoples needs to incorporate the effects of colonization, oppression and attempts of assimilation on the wellbeing of Aboriginal peoples today. The past atrocities of residential schools, the continued paternalistic approach of the Federal Government of Canada and its policies regarding Aboriginal peoples continue to leave their mark on the lives of Aboriginal peoples. Further, the notion of historical trauma as it relates to mental health is not clearly understood in the literature. Historical trauma and its negative effects are interpreted as post traumatic stress or syndrome for some (Mitchell, 2005). Kirmayer, Brass, and Valaskis (2009) maintain, “ the cumulative effects of internal colonialism on cultural identity and continuing tensions between the values of Aboriginal peoples and mainstream society complicate the efforts of Aboriginal youth to forge their identities and find their ways in the world” (p. 460). Hence, in any discussions of the determinants of health an inclusion of the historical, cultural, social and political factors warrant consideration.

The determinants of health, including the historical and social context of Aboriginal Peoples, are essential for promoting First Nations youth mental health and illness. Including the principles of mental health promotion, as described by Barry and Jenkins (2007) in Chapter 2, provide an avenue to identify potential actions for change. This is in keeping with some of the common understandings of mental health and illness from Aboriginal and Western understandings that include the community in addressing mental health.

Best Practice Models

There are many considerations associated with how to best treat Aboriginal mental illness and to promote Aboriginal mental health. The treatment of mental illness occurs within hospitals, offices of psychiatrists and psychologists, and in community clinics, half-way houses and other support systems within the community. As the The Standing Committee of the Kirby report (2006) identified, many institutions to treat mental illness have been disbanded. Further, the traditions, values and health belief systems of some Aboriginal Peoples are poorly understood by many mental health care providers, and Western approaches to counseling are not always conducive to addressing mental health and illness with Aboriginal Peoples. Although cultural sensitivity has been supported in the literature, the effectiveness of accommodating for cultural differences in mental health promotion is not clear. There is a suggestion by Stewart (2008), that Aboriginal peoples do not access Western mental health services but there is no research to support this claim. All of the above concerns illustrate some of the dilemmas associated with addressing Aboriginal mental health in general, in both urban and rural practice, and with rural Aboriginal youth mental health more specifically.

There are several practice exemplars that demonstrate how two world views can come together. Although the models are not comprehensive, their unique features illustrate how, in some ways, it is possible to overcome the differences described above.

Six Nations Reserve: Mental Health Services. Six Nations reserve in Ontario provides a unique mental health service that has been in existence since 1997. The community is one of the largest First Nations communities in Canada. In the community there is a distinct delineation between more “Westernized” individuals and those with a more traditional viewpoint (Wieman, 2009, p. 410). The service is a community-based mental health and psychiatric clinic. While offering conventional medical treatment for psychiatric disorders, clinicians have also strived to offer more culturally sensitive and appropriate care to community members. There are four full-time mental health nurses, three part-time psychiatrists, a mental health/addictions counselor, two case managers, a crisis counselor, an outreach social worker, and an administrative assistant on staff who are familiar with and involved with the community. Emphasis of care is on all ages and stages of life.

The unique features of this practice are such that the clinic promotes a “shared care” model and makes every effort to establish a mutually respectful collaborative working relationship with traditional healers in the community. Collaboration with agencies to promote culturally relevant programs and services within the community is another main goal of the staff. Cote (2007) explains how community members present with a host of psycho-social stressors that need to be included in a management plan before their mental health can improve. “They deal with poor education, employment, finances, housing as well as historical factors such as colonization, residential schools

and racism” (p. 36). The year prior to the clinic opening, 17 individuals from the community accounted for 54 hospital admissions. After one year of service, there were three individuals hospitalized for a total of five admissions (Wieman, 2009). Based on these outcomes alone, it appears that this model of care provided the community with a balanced mental health care service that reduced hospital readmissions. This model could serve as a framework for other communities to adopt and modify based on their size and resources. The strength of this model of wholistic care when addressing Aboriginal mental health is the ability of staff to address mental health and illness, in the context of the community, and employing interdisciplinary strategies. Such a model includes strategies identified by participants in Vukic et al.’s (2009) research. In Vukic et al.’s study participants expressed concern that healthcare members worked in isolation of each other and community members did not know who to go to with their mental health concerns. They stressed the need for agencies to work together as is evident in the model presented from Six Nations community.

Traditional Pathway to Health Project (TPTH). With respect to Aboriginal youth, certain models of research also provide insight into promoting Aboriginal mental health and incorporating cultural knowledge. Riecken, Tanaka, and Scott (2006) present the TPTH established in Victoria, British Columbia. This project is a participatory action research project that “moves toward an in-depth, multifaceted understanding of the urgent and pressing health issues of contemporary Aboriginal youth” (p. 29). Students plan, videotape and create a video with their message about promoting positive mental health and present it to their community with the support of educators and University of Victoria researchers to ensure ethical guidelines of social science research are maintained. The

outcomes to date clearly highlight the bridging of Indigenous science and medical science. Students speak knowledgeably of respect, interconnectivity, culture, listening to Elders and other Indigenous ways of knowing, which are all aspects for fostering positive mental health. “The students spend a great deal of time learning about traditional Aboriginal knowledge through their Elders and those recognized in the community as respected sources of knowledge” (Riecken et al., p. 39). These authors maintain that the role of understanding and embracing culture through the transmission of generational knowledge has an important effect on the needs of Indigenous youth and adds depth and insight into effective avenues for change.

Promoting cultural identity. The concern for cultural identity for promoting mental health among Aboriginal youth is a phenomenon that is not necessarily addressed in the literature on promoting Western youth mental health. In the Western world the emphasis is on youth developing a sense of self-identity rather than cultural identity (Dixon, & Stein, 2006; Kaplan, & Love-Osborne, n.d.; McCreary, 2008; Youngblade et al., 2007). The distinction is relevant as health professionals and communities advance the promotion of Aboriginal youth mental health. Current models, such as the one described above, and the Jacano and Jacano (2008) model, described next, establish the importance of cultural identity. Jacano et al. (2008) worked with a group of Mi’kmaq Elders and an interdisciplinary group of academics to blend traditional Mi’kmaq knowledge and Western science knowledge to develop a strategy to promote cultural continuity.

Jacano et al.’s (2008) strategy involved using puppets made from natural forest materials constructed by youth with Elders to promote culture, language, and history.

Based on this work, these authors proposed that increasing support for the history, language, culture, ritual, and stewardship of First Nations land can only enhance pride, and help dispel the notion of separateness or inferiority among young Aboriginal youth. The importance of cultural identity with youth is further reinforced in McCormick and Arvay's study described in McCormick (2009). Youth, in the study, spoke of the significance of cultural identity. Cultural identity was one of the important categories that facilitated healing and recovery from being suicidal.

These three exemplars acknowledge Western and Aboriginal understandings of mental health and help to clarify their distinctions and similarities. The Six Nations model demonstrates a collaborative approach of Western and Aboriginal understandings by seeking and maintaining mutually respectful relationships with traditional healers and involving agencies in the community to address mental health of all ages in the context of community. The other two exemplars focus specifically on Aboriginal youth mental health, and reinforce the importance of Elders and Indigenous ways of knowing as well as the use of multi-media and videos with youth.

Summary

In summary Indigenous knowledge was discussed to highlight the necessity of employing two-eyed seeing and ethical space as the theoretical perspective for this study. Western understandings may stand in sharp contrast to Aboriginal understandings that value the balance of physical, emotional, mental and spiritual wellbeing of an individual and his or her interconnectivity to family, community and the land. Aboriginal psychologists identified values, beliefs, worldviews and context that are important for promoting Aboriginal mental health. There is some common ground between these

understandings in the determinants of health. The three exemplars presented in this section demonstrate how Aboriginal and Western understandings can be included in mental health services, and the need to include Elders as their wisdom of Aboriginal traditions and ways of knowing are important for enhancing Aboriginal understandings. Research to address Aboriginal youth mental health must be done with recognition of Aboriginal and Western understandings. Aboriginal youth benefit from the knowledge and wisdom, or the best of both understandings of mental health, and these need to be included in future work promoting Aboriginal youth mental health.

Chapter 4 Methodology

In this chapter, I position my own role in the research, and explain the methods used for data collection and analysis of this qualitative inquiry. I present the process of community based participatory research (CBPR) and how the principles of ownership, control, access, and possession (OCAP) were maintained. The progression of building relationships in the community, establishing a Community Advisory Committee (CAC), the composition of the CAC and their intimate involvement with the research, along with a description of the community where the research took place are provided.

Situating the Inquirer

I have worked with Aboriginal Peoples as a non-Aboriginal registered nurse for over thirty years. The relationship began when I was a northern nurse in a fly-in community, where there were no resident physicians, and later as a nurse educator in an access program for First Nations in northern Manitoba, and then as an educator preparing nurses to work in northern remote communities. More recently in my role as a university educator, I am involved in the recruitment and retention of Aboriginal Peoples into nursing and providing consultation to Aboriginal nursing education programs. My longstanding nursing work with Aboriginal Peoples has enabled me to build relationships and collaborate with Aboriginal communities to address health issues using clinical, community development, and research-based approaches.

I have been involved with Aboriginal Peoples in the Atlantic Provinces in developing curriculum for community health representatives, teaching mental health to community health representatives and delivering classes on alcohol and drug abuse to community members involved with the Native Alcohol and Drug Abuse Program. More

recently, at the request of 13 Mi'kmaw communities in Nova Scotia, I collaborated with the Mi'kmaw health directors in a research project to determine the gaps in mental health services for adults living in the communities (Vukic et al, 2009). Although the focus of that study was on adults, participants in the research expressed that youth mental health was a major concern and that research efforts should be directed to promote Mi'kmaw youth mental health in the community. I presented the findings of this research to the Provincial District Health Authorities, the Atlantic Policy Congress of First Nations Chiefs Secretariat, and the Atlantic First Nations and Inuit Health (FNIH).

In follow-up, I began discussions with a specific Mi'kmaw community to explore their interest in research that would focus on rural Mi'kmaw youth mental health. My interaction began with a Mi'kmaw Elder from the community. He supported the need for this study, a community-based approach to the research and expressed interest in participating on a Community Advisory Committee (CAC). I also had a discussion with a grandmother from the community, who was recommended by an outreach worker from the Izaak Walton Killam (IWK) Choices Program in Halifax. She indicated an interest in being a part of the research process, and volunteered to talk with other grandmothers from the community about participating. Another person I spoke with was a traditional healer from the community, who knew me well and was supportive of the proposed study. In addition, as part of my initial explorations, I spoke with the clinical youth mental health nurse specialist employed by the Atlantic FNIH and with the health liaison worker from the Confederacy of Mainland Mi'kmaq (CMM). Both were supportive of research to promote Mi'kmaw youth mental health. I visited the community to talk with the Elder, the traditional healer and the grandmother individually. I met with the Mental

Health Coordinator and the Health Leader in Mimikej⁹ to discuss the study. I had taught the nurse in the health center and this helped me establish credibility. As well, the community respected the Elder that I was working with and this helped to reinforce my role as researcher collaborating with the community. As a white woman, and an outsider doing research, I was met with skepticism by some members in the community; however, I assured people that this research was being done with an Advisory Committee from the community, it would remain confidential, and the findings would belong to the community.

Near completion of the research, by request, I worked with the Mental Health Coordinator to submit a proposal to promote Mi'kmaw youth mental health based on preliminary findings of the study. The proposal was accepted by the Mental Health and Addictions Community Grant Program, funded through the Government of Nova Scotia's Mental Health and Addictions' strategy "Together We Can". Community leaders and the CAC were informed and engaged with the research which enabled a mutual partnership, and provided an opportunity for myself and members of the community to collaborate in ways that were beneficial to the community.

Community Based Participatory Research (CBPR)

This was a community-based participatory research (CBPR) study. The research is more than community based. The research was participatory as the focus was on creating action for change. Participatory action research (PAR) does not necessarily consider a geographical community, hence CBPR captures the focus and intent of this

⁹ Mimikej is a pseudonym for this community to maintain confidentiality and is pronounced *mid ga deg jij* which means butterfly and was chosen by a respected member of the community

study. (CBPR) is an umbrella term that has been used interchangeably with action research, participatory research, participatory action research, and collaborative inquiry (Israel et al., 2005; Kemmis, & McTaggart, 2005; Minkler, & Wallerstein, 2003). “Although there are differences among these approaches, they all involve a commitment to conducting research that shares power with, and engages community partners in the research process and benefits the community involved, either through direct intervention or by translating research findings into interventions and policy change” (Israel et al., 2005, p. 5). Israel et al.’s explanation includes the intent of CBPR. CBPR provides a systematic approach for understanding Mi’kmaw youth mental health and for identifying action plans for Mi’kmaw youth mental health promotion. MacAulay et al. (1999) explain that participatory research increases lay involvement, encourages community development and mutual partnerships which are all activities that are advocated in the literature to address Aboriginal youth mental health in First Nations communities. CBPR is not a method per se; rather, it is a collaborative approach to research that may draw on a full range of research designs and methods (Israel, Eng, Schultz, & Parker, 2005; MacAulay, 1999).

According to Israel et al. (2005), critics argue that CBPR, action research or participatory research lacks scientific merit or rigor and is synonymous to community development or social activism. Although there may be similarities, CBPR differs from community development activities as CBPR is the design, and the researcher employs systematic research methods, including analyses for generating knowledge (Greenwood, & Levin, 1998; Kemmis, & McTaggart, 2005). Creswell (2003) explains how participatory knowledge claims can more adequately address social justice issues as

researchers collaborate with participants to advance action for change. Creswell (2003) clarifies how knowledge claims based on multiple meanings of individual experiences or socially constructed knowledge is in alignment with advocacy research to adequately address issues of social justice with individuals and groups who are marginalized.

Action research is known to have its roots in the 1940s with Kurt Lewin (Greenwood, & Levin, 1998; Minkler, & Wallerstein, 2003), who is known for his work on change theory (unfreezing, changing and refreezing). Lewin's action research was instrumental in shifting the role of the researcher as distant observer to an involved co-participant in concrete problem-solving; however, the co-participation with participants in the research was limited. In Lewin's view, the researcher possessed the expert knowledge, involved participants in the change and evaluated the change (Greenwood, & Levin, 1998). In this first action research approach, the researcher retained the role of 'expert' and there was minimal mutual collaboration with participants in the research process.

Participatory action research has evolved since then with participants taking on roles formerly carried out by researchers from outside the social setting (Kemmis, & McTaggart, 2005). Contemporary participatory action research is a process of critical and reflective inquiry that gives voice to those who are usually silenced and serves to empower people to analyze their experiences as a means of effecting change (Etowa, Thomas-Bernard, Oyinsn, & Clow, 2007; Israel et al., 2005; Kemmis, & McTaggart, 2005; Koch, & Kralik, 2006; McNiff, & Whitehead, 2006; Park, 1993). Community involvement with the research design, implementation, and analysis, with the aim of combining knowledge and action for social change to improve community health and

eliminate health disparities, is fundamental to community based participatory research (Israel, et al., 2005; Minkler & Wallerstein, 2003).

MacAulay et al. (1999), researchers who have worked with First Nations communities to address diabetes in the community, identify that the key components of CBPR include: mutually-created knowledge; sharing of expertise and resources of community members through collaboration; mutual education; and, acting on results of research that addresses questions that are relevant to the community. The process is based on mutually respectful partnerships between community and researcher. Such partnerships are strengthened through mutual agreement concerning the research question, design, implementation, analysis and dissemination. Having community members involved with making decisions about the research questions, design, implementation, analysis and dissemination of research specific to the mental health promotion of Mi'kmaw youth was a major component of this study.

Lay persons' involvement in the analysis of research data is important in CBPR. Szala-Meneck and Lohfeld (2005) identified the significance of the community advisory team's involvement in developing interview questions and analyzing interview data in a Hamilton Care Giver Respite Project. According to Szala-Meneck et al. (2005) by including the community advisory team in the analysis, the rigour of their qualitative data analysis was increased, and the process provided community members with an opportunity to learn new skills. Castleden, Garvin and HUU-ay-aht First Nations (2008) present a CBPR project where HUU-ay-aht First Nations were interested in better understanding the environment and health risk perspectives in HUU-ay-aht traditional territory. The research process was inclusive of the HUU-ay-aht First Nations community

from inception to dissemination of the research findings and is an excellent example of the principles of CBPR: sharing power, fostering trust, developing ownership, creating community development, and building capacity with First Nations and academic institutions (Castleden et al., 2008).

This research followed the principles outlined above as suggested by Israel et al., and MacAulay et al. CBPR enabled a focus on both understanding rural Mi'kmaw youth mental health, and developing an action plan to promote rural Mi'kmaw youth mental health. The systematic process engaged the community and kept everyone informed about each stage the research. The Community Advisory Committee (CAC) was established at the inception of this research which is explained on page 82. Community members would ask the (CAC) any questions or express concerns to the CAC when I was not there. Questions were related to who was I, what was I doing there, what will happen with the research and when will it be completed

Ownership Control Access and Possession (OCAP) Principles

As a result of heightened interest in the issues of First Nations ownership of information, the OCAP principles were developed during the inception of the Regional Health Survey by the National Aboriginal Health Organization (First Nations Center, 2007). The initial acronym OCA was framed in 1998 and later possession was added to be more responsive to the critical issues of First Nations research. First Nations have expressed many concerns about the way research has been conducted on them, and in their communities (Brant-Castellano, 2004). The lack of meaningful research, research that does not benefit the community, pressure to support a research project, agendas dictated by others, lack of respect towards First Nations, misinterpretation of traditional

knowledge and practices, stigmatizing and stereotyping and not having control over data are some of the research issues expressed by First Nations. First Nations Center (2007) explains the principles of OCAP are in response to: “colonial, oppressive and exploitive research; an increase in First Nations research capacity and involvement; and widely shared core values of self-determination” (p.9). CBPR is consistent with the OCAP principles outlined by Schnarch (2004) and the Canadian Institute of Health Research, (CIHR), (2008). According to CIHR, participatory research is a valuable method for Aboriginal people to be agents of the research and agents of change. Further, the Interagency Advisory Panel on Research Ethics (2008) supports engagement between the community involved and the researcher which is initiated prior to the actual research activities and promotes mutual trust and communication. First Nations, Inuit and Metis organizations and communities propose participating as partners in all phases of the research process to protect their heritage, to ensure that their knowledge systems are authentically reflected in the research practice, and to secure equitable distribution of the benefits (Interagency Advisory Panel on Research Ethics). Implementing CBPR with Mimikeyj, guided by the principles of OCAP to understand Mi’kmaw youth mental health supported the creation of respectful knowledge, inclusive of local Indigenous knowledge and enabled the development of potential plans of action for Mi’kmaw youth mental health promotion. By obtaining community consent before initiating the research, and including the CAC in developing the research question, design, data analysis and report of findings, this study adheres to the OCAP principles. Although I maintained the raw data in a locked filing cabinet in my office at the School of Nursing for confidentiality reasons, the OCAP principles were maintained by having an open,

collaborative, transparent process with the CAC, and responding to questions about the research with community members. The CAC reviewed data and provided analysis of individual anonymized transcripts of the initial story telling transcripts, and provided ongoing interpretation of the findings. Maintaining a mutual partnership with the CAC to explore the community's understanding of mental health and identifying potential action plans with the community was fundamental for ensuring the OCAP principles were upheld. Any publications or presentations will be done in consultation with the CAC. Most importantly, the community will have the research report to support and substantiate any mental health promotion initiatives with youth in their community.

Critical Indigenous Qualitative Inquiry

Denzin and Lincoln (2005), advocate for Indigenous research that is committed to dialogue, community, self-determination and cultural autonomy. There is not one Indigenous methodology, however; the generally accepted principles of Aboriginal health research call for scholars to include dialogue, community, self-determination and cultural autonomy in the process. Denzin et al. (2008) describe how qualitative research has evolved over the decades. In their view, qualitative research has progressed from the expectation that researchers report an objective account of the lived realities of participants to recognition that observation is filtered through the lens of gender, class, socioeconomic status, race and language. At the same time, the previously held tenet that participant voices capture the essence of their lived experience has changed to acknowledge that participants in qualitative research are seldom able to give full explanations of their actions or intentions. "Consequently, qualitative researchers deploy a wide range of interconnected interpretive methods, always seeking better ways to make

more understandable the worlds of experience they have studied” (Denzin et al., 2008, p. 29). These authors contend that qualitative research is in the eighth moment where humanities and social science research become sites for critical conversations about race, class, gender and nations, and they encourage a productive dialogue between Indigenous and critical scholars to merge critical and Indigenous methodology.

Further, critical Indigenous qualitative inquiry must be ethical, healing, decolonizing, transformative and participatory (Denzin, & Lincoln, 2005). L.T. Smith (2000), a Maori scholar, reinforces “critical theory must be localized, grounded in the specific meanings, traditions, customs, and community relations that operate in each Indigenous setting” (p. 229). Smith (2000) claims localized critical theory can work if critique, resistance, struggle, and emancipation are not treated as universal characteristics independent of history, context and agency. She advocates for these ideas particularly if non-Indigenous scholars conduct research with Indigenous Peoples. Her concern is that Indigenous Peoples have been researched “to death,” (p. 227) but still have not seen any benefits. Localized qualitative inquiry in my study focused on a specific community, with unique characteristics, history and struggles, and is consistent with the goals outlined by Smith (2000) for critical qualitative inquiry.

“An Indigenous framework confirms meaningful and useful knowledge translation and self-determination by using dialogue and ethical space theory as the cornerstone for future development” (Dr Charlotte Loppie, Aboriginal Health Summer Institute, Halifax, personal communication, August, 2008). Kovach, an Indigenous scholar acknowledges there is not one Indigenous framework and that an Indigenous framework is broader than incorporating methods, such as storytelling and talking circles.

Mapping out an Indigenous framework requires consideration of how to conduct the research in a way that is inclusive of Indigenous epistemologies and is decolonizing (Kovach, 2009). The qualitative framework used in this study was built on a mutual partnership with a CAC, incorporating CBPR, and the OCAP principles. The intent of the research was understanding rural Mi'kmaw youth mental health, and identifying potential actions to promote rural Mi'kmaw mental health. This framework is in keeping with the goals of self-determination and was inclusive of Indigenous epistemological and ontological ways of being.

Loppie (2007) described how she was able to integrate Indigenous principles into her qualitative doctoral study which included Western methodological traditions within the context of an Indigenous worldview to explore menopause. Loppie employed ethnography, participatory and feminist principles in the research and included wholism and spirituality as Elder women shared their stories in group discussions. She acknowledged the wisdom of Elder women, and invited their partnership as a vehicle for teaching, learning, and sharing (p. 277). Loppie was respectful of Aboriginal Peoples and included the OCAP principles in the study. The outcome of this research enhanced the understanding of menopause, as it is understood by Mi'kmaw grandmothers.

Qualitative inquiry grounded in the history, context and understandings of community members in Mimikey formed the basis of this study. When employing critical social theory, the focus of inquiry is on the discovery, interpretation, and application of local knowledge to resolve local problems (Averhill, 2005; Fontana & Frey 2008; Mohammed, 2006). Critical social theorists, such as Paulo Friere (2000), emphasize dialogue, problem-posing, and raising consciousness with participants and the researcher

to affect change. This approach supports L.T. Smith's (2000) claim that critical research, and emancipation with Indigenous Peoples includes history, context and human agency, which is accordant with this study to understand rural Mi'kmaw youth mental health in Mimikej and to identify potential action plans to promote Mi'kmaw youth mental health.

The process of storytelling and talking circles is more consistent with Indigenous methodologies (Loppie, 2007) than semi-structured interviews and focus groups.

Storytelling emphasizes that the individual interviewee shares his or her story with the interviewer, and the session is less directed by the interviewer. Although Kovach (2009) explains it is not the methods that shape an Indigenous framework, these methods are in keeping with Indigenous traditions. Storytelling creates a space for the storyteller to share the meaning of mental health based on his or her conceptions without distraction from the interviewer's preconceived questions. Similar to photo elicitation as described by Liebenberg (2009), storytelling engages participants in an oral process of self-exploration and understanding with the researcher as participants share their stories of how they have come to understand a phenomenon such as mental health.

Talking circles provide a process whereby each individual in the circle shares ideas with other members of the circle without interruption, and could be facilitated by an Elder, each of whom has their own traditions for conducting a talking circle, as occurred with this research. For example, the Elder may decide to begin the talking circle by starting clock-wise or counter clock-wise. Other options include use of smudging, use of a stick or another important object for the individual speaker to hold, and how many times the talking circle goes around, and the focus for each time the circle goes around. Talking circles can contribute to research by offering a unique opportunity to work with

individuals in their social contexts, by generating high-quality interactive data, by contributing to the social construction of meaning and by accessing shared, and often ignored individual knowledge (Madriz, 2003). Although talking circles may not be perceived as interactive, talking circles provide equal opportunity for participants to share and build on the focus of the discussion or to present new insights. All members are considered equal in a circle which has no beginning or end. The structure of the talking circle enables everyone to face each other, to actively listen, and share their thoughts if they want to when they hold the stone, stick, feather or whatever is meaningful to the Elder initiating the talking circle. No one else should interrupt the person holding the object. The structure and format of talking circles in this study provided a forum for stimulating interactions that promoted engagement of all members in the circle. As the object was passed around the circle they co-created their understanding of mental health and potential action plans. The interactive nature of a talking circle is enhanced if participants feel comfortable, confidentiality is maintained within the group, and they are allowed to share openly in the circle.

The Setting

The community is instrumental in affecting the mental health of Aboriginal youth (Chandler & Lalonde, 2008; Mignone & O'Neil, 2005; Mussell, Cardiff, & White, 2004; NMHAC, 2007). The community for this CBPR, Mimikej, is relatively small with a population less than 1000 (Statistics Canada, 2006) with defined geographical boundaries. The community is less than 50 km from an urban center. The medium household income for one person in 2000 was \$8,176, and for two or more persons, the household income was \$25,280 (Statistics Canada, 2006). The language first learned and

understood is English (805 persons) and “other language not specified” is spoken by 125 persons. The largest age cohort in this community is 5 to 19 years of age (n=300) followed by the 25 to 44 year group (n=275). There are 110 youth aged 14 to 19, 45 of whom are males and 65 are females (Statistics Canada, 2006).

A Community Well Being (CWB) index, expressed as a number, includes indicators of income, education, labor force activity and housing to determine wellness. The CWB index of this community was calculated as 69. The lowest index rating of all communities in Nova Scotia is 59 and the highest is 88 (Statistics Canada, 2006). The CWB index provides a basic overview of this rural community and reflects a community with high unemployment (30.4%), limited housing, and with 33.3 % of the population aged 45- 64 having less than a high school education. Services are consistent with those described previously in Chapter 1.

Establishing and Building Relationships

Although Mi'kmaw youth mental health was expressed as a concern within the general Mi'kmaw population in previous research (Vukic et al., 2009), working with a specific community to focus on understanding Mi'kmaw youth mental health requires relationship building, mutual goal setting, and trust with a community through a community based participatory research (CBPR) project. While respected members of the community expressed an interest in working on this project, permission from Chief and Council (Appendix B, p. 285) was critical for the project to develop. It was helpful that I knew some members of the community but to most of the community I was a stranger, not necessarily trusted, and I had to explain what I was doing in Mimikey. Some asked if I had the Chief and Council's permission. My familiarity with the community was based

on 18 years of direct and indirect involvement with specific members of the community as a researcher, educator and as a learner. I visited this community on numerous occasions in the above capacities and welcomed the opportunity to engage with this community for the purpose of this study. I planned to work with this community until the research was complete, and although some would jokingly state, “Oh here she comes again”, or “what is it you want now?”, most were interested in what I was doing. Everyone I encountered knew, or was informed that I was a student, and believed they were contributing to my education, which facilitated building my relationships within the community.

Because the summers and Christmas were busy in the community, I was not present as much during those times. Over the two and a half years of building relationships, establishing a CAC, developing the proposal and conducting data collection and analysis, I became known in Mimikey as the white woman, who was a student doing research on Mi’kmaw youth mental health with members of a Community Advisory Committee. I believe the relationship with the community went from skepticism, to curiosity, to interest in how the research was progressing, as well as coming to know more about me as a person, student, researcher, nurse and nurse educator.

Establishing and Working with a Community Advisory Committee (CAC)

One consideration for establishing the CAC was to determine the membership of the committee and to ensure that diverse perspectives from within the community were represented (Israel et al., 2003). Based on my preliminary discussions with an Elder, the CAC membership list consisted of the following:

- 2 well-respected Elders of the community

- 1 employee of the health center involved with youth health
- 1 employee of the school teaching youth between, but not necessarily inclusive, of the age 14 to 19
- 4 youth from the community, 2 females and 2 males
- 2 representatives of the community involved in an organization responding to youth

The Mental Health Coordinator in Mimikej recommended members of the Youth Council and other community members who could be a part of the CAC. I contacted them and our first CAC meeting was held in June 2011 to discuss the research question, purpose, process and what they believed their roles and responsibilities should be. When an advisory committee is incorporated into CBPR, the roles and responsibilities of the committee are clarified and negotiated at the beginning of the partnership, and as MacAulay et al. (1999) stress, at the beginning of the partnership it is important to articulate how much involvement the committee has, and in what aspects of the research process. The CAC was involved in this research at the inception, before presenting the proposal to Mi'kmaq Ethics Watch, (the research board that oversees research with Mi'kmaw people) Dalhousie University Research Ethics Board, and the Chief and Council of Mimikej. A representative for the youth, a teacher, and a parent on the CAC changed during the time of the study because of their other responsibilities; however, the majority worked with me on this research for the study duration. In our first meeting, an Elder, a teacher, a representative from the Native Alcohol and Drug Abuse Counseling Association (NADACA), a parent involved with youth, three youth, and the Elder's wife were in attendance at the Elder's home and since then, all of the CAC meetings took place in his home.

At this first meeting, the Terms of Reference for the CAC were negotiated based on a preliminary draft of the terms of reference (Appendix C, p. 287). Based on the draft, the group did not think there would be problems reaching consensus and indicated that reaching consensus was important to them as they believed this was a better process than voting, and promoted more dialogue on issues and concerns raised at the meetings. At our last meeting, CAC members commented on how we were able to work through issues by discussing them and coming to an agreement. For example, we discussed how Catholic and Traditional ways are enacted in the community. There was some concern expressed by CAC members as to whether aspects of Traditionalism were valued in the community; however, members conceded that both practices are a part of life in Mimikey. During the initial meeting, those present agreed that in order to insure that all members be treated equally, an honorarium should be provided to all members of the CAC as opposed to only providing honorariums for parents, Elders and youth. The purpose, research questions and data collection methods were also discussed at this initial meeting.

The CAC met monthly with breaks on holidays, and in the summer when it was difficult to have a quorum. Near the completion of the study we met less frequently. After the open forum, we did not have another meeting until I had completed the write-up. In this meeting we discussed the drawing of youths' understanding of rural Mi'kmaw youth mental health (Figure 2, p. 110), the summary of findings (Table 3, p. 212) and the resource planning model (Figure 3, p 263). I shared three drafts of the drawing (Figure 2) as the CAC had only seen my rough sketches. We discussed whether there should be words in the figure and all agreed that words would detract from the image. The final choice is presented as Figure 2 (p. 110) which is described in more detail in Chapter 5.

No changes were made to the summary of findings, or the resource planning model as the CAC was intimately involved in creating the content, had seen drafts, and had no concerns with the final product. I also presented how I described participants interviewed in the write-up of the study to determine if they were identifiable to others. CAC members were confident that participants could not be identified based on the descriptions, as the descriptions were general and could be related to many members in the community. In total, there were 10 CAC meetings, the first couple of meetings focused on coordinating the data collection. In subsequent meetings coordination of data collection was still important, and also included analysis of the data. Our final meeting was held after the community open forum.

Initially, I kept minutes of the meetings and shared them at subsequent meetings; however, this action seemed to be more for myself than for the CAC. One youth mentioned how she felt more relaxed after the meeting without minutes. They enjoyed less formal meetings where we would plan and discuss data collection, how many more interviews needed to be done, organizing the talking circles, times and places, recruiting and advertising for the talking circles and the open forum. As the research progressed, I shared transcripts with the CAC removing names and other identifiers. For example, if a transcript had information about what the interviewee's specific role was in the community this was deleted. We did not identify codes, rather CAC members shared what they perceived as highlights on a flip chart. They discussed ideas presented in the transcripts on spirituality and the broad understanding of mental health. They also discussed how alcohol and drug abuse in the community was identified as a mental health issue. Another discussion was the wholistic nature of mental health. The CAC believed

that this wholistic understanding reflected their values and emphatically reaffirmed this interpretation. For example, one member stated: *“We have been telling white people this for a long time and they do not seem to understand”*.

Half-way through the research process we decided to have our own talking circle about the research. There were tears about some of the findings. There was an affirmation of the need to continue with this study as one of the youth on the CAC had proclaimed at least now, since the study began there was more talk about mental health in the community. The CAC members were engaged in the research process and offered support and encouragement as the data collection and analysis evolved. The Committee organized the data collection sessions, made recommendations on who I should interview for the individual sessions, and when, and where I should conduct the talking circles and open forum. The Elder and I conducted the talking circles, and the CAC helped with the interpretation of the findings, first through reviewing transcripts and then later discussing my interpretations of later transcripts. They did not want to read the transcripts after the initial individual ones; rather, when we met we discussed key points from the data. A more detailed account of the process is explained in the data analysis section.

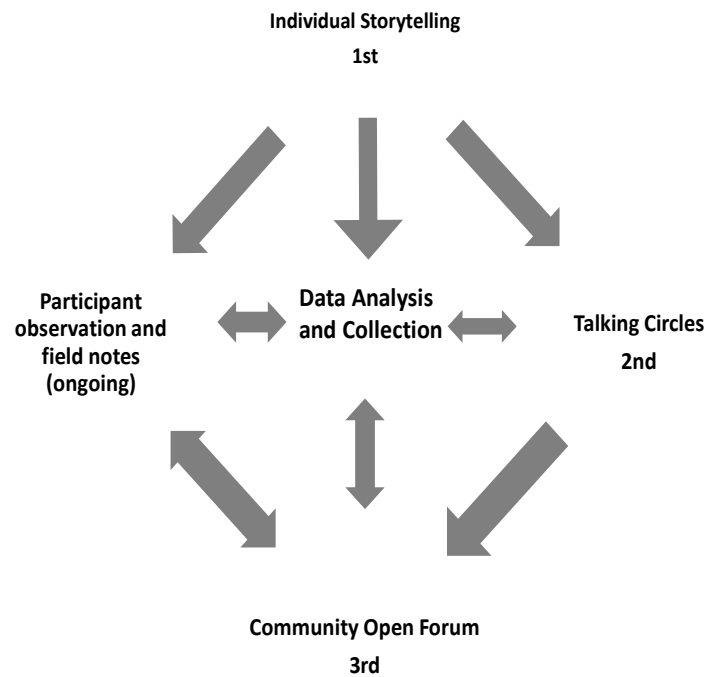
Overview of Data Collection Methods

This research incorporated data collection methods of storytelling, talking circles, an open community forum, field notes, and participant observation. Discussion of what this entailed for each method is presented subsequently in separate sections. The initial focus of the storytelling sessions was on identifying individual community member’s understanding about Mi’kmaw youth mental health, and priorities for promoting Mi’kmaw youth mental health in the community. When the data collection and analysis

from the individual story telling sessions were completed, in-depth talking circles with youth and Elders were conducted. The talking circles focused on the findings from the individual sessions to gain more depth, breadth and clarification of the findings from the individual sessions. An open community forum was conducted after the talking circles to provide community members with an opportunity to share their perspectives on the preliminary findings. Data collection started in January 2012 and ended in June 2013. There were several reasons for the lengthy 18 months for data collection and analysis. A member of the CAC was ill for a time, and neither I, nor the CAC wanted to exclude this member. CAC members had other responsibilities and therefore it was sometimes difficult to arrange meeting times, and sometimes there were other priority events in the community, such as funerals. Lastly, organizing and implementing the talking circles and open forum at times that were convenient and appropriate for community members to participate required substantial time. Figure 1 (p.88) represents the integrative process of data collection and analysis.

The talking circles and the community open forum began and ended with an Elder who employed his own traditional approaches. He did not smudge, and we used a small stone that was passed numerous times in the talking circles, we also had a feast before or after the talking circles. The open forum was not conducted as a talking circle. I worked with a member of the CAC to conduct the open forum, and the Elder who opened and closed the forum. I shared the findings to date, asked participants for their perspectives, and for clarification and invited them to share their understandings and took notes. A traditional feast was provided as part of the open forum before initiating the discussions.

Figure 1 The Integrative Process of Data Collection Methods and Analysis



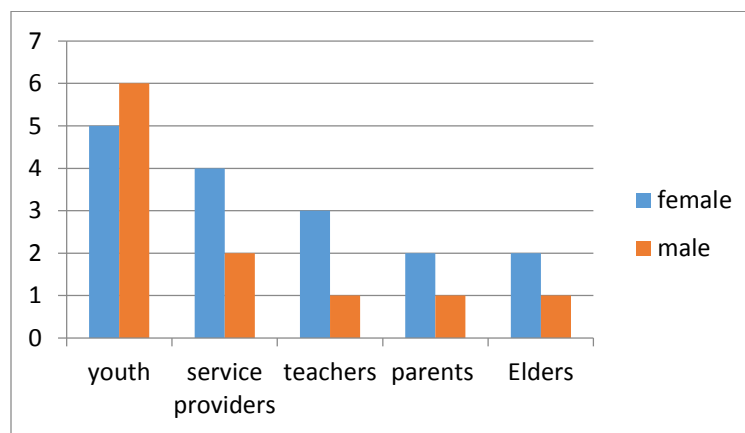
Individual storytelling sample, recruitment and data collection. The CAC provided a list of potential participants based on who they anticipated could provide in-depth, information-rich data. Other people, such as the mental health coordinator, the nurse, the principal and the guidance counselor of the local school were consulted to suggest potential participants. Purposeful sampling is a conscious selection of participants that would best help in understanding the problem and research question (Morse & Richards, 2002; Creswell, 2003). I contacted participants either by phone or in

person from the suggested list. CAC members asked potential youth participants if they were willing to be contacted before I contacted them. The number of youth and community members selected for the individual story telling provided for maximum phenomenon variation, ensuring that many different variations of understanding were explored (Miles, & Huberman, 1994). I explained the research with the use of a script (Appendix D, p. 289) and asked if they wished to participate.

The individual story telling participants included youth aged 14 to 18, parents of youth aged 14 to 18, service providers who worked directly with youth aged 14 to 18, school teachers who were teachers of students in this age range and Elders from the community. Table 1 below provides demographic details. I have not provided an in depth description of participants to protect their anonymity. Criteria for participation in the storytelling included:

- Resident of the community for a minimum of 1 year
- Of Mi'kmaw ancestry
- Having confidence in speaking and understanding English.

Table 1 Individual Storytelling participants n=27



Note: One service provider was also a parent of youth aged 14 to 19 and is identified here as a service provider.

The storytelling sessions were held in participants' homes, places of employment and my car, depending on participants' preference, at a time and place that was convenient for participants. Interviews, particularly with the younger adolescents (14-15 years of age), were conducted over 30 minutes, while others lasted 60 to 90 minutes. The majority were around 45 minutes to an hour. Although the topic was sensitive in nature, no participant voiced feeling uncomfortable or appeared to be ill at ease. Some participants seemed to feel a bit awkward at times, when telling their stories, yet after the interview ended, many commented that they appreciated the opportunity to share their insights and hoped that this would bring changes to the community. The intent of the storytelling session was not for participants to share their personal experiences with mental health and illness; however, most of the participants had witnessed tragedies (suicides and drug dependency of Mi'kmaw youth, friends and/or family) and explained in their stories how these tragedies have helped them come to understand the meaning of mental health.

Description of participants in the individual storytelling sessions. A total of 27 community members participated in the individual storytelling sessions. All were Mi'kmaq. Eleven were youth ranging in age from 15 to 18; 5 females and 6 males. Three parents of adolescent youth participated. They were recommended by the health center and/or the CAC and/or volunteered because they were concerned about Mi'kmaw youth in the community. Six service providers participated; four females and two males. As service provision in the community is not targeted exclusively to youth and to protect their confidentiality, they are presented here as providers who have some responsibility with this age group in various capacities, not exclusive to providing direct health care

services. Four teachers from the local school participated, three female and one male. Three Elders, two female and one male, also shared their stories. They were recommended by several community members because they are respected and knowledgeable about Mi'kmaw youth.

Table 2 provides some context of the individual youth who participated in the storytelling. The descriptors provide context of the youths' lives without revealing their identity.

Table 2 Individual Storytelling: Demography of Youth Participants				
Age	Gender	Family	Length of Time in Community	School
14-15	2 Male	1 (single mom)	4 (all life)	3 (off reserve)
	2 Female	3 (both Parents)		1 (on reserve)
16-18	4 Male	4 (single mom)	6 (all life)	4 (off reserve)
	3 Female	3 (both parents)	1 (5 years)	2 (experienced both)
				1 (on reserve)
Total:	11 6 males 5 females	11 6 both parents 5 single parent	11 10 entire life 1 five years	11 7 off reserve 2 on reserve 2 on/off

I had a storytelling guide (Appendix E, p.290) which asked participants to share how they had come to know and understand Mi'kmaw youth mental health and what actions they thought would promote Mi'kmaw youth mental health in the community. I began the interviews using the storytelling guide that asked participants to relay stories of how they have come to understand youth mental health and how youth mental health can

be promoted in the community. I used probes to ask for more detail, clarification and explanation. I applied this guide with a youth and a parent initially to pilot-test the feasibility of this interview guideline in the context of storytelling which did not result in any modifications. The guide encouraged individuals to convey their understanding, although for the younger adolescents there was more prompting than for the older adolescents and adults. For example, when a younger adolescent said “I have never thought about mental health”, I would respond with “Well, that is okay...but just try to explain what you think it is”. The storytelling focused on the interviewee’s understanding of Mi’kmaw youth mental health in the community. Data from each individual story was not used to direct subsequent individual stories. The storytelling method enabled storytellers to tell their story without structured questions and empowered interviewees to share, in their own way, how they have come to understand mental health, and priorities for action to promote Mi’kmaw youth mental health in the community.

Talking circles sample, recruitment and data collection. Five talking circles, with a maximum of eleven participants and a minimum of three in each group, were conducted. The focus of the talking circles was to build on the understanding of Mi’kmaw youth mental health and potential plans of action for promoting Mi’kmaw youth mental health found in the individual storytelling sessions. I conducted four talking circles with youth totaling 25 youth participants and one circle with Elders. There was one or two youth who participated in an individual storytelling session who also participated in a talking circle with youth, and one Elder from the individual storytelling session who participated in the Elder talking circle.

The five talking circles consisted of:

- Talking Circle #1 (5 female youth)
- Talking Circle #2 (3 female and 1 male youth)
- Talking Circle #3 (5 female and 6 male youth)
- Talking Circle #4 (6 female youth)
- Elder Talking Circle 1 female and 2 males

The number of talking circles was determined in partnership with the CAC and the co-chairs of the thesis committee. We determined that an emphasis should be on conducting youth talking circles. The CAC also determined that a talking circle with Elders was necessary as the CAC valued the wisdom of the Elders. The talking circles enhanced the opportunity for community members to participate and ensured a robust data set. The number and the composition of sessions enhanced maximum variation (Miles et al., 1994) ensuring that many different understandings of mental health and potential action plans were explored.

Criteria for participation in the talking circles were the same as the individual storytelling sessions. Participants had to be:

- Resident of the community for a minimum of 1 year
- Of Mi'kmaw ancestry
- Have confidence in speaking and understanding English.

Homogeneity of a group for data collection is supported by Krueger (1994) to promote open discussion, or as Sim (1998) explains, the more homogenous the group is, the more confident an individual group member is in expressing his or her views. The size of the group should be no more than 8 to 10 for manageable time and discussion

(Krueger, 1994; Sim, 1998; Ulin et al., 2005). These guidelines were discussed with the CAC and considered for the talking circles. The size of the group was relevant for talking circles, however, we had discussion on the other stipulations. Strickland (1999) and Lucero (2011) identify the relevance of talking circles for research and provide some cultural considerations such as length of time, homogeneity of the group, providing a feast and gifts, all of which were discussed with the CAC. The CAC, and the youth members in particular, did not want to have the talking circles separated by gender. Hence the talking circles with youth were open to both males and females.

Individuals were invited to participate in the talking circles by way of a recruitment poster (Appendix F, p. 291) placed in buildings such as the health center and band office, and distributed electronically through the band office. However, the recruitment posters were not particularly useful in recruiting participants. When I asked participants how they had heard about the talking circles, most indicated it was by word of mouth and volunteered through invitation by youth members of the CAC. The youth stated they did not read posters, and they did not view messages sent electronically from the band office.

The talking circles with youth were one hour to two and a half hours in length with food provided at the beginning as opposed to the conclusion as the timing was usually after school. They were held in the church basement or multipurpose building. I presented the focus and purpose of the talking circles. In the talking circles, the Elder did not smudge, but started and ended each session with a Mi'kmaq and English prayer to the Creator and we used a small stone to pass around. The Elder facilitated the process of the talking circle, and I shared the responsibility of conducting the talking circle for data

collection. For example, after the stone was passed around once, when it came to me I summarized what was said and asked for clarification or presented a new idea based on the findings from the storytelling sessions. I used a guide to introduce the talking circle and provide direction (Appendix G, p. 292). The discussions were informal and youth talked freely about their understandings of mental health and priorities for action.

For the individual Elder talking circle, the CAC and I invited Elders personally and arranged a time and place that was convenient for them. At the last minute some Elders were not able to attend because of other commitments. In the talking circle with Elders, we did not employ the same methods as with youth. We conducted this talking circle more as a kitchen table conversation in one Elder's home, and I used the guide (Appendix G) to provide direction for the talking circle. We also had a meal at the end of this Elder talking circle.

Community open forum, recruitment and data collection. After completing the talking circles and analyzing this data, a community open forum was conducted to enable community members to have another opportunity to share their understandings of youth mental health and potential plans of action for Mi'kmaw youth mental health promotion. A recruitment poster was distributed electronically (Appendix H, p. 293) through the band office, and by personal invites by word of mouth from the CAC. There were approximately 35 community members in attendance, some of whom were young infants and children. The majority of attendees were comprised of adults. According to some of the participants that were in attendance, there were no adolescents present as they had just received their incentive checks (checks supporting their attendance at school) unexpectedly that day, and were shopping or going to dinner. Most of the

attendees were parents, representatives from the local school, or service providers. I did not ask individuals to delineate their roles in the community by way of a show of hands as this seemed awkward after having conversations with them on their arrival and during the traditional meal before facilitating the open forum. None of the individuals present participated in the individual storytelling sessions. During the open forum I provided community members with findings to date so that they could provide feedback, more in-depth understanding and potentially generate new data for analysis. I used a guide (Appendix I, p. 294) to facilitate discussion. No new data were identified from the open forum; however, participants did substantiate and clarify the findings, for example the importance of Elders in the community sharing Mi'kmaw traditions with Mi'kmaw youth in the community.

An Elder began and ended the forum with a Mi'kmaq prayer, and a CAC member assisted in the introductions and talked about the research process, and the work on the research to date. I recorded notes during the forum and prompted discussion with the use of the guide. The open forum was held in the church basement as there was a kitchen and a large room to accommodate a large group and to have a traditional meal. Although the gathering was three hours in length, the actual discussions took place over approximately two hours.

Ethical considerations for the storytelling and talking circle sessions and open forum. Before conducting the research, ethical approval was granted from Mi'kmaw Ethics Watch and the Dalhousie Social Sciences & Humanities Research Ethics Review Board. Before commencing the individual storytelling sessions, talking circles and open forum, I informed participants about the study. I reinforced that if they

did not wish to respond or wanted to leave at any time, they were free to do so. I acknowledged that there were no benefits to participating in the study, although what we learned from the study may contribute to knowledge in understanding Mi'kmaw youth mental health, and what could be done to promote positive youth mental health. I pointed out that some participants might find sharing their understanding of mental health upsetting, and a counselor or Elder was available if needed, although no one took this opportunity in the storytelling, talking circle or open forum. Many youth discussed how they enjoyed their talking circle session and thought there should be more. Participants were made aware that important excerpts might be shared with the CAC after demographic data, and readily identifiable quotes were removed. Signed informed consents for the storytelling sessions (Appendix J, p. 295), and talking circles (Appendix K, p. 301) were obtained after we discussed the research, what the expectations of the session were, the benefits, and risks. Youth aged 14 to 19 did not require consent from their guardians or parents to participate in the research as stipulated by Mi'kmaq Ethics Watch. However, discussions occurred with a parent or guardian of youth participants aged 14 to 16 to determine if they had concerns about a youth's participation before inviting these adolescents to participate in the study. No parent or guardian had reservations, in fact some parents offered that they would also participate in a storytelling session. In the open forum consent was implied through attendance as the forum was open and individuals attended voluntarily. An honorarium was provided to participants in the individual storytelling sessions and talking circles. Participants in the open forum did not receive an honorarium.

All the individual storytelling and talking circles were audio recorded as agreed upon by the participants. In the open forum I took notes as the room was large and the number of participants and discussions may have been difficult to comprehend on a digital recording. The recordings from the individual storytelling and talking circles were transcribed and each session was given a code number. A confidentiality agreement was signed by the transcriber (Appendix L, p 307). Names, locations and other potential identifying characteristics were removed from the transcripts. In the write-up of findings, a few quotes had to be adjusted to ensure readers would not know who the participant was and to decrease the vulnerability of participants. I maintained participants' confidentiality and anonymity by not telling the CAC who I met with in the individual storytelling sessions and talking circles. At the beginning of the talking circles all participants were asked to maintain confidentiality within the group. There was no confidentiality or anonymity within the open forum, however, in the introduction I asked that members respect the confidentiality of participants by not revealing what individuals said following the forum. Although community members knew each other, no individuals are identified in the written report. Audio recordings and transcripts were stored on my computer which can only be accessed with my username and password and will be destroyed soon after the research is completed.

Participant observation. Along with storytelling and talking circles and the open forum, participant observation enhanced the data collection. As acknowledged by Clifford (1986), participant observation has evolved from stand-by observation and objectified writing. Tedlock (2008) explains that observation acknowledges that “subjects” have become collaborators with the observer. Observation can be focused, and

observers interact with participants in dialogic relationship. Participant observation in this study included being present in the community, mainly at the local School, and the Health Center and when conducting individual interviews and talking circles. I visited Elders in the community for tea, and participated in one Elders' luncheon at the health center to talk about the research. I helped organize a class with the local high school on mental health and arranged for a guest speaker from the Izaak Walton Killam Hospital. I participated in these events with community members to understand the context of the community, dialogue with community members, and build trust, and also to be involved with activities relevant to Mi'kmaw youth mental health and familiarize community members with the research study. My participation was overt; I sought permission and in some instances was invited to participate. These activities enhanced my relationship with the community, and offered an opportunity for the research to be reciprocal and respectful of the community, two principles of Indigenous research. Participant observation provided me with a sense of the context of the lives of the Mi'kmaw youth in Mimikej and with an opportunity to explore and clarify my understanding. For example, when participants talked about their wholistic understanding of mental health, I saw images and pictures depicting this understanding on the walls and in conversations with Elders. When someone referred to the seven sacred teachings, I saw these identified in the multipurpose center and in the Native Alcohol and Drug treatment facility. When participants talked about the difficulties in transportation within Mimikej, I was a part of assisting some to get from point A to point B in the community after meetings or visits in the community. When others talked about the commitment to enhancing Mi'kmaw

language, I witnessed Mi'kmaw language classes within the local school. I recorded observations in my field notes and shared them with the CAC.

Field notes. Field notes are also integral to this qualitative inquiry. The summary of my field notes and observations were shared with the CAC. Field notes recording people, places, talks and events that were descriptive in nature allowed for analysis and interpretation as the study progressed (Emerson, Fretz, & Shaw, 2007). Field notes included places, or discussions, for example, an insight someone had on plans to promote Mi'kmaw youth mental health and events. Field notes were written after leaving Mimikey for the day, following data collection, meetings or participating in events. Each entry included the date. These notes helped me to remember events during my time in the field and helped to refresh my memory during the write-up.

The purpose of writing the field notes is important to data collection. Emerson et al., (2007) explain that there are two extremes to writing field notes, one being that field notes are the core of the project and the other being that field notes can be a crutch to help deal with the stress of being an outsider. I took the stance that field notes helped me in organizing the research process, and data collection and to remind myself of observations, the data collected and to follow up with the CAC or members of the CAC about thoughts or feelings I experienced, or other organizational details.

Data Analysis

Data collection and analysis was an iterative process with the CAC and helped to balance power, build trust and create ownership (Castleden et al., 2008). Initially transcripts from the storytelling sessions, with identifying data deleted, were shared with the CAC. The CAC identified understandings of youth mental health related issues and

ways to improve youth mental health from the initial three transcripts of a youth, Elder and parent. The thesis committee chairs analyzed these same three transcripts. The CAC did not wish to read future transcripts but wanted to be informed of my thoughts as I coded the data. My initial data analysis involved reading and rereading transcripts from the storytelling interviews and underlining phrases, a common practice in qualitative data analysis (Ryan & Bernard, 2003; Lincoln & Guba, 1985; Ulin, Robinson, & Tolley, 2005). Developing codes from the transcripts involved generating concepts or assigning units of meaning from the data (Coffey & Atkinson, 1996; Miles & Huberman, 1994). Atlas Ti was used for data management. Codes were categorized into patterns and themes iteratively throughout the analysis. The talking circles and open forum provided opportunities for themes to be affirmed, enhanced or generated new ideas.

New categories were discovered as codes were stored and some categories were changed (Ulin et al., 2005). I generated patterns and themes through constant comparison and contrasts of the data collected from the storytelling and talking circles and shared these with the CAC along with questions from my field notes, and my understandings from participating and observing in events related to youth. For example, we discussed the connection of spirituality and mental health as a wholistic condition for conceptualizing mental health. Some themes related to others, and this relationship was identified as the data were analyzed and some themes had no connection with other themes. Further, as the data were analyzed there were distinctions and commonalities made between youths' understandings and adults' understandings. In the CAC meetings we discussed the interconnectedness of community, family and friends in understanding rural Mi'kmaw youth mental health and discussed the distinctions between the adult and

youth data. This process of comparing and contrasting continued until all the data sets from the multiple methods of data collection were analyzed and no new ideas were identified. Ulin, et al. (2005) explain that saturation of the data is established when additional data collected are not yielding new insights (p. 177). The iterative process of data collection and analysis enabled an in-depth analysis and provided an opportunity to uncover additional understandings of the initial themes identified during the storytelling sessions.

Trustworthiness and Rigour

Qualitative research has specific criteria to determine the rigour of the research findings. Credibility, dependability, confirmability and transferability are the standards for evaluating rigour in qualitative research (Bloomberg, & Volpe, 2008; Creswell, 2003; Lincoln & Guba., 1985; Ulin et al., 2005). The design and methods used in this study incorporated trustworthiness criteria.

Credibility of findings. This criterion refers to ensuring that the data and interpretation accurately reflect participants' responses. The strategies I chose to ensure credibility were to use multiple sources of data collection. Another strategy was to include others in the interpretation of data. The CAC was involved in the analysis; of our 10 meetings, 6 meetings focused on the analysis and interpretation of the findings. The two co-supervisors of this thesis aided in the coding of the first three transcripts and were involved in ongoing discussions of the analysis and interpretation of findings. Further, analysis was supported by quotes to support the analysis and provide readers with confidence in the credibility of the data. These strategies are consistent with those

advocated by other methodologists (Bloomberg et al., 2008; Creswell, 2003; Lincoln & Guba, 1985; Ulin et al., 2005).

Dependability of findings. This criterion refers to being able to track the way the research was conducted and how decisions were made in order to demonstrate confidence in the findings (Bloomberg et al., 2008; Creswell, 2003; Lincoln et al., 1985; Ulin et al., 2005). By documenting the process of this dissertation in detail, readers can identify the way the research was conducted and how the findings were determined. This documentation strengthens the dependability of the research findings. Further, including reflexivity in the data collection and analysis process makes my own personal perspectives transparent. My reflexivity is included in the concluding chapter of this dissertation.

Confirmability of findings. Ulin et al. (2005) recommend maintaining an audit trail to demonstrate how the researcher is not inculcating his or her own subjectivity entirely into the research findings. An audit trail is a record to track the process of the research that has led to the conclusion. The field notes I wrote, and memoing in Atlas ti provided an account of what transpired during my time in the community. Field notes, and the write-up of this research demonstrate the critical decisions made in the study. For example, myself, and the CAC revised Msit no' kmaq, (all my relations)¹⁰ to more accurately represent the relational dynamics of Mi'kmaw youth mental health. Initially this interconnectedness was referred to as 'community as root' and after much discussion

¹⁰ "In many Indigenous languages there is a phrase that translates into "all my relations". It is intended to express that one's community is an extension of one's family, that interdependence is valued, that we must care for one another, and that it is important to focus all our efforts on the betterment of our community" (Baskin, 2011, p.120).

about the data we concluded that Msit no' kmaq (all my relations) more accurately reflected this interconnectivity. Confirmability was also strengthened by reporting and discussing contextual factors in detail in the research write-up.

Transferability of findings. The purpose of qualitative research is to achieve more in-depth understanding. Qualitative research can be useful for applying the current research process and understandings to similar settings with modifications, based on the context (Bloomberg et al., 2008; Creswell, 2003; Lincoln et al., 1985; Ulin et al., 2005). If the research write-up is described in detail with respect to the context, the characteristics of the participants, and the nature of the interactions and rich descriptions, while still maintaining confidentiality, it may be possible for other communities to apply lessons learned in the context of this research to similar contexts. Mimikey is unique, as are all Aboriginal communities. However, the research is written with significant contextual detail to render the findings potentially applicable to similar rural Aboriginal communities.

Summary

In summary, I have explained the research design and methods of data collection, and analysis for conducting this qualitative inquiry following the general principles of Aboriginal health research. I have portrayed the intimate involvement of the CAC and how CBPR and OCAP informed the research process. Data collection methods of storytelling, talking circles, the open forum, participant observation, and the use of field notes were described. The process of data analysis, and the means for maintaining trustworthiness and rigour were explained in this chapter.

By incorporating multiple methods of data collection including storytelling and talking circles, along with a community open forum, participant observation and field notes, this qualitative inquiry generated an in-depth understanding of Mi'kmaw youth mental health in the local context of Mimikeyj. The community members co-created knowledge that was participatory and transformative. Examining the local knowledge of rural Mi'kmaw youth mental health, in the local context of the community enabled participants to present their understanding of Mi'kmaw youth mental health, and to identify potential actions that could promote the mental health of Mi'kmaw youth.

Given the complexity of the findings, I have presented and organized the understanding of rural Mi'kmaw youth mental health in three chapters. In Chapter 5, I present Mi'kmaw youths' understanding of mental health as Living my Life Well; Msit no'kmaq, (All My Relations). Living my life well comprises a number of subthemes that youth spoke about which include: 1) self-reflecting, knowing more about oneself and taking action; 2) bad feelings, letting go and moving on; and 3) integrating physical and mental health; and 4) Msit no'kmaq, (all my relations), which consists of the interconnectedness of Mi'kmaw youths' lives with the community, family, and friends and peers. Further the complexity and fluid nature of youths' understanding prompted me to sketch a figure (Figure 2, p. 110) to represent their understanding in a way that did not categorize or reduce their understanding to themes and subthemes. A member of the community suggested a Mi'kmaw artist who could draw an image to capture this understanding. After consultation with the artist, he developed a figure to depict my sketch. I shared this figure with the CAC, who concurred that it is full of positive

symbolism and Mi'kmaw imagery, colorful, bright, projects energy and will stand alone with what we want to represent.

In Chapter 6, I focus on adults' understanding of rural Mi'kmaw youth mental health as wholistic and relational. The major wholistic and relational theme of their understanding includes the following subthemes: 1) emotions and mental health; 2) being proud of who they are; 3) spirituality and mental health; and 4) Msit no'kmaq, (all my relations), which represents the connection of individual Mi'kmaw youths' lives with community, family, and friends and peers.

In Chapter 7, I explain navigating, negotiating and creating a sense of self as a major theme which represents the active journey of individual rural Mi'kmaw youth to live life well in Mimikey as described by all the participants in this study. In this chapter, I present the subthemes of this active journey which include: 1) the complexity of a trusted listener; 2) supportive/ unsupportive relations and role models; 3) community events; 4) leaving the community; 5) becoming sidetracked with drugs and alcohol; and 6) youth and suicide. I delineate youths' perspectives of each subtheme followed by adult participants' explanations.

Chapter 5 Living My Life Well; Msit no'kmaq (All My Relations)

Living My Life Well; Msit no'kmaq (all my relations) represents the wholistic and relational understanding of Mi'kmaw youth mental health as conveyed through the individual storytelling and talking circle sessions with the youth participating in this study. This overarching theme addresses the first part of the research question: How is the mental health of youth understood by youth and adults living in a rural Mi'kmaw community? Adults' conceptions will be presented in the following chapter. *Living my life well* comprises a number of subthemes that youth spoke about which include: 1) self-reflecting, knowing more about oneself and taking action, 2) bad feelings, letting go and moving on, and 3) integrating physical and mental health. *Msit no'kmaq, (all my relations)* consists of the interconnectedness of Mi'kmaw youths' lives with the community, family, and friends and peers. Friends and peers are delineated as youth identified a distinction between the two.

Many youth prefaced their stories with how difficult mental health was to describe, not because they did not know what constitutes mental health, but rather in expressing the complexity of its meaning. Emerging from their stories was a clear sense that youth mental health is not a passive process or a reactive response to life. The essence of their understanding was that youth mental health necessitates an existential introspection of self, as the youth live their lives, and that their lives are interconnected with the community of Mimikej, family, and friends and peers. *Living my life well* involves the active arduous labor of self-reflection and self-awareness as youth come to know who they are. The youth discussed how this work is necessary for maintaining or attaining the courage to be, as youth make difficult decisions on their journey of living

their lives well. Many Aboriginal traditions have rich vocabularies to discuss healing and renewal with multiple terms expressing “living well” (Adelson, 2000). *Msiit no’kmaq (all my relations)* refers to youths’ understanding of the relations they have within Mi’kmaq communities such as Mimikej, and how these relations are instrumental to a process of self-reflection and self-awareness as youth live their lives in a way that promotes mental wellbeing. Relations, including relations outside the community, mattered to the youth participants in this study, yet the meaning of mental health originated from living their lives in a small rural Mi’kmaq community.

Although the setting of this study was described in Chapter 4, in this section the context of the historical legacy of residential schools, unresolved grief in the community, the impacts of forced assimilation and the outcomes of colonization, and the Indian Act¹¹ are reintroduced briefly as this background is a part of understanding rural Mi’kmaq youth mental health. The social topography of Mimikej is a small rural Mi’kmaq community where the number of people receiving social assistance exceeds those with employment, financial and community resources are limited, and access to tertiary health care services is problematic because of transportation difficulties. In the youths’ stories there is an overriding sense of the caring, concern and commitment that is experienced among community members, juxtaposed with contemporary realities of violence and substance abuse. Hence, a paradox exists whereby youth recognize a close connection to

¹¹ “The present-day *Indian Act* is the result of the major revision that occurred in 1951. The net effect of the 1951 revision was to return Canadian Indian legislation to its original form, that of the 1876 *Indian Act*. The 1876 and 1951 versions are very similar in essential respects. For example, although the number of powers that can be exercised by the Minister of Indian Affairs and the Governor in Council was reduced in 1951, their authority nonetheless remained formidable. In the current version of the Act, nearly 90 provisions give the Minister of Indian Affairs a range of law-making, quasi-judicial and administrative powers in all-important areas. In addition, another 25 provisions give the Governor in Council wide powers, including that of making regulations in areas otherwise covered by band council by-law authority” (RCAP, 1996)

the community of Mimikey, and at the same time acknowledge difficult relations in the community.

The youth participating in this study did not describe mental health as simply the absence of mental illness. A few youth talked about mental illnesses such as schizophrenia and bipolar disorder; however, the stories of most youth focused on mental health and not mental illness. The majority of participating youth had a broad understanding of mental health which had developed over time. For example, in an individual storytelling session, Debbie explained;

I don't know, at first when I was a kid, I used to think it was like the diseases that you could get. But now it's different because I just don't think of it as the illnesses.

Figure 2 (p.110) illustrates the dynamic wholistic nature of *Living my life well; Msit no'kmaq, (all my relations)*, and represents rural Mi'kmaw youths' understanding of mental health as youth undertake their journey to live life well. The tree is representative of Msit no'kmaq (all my relations), and the strands extending from the tree depict the journey youth conveyed which included: 1) self-reflecting, knowing more about oneself and taking action, 2) bad feelings, letting go and moving on, and 3) integrating physical and mental health. The orb is reflective of the balance and wellbeing individual youth strive to achieve or maintain, and has a shadow to reinforce the interconnectedness of individual youth with the community. In the following sections I focus on the subthemes described by the youth as they strive to *live my life well; Msit no'kmaq, (all my relations)*.

Figure 2: Rural Mi'kmaw Youths' Understanding of Mental Health



Self-Reflecting, Knowing More About Oneself, and Taking Action

Many of the youth presented understandings of mental health constituted by the complex performance of attentive awareness and coming to know one self. Their stories suggested that mental health necessitated self-reflection contingent upon an active, purposeful self-awareness of their life's work in coming to know who they are, and living their life well based on this knowledge. The stories revealed how youth enact a process of self-reflection, and are able to increase their self-awareness through their lived experiences and relations in the context of living in Mimikej. For example, Jim described mental health as a process of self-reflection, and being conscious of his own inner being. Integrating his life experiences and coming to terms with his life by being mindful was an important progression for living his life well.

What I think is mental health? How you really think about life, how you put your own spin on it. Because I've been through a lot of stuff. So there are people that went through different things also. And it's all how you really think about life and think about your past, and how you can live with it.

Jim, in his earlier adolescent years experienced abuse, witnessed suicide (which he did not elaborate on) and the pain of facing daily discrimination because of his sexuality. Most youth do not experience the day-to-day distress described by Jim. For example, Jim described reflecting on his sexuality, his fears and his concerns, he chose to let others know this about himself. Jim explained the meaning of being mindful, and having the courage to triumph over his fears so that he could maintain his mental health, regardless of the consequences.

Like being bi-sexual, I was always afraid to tell my friends. Because I was like what if I lose some of my friends, some friends don't want to be around me? And it's like I manned up and I told them.

Jim shared how he struggled through name calling, such as ‘faggot’, by people in the community and others who continuously used derogatory phrases when talking with him. He lost a few friends but the ones who stayed by him continued to support him. His mother and brother were the last people whom he told as he feared their response, and Jim was concerned they would be ridiculed by the community. His act of bravery in “coming out” in a small community demonstrated courage to stand up against possible ridicule and discrimination by some community members. Jim thought through his decision to acknowledge his sexuality as he explained;

But you’ve got to know your moral rights. You’ve got to know when it’s the right thing to do it, even if you might get rid of some friends.

Jim’s discussion of how he reflected on his life and chose how to live his life is not unique. David, another older male youth, who was in the midst of being diagnosed with a mental illness, presented a similar process of self-reflection connected with youth mental health. His explanation is similar to Jim’s as he spoke of his agency in living his life, saying it was up to him and nobody else.

I am trying to think how to explain it, well you live your life....like whatever you think it’s your own doing it’s not like anyone did anything to make you think this way, it is your own doing.

David was not referring to his mental illness; he believed the medicine controlled his hallucinations. He was referring to how he lived his life. Similar to many of the youth in this study, self-reflection, being mindful of his life, and developing a sense of autonomy were fundamental for maintaining his mental health. The active process of in-depth self-reflection, knowing oneself, and decision making was further explained by

Kevin. He conveyed that each youth needs to come to know who he or she is as a person, and this is a critical component of Mi'kmaw youth mental health. He referred to the need for youth to know themselves as this would affect the decisions they made.

Well, like I think mental health is more of like knowing more about yourself than anything. Because I don't think if you know like a lot then you're just going to use drugs just to get on with the day.

Jennifer demonstrated the same act of self-awareness as Jim, David, and Kevin as she explained how she had to make some decisions about her life. Her story links with Jim's ideas of self-reflection and the courage to be. Reflecting on her life, gaining new insights and taking action accordingly is evident in her explanation of making decisions and being mentally healthy. She described her decision to move on with her life, and how no one was going to tell her to change. Similar to the other youth participants, Jennifer's story illustrated the necessity of self-reflecting, changing perceptions, and making decisions as instrumental for fostering her own mental health and to live life well. Further, she claimed she would be happy regardless of what others thought, reinforcing a sense of personal autonomy that was also suggested by other youth participants.

I just changed the way I looked at things and I stopped hanging around people who brought me down, and I just decided that I am going to live for myself and I'll be happy for who I am. And I wouldn't let anybody tell me to change.

She demonstrated courage and confidence in thinking for herself, regardless of how she was perceived by the community and in thinking no one else could change who she decided to be. Jennifer cut herself off from friends who were bringing her down; her story illuminated the deliberative processes of *living my life* that entailed a difficult decision that could have ostracized her from other community members, including her

peers. Debbie also referred to the importance of decisions on the journey of mental health and wellbeing. The “it” she was referring to is mental health.

I think of it as how you make decisions and go about in your life.

Most of the youth talked about self-reflection, knowing oneself, and having the courage to be, and to make decisions as iterative, thoughtful and necessary for mental health. They were mindful of the decisions they made in the context of their lives. Erin found it difficult to express her understanding of mental health. Erin was feeling sad and alone because her friend was under house arrest and so she did not see her friend much, nor did she associate with other friends. Erin said; *I like to keep my mind off of those things*. In other words, she was actively trying to keep her mind off of her friend who was in trouble with the law, and trying not to think about her other friends who were getting into trouble.

The talking circles with youth affirmed and expanded on what youth were saying individually. For the youth participants, self-reflection, knowing more about oneself, making choices, particularly about friends, not taking drugs, and maintaining schooling were core to rural Mi’kmaw youths’ understanding of mental health. In one of the talking circles, this male participant explained;

Like it can be how you were born and your brain and stuff but I think it also has to do with like the choices you make in life. And like if you decide to do bad things then you’re obviously going to think that way. Talking Circle #2

For this male, bad choices can lead to doing bad things resulting in a spiral of ongoing negative thinking. In talking circle #4, one youth described her understanding of mental health in relation to addictions, and the hard work of self-reflection and awareness to overcome her addictions. She demonstrated maturity based on her life’s work to date on

processing her emotions, self-reflection and acknowledging the need to forgive but not forget. This self-work was germane to her mental health, and illuminated the conscious and purposeful effort youth invest in to attain or maintain their mental health. She explained;

Because I myself have an addiction, and I didn't want it. Like it makes me feel like [pause] it helps me escape. But once you come to peace with yourself, and like stop holding things in, and you just forgive. You don't have to forget but forgive. It helps a lot. Like I no longer have any of those addictions.

Her explanation, that she did not choose to have an addiction, and that it helped her escape is relevant. Unlike Jim, who attempted suicide, this adolescent initially chose alcohol to alleviate her emotional pain. She understood she needed to come to peace, not hold things in, and forgive, but not forget, as she described her quest to *live my life well; Msit no'kmaq (all my relations)*. In the talking circle, she did not describe who she needed to forgive, or what she needed to remember. She demonstrated a profound sense of self-knowledge similar to the youth in the individual storytelling sessions.

In summary, some youth in this study overcame the traumas in their lives through the hard work of self-reflection, and knowing themselves which was necessary for living their life well. The remarkable insights presented by the youth participating in this study when describing their acts of self-reflection and decision making in the midst of the distress in their lives revealed the efforts required by some youth to strive for, and foster mental health. The youth participating in this study demonstrated how they labored through the act of mindfulness which required in-depth self-reflecting, knowing themselves, and the courage to be who they are in order to make decisions that would affect their journey in life. The arduous iterative journey necessary to figure out their life

constituted a part their understanding of a wholistic nature of mental health. The youth included more than the act of knowing themselves and making decisions in their stories explaining mental health, and I present the other subthemes of their wholistic understanding of mental health in the following sections.

Bad Feelings, Letting Go and Moving On

Although awareness and self-reflection includes being aware of thoughts and emotions, explicating the interplay of emotions and mental wellbeing provides a broader understanding of youth mental health as told by the youth. In the individual storytelling sessions, many youth talked about emotions in connection to mental health. For example they explained how poor mental health is connected to “*feeling overwhelmed with everything,*” (Sara, a young adolescent), and “*feeling sad for no reason,*” (Keith, a young adolescent), “*feel[ing] depressed,*” (Jennifer, middle adolescent), “*feeling down in the dumps,*” (Leah, middle adolescent).

Jim talked about feeling “*bad*” for a long time, and how time, and letting go helped him heal “*bad*” feelings. Letting go was not a passive process and not the sole strategy for feeling better. The “*it*” Jim refers to were the traumatic experiences in his life, and the interplay of his bad feelings and letting go were vital for his healing. His stories support a strong sense of conviction and understanding of healing. He spoke of his emotions, but he also referred to his brother’s story to reiterate the process of healing.

Oh, yeah, there’s no denying that you’re going to feel bad for a long time about it. But after you move on, like you’ll think about it... Like you’ll slowly start to forget about it, like you do with anything else in life. But you’ll remember at certain times. Like for example, a relationship. Like my brother just got out of a relationship for about 3 years. He broke up with the girl about last month, and he’s slowly moving on. He thinks about it, he cries about it every now

and then. That's alright, it's human nature to cry and be sad about things. But he's moving on. He remembers the good times. And that's what I do too.

Jim was able to heal his “bad” feelings over time, through a determined effort of contemplation and introspection realizing the need to move on.

Patrick talked about his feelings of anger. He spoke of how his parents forbade him to go out in the evenings for a specific period of time because of the behaviour stemming from his anger. The push he referred to was how his parents and teachers motivated him to change the behaviours that stemmed from his anger.

I've always had a bad anger problem. But it's gotten a lot better as have the years of getting grounded and also that push.

The understanding that emotions are integral to mental health was equally understood among the male and female youth. In other words, the male youth did not isolate how their thoughts were the only part connected to mental health, and the female youth did not present emotions as the only component of mental health. Their stories illuminated that emotions are actively intertwined in their conceptualizations of mental health.

Further, most of the youth did not talk about the extent or intensity of their emotions, i.e., if they were feeling severely depressed, extreme sadness, or overwhelming anger, or for how long those feelings persisted. They also did not talk about what made them feel angry, depressed or happy. In the individual sessions and the talking circles with youth, the focus on emotions such as anger, depression, sadness, or feeling overwhelmed centered on emotions untowardly influencing their mental health and how to overcome the negative emotions. For example, Jennifer explained;

I think we really should have professionals in this community because there's a lot of teenagers that are depressed. And some of them don't talk about it and they go out and they do drugs because they think the drugs will help them in a way.

Many youth described depression as a feeling, not as a pathological entity of mental illness or as a condition. The youth did not elaborate on their personal emotions in great detail; rather, they talked about emotions in connection with their understanding of mental health and how emotions can undermine their self-reflection, courage to be and to make decisions to live life well. Leah, like Jennifer, identified how feelings can have serious consequences for youth; however, she did not refer to depression as a feeling. From her discussion, depression was framed as a condition.

I had this friend a while ago who committed suicide because of depression.

The interplay of emotions and mental health was stressed by all the youth in this study, and was an essential component of understanding Mi'kmaw youth mental health. Although youth participants discussed the need for youth to express their feelings, because some emotions could lead to negative effects, for example either through addiction, or suicide, others also talked about how youth did not want to be singled out for their feelings. For example,

Like when you're sad, you don't want to be targeted. You want the attention taken away from you. Talking Circle #4

When youth participants talked about emotions as an essential component to mental health, the emphasis was on the importance of sharing their emotions to promote positive mental health. The youth talked about the uncertainty between the need to share

feelings, and the inability of some youth to share their emotions with because of the concern of being singled out.

The integration of emotions and self-reflection, in relation to understanding mental health, was suggested in the individual sessions and talking circles. Some youth reflected on the traumatic experiences in their lives, learning to forgive, but not forget in some instances, and acknowledging feelings of sadness or sorrow. For the youth participating in this study, emotions were another important connection to their mental wellbeing.

Integrating Physical and Mental Health

Some of the youth in the individual stories and the talking circles also identified an association between emotions and the physical self. For example,

Yes, and not to hold emotions in. If you hold emotions in, it can do a lot of damage to your body by itself. Jim

In their individual stories and in the talking circles many youth focused on a connection between physical and mental wellbeing in their understanding of mental health. Most of the youth participating in this study did not separate the body from their mental wellbeing as they talked about how one can influence the other. As Jim explained;

I used to be depressed. I used to be crazily depressed. And that led to different things to my body.

The following quote from a male youth in talking circle # 3 reaffirmed how “*bad mental health*” can lead to poor physical health.

And the physical health thing wouldn't always be connected to mental health but if you have good physical health and you have bad mental health that can also lead to bad physical health

Although some youth identified how mental health can affect physical health, other youth suggested how physical health and activity promotes mental health. Patrick explained how the physical activity of sports helped him clear his mind. Patrick was the youth who shared how anger undermines mental health. Although he does not speak of anger here, his explanation of how sports helped him clear his mind, and “*see things*” is revealing. Sports for him, and other youth in this study, influenced mental health, and took on a broader meaning than building self-confidence and relieving boredom.

Sports has always been there for me. And it's just something to help me clear my mind. And that is also mental health. You need to be able to think. You need to be able to see things, how you're supposed to see them.

For Patrick, clearing his mind meant he was able to think better. Possibly the anger he felt was cleared from his mind when he was doing physical activities and this enabled him to reflect and “*be able to see things*”.

Some youth explained how important activities are in promoting their mental health.

I believe that physical activity really gets you in that place where you want to be in. For most people anyway. But there's other people that like don't go to that place when they play physical sports. They do other stuff like play video games. Talking Circle# 2

I am not certain where or what “*that place*” is, but in all likelihood the youth may be referring to a place where they can forget their troubles or emotions for a brief period in order to reflect with a clear mind, “*to be able to see things, how you're supposed to see them,*” as Patrick suggested. The understanding of how activities promote mental health

was talked about by all the youth. Some male and female youth valued sports as described by this female;

I like the idea about sports because I find like with sports, you're kind of like focused on your sport. So you want to like train for it. So you don't like spend your time like goofing off or like doing drugs or getting pressured into drugs. Talking Circle#4

For this participant, learning to focus was important for mental health, but sports also enabled her to do something more meaningful than “*goofing off*”, taking drugs or being in situations where she may be pressured to do drugs.

The youths' explanations presented an understanding of mental health which included the physical self as a part of a wholistic conceptualization of mental health. However, the physical self was not always a priority in their stories. For example, in talking circle #4, one youth described how her self-reflection changed her emotions, but she did not believe her self-awareness affected her physical wellbeing. In the following quote, the “it” she refers to is her reflections. She is saying is that how she thinks can change how she feels, but not necessarily affect physical wellbeing.

I think it changes your emotions but it doesn't really change your physical and your spiritual....

She understood that her thoughts influenced her emotions; however, this process did not affect her physically and she was not sure how her thinking would influence spirituality. Others talked about how depression affects youth physically resulting in excessive eating or loss of appetite,

Like I've witnessed like people who are like depressed. Like it does affect them physically. Like I don't know, some people like it affects them. Like they won't be able to eat or like they'll just constantly eat. Talking Circle#4

Their stories illuminated the interplay of physical actions and physical wellbeing with their wholistic understanding of mental health. However, others referred to the “body” (physical) and how it is not always connected with feelings, and described how this disconnect is sometimes evident with their friends. For instance, they knew a friend was feeling down but the friend acted outwardly like he or she was happy. In this instance, the youth were not talking about how physical health promotes mental health or vice versa, rather they were pointing out the incongruence between body language and emotions. This incongruity could be interpreted that youth may not want to show how they are feeling, which is not unusual for adolescents. The concern of hiding their feelings may be significant in Mimikej, in the context of “*where everybody knows everybody’s business,*” and as described earlier by one of the youth, they do not want to be singled out as being sad. Hence, the need to look outwardly happy would be paramount if one does not want to be targeted as sad. One youth in a talking circle described it as;

Like you could be like sad, but you look happy on the outside.
Talking Circle #4

Later, in this same talking circle, one youth went on to explain the interconnection of the physical and emotional, and identified there is a spiritual connection to mental health as well. Her explanation of the interconnection was difficult to follow, yet, what she described was the connection of how the body feels when someone feels down, and “*what’s going through your mind*” is also connected to mental health. She identified insight into the integration of the wholistic aspects of mental health. From her perspective “*what’s going through your mind*” was core to mental health.

It is kind of physically because the way you feel, like if you're feeling down and you mentally feel that way, and it makes your body physically feel that way. Because even if you do look happy and you're not, your body doesn't feel happy But I think mental health is spiritually and physically. And it mostly has to do with what's going through your mind. Talking Circle #4

Living Mental Health in Relationships

The youths' stories of their wholistic understanding of rural Mi'kmaw youth mental health were connected with living life well which involved relationships within their community. Most youth talked about their individual acts of coming to peace with themselves and developing the courage to be, and making decisions for living life well in connection to community, peers and friends, and family. They talked about the connectedness of relations in the context of their lives, and how this affected their mental health, positively or hindered their mental health. In this section of the chapter, I will present how the various relationships were important to the youth. These include their relationships with their community, families, friends and peers. The youth emphasized the collective of the community as they conveyed their understanding of mental health. The social determinants of health, such as poverty, were talked about in relation to the community rather than as an individual issue. In talking circle #3 one youth explained;

Just because we're kind of an under-developed community. And it's just since the government doesn't really care about natives to a certain extent, it's going to be hard because we would have to earn the money to develop [Mimikej] on our own.

He presented how the lack of funding in the community, not his own personal lack of finances, or limited employment opportunities to obtain funding was a barrier for his personal activities. His explanation of how “we [the community] *would have to earn*

money” centered on his bond with the community, and the need to collectively identify means to earn money to develop activities for youth together. In the following section youth describe dynamic relationships within the community that are relevant to their mental health.

Community connections: “security blanket, one big family, celebrating culture”. All the youth in this study were born and raised in Mimikej except one from the individual storytelling sessions, and two from the talking circles. Many talked about living on the “*reserve*” or “*reservation*” or “*reserve life*”.

Some perceived their attachment to the community as a security blanket which could be either positive or negative. For example, in talking circle #4, one youth explained the connection or attachment and how the attachment could be too strong.

One thing about this reserve that I don't like is to me, it's a security blanket. And to many others, it's a security blanket too. However, I'm not too attached like others. Others are really attached.

Living on the reserve was seen by some youth as curtailing motivation, or the drive to go to school or seek employment. As this youth explained in talking circle #1;

And they think that just because they're from the reserve that they don't need to go to school because then they can rely on welfare and all that other stuff.

When youth spoke of these potentially negative effects of “*reserve life*” on themselves and other youth, they did so to bring attention to the context of the lives of youth in the community, and how this may influence youths’ decisions to go to school or seek employment. Their stories illuminated youths’ journey to *living my life well; Msit no'kmaq (all my relations)* with community as meaningful to their understandings.

The majority of youth participating in this study talked about the intimate nature of living in a First Nations community and that this intimacy had mixed effects on youth mental health. Keith described how the community is small and isolated and therefore everybody in the community knows each other.

It's just around here, there's everybody knows each other pretty much. It's kind of small or isolated pretty much from everywhere else.

Some youth expressed the benefits of knowing everybody. Debbie, for example, explained the unique features of the community and framed her understanding of this connection as positive.

But you have to think of the good things that happen here too. Like off-reserve, you probably wouldn't know your neighbours. But here, you know everyone. You could go next door and say hi if you wanted to. It's like one big family really.

Another youth explained that having a common bond within the community is important for promoting positive mental health and is something they should celebrate and foster.

I like the fact that because we're a community, we all share something, and that's our cultural background. So celebrating our culture. Talking Circle #4

For Debbie, and some other youth participating in this study, knowing everyone was a benefit of living in this particular community. At the same time, the intimate nature of living in the community could be problematic for youth who did not like to be singled out, something that is hard to avoid because “*everyone knows everyone's business*”. The disjuncture here is that although youth valued this connectedness, they also had concerns about the lack of privacy, and the associated negative consequences for youth mental

health. As the following section shows, their stories revealed a complex paradox. The community relations and connections that youth respected sometimes challenged their mental health.

The multifaceted dynamics of relationships within the community as they connect to Mi'kmaw youths' understanding of mental health was a dominant discussion in the individual storytelling and talking circle sessions with youth. Todd explained how relations in the community can “*keep you down*”.

If you're around people, that's going to put you down and you're going to see stuff that's going to keep you down, you're not going to have good mental health in the end.

Jennifer, in her individual session expressed she had experienced depression and explained her relational circumstances and how she was “*able to get on with her life*”.

Really, really depressed and down all the time. That's when I realized the people that I was around with, they didn't make things better for myself. So I had to cut them out of my life just to make things better for myself.

This complexity is evident in the following youth's description of her connection with the community;

Again, this community is somewhat safe. I don't necessarily trust everybody here but I do trust the community as a whole. Talking Circle #4

The lack of trust with some members in the community was mainly related with who they could talk with in the community, and whether it was safe to share their concerns.

Knowing some families in the community who struggled with drinking, for example, influenced youths' relations and mental health negatively. Debbie talked about some people being alone in the community. Being alone, or the absence of relations and connections, was regarded as “*not mentally healthy*”.

Because a lot of people here are into drugs and stuff like that, and they're not as mentally healthy because they don't have much people to rely on. As much people that are here, they kind of separate themselves.

Debbie was not referring to youth who are drinking in the community. She was explaining her understanding of how drugs and alcohol affect relationships in the community and mental health.

Although youth referred to the negative aspects of life in the community, many of these same youth also talked about the important positive connections they had to the community. For example, one youth talked about participation in community events and another discussed her connection with the Elders in the community.

Like the sports every day of the week except one. And then youth council keeps you busy.And like this Sunday, we're having a big fire of trees and we're cooking for everybody, and giving them food and stuff. Todd

Like if we're going to do like a basket-making workshop, they're there. Like if we're doing something like that, it's cool to see them like there. And like you get closer to them and they tell you stories. And it's really cool because I remember one time we were making shawls, and I got so much closer to like two Elders that I still talk to now. Leah

The youth in this study conveyed how community relations in Mimikey are an integral part of their understanding of rural Mi'kmaw youth mental health. This explanation extended beyond community to include family, friends and peers which I describe in the following sections.

Families; “the higher generations matter”. The youth spoke of their connections with families in Mimikey as much as they did about community, friends and peers. Their explanations illuminated the positive and negative relations associated with

their mental health and the mental health of their friends. In this talking circle, one female youth explained the significance of family, although she did also mention friends.

Because some people say if you're dealing with something alone, it makes you stronger. But I don't really believe that because when you're doing something alone, you can't really...it doesn't really help as much as if you were to have a friend by your side or a family member. Talking Circle #4

Kevin, who spoke about knowing yourself as being important for mental health, talked about the positive effect of his family on his mental health. When he referred to his family shedding, or keeping him away from “it”, he meant keeping him away from the drinking.

I'm just glad I have, you know, my family, my parents to shed me away from it. And they don't let me do too much but you know, they let me do enough.

Some youth talked about how, until they were around the age of twelve, their parents were strict. The strictness ranged from imposing curfews at night to not being allowed to swear. These youth perceived this as being important to their upbringing in their earlier years in the sense that they did not get into trouble or make bad decisions, such as drinking. Also, many presented the other positive effects of family relations, and the interconnectedness with mental health. For example this youth, like many others in this study, spoke about how important it is to talk to someone, and it was his grandmother he talked with; “*Me and my gram are tight so we talk about everything*”, Talking Circle # 3. Many of the youth discussed how important their mothers, aunts and grandmothers were as they shared everything with them. One youth indicated that she talked with her dad in this way. When other youth, in one of the talking circles described how they

talked with their mothers she interrupted and said; “*I talk with my dad all the time*”,
Talking Circle #4.

Jim talked about the positive connection with his grandfather, who was no longer alive, as well as his mother, when he (Jim) was thinking about attacking his abusive father. The positive and negative situations that Jim talked about in his life were relational.

And I was thinking... And I always grew up loving my granddad because on the weekends, he'd take me and my brother with him. And my granddad will always be my hero. The same with my mom. \And I grew up thinking about what would my granddad do? I broke down and cried. I did not attack my father and that was probably the second night I cried myself to sleep ever. I just laid in bed crying.

The powerful interplay of the relationships in Jim's family, including both his mother and his grandfather, provide an example of how youth reflected on family and the influence of family on youths' mental health and how they live their lives. Jim thought of his family when he made his decision not to attack his father; it was not the law that deterred him; it was his family, past and present. Jim's mother and grandfather had a profound impact at a crossroad in his life when he was most vulnerable. When his mother found out about the father abusing Jim, she left Jim's father. Currently, Jim is not in an abusive environment, and although he did not attack his father, he did attempt suicide and his friend stopped him. Ideally, family should be a safe haven, when in fact, for Jim, it was a nightmare in his earlier adolescent years. His choices helped to end that nightmare. His decision was not done in isolation of others. He was able to resolve his dilemma by consciously being aware of his grandfather and his mother in his deliberations. Family are influential in many of the important decisions youth make. Jim's decision for

“coming out” was done on his own; however, when he reflected on his choice, he was concerned of how his decision would impact his family.

The powerful influence of family on youth mental health was further revealed in the stories of other youth. Keith talked about some of the youth in the community being sad. Later in his story, he commented on family problems in the community contributing to youth being sad.

Because some people, I guess, have families that are complicated. You know, some people that are fighting and all that.

Other youth presented stories about friends whose parents were not supportive or did not foster positive mental health. They described their understanding of family and mental health in general terms. For example,

I would say like the socialization in the family would be a big contributor to their attitude. Like if you're in a home that isn't very positive, the socialization would be poor and you wouldn't have a good thing on life. Todd

The youth perceived that family influenced youth mental health in their community. For example, a youth in this talking circle referred to how his mother was instrumental in his life, and what he meant by “*that's what they're going to be taught*” is that the youth learn from their parents.

If you want to change what's going on with the youth, you have to go to their parents first, the higher generations, because that's what they're going to be taught. Talking Circle #2

He believed the parents in his community are instrumental to Mi'kmaw youth mental health. His sentiments were similar to many of the other youth participating in this study. The youth perceived that family influenced youth mental health in their community. The

relationships youth had with family were valued although they recognized that there were problems within some families.

Friends and peers: “making connections”. The youth participating in this study talked about friends and peers from the community of Mimikej in their explanations of understanding mental health. The distinction between friends and peers is relevant. The youth conveyed that peers are important in their understanding of mental health, yet the relationship with friends is stronger. Their stories included how friends could bring them down, yet also included how they looked to friends they could trust to talk over their problems and their feelings. For example,

But I found it was easier for my friends to help me because they know about my life and what I've been through. Jim

Erin, who was feeling sad and alone because she was not associating with her friends much lately, shared how important these friends were to her.

Like I used to like turn to and talk to my friend about my feelings and stuff. But she's never around so I just keep it to myself.

Patrick talked about his connection with his girlfriend in deterring him from taking drugs.

Like when my parents said you can't do it, I didn't care. Who were they to say I can't do it? I can do whatever I want. You know what I mean? But when she says it, I actually connect and I'm saying oh, well, okay, I really don't want to lose you. Like I don't want to lose my parents either. If I lost my parents, I'd drop to my knees and cry. But with her, it's an immediate thing. I'm constantly with her.

Some of the youth in this study also presented the importance of being supportive to others. For example, Todd talked about having the right attitude and what you do with

that attitude to influence others. In other words, youth were moving beyond “self” and considering others.

Like have the right attitude towards stuff and not be so down, yes, and think about others

Most notable, in terms of this relationality was Debbie’s story of helping her friends and peers. Debbie’s story does not explicate an understanding of her personal mental health, although she did share how hard it was for her to experience a friend commit suicide. Her emphasis was on how this suicide influenced her to help her friends and peers so they do not do the same. She talked about how youth are in relation with other youth in the community, how these relations are connected, and how experiencing the suicide of a friend is a driving force for her to be supportive of other youth in Mimikej.

Yes. I just try to help as many people as I can because, you know, because we just lost a girl that took her own life maybe last month, I think. And it was hard because I’ve known her all my life. And like all my friends were friends with her, and everyone just knew her. And then she did that and it just like... I don’t know, You just try to help as many people because you don’t want them to end up like her.

Debbie was referring to her friend who committed suicide. Similar to other youth participating in this study, their descriptions of the nature of friendships and peer relations were intense. The overriding dimensions of the relationships youth talked about were complex and complicated. They explained how youth supported, and received support during difficult times such as abusive family relationships, issues of substance abuse and suicide. Further, for the youth participating in this study, friends and peers were important to their mental health either positively or negatively. Their friend and peer relations were compounded in a rural community where everyone knows everyone concomitant with

issues of alcohol and suicide. Some friend and peer relations were positive, yet other friends and peers could bring them down. The youth in this study illuminated the contradictions of the relations with friends and peers.

They spoke of the meaning of being supportive to others, and, in turn, their own need for support from their friends and peers. For example, Jennifer, who cut herself off from friends who were doing drugs, expressed her frustration at not being able to help her cousin who was her friend, and was also using drugs. She explained;

There are days when I just want to go to her house and just grab her and make her realize that what she's doing is wrong.

David referred to the importance of friendships, and how friends can make a difference to youth mental health.

We got to put [youth] back in their comfort zone because like what I was saying about my friend is like when he told me I could tell he was very uncomfortable but just by telling him I am not going to stop being your friend just because there's something wrong with you according to society and that made him a lot more comfortable and ever since then we have been the closest we have ever been we just kinda let these people back in their comfort zone because right now they might be uncomfortable

The kindred spirit that youth described when they spoke of the importance of friends and peers with respect to rural Mi'kmaw youth mental health was insightful. Some, like Jennifer and Todd, talked about how friends could bring them down, yet they and other youth also talked about how important friends in the community were in helping them foster their own mental health, and that they in turn believed in supporting their friends and peers.

Summary

The stories youth told affirmed a focus on kinships ties, as well as an individualistic notion of mental health. Many of the youth focused on “*it was how you got on with your life*” and most often prefaced this with how they got on with their life in relation to the community, family, friends and peers in Mimikej. They spoke of the reciprocal nature of these relations such that they gave support or received support, and presented an understanding of mental health lived in relations, both positive and negative.

Msit no’kmaq, (all my relations) as conveyed by the youth in their stories about their understanding of Mi’kmaw youth mental health represents the interconnected relations youth have in the community. The youth talked about how relationships were positive and negative and these relationships had significant bearing on their mental health. They presented contradictions and tensions in their connectedness with the community, family, friends and peers. Jim’s story is an exemplar of the ties with family and friends and epitomizes the complex positive and negative dynamics of these relations. His father abused him, yet it was being mindful of his grandfather and mother that enabled him to choose the morally right action to not attack his father. Further, it was Jim’s friend who prevented him from committing suicide. For the youth in this study, kinship ties were not isolated to a nuclear family, but rather as a network of families, extended families, grandparents and clan members.

Overall, the dynamics of a wholistic understanding of mental health in connection to the people of Mimikej was revealed in their stories, and depicted in figure # 2 (p.110) representing the processes of a wholistic and relational understanding of rural Mi’kmaw youth mental health. The complexity in this finding is that youth described a community

in which relationships are connected to promoting mental health, yet also undermined their mental health. The youth explained how they understood the fluid nature of mental health as wholistic and relational.

Their stories individually, and in the talking circles, conveyed a profound understanding of mental health in the context of their lives and the social topography of a rural Mi'kmaw community. The community of Mimikeyj is striving to overcome the outcomes of its traumatic historical past, the residential school experience, forced assimilation, and the current day-to-day problems in the community associated with colonization. Individually and collectively the youth are a part of this journey with the community. They are not isolated from the community's past and current circumstances as they actively reflect on their own way of being, knowing, feeling and living within this context. The dynamic interplay of a wholistic self, connected to community, family, friends and peers was prominent within the youth participants' understanding of rural Mi'kmaw youth mental health as *Living My Life Well; Msit no'kmaq (All my Relations)*.

Chapter 6 Adults' Understanding of Mi'kmaw Youth Mental Health; Wholistic and Relational

The wholistic and relational understanding of mental health represents the knowledge of rural Mi'kmaw youth mental health as explained by parents, teachers, Elders, service providers, the Elder talking circle, and the open community forum. This section is in response to the latter part of the research question: How is the mental health of youth understood by youth and adults living in a rural Mi'kmaw community? In the individual storytelling sessions, the Elder talking circle, and the open community forum the adults described an understanding of a wholistic and relational view of rural Mi'kmaw youth mental health similar to the youth; however, there were some distinctions in perspectives between the adults and the youth.

With respect to the wholistic nature of mental health, the adults did not elaborate on the physical aspects of mental health. They spoke of how youths' emotions, identity development, and spirituality were a part of rural Mi'kmaw youth mental health. The effects of Indian Residential School (IRS) were included in their stories of understanding Mi'kmaw youth mental health; however, the arduous labour of being mindful, self-reflective, and self-aware as youth engage in the courageous work of making difficult decisions to *live well*, were not discussed in the interviews with the adults. Parents, teachers, Elders and service providers spoke to the importance of self-esteem and identity development, in particular Mi'kmaw identity, in their explanations of the mental health of youth in the community. Further, they positioned identity as problematic among the youth and in the context of living in Mimikeyj; i.e. "*feeling lost*", "*feelings of low self-esteem*". They were concerned that some youth do not have a sense of belonging, and

they do not feel good about who they are. Similar to the youth, the adults identified a relational dimension in being with community, family, friends and peers in their understanding of mental health. However, they focused more on the dynamics of community and family in contrast to the youths' emphasis on family, friends and peers. The adults identified friends and peers briefly in their explanations.

In the following section I focus on adults' understanding of youth *living their life well*; *Msit no'kmaq, (all my relations)*. The wholistic dimensions of their understanding are identified as subthemes and include; 1) emotions and mental health, 2) being proud of who they are, 3) spirituality and mental health. *Msit no'kmaq, (all my relations)* represents the interconnection of individual Mi'kmaw youths' lives with community, family, and friends and peers.

Emotions and Mental Health

Parents, teachers, Elders and service providers identified emotions as core for understanding rural Mi'kmaw youth mental health. Elizabeth, a parent, included four dimensions of a wholistic understanding of rural Mi'kmaw youth mental health. She included emotions and talked about how she perceived the four as one.

Well, mental health is part of the four aspects of your being - physical, mental, emotional and spiritual. I see it as one aspect. But it encompasses the state of wellbeing for any person.

Carey, another parent, was an informal resource for youth from Mimikeyj. Youth came and talked to her when they needed someone to listen to them. She associated poor rural Mi'kmaw youth mental health to "*losing your mind*". "*Losing your mind*" is the antonym to an Elder's description of mental health being "*when your mind and your thoughts are clear*". Although she identified physical aspects of wellbeing, emotions

were prominent in her understanding of rural Mi'kmaw youth mental health. Carey was explaining how youths' emotions are core to understanding rural Mi'kmaw youth mental health based on her conversations with youth who came to talk with her. She explained;

Losing your mind, you know, with everyday living. It could be physical, emotional. Mostly emotional though about mental health. Carey

One teacher presented how Mi'kmaw youth mental health was an inherited trait. The "it" this teacher referred to was mental health, and for her it involved emotional wellbeing.

I think it means emotional wellbeing, whoever it is we're talking about. Mary

One Elder presented her understanding of depression similar to how youth presented depression, and that this could lead to suicide. Her understanding of depression was situational more so than a pathological entity or an inherent trait.

Well, their mentality. They go under stress and then they deal with so much that they become depressed and suicidal after. Margaret

Although the adults in this study identified that emotions are core for rural Mi'kmaw youth mental health, the service providers described the emotions youth were experiencing more than the other adults in the individual story sessions. Cynthia, one of the service providers, acknowledged depression and anxiety.

And between like depression and I think anxiety. Anxiety is another big thing for our kids. It could be many reasons for anxiety - out of their community, away from their family, not comfortable in school systems, not comfortable in public.

Cynthia elaborated more on the emotions she was witnessing in her practice.

But it just seems like depression is becoming more [of a] trend from what I'm seeing. And I think it could be situational, it could be, you know, their life experience. I'm not sure.

Although Cynthia discussed emotions in relation to rural Mi'kmaq youth mental health, she referred to a broader understanding in her story.

Emotionally, mentally, spiritually. Like you know, we look at the wholistic approach. If those are healthy, that it will be a healthier place for our youth.

Kim, another service provider, elaborated on depression and linked it to the tragedies that some youth may be experiencing in their lives.

I think just the feeling of depression, in amongst all... Like in amongst the tragedy that they have in their life, right.

Susan spoke of parents referring children to her because their child was depressed.

And then, you know, they'll come to me because their child is depressed.

In their individual stories, many adults, like the youth, discussed the importance of having youth express their emotions. For example, Carey, the parent who is an informal resource for youth in the community, explained;

Yes. Or they're seeing abuse with the parents. You know what I mean? And they don't have no one to talk to or, you know, just to vent out a little bit too. I mean like it could be a big impact on especially suicides.

What Carey meant by a “big impact” is youth who may have witnessed suicide or abuse could be affected emotionally as she describes in the next quote, and youth need the opportunity “to vent”. She went on to explain how youth may develop an “I don't care” attitude if they are hurt and do not express their emotions.

Like oh whatever, I don't care. You know? They don't know how to express their emotions. They figure oh well, oh, yeah, whatever. You know what I mean? But that's just a sign of a little bit of hurt too but they just don't know how to express themselves.

Another parent talked about the suppression of emotions, and the importance of expressing emotions, like he was able to do when he was a youth;

But there's no emotions behind a conversation anymore. You know, there's no body language. So your expressions are being kind of suppressed. You don't express them much. And when you do express them, they're uncontrollable. Because again, back in the day, that was our main source of communicating. We'd sit there and we'd talk with our parents and we'd talk with our grandparents. Matthew

One of the teachers who witnessed youth “acting out”, or misbehaving in the hallways by name calling and teasing other youth attributed the misbehaviour to youth keeping their feelings “bottled up inside”. She explained;

Whereas before, like people used to keep stuff bottled up inside. So we had more issues with aggression and like acting out and turning to drugs.You need to express how you feel to be in a healthy state of mind. Andrea

Margaret, an Elder, discussed how important it is for youth to express how they feel and how she was conscious of this with all her children; *I always asked them how their day was.*

This service provider also identified the importance of talking;

And I'm thinking, what's so wrong with talking to somebody? They'll feel so much better. And usually they do. They'll say, "I don't have to carry that alone anymore," after talking. Susan

Emotions were understood as an integral part of rural Mi'kmaw youth mental health by the adults. Like the youth, the adults explained the need for youth to express

their emotions. Some of the adults emphasized emotions as a core aspect of rural Mi'kmaw youth mental health whereas the youth emphasized how actively being mindful and self-aware was core to their wholistic understanding of rural Mi'kmaw youth mental health.

Being Proud of Who They Are

In the individual storytelling sessions, the adults described an aspect of understanding rural Mi'kmaw youth mental health in relation to self-esteem, sense of belonging, and feeling proud of who they are particularly as a Mi'kmaw person. They suggested the need for youth to think positively and to make good choices because this contributed to the promotion of a healthy identity.

This mother of two adolescent youth explained her understanding of rural Mi'kmaw youth mental health which was related to youth not loving themselves or respecting themselves;

They don't have respect for themselves. They don't love themselves. You have to bring back the teachings. Elizabeth

The teachings Elizabeth referred to are the seven sacred teachings; love, respect, wisdom, honesty, courage, humility and truth. She claimed that these teachings are not shared as much today in Mimikey because they were not taught or practiced in the residential schools and passed down from generation to generation. She referred to these seven sacred teachings as necessary for the youth to live their lives well, and was concerned that youth are “*missing the pieces*”. She explained;

They give them a lot of information on how to, you know, live a good life and to be alcohol-free and to look for outside supports and all but those are only words. You need those actions and you need that support. You need to feel that. It's a feeling. It's something that happens to you when

you're there. It's something that's spoken to you and then you're supposed to feel that some other time, I don't know. And then you feel it, you do it and you live it. They're missing some pieces there. And I think that's a lot of what's happening with our youth. They're missing the pieces.

Although some of the youth in Mimikej may be familiar with the seven sacred teachings, Elizabeth observed that the youth do not live by them. Living life well was not associated with worldly possessions but with the seven sacred teachings. She claimed the seven sacred teachings should be witnessed in words, actions and support, and that youth may know them intellectually but not affectively or experientially.

Andrea, a teacher, articulated that as the youth get older they do not feel as valued by their parents and community. For example,

I think the problem with the youth is as they get older, they start to feel less important, not only to their parents but to people in the community as well.

Another teacher explained that youth mental health starts with being proud of who they are and that self-esteem is an important aspect of mental wellbeing;

Where it starts? With the low self-esteem, not being proud of where they're at. Ellie

Maxine, a service provider, also referred to self-esteem when she expressed her understanding of mental health of the Mi'kmaw youth in Mimikej.

And the self-esteem issues, if they could be directed, it would be great.

Maxine elaborated on the self-esteem of youth as she explained rural Mi'kmaw youth mental health. She explained that youth need to “*feel good about them-self,*” and feel important, and that this builds confidence and contributes to youth wellbeing.

Maxine stated;

I think wellbeing is more of a generalization of, you know, that feeling good and that feeling important, and knowing that you are significant and you can do things that you apply yourself too. But overall, it's just, you know, it's feeling good about yourself.

Maxine also discussed her understanding of Mi'kmaw youth being lost. Maxine had a young child so she referred to her baby in this explanation as she talked about the importance of Mi'kmaw youth knowing who they are, and knowing about their heritage, about the past and the present in relation to being Mi'kmaq. She explained that Mi'kmaw youth need to be proud of the history of their ancestors and that Mi'kmaw identity is rooted in family and Mi'kmaw traditions.

You know, the feel good and the knowing and the being part of something and having a belief. And a lot of people are lost. They don't know who the hell they are. If you don't know who you are, where are you going? What are you supposed to do? What's your purpose, you know? And it contributes to that ambition. And I want her to know who her grandfather was and all the great things he did, and why he did all those things. And you know, some day I'd like her to say okay, mom, I want to go to a sweat. Mom, I want to go to a shake tent. Or they're having a ceremony for this, can I go?

The ceremonies, sweats and shake tents are a part of Mi'kmaw traditions that were outlawed up until the last part of the century (RCAP, 1996). Later she mentioned that if her child chose not to be traditional that she would be okay with it; she stressed that youth should learn and have choices.

But she can learn about Jesus or she can learn about Glooscap. Both preferably. I support both. But ultimately it will be her choice what she wants to do.

Glooscap (Kluskap) is an important historical figure for the Mi'kmaw people. He was a mythological hero featured in many legends and early recordings of the history of the Mi'kmaq. The stories are adapted to local circumstances and speak to the past, and the

traditions of Mi'kmaw people that predate the arrival of other cultures by thousands of years (Sable & Francis, 2012). The importance of the past and how it relates to the present was something Maxine referred to when she identified what was missing for the youth. She described how youth should learn about Mi'kmaw ways of knowing and to be proud of their history and traditions. She realized she was not involved with understanding the past when she was an adolescent and wished she was more involved. According to Maxine, knowing the past would have given her a better sense of what she was meant to be. She explained this understanding in relation to her own child.

And to want to do those things and to be involved in the past. It's not only the past but it's also the present. It's important for me because I want her to be more involved than I was. And maybe she will have a better sense of where she's going and what she's meant to be.

Similar to other adults in this study, this service provider was concerned that the youth are missing something. For Susan, the missing piece was related to youth not being proud of their Mi'kmaw identity. She was concerned that youth should be feeling proud of who they are, and that they are missing something.

When you know who you are and all the struggles that our ancestors have overcome, and understand that that blood runs through our veins, and the youth have the same strength and resilience, that they have something, even if they haven't found it yet, to be proud of. We have so much to be proud about. And when you don't have that, it feels like a piece of you is missing. Or when you hear your language but you don't understand it, there's a yearning to want that. But feeling a part of something, feeling good about that, being proud of yourself, being happy.

The “we” she was referring to was Mi'kmaw people in the community and she explained that youth have the same strength and resilience as their ancestors and should be proud, but they have not found what it is to be proud of yet. Susan stressed, in her individual

storytelling session, the importance of a sense of Mi'kmaw identity as it relates to youth feeling good and feeling a sense of belonging. The "it" Susan referred to was Mi'kmaw identity.

I think it gives them a sense of belonging. And I think when you belong, I think you feel good about yourself. Like they're struggling to be a part of something. Because so many people around don't have identity.... we have identity issues. And so I think that's what that is. And I think mental health is a whole lot of things besides just what we've talked about in the brief little bit here.

John, an Elder, talked about some of the youth in Mimikey being lost and unhappy. Although he mentioned that some youth may not be living with their mothers and fathers, he was concerned that there was "a lot of different things" (which he did not elaborate on) contributing to youth being lost.

They're lost kids, some of them. Some of them, they don't have their moms and dads. You know, some of them are living with their aunts. A lot of different things. But they don't have that fun, that smile on their face

In the community open forum many adults suggested that their history and traditions are being lost. One adult explained that Mi'kmaw history and traditions may be found in research and in writings that are stored on shelves. She believed Mi'kmaw history, traditions and ways of knowing are passed down orally from generation to generation amongst the Mi'kmaw people, and many of the Elders are dying and their knowledge is going with them. She explained;

It is time to take our history and bring it off the shelf to the future. The longer it sits on the shelf the longer it will get lost.

The adults interviewed in the individual sessions, the Elder talking circle, and in the open forum conveyed that Mi'kmaq are strong because they have learned years ago to live off

the land with very few resources, such as flour and shortening and little else, and that has made them strong, built their confidence and helped them to appreciate the land. They stated how their strength and connection to the land cannot be learned through technology and books. Although the adults in the open forum did not suggest that youth should go back to the old ways, they were concerned that Mi'kmaw youth may be losing their connection to the land.

Identity was interconnected with Mi'kmaw youth mental health in relation to self-esteem, being proud of who they are, and having a sense of belonging. Some adults referred to the importance of Mi'kmaw identity. Mi'kmaw identity and being proud were connected not simply to the community today but to the history of their ancestors, their traditions and ways of knowing. The process for building their identity came from the people surrounding the Mi'kmaw youth, their physical environment, opportunities and positive reinforcement.

As Maxine explained;

Like it would be the people surrounding them. It would be their physical environment.....Their opportunities..... Their positive reinforcement. All these things contribute to them feeling good and wellbeing.

Similar to the youth, parents, teachers, service providers and Elders also suggested being positive and making decisions was a part of rural Mi'kmaw youth mental health.

Being positive and making good decisions was described as a characteristic. For example, Alan, one of the teachers, referred to mental health and thinking positively, and conveyed how positive thinking is important for decision making;

Well, I think being positive is really good for mental health. You know, it's better for making good choices too, when you think positive.

The good choices he was referring to related to not doing drugs or getting in trouble. He explained how youth could choose to be positive and could choose to be angry.

Because you choose to be positive. You choose to be negative. You know, if you're angry... I mean angry is a choice, right.

Although anger is not necessarily a choice, what you choose to do with anger is important. Andrea, another teacher, explained characteristics of youth in relation to the decisions youth make, and conveyed how some youth are strong willed, which is similar to what the youth were saying as she recognized the strengths of youth.

So for youth however, I find a lot of them are a lot more strong willed than people realize. Like a lot of the kids I work with, they have their own minds and they make their own decisions.

This service provider shared how negative thoughts affect motivation which affects how youth *live their lives*. She elaborated on what negative thoughts stemmed from, such as being on a reserve.

Because you know, if they always have these negative thoughts, oh, I just came from here, I can't do this because I come from a reserve, I don't have an education, I don't want to go to school, then they don't have the ambition and the drive to say okay, I'm going to go a step further and I'm going to go to university or I'm going to start this program.
Maxine

Not all parents, teachers, Elders and service providers referred to negativity associated with being on a reserve. For example, this teacher presented how youth may be surrounded by negativity not just on the reserve but in the media, their homes and on Facebook. She described how youth may find it hard to be positive;

The media, the news, the newspapers. They focus on negativity. And with all this negativity surrounding them, not only on the news but in their homes and on Facebook.

It's hard to be positive and to be in a healthy mental state if negativity is overruling your life. It's hard for them to be in a good state mentally. Andrea

She referred to some youth being stuck in a negative state of mind based on all the negativity surrounding them which created mental health issues;

And I think that's where mental health issues are formed from, is being stuck. Stuck in such an aggressive, negative state of mind. And it causes you to have issues with yourself. Not anybody else but you're having issues with yourself.

The adult stories provided some insights into youths' decision making as it relates to rural Mi'kmaw youth mental health. The adults' stories centered on the need for youth to feel good about who they are, and to be positive and strong willed.

One Elder referred to the youth he met in the community who have a clear mind and clear thoughts.

Well, when they say mental health, the first thing everybody thinks of, they're being sick. You know? But ...there is the good side. There is a good side when your mind and your thoughts are clear, you know. John

The adults conveyed that youth need to have a sense of identity, and more specifically, many spoke of the importance of Mi'kmaw identity for the youth of Mimikej to *live their life well*. Some adults conveyed that youth need to know and be proud of the history of their ancestors and Mi'kmaw ways of knowing, which is missing in their contemporary lives. Being positive or negative was also another aspect of mental health as revealed in the stories told by the parents, teachers, Elders and service providers. Some adults elaborated on the importance of a supportive environment instilling a sense of confidence or "*feeling good about themselves*". The teachers mainly concurred that youth have either the will to be positive, or to remain stuck in a negative frame of mind.

The appreciation of the decisions youth have to make to *live life well* are similar to the youths' understanding; however, most adults did not speak about the active mindful processes of self-reflection and self-awareness to develop the courage to be and to make decisions described by the youth. Overall, adults conveyed that identity, and Mi'kmaw identity in particular, self-esteem, a sense of belonging and being positive were components for understanding rural Mi'kmaw youth mental health, for youth to *live their lives well; Msit no'kmaq, (All my relations)*.

Spirituality and Mental Health

Some adults participating in this study shared their understanding of spirituality as it relates to rural Mi'kmaw youth mental health. Elizabeth, a parent of two teenage children spoke about a wholistic understanding of youth mental health and included the dynamics of spirituality.

I would say that they're missing a lot on their healing journey and their mental wellness, and how they can hope to heal that aspect. Which is their spiritual aspect will help heal their mental aspect and their physical and their emotional. All of these things are connected. You can't take one thing out.

Elizabeth explained how spirituality is a part of being Mi'kmaq, and that attempts by the Western world to assimilate Mi'kmaw people have impacted the spirituality of Mi'kmaw people. She does not equate spirituality to religion and highlights how religious practices cannot stop her from being Mi'kmaq.

Our spirituality is part of who we are. It's not our religion. And I can be Mi'kmaq, it's who I am, and I can practice Buddhist, Roman Catholic. I can practice Judaism. I can go to any country in the world and learn about their religion and practice those if I choose. But I cannot stop being Mi'kmaq because that's who I am. You know, I'll still be Mi'kmaq no matter where I am in the world. And that's

what I teach them to know. So that's the kinds of things that we have to teach. And it hasn't been taught. You know, we've been too busy, I think, being assimilated. We've been told to leave the reserve, go get a job, and we'll be better off blending in, you know, wherever, and just being Canadian. And everything else... I mean that's the policy forever. It's been the policy. So every program and everything that ever came here has always been funded to do that.

Another parent presented her understanding of rural Mi'kmaw youth mental health and spirituality and discussed how Catholicism is the dominant religion in Mimikeyj.

Like we're all Catholics on our reserve. We're all Catholics. But that's something that I feel, that you can't judge your spiritual way. You can't really judge who's who and what you want them to be. It's totally up to them. Carey

Carey valued spirituality and did not judge others' spirituality. She perceived traditional and catholic practices as problematic for youth. She was concerned that practices associated with spirituality could “*come back to them*” or provoke bad memories for youth if they had participated at an event such as a funeral, or drumming ceremony for someone they loved who had committed suicide. She explains;

Then it might come back to them as they were in church at a funeral or in a yard drumming outside the church or outside the road, walking up the road with the drums singing Indian music. And it might have been their loved one.

She believed it was totally up to the youth how they practiced their spirituality and others should not judge how youth practice their spirituality. Few teachers spoke of spirituality; however, Andrea, one of the teachers interviewed explained the wholistic meaning of rural Mi'kmaw youth mental health incorporating the need for help or assistance inclusive of the soul. She stated;

Everybody needs help when it comes to their health, their mind, their body and their soul.

The following quote from an Elder in this study reinforced the importance of the metaphysical;

But they've got to have something to believe in or else they'll have nothing. No matter if you want to believe in religion or if you want to believe in the culture or go to church or do sweats or do both, whatever. But you've got to do something. John

A service provider, Susan, referred to the churches and the sweats when she shared her story of understanding Mi'kmaw youth mental health. For example, she expressed concern that some youth are not practicing their faith and are struggling with this part of their lives. She, like the Elder, acknowledged it is not a matter of sweats or churches but sees the relevance of believing in something and, *"to be able to see the beauty in both"*. Susan further elaborated on being Mi'kmaq and spirituality and the need for youth to explore Mi'kmaw practices and take the opportunity to explore their spirituality.

All the things that make us Mi'kmaq. I mean our sweat lodges aren't packed but neither is our church. So I mean whatever which way that makes you feel best, either way is not being practised. So the church is empty and the sweat lodges are empty.

Cynthia, another service provider, discussed how she shared her conversations with youth about their practice and understanding of religion.

I know many of our kids, like you know, we ask them what's their religion, and it's Roman Catholic. And are you practising? "No." Like you know, are you Roman Catholic? Are you traditional? Some are saying they're traditional. Do you practise? "No." So they can identify with [which] route they want to go but they're not practising.

The following service provider expressed her frustration in youth not practicing their cultural beliefs by participating in sweats and understanding the relevance of sweats and their culture.

If someone does not believe in the Creator and all the spirits then why the hell are you going to a sweat? Are you going there for a sauna, like to exfoliate? Honestly. For a long time I didn't understand. And then I got a little older and then I started to appreciate my culture more. Maxine

Spirituality was described as important for understanding the wholistic nature of rural Mi'kmaw youth mental health by many of the adult participants. Some adults expressed frustration that the youth did not seem to appreciate or understand what they perceived as important for youth to live their life well. They described the meaning of spirituality in relation to Mi'kmaw youth mental health, that they would not push one way or another on the youth in Mimikej and, that it was up to the youth to develop their own sense of spirituality.

Community: “the connection of everybody here”

Similar to the youth, the parents, teachers, Elders and service providers talked about the importance of understanding Mi'kmaw youth mental health as relational. For example, Jeff, a parent and service provider, described an all-encompassing consideration of mental health and its interconnectedness;

My understanding of mental health; I can't say wellbeing because mental health is a broad... it's everything, I guess. It's a whole wellbeing of the body, mind, spirit connection of everybody here.....It's just a wellness of... It's the glue, I guess, that would hold everything together.

When Jeff was explicating his story, he spoke of mental health in connection with the

community. Mental health took on great importance for Jeff as he stated “*it’s the glue, I guess that would hold everything together*”. The “*everything*” and “*everybody here*” he referred to was the whole wellbeing of each and everyone in the community and their connections within Mimikey. Jeff’s understanding was abstract and he struggled with words to describe this abstract conceptualization of mental health. However, Matthew, another parent, presented a tangible detailed description of how he perceived rural Mi’kmaw youth mental health similar to Jeff. Jeff’s description referred to the “*connection of everybody here*”, and Matthew referred to the collective as he illuminated what he experienced in relation to rural Mi’kmaw youth mental health in the community.

As Matthew explained;

Mental health to me, I always viewed it as... Overall are they active in the community? Are they active people in the community, at home or with themselves as far as sports and recreation? Like a lot of times somebody would sum it up in one specific category and say, you know what, this is how I view it. But in my opinion, it’s collective amongst how our society is and how it reflects the young fellows in our community. That’s how I view mental health in our community - collectively.

The connection of the relations in the community as a major aspect of understanding rural Mi’kmaw youth mental health was described by most of the adults in the community and their stories established these relations in the context of Mimikey and family. The relevance of youths’ friends and peers were also discussed by the adults; however, the adults did not emphasize the relations of friends and peers as much as the youth did.

The adults presented more detail of the dynamics of community relations and rural Mi'kmaw youth mental health compared to the youth. Jeff shared the interplay of these relations in the following quote;

We might have, you know, ups and downs but everybody has their ups and downs. But our community comes together when it's time to come together. And they can do it. It's not individuals; it's our whole community always. Jeff

The following lengthy excerpt is from Mathew, a parent, and it demonstrates the interconnectedness of Mi'kmaw youth mental health and the community. Matthew conveyed the day-to-day life of Mi'kmaw youth living in Mimikej and the powerful influence of the collective. The boundaries he described are revealing and can be seen as positive or negative. There is power in the collective; however, as youth live their lives and make choices, some of the choices may not be in accordance with community norms. It is not easy to escape the community's watchful eye, and from Mathew's description it appears that youth may be suppressed or supported within the confines of the community;

Now, inside the community, we have... And there's lots of ways you can look at the First Nation community because what makes it a First Nation community is there's a little red line that goes all the way around it. It's called the boundary line. Some people call it the restriction line... So inside the community, our young ones are confined to small residential areas and patches..... And it's not as easy to escape conversation, subject or an event because the families are so closely knitted that their families cover all aspects of the community. Your family is everywhere. So if a young one has a problem in the community, automatically... You know, it will only take maybe 10 or 15 minutes before somebody of this part of the community knows, down here, and so on. And then they tell a couple of people, and before you know it, the community knows within the hour of what's going on.... Like I say, it has its pros and its cons. Because if it's a negative impact, bullying as an example or calling people names or something that's a personal issue, it's not a good thing. But from a safety

aspect, it's a good thing. You know, if you had somebody coming up into the community in a car that wasn't recognized, it would be very easy... You know, you're thankful for that short networkSo it has its pros and cons in that area. So a young fellow that's being subjected to lifestyle in the community, it has its pros and its cons. So when you compare it to a young person living outside of the community, those boundaries are not there.

Mathew's description may portray a restrictive perspective, in the sense that youth are under the watchful eye of community members and it is not easy to “*escape conversation, subject or an event*” which could restrict youth from developing their own sense of self. The disadvantages, for example, “*being subjected to lifestyle in the community*” may be problematic as youth develop their sense of self which may not be in keeping with the values of the community. Further, Mimikej is close knit, everyone knows everyone, which could be problematic with respect to confidentiality. He does refer to the benefits, or the protective elements; for example, safety and “*knowing who is in trouble*”. Overall, Matthew's description conveyed the uniqueness of First Nations' communities. He referred to the red restriction line as symbolic of First Nations peoples and the restrictions are not necessarily imposed by community members but by policies and agencies that control the community through the Indian Act. Although there are restrictions, Mathew summarized his notion of community connectedness by explaining;

So in short, I'm saying that, you know what, we share community values that are all recognized by almost 100% of our community members.

Although Matthew claims the community shares values that are all recognized by 100% of community members, the values are implicit and ever changing. For example, an Elder in the talking circle explains her perspective of a value that she perceives has changed over the years.

But we were never rich. We never worried about what other people had. We all shared too. It was nothing to go ask somebody for a bowl of sugar that you never paid back. Because this person is going to come back to your house...

But now if you borrow sugar, my god, they'll go 20 miles up to tell their neighbour, they're bumming. Oh, that makes me mad. [Laughs] Talking Circle with Elders

Although some adults in this study understood values in the community are implicit and evolving, they also explained the importance of community dynamics and Mi'kmaw youth mental health. As Carey explained;

Because really, you know, it's what's on the reserve and who you're around the reserve, that's your reserve. That's your community. It takes a community to raise kids, to raise children.

Carey elaborated on the uniqueness of Mimikej;

Because we have a big reserve but our reserve is small enough for everyone to know everybody. We're all one big family really when we come down to it. Even on some other reserves. I find you go to different reserves and you ask them where does this person live, and they're like, "Who are you talking about?" You know what I mean? But I find in our community that everybody knows everybody.

Another parent was more concerned about the political structure within the community.

She explained that the context and the politics in community affect the youth.

Looking at the structure of our communities, you know, the political. How the politics affects so much in people's lives. Whether they get a home, whether they get a fridge or a stove, whether they get things that they need, oil in their furnace tonight, a lot of that is based on who you know, who you vote for, your loyalty towards those things. And regardless of what's going on around you. And it's really sad. You know, people have had to go without. So it's that kind of mentality that I think our youth...that affects our youth. Elizabeth

The teachers in this study focused more on Mi'kmaw youth mental health and parental relations than community relations, however, they did believe events in the community contributed to rural Mi'kmaw youth mental health by promoting their confidence.

Where like I think they need more programs for the kids and to give them confidence. And I think that will help with some of the issues that they're having mentally. Andrea

The Elders spoke of how the community works together to try and establish activities for the youth. These activities helped to create connections with the youth and the community. For example,

We try everything. Like there's a lot of people that get involved with the kids. They've got the baseball teams, they've got the hockey teams, and everything else. John

In their explanations of rural Mi'kmaw youth mental health, the service providers conveyed how the community is “a big part of who they are”. For example,

For kids that are raised, in particular when you think of [Mimikej], this is what they know. This is their home, this is their roots, and their family is everywhere. You know, they have an auntie down the street. They may have a grandparent. It's such a big part of who they are. Kim

A disconnect of relations in the community, is the intergenerational gap in understanding between Elders and the youth in the community as shared by a parent in her individual story. Although formal education was one of the goals of the Residential School experience, the Regional Health Survey (RHS) (2002/2003) maintained that few who attended the Schools acquired anything but the basic academic skills. Certainly, many who have attended residential schools have gone beyond the basic academic skills

over the years, however, this parent shared the significance of education historically and how it has impacted relations with the youth today.

Back then, they weren't educated as good as I was or the kids are now and the kids that are growing now. You know what I mean? And I think that's probably really the fault of it, is the education and how they were taken away all the time. Carey

Carey was referring to how the youth are being educated in the school system better than the Elders who were taken away to residential schools. She communicated the fault is that Elders in the community were taken away to be educated and may not have the same education as the youth today, so there is a gap in this aspect of their relations. Some of the youth referred to Elders in their accounts and acknowledged that they would seek out Elders in the community to learn from them, and they valued the wisdom of the Elders' lived experience; however, as this Elder explained, it is difficult to talk about some aspects of the past with youth today.

But you know, it's a different thing. Like I can talk about alcohol and drugs, cooking. I can talk about anything. But I can't talk about the residential school because of the hurt and pain. Talking Circle with Elders

All of the adult participants' broad explanation of Mi'kmaw youth mental health led to stories of how mental health can be viewed as relational. The parents, teachers, Elders and service providers, the Elders in the talking circle and participants in the open forum discussed the community in context of Mi'kmaw youth mental health. Their stories illuminated how *living their life well; Msit no'kmaq (all my relations)* and many of the aspects of community life, past and present are interconnected with rural Mi'kmaw youth mental health.

Family: “They Start and End Their Day at Home”

Similar to the youth, the parents, teachers, Elders and service providers referred to the importance of family in relation to rural Mi’kmaw youth mental health. The adults referred to youth and family relationships and the effects of the Indian Residential School (IRS) experience on family dynamics which was not found in the youths’ understanding. They discussed how family is instrumental in promoting rural Mi’kmaw youth to *live their life well*. As this service provider explained;

It needs to start at home. Because I don’t know, it doesn’t matter if you have it in school or if you have it after school, where are they spending the majority of their time? They start and end their day at home. Maxine

Earlier in her storytelling session, Maxine referred to the support and positive reinforcement youth need to promote mental health and the “it” she is referring to here is an extension of her explanation of where the support and encouragement should start. She stated the importance of the community environment is crucial yet ultimately the home environment is particularly important for youth as they *live their life well*.

In most of the sessions with adults, family relations were explained in the context of how mental health is hindered. This parent identified how youth do not learn how to *live life well* in families that have had disruptions. She referred to how families were “*broken up*” during residential school. The “it” she referred to are the seven sacred teachings as she had explained in her interview initially. She was concerned families in the past were broken up because of the residential experience and that families were not able to pass on their knowledge orally from generation to generation.

It’s just something that we weren’t taught growing up in the residential schools. It’s not something we were taught even in our broken up families. Elizabeth

This teacher presented an association between youth who are neglected or misunderstood, and the youths' parents or grandparents past abuse.

And I think that a lot of that stems from past abuse. Not abuse on them but maybe abuse on their parents or grandparents or the way they were raised. I find a lot of kids are neglected or misunderstood. Andrea

Another teacher referred more specifically to the vicious cycle of abuse in relation to the IRS experience and some families.

The adults that live with it, that were abused, they're still here. And their mental health regarding that abuse issue has not been addressed in any other way except a conference at residential school. And not just them but they came home from residential school and that's all they knew. Who did they abuse? Their women, their children, their cousins, babysitters, kids abused other kids. You know, it is a vicious circle. Mary

This teacher did not talk about the influence of the IRS experience and parenting, however, he spoke about the support Mi'kmaw youth need from their families. He explained;

I think they need the support at home. I think they need structure. And I find a lot of kids don't have that structure at home. Alan

This Elder described how the past IRS experience has impacted Mi'kmaw youths' way of living in the context of the values of love, respect and caring, and how these values influence the youths' relations with parents, including extended family members. He explained;

But I think the residential school survivors, there's a big difference because their kids were taken from them and they didn't learn how to bring their kids up. And while the kids were in the residential school, they weren't taught how to bring children up.....And that's the whole thing. You know,

love, respect, caring for one another and all that, you don't see too much of that. John

Although John was explaining the effects of the IRS experience and parenting, later in his story he did acknowledge that there was love out there. He stated;

We have to open their eyes and let them know there is good things out there, and there is people that love you guys.....

All the Elders spoke of the need for youth to have support from their families.

Margaret, another Elder, described her parenting. She was involved with her children's lives and was concerned because some parents today are not as involved with their children. She stated;

The children here need support from their parents.

She went on to explain;

I raised 12 children and they are all working and are independent. I was always involved with their lives, I always asked them how their day was.

This service provider referred to how the parents of the youth are still grieving from the residential school system, or have other problems in their own lives, and still need to heal as their grief affects the youth.

If I look at the kids who have either committed suicide or they're at risk, showing some mental health, like they need their families to be healthy. And when I look at them, I see their family members that are struggling with depression themselves, struggling with grief, struggling with addictions. Kim

She knew the families and extended family members of the youth she was working with, and she presented a connection between the poor mental health of youth she was working with, and family members that were grieving. Although the youths' parents in this study may not have gone to a residential school, the youths' grandparents

may have. Some service providers did not refer to the IRS experience but did refer to family dynamics and rural Mi'kmaw youth mental health in Mimikej. For example,

I can't see how a kid is going to overcome everything when they come home and, you know, their aunts and uncles are having addictions. And obviously you can't talk to that person. Cynthia

Cynthia was not referring to the past experiences of the family, but the problems some youth have with families who are drinking and how some youth cannot talk with family members if they need to talk when they come home. All the adults in this study explicated how important family life is for rural Mi'kmaw youth mental health. They stressed the relevance of families and rural Mi'kmaw youth mental health. Although the adults spoke about the negative influences of family, many of the youth in this study recognized how their family contributed to their mental wellbeing. Adults spoke of the impact of the residential school impeding the values of love, respect and caring as well as the concern that some families are grieving because of the IRS experience. Although the youth participating in this study did not explicate these aspects as it related to their mental health, they described how “*some families are broken*” and the importance of family for *living their life well*.

“Youth Helping Youth”

The adults described a similar understanding as the youth participants of how friends and peers in the community are interconnected to rural Mi'kmaw youth mental health. The adults expressed more emphasis on family and community than friends and peers; however, they did discuss the importance of friends and peers in connection to the mental health of youth in the community.

Some of the adults presented how the friendships youth have in the community are important and the commonalities youth share with each other helped them relate to each other. For example, this parent explained;

Because the youth can talk to the youth in their own language, their own lingo sort of deal, right. And it's something that gets through. Jeff

This Elder perceived youth helping friends and peers as beneficial. He believed this relationship was relevant for the mental health of youth in Mimikej. He added that this would have a positive impact on the other youth wanting to help each other.

And we have the youth helping the youth. That's what I like. That's what I like to see because I think when they see their friends doing that, they want to do it. John

Other adults did not discuss the importance of youth helping other youth but did present their perspective of the bond youth have with other youth in Mimikej. For example, this service provider explained;

But they still want to be in their own communities because they have the friends that they grew up with. Kim

The adults' explanations centered on the relations youth have with each other in the community but they did not stress friend and peer relations as much as the youth did.

Summary

Many parents, teachers, Elders and service providers spoke of pride, self-esteem, a sense of belonging and feelings of depression in their understanding of rural Mi'kmaw youth mental health. One service provider also talked about anxiety. Emotions were core to the adults' understanding. Identity and feelings were connected to youths' positive and negative thoughts and decision making which influenced Mi'kmaw youth mental health.

A most noteworthy distinction is that adults did not identify the arduous labour of self-

reflection and self-awareness in coming to know oneself, and the courage to be and make decisions as described by the youth.

Although adults did not talk about physical aspects connected to mental health, some adults conveyed how spirituality is a part of a wholistic conception of rural Mi'kmaw youth mental health. Most adults did not stress friends and peers as much as the youth explained in connection to mental health, however, youth and adults all talked about the relevance of family and community for understanding rural Mi'kmaw youth mental health. Some adult participants referred to the IRS experience as interconnected with rural Mi'kmaw youth mental health, particularly with respect to the wholistic nature of youths' identity and emotions (not feeling proud of who they are), and spirituality (not being familiar with Mi'kmaw beliefs). They also talked about how the IRS experience impacted family relationships, parenting and the community of Mimikej. All the participants in this study, youth and adults alike, shared an understanding of Mi'kmaw youth mental health as *living their life well; Msit no'kmaq, (all my relations)*.

Chapter 7 Navigating, Negotiating and Creating a Sense of Self

Navigating, Negotiating and Creating a Sense of Self represents the active journey of individual rural Mi'kmaw youth to *live life well* in Mimikej. The arduous interactive journey, as depicted in Figure 2 (p. 110), and described in Chapter 5 illustrates the strands extending from the tree, which represents how youth navigate, negotiate and create a sense of self. The path is not linear, but dynamic and wholistic, and the youth do not always walk it alone. In this chapter, I describe the topography of their journey and the facilitators enabling Mi'kmaw youth to make decisions, as well as the contradictions and tensions youth encounter on their journey. The chapter is comprised of the following subthemes: 1) the complexity of a trusted listener, 2) supportive/ unsupportive relations and role models, 3) community events, 4) leaving the community, 5) becoming sidetracked with drugs and alcohol and, 6) youth and suicide. Many youth and adults shared similar perspectives about the journey; however, I delineate youths' perspectives followed by adult participants' explanations to identify the distinctions. Explicating these distinctions may contribute to bridging the gap between generations, and inform future priorities for promoting rural Mi'kmaw youth mental health.

This chapter builds on the first research question of understanding rural Mi'kmaw youth mental health, and provides a foundation for the second research question: What actions are needed to support mental health promotion of Mi'kmaw youth living in a rural community?

The Complexity of a Trusted Listener

All the participants described how important it is for youth to have someone listen to them. The purpose of listening, the processes, and the issues as identified by the youth

are presented first. The adults talked mainly about the purpose and the process which will be presented following the youth participants' explanations. The characteristics of the listener were described diversely and were not dependent on whether the participants were youth, or adults, or what role the adult played in the community. In other words, service providers did not emphasize that youth needed to talk with a therapist. The most important purpose of the trusted listener was to "*just listen*".

Youths' perspectives: "opening up to someone else". In the individual storytelling sessions and the talking circles an overriding aspect that youth discussed was the dynamics of a trusted listener in their journey to *live life well*. What the youth spoke about in their individual storytelling sessions was supported in the talking circles and conveyed the complexities of having a trusted listener. The following sections focus on the purpose, process and issues as described by the youth.

Jennifer, expressed the sentiments of most of the Mi'kmaw youth participants in their journey of *living life well* and having a trusted listener.

Anyone you feel comfortable with. Because if you don't talk about it, eventually it's just going to eat you alive basically and hurt you even more.

This quote from Jim supports the value he placed on talking with someone.

Well, if they just opened up with other people and talked with someone. Because I believe not many people know how it feels to open up to somebody else.

Although Jim did not think other youth knew how it feels to "*open up*", other youth in this study expressed similar sentiments as Jim on the value of talking with someone. For example, Debbie discussed who she confided in.

I know I could talk to my mom and my aunts and uncles and my friends if I wanted to.

Recognizing their own emotions and the process of sharing their emotions was stressed as important for *living my life well* by most of the youth participating in individual storytelling and talking circles. One youth, in talking circle #4, explained how she perceived talking with a dog as therapeutic. Although she did not have a dog, and did not participate in this therapy, she shared how it may be “*cool to have a therapy dog*”.

I went to [a university] this weekend, and they have a little therapy dog that comes in every Thursday. And it's called Cuddle with Oscar. And they just like go in and like I assume just talk to the dog. I don't know. But like the owner lady said that everyone was really iffy about it at first but it's been helping a lot of people. Like it would be cool to have a therapy dog.

In this talking circle, she was suggesting the importance of having a trusted listener. Another youth interrupted and said; *I talk to my dog*. The youth in this talking circle were conveying the importance of letting their emotions out by talking. The need to talk about their emotions was a dominant discussion in the individual storytelling sessions and talking circles with youth. They discussed who they talked with, for example, friends, family, and for one, her dog, and the importance of talking.

Youths' perspectives: “someone I know and trust”. The youth participating in this study talked about letting their emotions out, or having a friend, or mother, or an adult person whom they could confide in. Many stressed the need for the conversations to remain confidential and that the person listening was trustworthy.

I don't know, I think I'd be comfortable talking to someone I know and trust. Talking Circle #4

Todd, similar to other youth in this study, referred to how it was his mother that he was most comfortable talking with;

Oh, she's there when I need someone to talk to. I tell her everything.

The significance of being most comfortable talking with his mom is similar to what other youth participating in this study conveyed. A few youth in the study did discuss formal resources. For example, Jim was referred for counseling outside of Mimikej. He spoke of the counselor who he had seen, and how she helped him. He stated the counselor helped, but he felt more comfortable with his friends and people who were “*native*” or who knew him well.

And I seen her for about 4 months on and off. She really helped.

Jim stated that people who knew him helped him the most, as they could connect with him and understood his lived experiences in the community. Although it was easier for him to talk with them, he acknowledged the counselor outside of Mimikej did help him.

The emphasis on the need to talk with someone who could connect with youth and their lived experience was conveyed by most of the youth in this study, and many youth preferred that the listener was someone from the community. A few youth explained that a person trained to respond to anything they shared made it easier to talk. For example, this youth disagreed with other youth in talking circle #4, who stated the listener should be from the community.

Like she wouldn't talk to people that weren't like from the community or something. Well, like I've had a therapist that I went up to [town outside of Mimikej]. And I found it really easy to talk to her because she like knew how to react to anything because she was trained to do it. Like at first I wasn't comfortable talking to her because I didn't know her. But after a while, it like got easier to talk to her because you built that trust.

She identified that a therapist outside the community was helpful, and the important aspect of the relationship was that the therapist was non-judgmental and that for this youth it took time to build trust. The abilities of a professional were acknowledged by some of the youth. They consisted of being non-judgmental, trustworthy, that the professional maintained confidentiality and could relate to their situation. For example,

But like if they're professional, like it's their job. Like it's confidential. And like you know for sure it's going to be..... And I just would have to gain trust before I tell them anything, like let them know my whole experience. And like [Samantha another participant] said, she feels safe in the community because she grew up here. But I feel that way too but also I've grown up like leaving the community, not being on the community. So I feel comfortable doing both. Not just staying in the community. Talking Circle #4

For some youth it was a problem to talk with someone from outside the community, however, as the youth in talking circle # 4 identified she was comfortable talking with someone outside the community, and suggests that part of the reason is that she has not always lived in Mimikej.

A few youth did state the benefits and appeal of talking with professionals. For example, Jennifer wished she could have spoken with a professional when she was depressed. She explained;

Because most of the time they have a better understanding of it rather than your family or friends because they have the right to judge you at any moment.

The” it” she was referring to was what she was going through when she needed help. The concern that family and friends have the “*right to judge you at any moment*” was identified by many youth participating in this study. For example,

People that won't make fun of you or judge you or anything like that you can trust. Leah

Leah discussed who she could talk with and the importance of knowing the person;

.....but there was this one teacher that I would talk to because I've known her for a while and she was really close to my family. And like I would talk to her but I wouldn't talk to the counselor because I hardly knew her. And then like I'd feel like they would be judging me. I know they probably wouldn't but I'd feel like it. And I'd feel like I was doing something wrong or something, and then I just wouldn't... I don't know.

Leah emphasized the importance of being able to talk about what was bothering her (I cannot identify what it was for confidential reasons, and only state that it was not related to harm to her or others). She also identified some of the same concerns that were expressed by other youth in this study including the importance of the listener being someone she knew, and the fear of being judged.

In the individual storytelling sessions a few youth also described healing circles¹² as helpful. Jim explained the benefits of being able to express his emotions in a supportive environment, as well as sharing his ideas with others in a healing circle. The importance of not being interrupted if you have the stick was identified, and another important consideration that Jim expressed was that in the healing circle you had an option to pass, if you did not want to talk.

Like he'll [the facilitator will] get a mixture of grade 9's to grade 12's to come in, have a mixture of everyone there, and we all just talk. And whoever has the stick, like whoever has the stick is the only person who is allowed to talk. And some people just open up and some people just pass.

¹² In the literature there are distinctions made between different talking circles; sharing circles, healing circles, sentencing circles, talking circles and spiritual circles (Kirmayer, Whitley & Fauras, 2009) Here I will use the term healing circles to differentiate between the talking circles I conducted for this study and use the term healing circles to refer to talking/sharing/healing circles described by the youth.

In the talking circle sessions in this study, youth confirmed the value of healing circles. Sharing emotions was an important healing process for this youth as she explained the benefits of healing circles.

And even after our first healing circle, it made a lot of improvement. And since we've been doing the healing circles, we talk and we listen. And we hear how other people feel. Not everybody has the same feelings. No one's feelings are the same. And you can't know someone's feelings unless you listen. Talking Circle #4

Further she stated that healing circles were not so much for the purpose of expressing emotions, but for the purpose of mutual learning including how others handled situations in their lives. This youth also expressed that she was not concerned about confidentiality with what was said within the circle.

Personally, I think the talking [healing] circles help a lot. I don't really think it matters who's there because if something happened to you and then it happened to someone else, and they hear your story.....Like someone hearing your story and just storing it away in their memory will help them in the long run if they need to. And sometimes, like how these guys were saying people are hearing, like they don't want people to know their business, like that really doesn't bother me any.

Conversely, some youth were not as comfortable with healing circles as this youth explained;

I feel like I would feel more comfortable being one-on-one with someone. Talking Circle #4

While there were common characteristics in youths' descriptions of what constituted a trusted listener, there was variability in who they thought was best suited to fulfill this role. All youth wanted to be able to share their emotions and concerns with someone they knew, and trusted and could understand their lived experiences in Mimikey.

A trusted listener would maintain confidentiality and be non-judgmental and just listen. Healing circles were presented by some youth as instrumental on their journey to *live life well*, however, some youth preferred to have one-on-one interactions with a trusted listener from the community and others valued a professional. One single counselor in the community, or outside the community, would not meet the needs of the youth in Mimikej. Based on the youth's descriptions, a multifaceted approach inclusive of many different options is needed.

Youths' perspectives: "there should be an option there". Youth in this study expressed the need to have a trusted listener; however, they identified some ambiguities related to the process of talking with someone. The options they described for a trusted listener reinforces their commitment to a sense of personal autonomy which they described in their understanding of mental health. For example, the youth conveyed that they should decide who, when, or if they should talk with someone. Although confidentiality, trust and being non-judgmental are issues that youth identified, they also presented concerns, opportunities, and the need to have choices for who they talk with.

The majority of youth referred to the significance of friends listening to them and how important talking with a friend was. However, from another perspective, some youth, who were the listeners, were afraid they would say the wrong thing. As Debbie explained in her individual storytelling session;

Well, most of us usually just talk to each other and we kind of just like... But some of us, that wouldn't be okay because some of us wouldn't know what to say, and they might say the wrong thing. And then that wouldn't be good. Because like if someone was coming to you and talking to you about like suicidal problems, and you had no idea what to say and you accidentally said the wrong thing and they ended up

like doing the worst thing. And then you'd have to live with that.

Leah, in the individual storytelling sessions also talked about being a friend who listened to her peers who needed help with issues they were dealing with. She explained that although medication was perceived as helpful for some youth who were struggling with mental health issues, the importance of having someone to tell “*what you really want to get off your mind*” was seen as necessary.

I don't know. I guess I would tell them to go see a doctor because it's not all... I don't know, they can give you medication for it and stuff but it's still going to be there. So you could talk to them and try to help them as much as you can.

The youth in the talking circles confirmed the concern Debbie described of not knowing how to respond to a friend who had a problem. For example,

If someone came to me and they had problems, I wouldn't know what to say. I'd be way too scared to say the wrong thing. Talking Circle #2

Some youth stated they would refer their friend to someone else. For example, this youth named an Elder (a pseudonym is in this quote to maintain anonymity of the Elder) in the community that she would send someone to if she knew a friend was addicted to alcohol;

Well, I would send them to [Wes]. I really would. I've known him my whole life. I trust him with my life. Talking Circle #3

Another ambiguity was that some youth spoke of resistance in talking with formal supports from the stance of not wanting to acknowledge that something was wrong, and they would be embarrassed;

But most times, people, they would be embarrassed because they feel like they're different. Talking Circle #4

In the talking circles, youth elaborated more on the problems associated with sharing their emotions in the context of their lives in Mimikej. For example,

So with someone you know, like you never can be too sure because on a reserve, everybody knows everybody. And a lot of the time, everybody knows everybody's business. So word gets out very quick. And I just would have to gain trust before I tell them anything, like let them know my whole experience. Talking Circle #4

The problems associated with sharing their emotions were focused on who they could know and trust, the need for confidentiality, and feeling embarrassed. Most youth participating in this study also spoke of the importance of talking based on their own accord and not being told they had to talk with someone and “open up”. This youth in talking circle # 2 explained how she would not open up if she was told she had to talk with someone;

My dad called one of them and made me talk to them. I didn't talk to them. Teachers had to force me. They said I had to go to anger management. I didn't go. I sat there and just nodded my head and said yeah, no.

Another male youth in the same talking circle expressed similar sentiments;

You see, if I knew that I had to talk to someone to open up, I wouldn't do it. Talking Circle #2

All the youth in the individual storytelling sessions and talking circles for this study expressed the benefits of having a trusted listener in their journey to *live life well*. Only a few mentioned that if they had problems they would like to deal with them on their own. For example,

I wouldn't want to personally talk to someone. I guess my problems are my problems. Talking Circle #2

A tension in this finding as presented by some youth participants is that there is strength in dealing with something alone. For example, this youth explained the contradiction in one of the talking circles;

I agree that maybe yourself is the only person that can help you but I think there should be an option there still. I don't think it should be like someone that you don't know. Or like everyone said, the guidance counselor thing, that doesn't work. No one goes to a guidance counselor. Well, some people do but no one goes and says what they're actually feeling. They might say the other layer but they're not going to say their deepest layer, what's going on. But if you have that option, at least you know you have that option. And if you don't want to go to that option, you do have yourself. And that will make you dig deeper down in yourself, saying I need to fix this or else I'm going to have to go talk to that person. And then you actually might get it fixed. Talking Circle #3

This youth, in talking circle # 3 was agreeing with another youth in the circle that it is up to individual youth to help themselves. However, he did acknowledge that it is important to have an option of seeking help. Further, although he indicated many youth would not explore their deepest feelings with a guidance counselor, another youth in this same circle volunteered that she went to the guidance counselor at her school.

Like I myself, I'm one of those people that go to the guidance counselor because I don't know who I can trust around here. That's just me. Like the one person that I could trust at home, he died.

“The one person that I could trust at home” reaffirms youths’ explanation of a trusted listener. In other words, although some youth did talk with family members, they did not “open up” to just any member in their family; rather they talked with a member they could trust.

The incongruity that some youth participants presented was the understanding for youth to try and solve their problems on their own, and the acknowledgement that having a trusted listener was important to them. The drive for youth to initiate the conversation with a person they could trust, and a person they chose, was countered with a desire to deal with their problems independently. As this youth in another talking circle explained;

It's not going to help them unless they want it to help them.

Talking Circle #2

The “it” she was referring to was talking with someone, and the essence of her statement is that the motivation for help would come from within the individual youth.

The youth participants revealed that the role of the listener was mainly to be available for the youth to express their concerns or feelings, and not to advise them in their decisions.

The paradox was that all the youth participating in this study described a fundamental understanding that Mi'kmaw youth needed someone to listen to them; conversely the nature of the relationship was the listener did not provide solutions but mainly listened.

There was a tension identified in the findings that youth should be able to solve their problems on their own, and the listener's main focus was to be there for the youth.

Adults' perspectives: “It really does help.” The adult participants in this study discussed the importance of youth having someone to talk with. The adults talked mainly about the need for youth to talk. The parents, teachers, Elders and service providers' stories reinforced what youth were saying with respect to the importance of trusted listener, however they did not provide similar perspectives in relation to who youth should talk with. For example, this teacher talked about the importance for youth to express how they feel. She explained;

Expressing how they feel when they feel it. And then once they get that off their chest, I think they don't realize that once it's off their chest, they feel so much better. Andrea

At the end of her interview she concluded;

Like it really does work when you have somebody there to listen or to talk to and stuff like that. It really does help.

Another teacher spoke of youth needing to have someone to talk with if there was a concern of disclosure of sexual or physical abuse. In her individual storytelling session, she conveyed that she did not know how prevalent sexual abuse was in Mimikej. When Mary presented her story, she referred to a friend who was thankful for Elders in the community she could go to, and although her friend attempted suicide many times as an adolescent none of them were “successful”¹³.

Like there is no place for that. Disclosure. It's called disclosure. So she's saying if there wasn't a few people that she could disclose to, she may have been successful.

Although no other adults spoke of the need for self-disclosure, the Elders conveyed that youth need to have the opportunity to discuss how they feel and adults should stay connected and give support to the youth. As Margaret explained;

Some kids never get asked how they feel or how's your day today? Grown-ups need to stay connected and give support.

For this Elder, the point she was making was that youth need to talk about their feelings regularly and she believed that adults should be available and should reach out. She did not refer to the “grown-ups” as the youths’ parents but spoke of adults in the community in general. Susan, a service provider, elaborated more on the importance of listening;

Just listen. And that's what a lot of youth tell me - You just listen. And sometimes I don't even say anything. They just overpower the whole session, and I'm just, “Okay,” shaking

¹³ Successful is not a term used today to acknowledge a completed suicide

my head. And they, "Oh, I feel better. Thanks." I didn't do anything. And I let them know, you know, you did it all. But that's what they crave for.

Susan emphasized that youth 'crave' for someone to just listen. Earlier in her session she explained that youth test her first by telling her something and if that something is not spread out in the community they feel confident that they can talk to her without a breach in confidentiality. She also conveyed to the youth that she would not tell anyone anything unless there was harm to themselves or others. Her explanation was similar to the other adults participating in this study, that all they did was just listen. For example, another service provider, who was not a counselor, was upset that he had to spend five hours in the tertiary hospital. In his story he was conveying that the local emergency department should improve its wait time, but his storytelling also revealed how just listening to the youth, while waiting for the doctor helped the youth.

Because the whole point ofis to have someone talk with them and listen to their concerns Right? But the doctor comes in after 5 hours, they're like, "What's wrong?" "Nothing now. We're great." Sam

The emphasis here is that it does not have to be a professional a youth talks with. Although the youth in Sam's explanation waited for 5 hours in the tertiary center, having someone listen who was not a doctor seemed to be all that this youth needed. The youth felt great after having someone listen, and did not see the need to talk with the doctor

Adults' perspectives: "someone who would not judge and can relate".

This parent explained the lack of resources in the community, the inability of some professionals to relate to youth, as well as the fear youth have of being judged when talking with others who cannot relate;

Because I find that a lot of young kids think that they'd be judged off the reserve. You know what I mean? Like especially if they're very young and they have mental issues. You know, it's not like they're crazy or anything but there's a lot of... Mental health covers a lot of other things besides. And I think that when they're 14, 15 years old, they're scared to say anything so they just keep going on and on and on. And eventually when they're 18, 19 years old, it starts to come out. Carey

Carey is explaining how youth are scared to talk with someone when they are 14 or 15, so keep their concerns to themselves, and this affects them when they are older. Andrea explained one of the reasons youth may not ask for help. She used the word “stupid” and “retarded” but explained that she was conveying words she heard from the youth, and she did not normally say these words, but was presenting another barrier to youth seeking help.

I think they feel like if they ask for help, people are going to make fun of them or tease them or consider them to be stupid or retarded or whatever. And I'm like... I don't like the word retarded. And I know I'm throwing it around a lot here but that's just because I'm using their examples.

The word “retarded” or “dumb” are labels which create a stigma for youth to seek help, and the help is not just with their school work but to express how they feel as other adults had identified earlier. Other adults interviewed concurred that Mi'kmaw youth felt intimidated and could not relate to health professionals who were “*in three piece suits and taking notes*”, as Susan, one of the service providers described. The paranoia she speaks of is similar to what youth expressed as the *fear of being judged*;

Because teens have shared this with me, that they relate to me. That many times they've gone to see counselors and they're in blazers and, you know what I mean, suit and tie, and they're taking a lot of notes when they're talking. And they say it makes them paranoid. Like what are you writing down? Just listen.

The significance of a trusted listener was discussed by all the adult participants in the storytelling sessions. The need to have someone to listen and for youth to talk to someone was conveyed as important for rural Mi'kmaw youth mental health. This parent summarized the relevance of Mi'kmaw youth in Mimikej being able to have someone they can trust and talk to because of the traumatic events in some youth's lives.

I mean like it could be a big impact or especially suicides.....And it's something that maybe on the reserve, they can have someone to just go talk to and just listen to them or just sit with them for a little while. Carey

In summary, the youth and adults emphasized the need for youth to express their emotions, and their concerns as youth strive to *live life well*. Youth spoke mostly about sharing with friends they could trust, many youth spoke about confiding with mothers, aunts and grandmothers. Some youth had positive experiences in healing circles. Some youth expressed apprehension that they would say the wrong things to a friend who confided in them. A few youth expressed how Elders were also seen as trusted listeners who had experience and could relate to them, and they would refer their friends to an Elder. Many talked about the difficulty of relating to someone outside the community of Mimikej; however, a few youth talked about the benefits of a therapist outside the community. Many youth believed they should not be forced to talk with someone; however, all the youth expressed the importance of talking and having a trusted listener available when they needed one. A major barrier to talking with someone outside the family was the fear of being judged, or perceived as different. The emphasis, as explained by the youth was, that they (youth) needed to be the ones who determined who they could talk with, and when, and the nature of the relationship was focused on enabling the youth

to express their feelings and concerns confidentially. The fear of being perceived as different, and being singled out, and being stigmatized were suggested as barriers by some of the youth and adult participants. A few adults and youth talked about the fear of youth being judged by others and/or misunderstood by *non-natives*. Others concurred that it did not matter if the person was a professional or not. For example, two adults identified that all they did was just listen. The adults presented a strong need for the youth to have a trusted listener, for example, because of concerns of sexual abuse, and the need for youth to express what they feel based on other issues youth may witness in the community, such as suicide.

In the open forum participants believed youth talked more with women because traditionally women were perceived as listeners, and acted as advocates for people in the community; however, they did suggest that some fathers are taking on a greater role with the youth in the community. They concurred that youth should be given options of whom they could talk with, and did not elaborate on the availability of listeners except for possibly maybe volunteers within the community who could maintain confidentiality and refer youth to other resources if necessary.

Supportive/Unsupportive Relations and Role models

Many youth, and adult participants spoke of the supportive and unsupportive relations youth experienced as youth navigate, negotiate and create a sense of self. A wholistic and relational view of rural Mi'kmaq youth mental health was described by the youth and adults previously in this thesis. In this section, the emphasis is on the supportive and unsupportive relations youth encountered on their journey that impacted youths' ability to move forward. The support from friends, unsupportive relations and the

role models youth encountered were discussed by the youth and adults as they described the promotion of mental wellbeing of rural Mi'kmaw youth.

Youths' perspectives: supportive/unsupportive relations and role models.

The benefit of friends in the community was conveyed by most of the youth participating in this study. The youth described how important friends in Mimikej were for support and encouragement. As Jim stated;

I'll always go to those guys when I need help, and I'm always there for them.

Todd explained the importance of support;

But we're very supportive. Like come on, this is just for fun, you know. You can make your friends feel good by doing that.

Patrick described how he supported youth in Mimikej. He stressed the importance of youth helping youth by encouraging them, and made the point that youth are there for other youth to help motivate them.

The youth need the youth to push them, to give them that little push... And then when they say oh, I can do this, then you stay there and you're saying, "Yes, you can." And you continue helping...You support them. You stay with them.

The following quote illustrates the trauma some youth may experience, yet within this trauma, the supportive connections youth have with others are unparalleled. Jim's experience of attempted suicide and his friend's ability to stop Jim, and stay with him speaks to this strong support as well as the unwritten open door policy in Mimikej.

And all I remember is that I had the knife to my throat. And around here with my friends, we don't knock on each other's doors. We know each other. We're family. We just walk in. And my cousin [Trevor] came up and wanted to visit. He didn't tell me he was coming up. Just a surprise visit. He came through the door and he saw me. He just

grabbed my hands, threw the knife down, and he stayed the whole night with me, asking me questions. Like why would you do this? What happened?

Trevor stayed with Jim all night. There was no discussion of Jim getting other help in the community that night. However, Jim did get extra help later in his journey. The help came from other friends, his mother, talking circles and a therapist.

The youth in this study also recognized their limitations in helping each other. For example, the following quote refers to youth who were concerned about friends they knew who were drinking;

But like when it's your friend, it's like... Well, some people say don't worry about me, I can handle it. But then you don't know what to say to them because you're like, "Well, you're hurting yourself and you shouldn't do it." But like it's not like they're going to listen to you or they're not going to listen to like anyone else if they're so like addicted to it. They won't. And then like you try to help them as much as you can, and you just tell them, "Well, it's not good. You should just stop." Like something big has to happen for all of them just to realize that they should just snap out of it and stop doing it and stop taking drugs or doing stupid stuff like that. Leah

Leah's frustration in not being able to help her friend or friends whom she believed were addicted was conveyed in her individual storytelling session. She spoke of her concern with her inability to support her friends. The youths' explanations of the support between the youth in Mimikej stemmed from their day-to-day experiences living in the community, what they encountered on their journey and how friends supported them or how they helped motivate their friends.

A few youth and adults also presented how some relationships are unsupportive as some youth do "target other youth", or single them out. As Jim stated, youth did single him out because of his sexuality;

Well, it's a problem everywhere in life because kids today are like "Faggot, gay." They really... They treat it like it's a bad thing. But you really can't help it. It's the way you're born. You're born with it. You can't be like, oh, I'm just going to change - be gay tomorrow and be straight the next day. You can't. You're born with that.

Some youth discussed how, in the community, youth may call each other names or say mean things to each other. Some youth in the study did not refer to these acts as bullying; however, other youth in the community were actively engaged in raising awareness of bullying. For example,

Like we had a bullying march on Saturday, and we had all the kids come and we walked from the health center to the multipurpose center. And we did a presentation and we had [Jane Brown] come in. And she's like really good with bullying presentations and all that stuff. Leah

One youth described the targeted person as a "victim" as she explained how youth who have experienced rudeness are hesitant to come to events in the community. She explained;

So the people that is the victim, they're saying I'm not coming because so and so is there, and they're rude to me when I see them. Talking Circle #4

The youth participating in the study expressed how other youth may put them down. Saying mean things were issues like one youth telling the other youth "*she had a bad haircut*". This concern is inconsistent with youths' explanations of the supportive nature of friends, and illustrates the contradictions youth encounter on their journey. For example, this youth in talking circle # 4 spoke of her unease about youth being judged, and her desire to help within the context of the community of Mimikej;

And I believe that I can help a lot of people because of the situations I've been through and the people like I've talked to and all the situations I've heard about. Like I believe I

can help a lot of people with that. And I believe that a lot of other youth should be involved in all this stuff, and knowing anything that's going on like about people's feelings and not having to judge people. Like to me, that's what this res is. Like the reservation is always doing...judging people and not giving anybody a chance. Like I think that everybody should have a fair chance and be able to go out without being judged and being bullied or anything. And I think that's what we should be about.

The paradox of having support, or wanting to be supportive, yet acknowledging the unsupportive relations in the community with respect to being judged or bullied was not unique to this youth, and represents the tensions youth were experiencing on their journey to *live life well*. For the youth unsupportive relationships were not limited to friends; what part of the community youth grew up in was another influence. For example, Kevin described an area in Mimikej where some families are not supportive.

Like their family, it's like who you grow up around that shows like your light on stuff. Like if I grew up in like [certain area of Mimikej], I would always be out of school, wouldn't be doing this, wouldn't be doing that.....

What Kevin referred to as “*who you grow up around shows like light on stuff*” meant that families should be teaching youth to stay in school and about activities which would not lead into drugs. He was concerned that in some parts of Mimikej families do not encourage youth to stay in school and to avoid drugs.

In the individual storytelling sessions some youth spoke of the importance of role models. The role models that youth, mainly males, talked about often were their parents.

For example,

But what she did was she went back to school and she worked hard. And now she works hard. Like she leaves for work before I go to school and comes back like 4 after I get home from school. You see that and you think that's a

normal thing to do. You're supposed to work hard. So now I work hard because I see that. Todd

But he never did any drugs either so you know, he's a great role model for me and my brothers. And he tries so hard to promote it for everybody else. Kids come over to my house. And my dad is just like, well, if you want to come over any time, go right ahead. You know, we're not going to stop you. Because he wants the drugs to stop. And like he knows everybody around here. Like everybody knows him. And it works. Patrick

Kevin referred to role models in general, and not specifically in connection with parents. He explained the need for role models was important and the "it" he was talking about was positive change in the community.

That's what we need too, a lot of role models that, you know, want to help. And if they don't then it's not going to work.

Adults' perspectives of supportive/unsupportive relations and role models.

Similar to the youth, some adults spoke of the friendships youth have in Mimikej. They also talked about the unsupportive relations and the importance of role models. Jeff, a service provider and parent, explained how youth are extending their relations to other youth of families in Mimikej that did not associate with each other in the past. He expressed how youth have broken down the barriers between some families in Mimikej and attributed this to the youth being more open and better educated.

But now lately, recently, there's people getting together that you would never think that they would be together sort of deal. From these kids. These kids' parents and these kids' parents never even spoke when they were younger. But now that they're grown up and they have kids, it seems like them kids are sort of getting together and hooking up and stuff like that.

The adults also spoke of the benefits of friendships between the youth in the community.

For example, Cynthia, a service provider, stated;

But I think they do get a lot of strength from each other. I think that those opportunities help them. It helps them socialize.

Some of the adults interviewed talked about unsupportive relations. A few of the adult participants referred to bullying as it relates to the youth living in Mimikej and how they understood bullying as a mental health issue. For example, this parent explained;

Like the drama they go through, the bullying they go through, the peer pressure they go through, that becomes a mental health issue after. Carey

Another parent and service provider explained how some youth can be crude, or rude, and cruel or unkind. He described how this behavior was related to the youth's upbringing.

The other kids are... Some kids can be crude. Some are, you know, crude, cruel. And I know it's just from their upbringing. Everything starts at home unfortunately that way. Jeff

Similar to some of the youth, the adults referred to role models in general, and not specifically who the role models are, or could be. Rather they spoke of the need for positive role models; however, this parent stated that the positive role models should be those who walk the red road¹⁴ or practice Mi'kmaw teachings, and she was concerned that many of them are dying.

Having their own role models in front of them, and having experience, that healing, that wellness from walking the red road and learning these ways and practicing these teachings in your everyday life, more has to be done to promote those things, to promote that. And like I was saying

¹⁴ The red road is an Aboriginal concept of the right path of life, as inspired by some of the beliefs found in a variety of Indigenous teachings

earlier, unfortunately a lot of the people that our young people have looked up to have passed on. Elizabeth

This Elder was concerned about the effects on youth of negative role models or adults drinking in the community.

And that's where we get our negative role models coaching our youth to get into trouble. John

Service providers concurred that youth need healthy adults and healthy relationships in their lives. For example,

But they just need healthy adults in their life....they need good role models. Cynthia

Overall, the youth and adults conveyed how the support and or lack of support in the community facilitates or hinders youths' journey *to live life well*. The youth presented strengths such as positive role models, and concerns such as bullying, and negative role models of adults who are drinking. One adult expressed concern that role models who "walk the red road" are passing on. Unlike the adults, the youth spoke more of their supportive relationships with other youth in the community.

Community Events

Most of the youth and adults explained how events in Mimikey are important for Mi'kmaw youth mental health and for youth involvement in the community. The youth and adults presented how the youth group, activities, workshops, and community gatherings in the community promote rural Mi'kmaw youth mental health. Sports were identified by many, but not all, participants as an important activity for the female and male youth in Mimikey. Overall, events in the community were seen as essential for youth as they navigate, negotiate and create a sense of self.

Youths' perspectives of community events. As presented earlier, youth explained how activities helped youth clear their mind, and prevented them from participating in drugs or alcohol in the community. Sports, like hockey, lacrosse, rugby and baseball in the summer and sports at recess in school was identified by many youth as one of the major activities youth participated in on their journey to live life well. For example, Patrick explained;

Like I said, the athletics is a huge part of the [Mimikej] mental health.

There are no formal sports leagues in the community; however, youth do play in other leagues outside of Mimikej. One youth described how he would like to see Mimikej have its own teams.

Like we have like 4 or 5 tournaments that we go to for baseball. And it would be exciting to see younger kids go there. Like the Mi'kmaw Summer Games, I went but I didn't play for [Mimikej]. I had to play for [another Mi'kmaw community] because there was no team for us. Kevin

The youth in the talking circles confirmed what youth were saying in the individual story sessions. This youth perceived sports teams as an opportunity to increase community involvement and not simply as activities for the youth. She explained;

So something to get the community more involved or something like that. I don't know, physical activity like a sports team. Talking Circle #3

Todd, another youth in the individual story telling session, stated activities are important for the individual youth;

I don't know, like me and him, we go on everything we can. Like any sports or anything just to keep ourselves busy and not be like saying... You know how a lot of people do drugs and stuff, and they say they were bored or there's nothing better to do.

Not all the youth participating in the story telling session stressed involvement in sports. Some youth expressed the importance of other activities in the community for the youth in Mimikey. For example, the youth groups have only recently been established in the community and most youth participants in the storytelling sessions appreciated this initiative. However, some youth were not as optimistic about this activity. For example, Keith presented his perspectives about the youth groups. He explained;

There are some things that I choose not to. I think there's something up there that happens like every Monday or something. I find it boring. I went there a couple of times and I didn't like it.

Many of the youth participants suggested events in the community that did not just involve the Mi'kmaq youth were important. They discussed events that were inclusive of families and bringing the community together. Keith talked about what helped him in his journey.

When things happen around the community. I don't know, maybe a dinner or something. Something more.

The importance of involving families and the community in events was supported in the talking circles. For example,

Like even like a family fun day. More like activity stuff for youth to do to keep them out of certain kind of things. So it would be more fun. You know, something to look forward to other than having to sit and home and go to school and not do anything. Talking Circle #1

If we could get like barbeques or something. So something even basic just to bring people together. Like everyone likes food. Everyone needs it. Everyone loves it. You just get some food in here and you'll have a community event. And like the fun days, like the Fall Fiesta down at the school, a lot of people showed up for that. Talking Circle #3

In talking circle #4 the youth presented concerns that community events that were currently happening in Mimikej were attended by the same people in the community. For example,

Because we do have a lot in this community to bring people together. But it's that some people go and other people, they don't get along.

The youth participating in this study also discussed a broader scope of coming together as they explained the need for considering non-Aboriginal youth. For example, this conversation in talking circle #4 illustrates what youth were saying about events in the community and how this affects them;

Participant #1 Sports, different sports, we share with others outside of the community, like with non-Aboriginals. And I feel like staying specific to Aboriginal activities brings us together more because that's something that we share and no one else does.

Participant #2 I like how she said that. But like when we're coming together as a community, we're also like being taken out of like other people. It's like not just Aboriginals but like we're being taken away from like social life.

In other words, the youth expressed ideas about bringing their Mi'kmaw community together, but they were also concerned about not being involved in a social life inclusive of non-Mi'kmaw people. The benefits of the inclusion of “non-natives” in events were discussed by a few youth in the individual story telling session. For example, Jim discussed including “non-natives” in healing circles.

Like I kind of wish that we brought some of the non-natives in to show them what our culture is like and what really happens. That's how you can learn about someone.

The youth talked about how important activities in the community are in their journey and stressed how their participation in the activities that they chose was meaningful to

them individually. They also spoke of inclusivity by including family and community in activities and having them involved with events in the community. Some spoke of widening the boundaries and inviting non-Aboriginal people into the circle of events.

Adults' perspectives of community events. Similar to the youth, the adults identified how sports and the youth group in the community are important for youth in their journey to *live life well*. The following quote from Alan, one of the teachers, illustrates what other adults were saying about sports. He explained;

I find those ones, the kids that do that, they're involved in something. They're involved in some sort of sports, either hockey or soccer or whatever. I find those kids there, they have a strong mind.

Sports was not the sole activity in the community that the adults talked about in relation to events for youth as they navigate negotiate and create a sense of self. The youth groups were identified as very important for promoting Mi'kmaw youth mental health by the majority of adult individuals who participated in the individual story telling sessions. For example, Maxine a service provider stated;

There's 13 at that youth committee. I think that thing is great.

Although the youth groups were seen as beneficial for positive youth development some adult participants expressed concern about the youth in the community who were not involved, as this parent explains;

And you know, they have youth group here, and they do a lot of stuff with the youth, which is good. But I think there's some that don't involve themselves because they're already, you know, into smoking, drinking, and don't care. Elizabeth

This service provider talked about the importance of the youth groups, workshops, and trips and she emphasized that these activities should be ongoing and not isolated events;

And so I think that's what's working best for our youth, is the youth groups. Like they're going to be starting workshops like respect and dignity and self-esteem. So I think all that. And then they get to play. So there's that time for goofing around, still being teenagers, and then learning something too. And they have to be accountable. They're made to fundraise for their own trips. And so everything is not handed to them. And I think those are really positive things with the mental health, is knowing that something will be there no matter what. It's not just another program that's died out on them. Susan

Susan also stated that sports are not the only activity for youth. She explained that she was eager to introduce activities that youth wanted, and to bridge the gap of having other activities besides sports;

So maybe it's not sports. Maybe they're not the athletic type of people. Maybe they like art. So that's what we're looking at now, is trying to bridge those other gaps. And so now we're bringing up a graffiti person who actually paints graffiti. And we're going to teach them, you know, and give them walls that are designated for them, and see if we can bring them in that way. And then see what else are we missing after that point, and who else isn't coming, and what do they enjoy?

Catherine, one of the Elders in the individual story telling sessions, stated how she would like the youth to learn more life skills.

Like they could have sewing classes. They could have cooking classes. And they could have classes for making like a sewing group amongst the teenagers, amongst the younger people.

John, the male Elder, would like youth to be involved with as many activities in Mimikej as possible. He also included more traditional events;

Get them into all the sports and everything we can help them and do for them and do with them really... .. That's the main thing. You have to come up with something where it's going to captivate them. And I think like storytelling would be good because you sit there and you talk about what you did when you were young and how things were then, and compare them today. And there's not too much gatherings of any kind. The only gatherings there are is when they have our Mawio'mi or our pow-wows, whatever you like to call them.

For the youth and adults participating in this study, events in Mimikej were seen as central to rural Mi'kmaw youth on their journey to live life well. Sports and the youth group in Mimikej were identified as a major part of some youths' lives. The youth and adults spoke of the importance of activities, workshops and traditional gatherings. Some youth and adults expressed concern that some youth were not participating either because they were already involved in drugs and alcohol or because another youth who was at an event was rude, or because they found some activities boring. The overall emphasis was on youth involvement in the community. Unlike the adults, the youth spoke of events that involved the community as a whole, such as family fun days, as opposed to just events for youth, and about extending events with non-Aboriginal people.

Leaving the Community

Youths' perspectives of leaving the community. There is strength in valuing the community and the collective as suggested by the youth and adult participants as they spoke of the relational understanding of Mi'kmaw youth mental health. However, the youth also expressed the importance for youth to explore outside the boundaries of the community of Mimikej as they navigate negotiate and create a sense of self. This youth explained;

I thought it was very helpful when I... Like I always went with somebody like just for a day or something. It helped me. I thought it was pretty fun.... Like I said, getting off the reserve and doing stuff and socializing with others helps you in the future. Todd

Kevin had many opportunities for trips; he thought trips outside the community helped him and he wanted other youth to have the same opportunities he had. He stated;

Like if we wanted to like really make an impact, we have to take them off this reserve, put them in like a different placing, and, you know, let them explore it and let them unfold their story, and let them build.

Other youth in the individual storytelling sessions talked about trips for youth and the process of fundraising for these trips. For example,

Like a lot of them like to go on trips and like do stuff like that. But a lot of them don't like to fundraise for that kind of stuff. And some people... Like we're not just going to get money handed to us just for nothing. And then I think they just like trips. Leah

Youth in the talking circles concurred with what youth were saying in the individual story telling sessions about taking trips and seeing what life is like outside of Mimikej or outside of Nova Scotia. For example,

I think we should have trips, like actual trips. Like go somewhere like Ontario or... Quebec and cool places, and go see things. Talking Circle # 3

Although youth talked about exploring life outside of Mimikej, a few youth in the individual storytelling sessions expressed how some youth wanted to leave the community to get away from the drugs and vandalism in the community. This youth explained;

Like maybe if there were less drug addicts and less vandalism, obviously as you can see, then maybe I'd like to

stay and raise my own family here. But right now, I'm just looking forward to getting off the reserve. Jennifer

Very few youth talked about leaving the community forever. For example,

Yes. That's why I've been saying I want to get off the reserve for a little bit. I want to live on reserve but I just want to get off and meet people first. Todd

Most of the older youth spoke of opportunities for youth to explore the world outside of Mimikej. Their intent was not to leave forever; rather it was so that youth could experience life either on trips as a group, or individually on their own to learn what life is like outside of Mimikej. Some saw these excursions as fun. A few mentioned a concern that some youth want to leave to get away from the drugs and vandalism in the community.

Adults' perspectives of leaving the community. The adults participating in this study also spoke about how youth should leave the community and the benefits of youth exploring outside of the community. They stressed the need for the youth to leave Mimikej to broaden their perspectives more so than the youth did. For example, Jeff, the parent and service provider, had mixed emotions about youth staying in the community. He wanted them to stay, and he believed many stay in Mimikej, but he also saw the benefits for youth to go out and explore life outside of the community and to get 'educated about things'. This teacher did not want to see youth stuck in the community, and also discussed the need for the youth in Mimikej to interact with other youth who are not Mi'kmaq.

Like conferences, like seminars, conferences but with other youth. Not just Mi'kmaw youth, all youth. You know what I mean? Or even like start small and do it with just the Mi'kmaw kids or whatever. But I think eventually they need to interact with all youth and see that there's other things

you can do out there and other things you can be. You don't have to be stuck here. Andrea

Maxine, the young service provider who works with the youth, expressed concern that some of the youth in Mimikej are not appreciative of life outside of the community.

She explained;

Like you have to want to go into the world because the world is a lot bigger than [Mimikej] and a lot of kids don't know that.

Later in her interview she talked about the need to enhance the lived-experiences of rural Mi'kmaw youth who live in Mimikej.

Take them out there. Create the opportunity....Give these kids the chance and the opportunity to do these things that aren't just involved with being here... Just learn anything of what this world has to offer and what they can do.

Although youth are exposed to life outside of the community through the media, and for some school, the adults suggested it is the lived experiences that enable youth to learn more about life outside of Mimikej. Some thought families should take their youth on outings but realized this was an added expense for families that may not be able to afford day trips. For example, this Elder explained;

That will take their kids bowling....And go to a movie. A lot of them don't have people. A lot of them don't have the money. Catherine

The following quote from another Elder illustrates how adult participants understood how important it is for youth to explore beyond the boundaries of Mimikej. John refers to “my kids”; however, they are not his offspring, they are youth he encounters within the community and school.

I tell my kids all the time, I say you guys go to school, get your education, get off this reserve, and go see how other people live. And then when you're ready, come back.

John referred to the need for youth to leave the community for work and education but he also referred in the next quote about the need to get out for day trips.

Then we take them for walks. We take them in the woods and we talk about different plants with them and things like that. We took them fishing a week ago, just down the brook here. They loved that. They didn't catch one fish at all but they loved it. They were soaking wet up to the hips and falling in the brook and everything. They just loved it. But you know, that's what they need. They need that laughter. They need to get out.

He also discussed the importance of visiting other reserves to experience how other First Nations communities live;

The only gatherings there are is when they have our Mawio'mi or our pow-wows, whatever you like to call them.They're on all the different reserves. We call it our pow-wow trail. They just keep going around. But there's not that many getting involved. Before there was a lot of youth and they wanted to dance, and they learned to dance, and they made their own regalias and stuff to dance with.

Leaving the community was suggested as critical for rural Mi'kmaw youth mental health by the youth and adults as youth navigate negotiate and create a sense of self. The reasons for leaving Mimikej were presented as an outing for the day, to gain new perspectives, to visit other First Nations communities, for postsecondary education, or just to see what life is like outside of Mimikej. The adults, more than the youth, expressed the importance for youth to explore outside of Mimikej so that youth can broaden their perspectives. Some youth wanted to leave forever because of the drugs in the community, and others claimed they would have to leave Mimikej as jobs they were interested in were not available in Mimikej.

Becoming Sidetracked with Drugs and Alcohol

Youths' perspectives of substance abuse. A major topic in the individual storytelling sessions and talking circles centered on the use of alcohol and substance abuse in Mimikej, and how this sidetracked youth from living life well. Throughout the preceding sections reporting the study findings, drugs and alcohol were presented in the context of understanding mental health. The focus in this section presents specific perspectives on the use of alcohol and drugs in the community as conveyed by the youth in relation to their journey. Some youth referred to their own problems of substance abuse or their friends' problems but they also spoke of issues of substance abuse in the community and how this embarrassed the youth in the community. For example,

It's like when you tell someone that you tell someone that you're from [Mimikej], it's like they always assume things. And it's like if you say you're from [Mimikej], they might think you're just like everyone else and you're into drugs or you always....Talking Circle #1

Many youth in the interviews spoke of their understanding of rural Mi'kmaw youth mental health and the arduous work of in depth self-reflection, and self-awareness to have the courage to be and to make decisions to live life well. One of the choices they included in their explanations was the mindfulness youth engaged in to refrain from using drugs and alcohol. Here I present their perspectives of the issues, the rationale for why some youth get started on alcohol and drugs, and what has helped youth to either slow down or refrain from using alcohol and drugs. Although youth spoke of themselves and their peers in relationship to the use of alcohol and drugs, many also spoke about their concerns of the younger youth, and about families in Mimikej that were involved with drugs and alcohol.

In the individual storytelling sessions and talking circles a few youth discussed how some youth use drugs to escape. Debbie explained;

Because of the stuff that's going on in their lives and they don't know how to get rid of it. So that just takes everything away for them. Like family problems.

Other youth talked about the impulsive action of an isolated incident of becoming intoxicated and the impact of this behavior. For example, this youth explained what happened to her when she drank one time, and the response from her peers when they heard about it. She did not like the fact that other youth found out before she even had time to process what she had done. She referred to this incident as '*an adolescent mistake*'.

Yeah, I did. You don't need to remind me. And like I just didn't like that. And I don't know, you don't really have... I don't know, everybody knows too quick. You can't even process it yourself. And like you just need time to. But like, I don't know....it just was an adolescent mistake. Most teenagers do this...And I was ashamed. And like people found out, and like I wasn't proud of it. I don't know, because I just never did anything like that before. Talking Circle #4

Other youth talked about youth abusing alcohol and drugs because their friends were using and it was available. A youth in talking circle # 3 used the analogy of sharing food with friends and about the common bond some friends have when they shared food. His example refers to how youth share with each other and the connection with food can be synonymous with the use of drugs and alcohol. He explained how youth would go to a friend's house if he or she had drugs or alcohol.

I mean it's sort of like if you're like obese and you have a few obese friends, and they have a lot of food at their houses... I mean it's sort of cruel but like if you are obese and your friends are obese, and they have a nearly infinite

stock of food at their house... Like you eat when you're obese. It's sort of the same with like drugs and alcohol and stuff. I mean like you may only be able to get high like two times a day. But if your friends are doing it like five to eight times a day, you're going to go hang out with them because you're going to get high more.

Some youth talked about peer pressure to go down the drug path. For example, Patrick explained how he went “*down the drug path*” but also presented how he is involved in other activities now and is a lot happier. He stated;

My friends are trying to move up sometimes and then my other friends are pulling them down. Like I went down the drug path too before but I got out and I'm... Like I'm involved in a lot more and I'm a lot happier.

Although youth talked about how they stopped doing drugs, other youth also talked about youth not getting help because of peer pressure to continue to drink. For example,

But I doubt if they're going to seek help anyway since all their friends are doing it. Talking Circle # 3

Conversely, other youth did not think that peer pressure was the only reason that youth in Mimikej were using drugs and alcohol. For example,

But then it's not necessarily you're doing it because your friends are doing it. Talking Circle # 3

Peer pressure, an adolescent mistake, the need to escape, or socialization may be some reasons youth may go down the drug path. Some youth also talked about how youth start doing drugs and alcohol because some parents are involved with drugs. For example,

I know some people who started doing drugs because their parents were doing drugs. And they got depressed over it so they started doing the same drugs that their parents did.

And their parents had no problem with it whatsoever.
Jennifer

Other youth expressed how youth decrease their drinking pattern and amount, and what needs to happen to change. This youth made reference to an incident when he was injured because of drinking, and how this changed his drinking pattern. To maintain confidentiality his injury is not described here.

And some people might go to like rehab or something and do something, and it might not work. Or someone could have a bad experience of doing something like say drinking... For example, wiping out and getting hurt really bad, and it would make you not want to drink as much as you did before but slow down a little bit. That's kind of a good example because not to really say anything, I used to drink a lot when I was younger. When I was younger, I used to drink a lot. Talking Circle #3

His explanation suggests that bad consequences from drinking could curtail some youth from drinking a lot. His injuries were not life threatening and although he recognized the injuries stopped him from drinking heavily he conveyed that everyone is different. He stated;

But everybody is different. Like some people might have to go get help, like a psychiatrist or addiction services counselor or something. But everybody's got their own different ways of doing it, I guess.

Some youth were not talking about the necessity of abstinence from alcohol, yet some youth did talk about how alcohol caused youth to become addicted and they need help.

For example,

I think it is different for everybody but yet again, like if you are on drugs or like doing alcohol or whatever, and you're too far way gone from yourself, like you are a really bad alcoholic and you can't really dig down deep into yourself and tell yourself to stop but you do need that extra little bit of help. Talking Circle # 3

In talking circle #4, one youth, who talked about using alcohol for escape, expressed her understanding of the need to get help.

... And like people, if they don't want to be helped, you can't help them. Like a lot talk about wanting to get help but that's all they do, is they talk about it. They don't ask someone. And asking someone helps a lot.

Alcohol and drug use in the community was a major concern for the youth in this study, and many youth participating in this study spoke of youth younger than themselves who were using drugs and alcohol. For example,

And I can name off 5 people right off the bat like that do drugs, and they're under the age of 15. Kevin

There's kids that are 8 on the res like drinking. Talking Circle #3

Alcohol and drug abuse is a complex issue in Mimikey as substance abuse does not solely involve the youth from 14 to 19 years of age. The number of male and female Mi'kmaw youth from 14 to 19 years of age in the community who were using drugs and alcohol at the time of this study was not identified. Youth spoke of the reasons why youth decide to use drugs and alcohol as being multifaceted and included socializing, peer pressure, the need to escape, impulsivity and some parents who were using drugs or alcohol or selling. The youth also spoke of how some youth were able to stop their use of drugs and alcohol, yet expressed concern about youth who may have an addiction problem. Many youth also identified an issue of youth younger than themselves who were using drugs and alcohol. The youth participating in this study also communicated the need for help for youth with addictions, as well as their concerns about parents and families in the community who were drinking or using drugs.

Adults' perspectives of youth substance abuse. Many of the adults participating in this study perceived alcohol and drug abuse as a major mental health issue in Mimikej and spoke about their understanding of why the youth in the community become addicted. Some parents stated how they perceived the youth as having low esteem or that youth think they will feel better if they consumed alcohol or took drugs. For example, these parents explained;

And it's very easy to fall into a pattern of alcohol and drug abuse, and just not caring about anything and having nothing to believe in. They don't believe that anyone cares about them enough. They don't believe that they are... They believe they're damaged goods. And they believe that nobody really cares about them anyway so why should they care about their own self? And the way they really do care for themselves is to be... They care about where they're going to get their drugs.... And they lose all sense of their family and community. Elizabeth

And then they'll go and do something that makes them feel better or think it makes them feel better. Like alcohol or the drugs or, you know. Carey

Carey was referring to youth who were having flashbacks of something terrible that happened such as remembering someone they knew who committed suicide, and they did not have someone to talk with. For some adults, the use of drugs and alcohol was perceived as youth thinking that drinking was fun. For example in this quote, Jeff, who was a parent and a service provider, explained the discussions he had with his own children about alcohol and drugs;

And I hope it sticks with them when they're older. You know, it's that you don't need to have...you don't need to get high to have fun. You don't need to get drunk to have fun. Or drink to have fun, I should say. Jeff

He also expressed his concern that some parents involve their youth in substance abuse “*And the sad thing is a lot of the kids partake with their parents*”. Similar to Jeff, other adults talked about the relationship of parents and youth in connection with drug abuse in Mimikej. For example, Sam, a service provider, stated; *There are a lot of parents selling drugs.*

One parent spoke more of issues related to the Youth Offenders Act and how youth underage sell drugs for older adults because the youth cannot get convicted;

And we’ve seen several cases throughout our community where the Young Offenders Act had provided that opportunity for their involvement. Matthew

This service provider spoke of the type of drugs she believed the youth were using;

And it’s not like ecstasy or cocaine or what have you. Like it could be, you know, a prescription pill here or there or codeine Tylenol. But we don’t have any hardcore yet, our kids. Cynthia

Many adults talked about peer pressure and the consequences of alcohol and drug abuse in relation to Mi’kmaw youth in Mimikej. This teacher explains the issues of peer pressure and drug use in the community and the lack of other activities for the youth;

Recently I think a group of kids, they had got caught by a parent doing it. And I think that’s because there’s no... They have nothing else to do. And then they see everybody doing it. “Oh, that must be cool.” When it’s really not. You really look like a fool. You look like a fool right now. But they think that oh, everybody likes him and he does this so I’m going to do it too. Andrea

This Elder also referred to his concerns of peer pressure;

They get hooked so fast. I see kids out there, they were doing really good. And their friends were, “Just try one. It’s not going to hurt you. You’ll like it.” And then, you know, 6 months to a

year later, you see them. They're not with the other kids in our group over here. They're looking back, probably thinking I remember when I was with them guys and I had fun. John

He also explained how drugs and alcohol interfere with other issues in the community.

And our culture, we're getting some back. But like I said, the interference, a big block today is the drugs, the alcohol.

One teacher explained how the consequences of drug abuse have ruined the individual lives of some youth in the community.

And we have a lot of young people that have been ruined from these things. Like they're only 21 and they've given up on life. They're walking on the roads like bums, picking up bottles and, you know. Mary

Mary also went on to explain the long term mental health issues connected with drug abuse and youth in the community. She was concerned because youth may be able to stop drinking; however, they need more therapy to heal and understand their self to make good decisions.

The drug disconnects them from their selves. And to me that is a mental issue, a mental health issue. So they can stop taking the drugs but there's nothing to reconnect them with themselves. So they're really injured. They remain injured. They're not healed from that.... They honestly really need therapy to work on their ways of thinking and make those connections back to their selves, and making good decisions.

Some adults also talked about the value of non-interference¹⁵ as a relevant barrier to addressing the issues of drug abuse in Mimikej. For example, Mary explained the ethics of non-interference;

People tend to turn their back and look the other way. It's part of our cultural way not to butt into other people's

¹⁵ “This value is about not getting in the way of another person’s journey or process or preventing someone from doing something simply because we disagree with it. It means not giving advice, not being directive and not participating in another person’s process unless invited to do so”. (Baskin, 2011,p.90)

business and not to go over there and yell at them and, you know, say stop doing that. Like to butt out. You know, if it ain't your place, keep your mouth shut type of deal. If you don't got nothing good to say, don't say it. It's part of a cultural norm. But yet we have an increase of widespread like drug use in the community with the young people. And you know, I think that attitude has contributed to that. You know, instead of people saying get rid of...you know, go see that person and tell them that what they're doing is wrong and they shouldn't be selling from their home and things. But nobody actually does that. But everybody knows who does it. You could count on your hands...

All the adults in this study conveyed a grave apprehension about alcohol and drug abuse in Mimikej as it relates to rural Mi'kmaw youth mental health. They spoke of the wide spread use of drugs and alcohol in the community and how people turn a “*blind eye*”. In the Elder talking circle the Elders spoke more about their concern of drug use other than alcohol, and how the RCMP are limited by what they can do with the dealers because of the fear of reprisal by the drug dealers if someone was “*a squealer,*” or in other words, told the RCMP who was selling drugs.

R: It's mostly pills, I'd say.

R: Yes, mostly the pills.

R: Because you can get a prescription, right?

R: Yes. They crush them up with water.

I: So what kind of pills?

R: T3's and Lectopans and...

R: Well, you see, the RCMP..... their hands are tied because nobody will tell them.

R: Yes.

R: We don't have no squealers around here. Nobody... You know, they would know somebody told them. But nobody will say.

Adults did not focus on the prevalence of drug and alcohol abuse of youth who are 14 to 19 years of age. As the following quote from the Elder talking circle shows, their concern was that many people of all ages are using drugs in the community.

R: Jeez, it's right up into their 40s, isn't it?

R: I think so.

R: Yes. Right from about 13, 14, right?

I: Right up.

R: Right up to about mid-30s or early 40s.

The adults identified their perspectives for the reasons youth used alcohol and drugs, and spoke of their concerns of the consequences and the need for resources in the community. Resources included activities for the youth to prevent boredom and resources for youth who are using, and long term follow up for youth who have stopped using. Adults also expressed concern that some in the community turn a “*blind eye*” in addressing the issues of drug abuse in the community because of the ethics of non-interference but also because the drug dealers would know who told the RCMP.

Youth and Suicide

Youths' perspectives of youth and suicide. At the time of this study there was a youth who committed suicide in the community of Mimikej, and although some community members spoke of why they thought she committed suicide, the reasons remain unknown. Not all youth talked about suicide in their individual storytelling sessions, and in the talking circles suicide was not referred to. In the individual storytelling sessions, youth spoke of how suicide is a problem, especially witnessing suicide, and having friends who commit suicide. Some of the youth participants that talked about suicide explained that suicide attempts are a last resort for youth, and stressed the need for youth to talk about their problems. Jennifer explained;

And some of them don't talk about it and they go out and they do drugs because they think the drugs will help them in a way. But it really doesn't. It just gets them hooked. And once they don't have that drug there to help them, they end up doing something silly like taking their own life because they don't think things can get better.

The 'it' Jennifer was referring to was the problems youth are facing. She did not elaborate on Mi'kmaw youths' problems, or her own, which may have been too sensitive of a topic. Further, as Jim explained when he attempted suicide, he saw it *as a way out* of his abusive situation.

At the time, I just saw it as a way out. I didn't want to be around him. I couldn't tell anyone. No one knew.

Adults' perspectives of youth and suicide. This adult explains how everyone in the community is affected by suicide, can relate to suicide, and how they learn about it really young. When there is a suicide in the community, everyone in Mimikej knows the cause of death, but not necessarily the reasons a youth would commit suicide.

When it comes to suicide, I think it affects the whole community, not just the family. Because everybody can relate to suicide because in a community, we seem to learn that really young. Carey

She went on to explain how the past suicides within families have affected youth today.

Like with the youth, you don't know. Like some child can be in a family that a lot of their family did suicide because there are a lot in our community. There's a lot of families that went through suicide, right.

Andrea, one of the teachers, explained how youth need to express how they feel and talked about what happens if youth do not express their feelings. "*If you don't*" represents the need for youth to talk as she had conveyed earlier in her interview, and from her explanation feelings of depression set in if youth do not talk about their feelings. "*They kill themselves*" highlights the finality of the act of suicide.

If you don't then that's when the depression sets in and the... Some people get so depressed, they kill themselves.

This service provider presented the ambiguity of suicide as a last resort or, as *a way out*, as she explained how some youth will call her when they think they cannot deal with their problems anymore.

People will call and say this is how I'm feeling and I just don't think I can deal with it anymore, and this is the only way I see out. So even though it's a crisis mode and they're telling me that they want to end their lives, they're still calling. So I don't think even without realizing they're ambivalent. That the part of them wants to live is calling.
Susan

Although suicide was discussed by some of the youth and adult participants in this study, participants also spoke of the positive events in the community that have decreased the number of suicides. For example, in the community open forum some spoke of how “*it was maybe about ten years ago there was an outbreak of suicides*” and they suggested that “*maybe it is all the activities we do with the youth.*” Since the activities and opportunities such as the youth groups and trips for the youth outside of Mimikej have been initiated there is a decreased incidence and prevalence of suicide for youth aged 14 to 19 years of age according to the participants in the open forum. However, it is not possible to determine from this study if this association exists as this was not the scope or focus of the study.

The issues of suicide in the community are complex. Although some participants described why they thought youth committed suicide, such as a last resort, or as a way out, or feeling depressed, these understandings do not provide evidence to inform prevention programs. However, these understandings do present the necessity of working with youth on their journey to live life well.

Summary

In summary, youth are navigating, negotiating and creating a sense of self in their journey to live life well in the context of a rural Mi'kmaw community. Individual Mi'kmaw adolescent youth are interconnected in their relations as they live their lives. The Mi'kmaw youth are living their lives in a tight-knit community as they become a unique individual. They are a part of the community, and work at understanding themselves in Mimikey. Their journey to live life well is dynamic and complex. The youth and adult participants expressed their concerns centered on how important it was for youth to have a trusted listener as youth undertake their journey. Youths' experiences with supportive and unsupportive relations, role models, participation with events in the community, and exploring outside the community were identified as being instrumental in influencing the directions youth took or the decisions they made. Getting side-tracked with substance abuse, and the issues of suicide in the community were explained by the youth and adult participants living in Mimikey. The need for resources and approaches to help youth dealing with addictions was conveyed by most of the participants in this study. The findings in this chapter also highlight how rural Mi'kmaw youth mental health incorporates more than an individual biological entity and requires a collective effort to support youth in their active journey of *Living my Life Well; Msit no'kmaq, (all my relations)*.

Table 3 provides a summary of the three major themes and subthemes presented in chapters 5, 6 and 7. In the subsequent chapter, I discuss these themes and subthemes in relation to the literature.

Table 3 Summary of Findings

<p>Youths' Understanding: Living my Life Well; Msit no'kmaq, (all my relations)</p>	<ul style="list-style-type: none"> • Self-reflecting, knowing more about oneself, taking action • Bad feelings, letting go and moving on • Integrating physical and mental health • Interconnectedness of community, family, friends and peers
<p>Adults' Understanding: Wholistic and Relational</p>	<ul style="list-style-type: none"> • Emotions and mental health • Being proud of who they are • Spirituality and mental health • Interconnectedness of community, family, friends and peers
<p>Navigating Negotiating and Creating a Sense of Self</p>	<ul style="list-style-type: none"> • Trusted listener • Supportive unsupportive relations and role models • Community events • Leaving the community • Becoming side-tracked with alcohol and drugs • Youth and suicide

Chapter 8 Discussion of the Findings

In this chapter, I discuss and analyze the key findings, unique contributions, and literature on adolescent development, and Aboriginal youth mental health. The key findings include the active processes youth identified in attaining or maintaining mental health, or living my life well, and the significance of Msit no'kmaq (all my relations) in their journey. I also examine the wholistic nature of Mi'kmaw youth mental health as conveyed by the adults. The findings of trusted listener as youth navigate, negotiate and create a sense of self, are also analyzed at the end of this chapter

Living My Life Well: Msit no'kmaq, (all my relations)

Living my life well, a component of rural Mi'kmaw youth mental health conveyed by the youth in this study, includes youths' understanding of their need to know who they are. Such knowing or self-awareness was fostered through an arduous process of self-reflection and self-care actions in the context of Msit no'kmaq. Figure 2 (p. 110), introduced in Chapter 5, represents Mi'kmaw youths' understanding of Mi'kmaw youth mental health, and the processes of self-reflection and self-awareness integrated with their physical and emotional wellbeing on their journey to live life well. Living my life well is fundamental for conceptualizing how Mi'kmaw youth actively promote their own mental health. The youth described courage, autonomy and strength as they come to know who they are. They reflected on sexuality, choice of friends, use of drugs and alcohol, whether to stay in school, how to manage schizophrenia and how to address abusive situations. These issues are not unique to Mi'kmaw youth. The uniqueness of their experience is revealed in both the substance and process of their journeys. Youth undertook such journeys to come to know who they are rooted in the

complexities of Msit no'kmaq, all my relations. Living my life well for these youth was a journey embedded in the socio-historical, political, cultural and contextual landscape of their world. Their personal journey of coming to know who they are is interconnected with the community as depicted in Figure 2.

While the community of Mimikej contends with past and present forms of colonization, and the effects of the Indian residential school (IRS) experience, the youth are a part of this process although the youth did not present how the IRS has affected them. Because the youth are interconnected with the community, their process of self-reflection and self-awareness is intrinsically interwoven with the process being undertaken by the community; and this is a distinct feature of Aboriginal youth mental health. Youths' processes in coming to know who they are is important for understanding rural Mi'kmaw youth mental health since the community influences the lives of youth, and youth influence the community. The community of Mimikej and the lives of Mi'kmaw youth in the community are intertwined. The individual journey of self-reflection, embedded in a wholistic understanding of mental health, and situated within the context of youths' interconnectedness with the community creates a particular dynamic within Mimikej. If the community is troubled, the youth are troubled; if the youth are troubled, the community is troubled.

Kirmayer et al. (2009) allege that "many Aboriginal individuals connect their sense of strength, safety and resilience to wider processes at social, cultural and community levels" (p.80). Chandler and Lalonde (2008) refer to cultural continuity factors which promote youth identity in Aboriginal communities in British Columbia. These factors consist of efforts to: regain title to traditional lands, to re-establish forms of

self-government; reassert control over education and the provision of health care, fire and police services; erect facilities devoted to cultural events and practices; enable participation of women in government; and gain control over the provision of child and family services. Although these scholars provide an association between the community and Aboriginal youth mental health, the association seems to go from community to youth, and there is no recognition of how youth can influence the community. Identifying the strengths of a community is important; however, there is a need to conceptualize the nature of relationships between individual Aboriginal youth and their communities. For example, strengthening a community's social, cultural, economic and political resources could promote Mi'kmaw youth mental health since youth are influenced by the community. However, a concurrent approach could be to focus on supporting Mi'kmaw youth, and building on their strengths as they come to know who they are, which, in turn, would influence the community. Investing in promoting Mi'kmaw youth mental health would also foster the community's development. This finding is important as it helps to bridge the gap of conceptualizing Mi'kmaw youth mental health in relation to community and individual Mi'kmaw youth mental health. In other words, the youth are part of the tapestry of Mimikey and their individual threads can help to strengthen the tapestry of the community.

The emphasis in Aboriginal youth mental health literature has been a problem-based orientation identifying suicide, depression, and substance abuse as major health issues. Statistics for these issues may be higher within some Aboriginal communities than non-Aboriginal communities as identified in the introductory chapter, and warrant attention and multiple approaches. The voices of Mi'kmaw youth need to be heard, and

their understanding is relevant in supporting efforts to promote Mi'kmaw youth mental health. The youth are an asset to the community, wanting to contribute positively to community life, and to discover more about themselves in the process.

Youths' understanding of living my life well. There is research on Aboriginal youth health identified in the literature that supports the understanding youth presented in this study about living my life well. McHugh (2011), in her research with Aboriginal youth, presented five themes associated with the benefits of physical activity: 1) it doesn't have to be sports, 2) builds bonds, 3) costs money, 4) makes one better, faster, stronger, and 5) needs Aboriginal community support. The youth in Mimikej identified how physical activity is related to their wholistic understanding of mental health. Although sports was important to many of the youth participants in Mimikej, they identified the importance of other avenues of physical activity and the need for the community to be involved in supporting the youth, and in particular by coming out to watch the games. Shea et al. (2011) employed photo voice and community based participatory research (CBPR) in their study, and found that Aboriginal adolescent girls link their health to traditional identity, good relationships and strong cultures. Goulet, Linds, Episkenew and Schmidt (2011) conducted theatre workshops which enabled youth to explore spaces of freedom and imagination, and experience the sharing of power which supported youth in their identity formation. These two studies support Mi'kmaw youths' understanding of the dynamic interplay of culture, coming to know who they are, and the relevance of relationships.

This study with Mimikej indicates that it is important to transcend youths' characteristics to understand the invisible processes Mi'kmaw youth undertake in the

community to promote their mental health. In research with Aboriginal youth, resilience has been defined as the ability of youth to overcome adversity, and has received considerable attention recently (Fleming & Ledogar, 2009; Dell et al., 2011; Kirmayer, Dandena, Marshal, Phillips, & Williamson, 2011; Tait & Whiteman, 2011; Ungar, 2010). Tait et al. (2011) claim research with Aboriginal youth is about focusing on unifying and positive factors so individual youth can overcome adverse situations (p.2). These authors support a strengths-based approach for understanding Aboriginal youth in the context of their lives. A strengths-based approach with youth is not often considered in research with youth, and in particular with Aboriginal youth, despite its potential utility to inform health program planning. The youth in this current study conveyed a strong sense of personal agency and engagement in self-reflection and self-awareness, processes that a strengths-based approach could support and encourage.

In their extensive survey of Aboriginal youth, Laframboise, Hoyt, Oliver and Whitbeck (2010) identified enculturation, maternal warmth and community support as protective factors, with enculturation being most prominent in their analysis. Hoyt et al.'s work provides a focus for future health promotion priorities. Although these researchers, and others, such as Ungar (2008), have developed tools to measure individual resilience, the representation of resilience as a static phenomenon does not fit well with the processes the Mi'kmaw youth in this study undertook in their personal development. These processes were evolving, thoughtful, maturing, dynamic, and interconnected with Msit no'kmaq, (all my relations). The profound relations of Mimikej and individual Mi'kmaw youth mental health supports the need to include Mi'kmaw understandings of how Mi'kmaw youth mental health can be promoted. The understanding of Mi'kmaw

youth mental health is particularly important as these youth continue to develop their sense of self within the context of their community.

Goodkind, Hess, Gorman and Parker (2012), in their qualitative study with the Dené, support the need to look beyond youths' characteristics and focus on the processes by which resilience and mental health are linked. For example, a survey of Mi'kmaw youth, which measured resilience, adversity and outcomes of individuals suffering from Posttraumatic Stress Disorder (PTSD), found youth with higher levels of resilience buffer the negative outcomes of PTSD when exposed to violence (Zahradnik, Stewart, O'Connor, Stevens, Ungar, & Wekerle, 2010). Their findings provide insight into how resilience may mitigate PTSD following traumatic events.

Current research with Aboriginal youth also needs to take into account the active individual processes youth undertake to overcome traumatic events, and make the invisible visible. For example, Tousignant and Soui (2009) identified forgiveness as an act to promote resilience within the Aboriginal context; however, they did not discuss who to forgive and for what, and dismissed this act as it may be "too difficult to reach" (p.47). Two youth from Mimikey talked about the act of forgiveness when referring to healing circles; however, forgiveness was not prominent in the data set. Kirmayer et al. (2011), in their work on Mi'kmaw mental health explain how forgiveness is similar to a powerful and sacred word in Mi'kmaq referred to apisiktuagan (p.87). The authors acknowledge this formal ceremony of apisiktuagan may be lost; however, contemporary Mi'kmaq usually practice this between individuals (Kirmayer et al.). Future studies on the processes of healing circles may inform understandings of the dynamic of forgiveness within Mi'kmaw communities.

Other scholars present the importance of being inclusive of Aboriginal ways of knowing when working with Aboriginal youth, and also identify the application of youth self-reflection. For example, Dell and Hopkins (2011) explain their work in an Aboriginal-run treatment center for Aboriginal youth. Dell and Hopkins stress that the success of this addictions treatment program is grounded in Indigenous cultural understandings. The authors explain the shift of treatment from “Benzos to blueberries” (p.75). This treatment was done in cooperation with Western science and an Elder. The treatment was eating unshelled peanuts and blueberries, a sacred traditional food; the time required to shell and eat peanuts promoted reflection, for example, when youth were angry. The Elder also encouraged the youth to speak with his counselor each time the youth finished his medicine of unshelled peanuts and blueberries (p.81). Dell et al.’s treatment center is an exemplar of how Aboriginal cultural understandings can work with Western science to promote Aboriginal youth mental health.

The conceptualization of living my life well, *Msit no’kmaq*, (all my relations), for understanding Aboriginal youth mental health adds to the body of knowledge identified from the literature. Incorporating *Mi’kmaw* understanding of rural mental health may be decolonizing since their understanding is contextualized within their lives as a *Mi’kmaw* youth living in a *Mi’kmaw* community. The youth presented their understanding embedded in the realities of their contemporary lives as they strive to come to know who they are. Their understanding is based on a process which is not often identified in the literature yet warrants recognition in order to support youth as they traverse this journey of coming to know who they are.

Youths' understanding of Msit no'kmaq (all my relations). The findings in this study reinforce a collective nature of Mi'kmaw culture. What is informative within this finding is that Mi'kmaw youth in Mimikey have not lost a sense of collectivity or relationality. The discourse of Aboriginal values, particularly the value of the collective as opposed to individuality, arises in the literature based on Aboriginal adult perspectives of their personal understandings and their lived experiences. For example, McCormick (1997), a Mohawk psychologist, maintains; "because [some] First Nations people tend to have a more collective orientation towards life they do not respond well to the individual orientation of mainstream counselling services" (p.172). Youth participants did not express an aversion or preference for individual counselling, however, their collective orientation for understanding mental health was identified in the individual storytelling sessions and their talking circles. Despite colonization and forced assimilation, the Mi'kmaw youth in Mimikey conveyed their meaning of mental health in terms of relationality. Attempts to assimilate Mi'kmaw peoples has not deleted a collective value orientation towards life for the youth participants in this study.

Culture is dynamic, fluid and expressed implicitly and explicitly. The implicit value of relationality prevails, and seems to be an intrinsic value of Mi'kmaw youth in Mimikey. In the process of assimilation the explicit aspects of a dominant culture may be adapted; however, the implicit values of a culture are not necessarily subsumed from the dominant culture. Poliandri (2011) suggests reserve life may promote a community's cultural values as the social isolation helps maintain values that do not become diluted. Although Mimikey is not socially isolated, the rural nature of the community provides less opportunities for socializing with larger urban centers and many different

populations. Few, if any communities exist in total isolation, given the technological advances in media and communications. Media exposure to the outside world is indirect. The youth and adult participants are aware of the lack of opportunities for youth to socialize and have experiences outside of Mimikej. Exposing youth to life outside the community was a subtheme in the youth and adult data as youth navigate, negotiate and create a sense of self. .

The Royal Commission of Aboriginal People (RCAP), (2006) explains that it is only a generation or two since extended kin networks of parents, grandparents and clan members made up virtually the entire social world for Aboriginal people, providing the framework for most of the business of life within Aboriginal communities. Although this framework for community life was dismembered by the Indian Act, the underlying values of an extended network of kinship and collectivity prevail. The Indian Residential School (IRS) experience, and colonization may have affected some of the explicit values of Mi'kmaw people; however, the findings in this current study suggest the Mi'kmaw youth in Mimikej honor the tradition of Msit no'kmaq, all my relations, and understand this connection in relation to mental health. This finding is important in understanding how youth are developing their sense of self in the context of a community which is also transforming as members work towards achieving self-determination.

An emphasis on Msit no'kmaq, (all my relations) is not unique to Mimikej. Many Nations have similar understandings, such as the Lakota Sioux, who refer to Mitakuye Oyasin, which emphasizes that we are all related (Baskin, 2011). There is a paucity of research on understanding the importance of the interconnectedness of all my relations within Aboriginal communities and how it relates to rural Aboriginal youth mental

health. Stiffman et al. (2007) focused on comparing rural and urban Aboriginal youths' personal, familial and environmental strengths, claiming the literature on adolescents in the overall population has been very narrow, and is typically applied only to personal strengths. The authors found rural Aboriginal youth identified their strengths in connection with their family and communities more so than identifying their own personal strengths. This was contrary to urban Aboriginal youth in the study, who could identify their own personal strengths more so than in connection with their tribal community. Urban Aboriginal youth readily shared personal strengths, and their ties with the community were also important; however, the ties were not as strong as the rural Aboriginal youth participating in the study (Stiffman et al.). The association between *Msit no'kmaq*, all my relations, and rural Mi'kmaw youth mental health found in this dissertation support what Stiffman et al. found with respect to rural Aboriginal youth finding their strengths in connection with their family and communities.

An explication of interconnectedness in Aboriginal communities is provided by Kral, Idlout, Minore, Dyck, and Kirmayer (2011). These researchers explored Inuit meaning of wellbeing, and happiness based on in-depth interviews with youth, adults and Elders in two communities. Although First Nations and Inuit people have different values and ways of knowing, the similarities in Kral et al.'s study and this thesis are revealing. Kral et al. (2011) found kinship and family were the central overriding theme of happiness. Unhappiness was tied to not being with family, not visiting, and with anger, alcohol, drugs, sexual abuse, and violence, often within the family context (p. 430). These authors were not researching mental health directly, rather their focus was on wellbeing, which is closely linked to the Mi'kmaw youths' wholistic understanding of

mental health. The youth in Mimikey did not refer specifically to happiness but their wellbeing was interwoven with community, family, friends and peers.

King (2011) claims mental health best practices focus on individual treatments and need to consider practices inclusive of relationships within the context of Aboriginal cultures and societies. She posits that community events that have increased over the last fifteen years, such as pow-wows and ceremonies are therapeutic for Native Americans as it brings community members together. She maintains policies and funding agencies are focused on individual counselling which may not support collective therapeutic interventions, such as healing circles and Indigenous ceremonies. This concern is noteworthy as some youth in this study conveyed the importance of healing circles in their journey to live life well.

The findings in this research support what some scholars have found in regard to the interconnectedness of Aboriginal youth mental health and strong kinship ties. It is important not to promote a dichotomy of individuality/collectivity or to perpetuate a stereotype of *Msit no'kmaq*, (all my relations). The findings from this study identify the strong links youth have with their community, and that these connections are relevant for understanding and promoting *Mi'kmaw* youth mental health in a way that is commensurate with this understanding. I offer the term commensurate as Wendt and Gone (2011) claim that services should be more than sensitive and accommodating and should embrace different ways of knowing and practicing to promote and treat mental health.

Adults' Wholistic Understanding of Rural Mi'kmaw Youth Mental Health

Another finding in this study is adults' understanding of rural Mi'kmaw youth mental health. The adults conveyed the wholistic nature of youths' identity, emotions (not feeling proud of who they are), and spirituality (not being familiar with Mi'kmaw beliefs). Some adults centered this understanding on the issues of the Indian Residential School (IRS) experience, and efforts to assimilate Mi'kmaw people. Correspondingly, literature on Aboriginal mental health suggests revitalizing culture, enhancing cultural identity and spirituality are interventions that promote Aboriginal mental health (Cross et al., 2012; DeGagné, 2007; Dell et al., 2011; Gone, 2013; Goodwill & McCormick, 2012; King, 2011; Kirmayer et al., 2009; Legha & Novins, 2012). This current study in Mimikeyj is not suggesting Mi'kmaw youth need to return to their traditional past, rather this study explicates the relevance of Mi'kmaw youth identity and spirituality in understanding rural Mi'kmaw youth mental health.

Two decades ago, Clare Brant (1993), the first male Aboriginal psychiatrist in Canada, maintained that the loss of culture, or a feeling of anomie, contributed to the mental health problems of Aboriginal Peoples. Outcomes of the IRS experience have been reported extensively in the Royal Commission of Aboriginal People (RCAP), (2006), The First Nations Longitudinal Health Survey (RHS) 2002/2003, The Interim Truth and Reconciliation Report (2012) and studies by scholars such as Elias et al. (2012) and Bombay, Matheson, and Anisman (2011). Bombay et al. (2011) found that adults whose parents attended residential school had higher depressive symptoms than adults whose parents had not attended residential schools. The Regional Health Survey (RHS), (2002/2003) ascertained there were 150 Residential Schools in the mid-19th century to the

late 20th century. The major negative impacts expressed by adults who attended residential school included isolation from family, verbal or emotional abuse, harsh discipline and loss of culture. The adults, whose parents and grandparents attended residential school and were also interviewed, identified the negative effects their parents had on parenting skills (RHS). Further, The Mental Health Commission of Canada (MHCC) (2012) acknowledges the negative intergenerational impact of colonization on the mental health of Aboriginal Peoples. The Commission asserts that residential schools and the child welfare systems have disrupted the ability of parents and Elders to pass on traditional ways of parenting, language and other cultural knowledge (p. 100). This literature supports what the adults in Mimikej conveyed.

Although the youth in this study did not discuss the impacts of the IRS, they did express concerns about some parents in the community who were fighting and drinking. Although these behaviours may not be associated with the IRS experience, some adults concurred that parents are still grieving over the residential school experience. It is difficult to determine if the youth in this study were aware of how the IRS experience affected their parents and grandparents. The youth discussed parents, grandparents, aunts and uncles' behaviours in terms of how adult family members' behaviour was interconnected with Mi'kmaw youth mental health, but did not discuss the grief and loss adults may be feeling in relation to the effects of the residential school experience. Miller et al. (2011) provide evidence of the need for Aboriginal youth to know the impact of intergenerational trauma based on their five-year prospective study known as the Cedar Project in British Columbia. They present the multiple factors affecting the transition to injection drug use among Aboriginal youth. Many of the youth in this study were

struggling with understanding their lives. Miller et al. (2011) claim; “Providing young Aboriginal people with opportunities to learn about the role of historical trauma in addiction is imperative” (p. 1152). Elders interviewed for this study explained that they do not want to talk about their experiences in residential school because it hurts too much; however, they could talk with the youth about traditional ways of knowing, and life skills. Newhouse (2004) suggests adults and youth, Aboriginal and non-Aboriginal, who were not given information in school, should have access to readily available and highly publicized information sources on Aboriginal issues (p.16). Publications from the Truth and Reconciliation Commission may be a valuable resource. Further, Newhouse recommends that school curricula for Aboriginal and non-Aboriginal people should improve to achieve greater mutual understanding of these issues. The adults participating in this study also identified the need for youth to understand and be proud of their ancestors, and know about Mi’kmaw creation stories such as Kluskap. A few adults discussed the need for youth to know all the struggles their ancestors went through; however, youth conveyed their understanding, not in terms of the struggles their ancestors went through, but in terms of wanting to learn more from the Elders about Mi’kmaw traditions.

Although two decades have passed since Brant acknowledged the association of anomie and mental health, the community of Mimikey has had minimal recourse to move forward on promoting Mi’kmaw identity with adolescents. A promising strategy is the resurgence of Mi’kmaw language in Mimikey. The local school is teaching the Mi’kmaw language to youth attending the school, and in the fall of 2013 the community planned to offer Mi’kmaw language to adults in the evening. The Mi’kmaq RHS (2008-2010) in

Nova Scotia identified 72.3 per cent of Mi'kmaw youth speak or understand the Mi'kmaw language. However, this statistic does not measure fluency, and represents youth in all 13 Mi'kmaw communities in Nova Scotia. Some communities have higher rates than others. Although the rates were not identified specific to Mimikeyj in Nova Scotia, participants in this study were concerned that few youth spoke Mi'kmaw. Further, although this initiative is important, promoting Mi'kmaw language as an isolated strategy is unlikely to promote positive Mi'kmaw youth identity.

Some scholars have positioned their understanding of the past atrocities experienced by many Indigenous people as historical trauma (Elias et al., 2012; Gone, 2013; Menzies, 2007). Elias et al. (2012) published the first study to empirically demonstrate, at the population level, the mental health impact of the IRS experience on survivors and their children in Manitoba. Kirmayer, Whitley and Faras (2010) emphasize the importance of knowing the impact of historical trauma to address mental health. "Researchers and health professionals need to understand and address the issues of trauma and loss (both direct and trans-generational, individual and collective) that continue to negatively impact on Aboriginal peoples in Canada" (Kirmayer et al., p.15). The findings in this study, from the adult participants, support the concerns posited by Kirmayer et al. The issues of parenting, language, and Mi'kmaw heritage and values were acknowledged in this study by youth and adults as integral for understanding rural Mi'kmaw youth mental health, and in promoting Mi'kmaw youth mental health. However, the youth did not refer to these issues as they relate to the IRS experience, or the struggles their ancestors faced.

The exploration and integration of identity is a primary developmental task in adolescence. The adults in this study explained that identity as a Mi'kmaw person, being proud and having a sense of belonging is important for Mi'kmaw youth mental health. A few studies have examined Navajo youth identity in the literature. Rieckman, Wadsworth and Deyhle (2004) investigated the relationship of cultural identity and depression with 332 Navajo youth. The authors found a high level of cultural identity had a moderate effect on reducing levels of depression. They acknowledged culturally appropriate definitions of the constructs in their study were not clearly established and this was a limitation to the study. Nonetheless, cultural identity is something to consider in research involving Mi'kmaw youth mental health. Jones and Galliher (2007), in their survey with 137 Navajo youth, found ethnic identity measures were strongly associated with positive indicators, such as self-esteem, school belonging, and social functioning. Jones et al.'s research findings are helpful for understanding cultural identity formation, and potential protective factors for Mi'kmaw youth mental health.

Spirituality and mental health. In the discourse of adolescent physical, social, and psychological development, understanding the development of youths' spirituality and /or religiosity is increasingly studied as it is recognized that spirituality and religion are relevant to adolescent development (Bullock, Nadeau, & Renaud, 2012; Good & Willoughby, 2008). Spirituality transcends formal or specific religious manifestations and is consistent with the adult findings in this study. Adult participants acknowledged the importance for youth in Mimikej to practice Traditionalism or Catholicism as they develop their spirituality. Poliandri (2011), in his anthropological ethnographic study exploring Mi'kmaw identity in two Mi'kmaw communities, explains his understanding of

Mi'kmaw spirituality. He claims Traditionalism and Catholicism are different ways in which Mi'kmaq express their spirituality and although some Mi'kmaq contend the two can co-exist as complimentary, some Mi'kmaq believe individuals cannot practice both (Poliandri). In this study, most of the adult participants concurred that Traditionalism and Catholicism could co-exist, and were concerned that the youth in Mimikey were not practicing either. This concern was important to most of the adult participants as spirituality was conveyed as integral to a wholistic understanding of Mi'kmaw youth mental health.

During adolescence, a greater capacity for abstract thought emerges along with a search for new meanings in life experiences. Thus, theologians and psychologists have identified adolescence as a period of “spiritual awakening” characterized by an existential search for meaning, an enhanced capacity for spiritual experiences, and a process of challenging religious values (Kim & Esquivel, 2011). Eade (2009) claims spirituality centers on the search for meaning and connectedness. He reasons this search does not involve turning inwards or avoiding difficulty, but involves meeting and making sense of challenges. Correspondingly, some Mi'kmaw adults in this study identified some Mi'kmaw youth seem lost, or do not have a sense of belonging or purpose in life which the youth participating in this study did not convey. A few adult participants suggested the youth need to believe in something, and need to feel good about who they are, particularly as a Mi'kmaw person. Some of the adults participating in this study communicated this understanding because as youth, they themselves were not allowed an opportunity to understand Mi'kmaw ways and traditions.

In the literature, some researchers have made associations of spirituality with mental wellbeing, identifying spirituality as a protective factor for youth at risk in the general population (Dadich, 2007; Kim & Esquivel, 2011; Kyle, 2013). Mota et al. (2012), based on data from the Regional Health Survey 2002/2003 in Manitoba First Nations communities, examined many correlates of suicidality including spirituality. In their study, suicidality included suicide ideation and attempts, not completion. The authors found most youth considered spirituality, or faith to be at least somewhat important to them. Although it is not clear in the report what non-Indigenous faith means, a large proportion of the sample was of non-Indigenous faith. The authors did not find a strong correlation between suicidality and spirituality in their study. Although the authors found faith to be fairly important to First Nations youth, a more in-depth study is required to determine the meaning of spirituality for First Nations youth. The adult participants in Mimikej conveyed the importance of spirituality in relation to Mi'kmaw youth mental health; however, it was not discussed in the individual storytelling sessions or talking circles with the youth. This finding does not mean that Mi'kmaw youth do not connect spirituality with mental health, as they all agreed in the talking circles that spirituality was a part of mental health. The youth in the talking circles focused more on activities to promote Mi'kmaw youth mental health. I did not redirect them to spirituality as youth seemed to find it difficult to articulate their understanding of spirituality, and I sensed their desire to share more about the concrete dimensions and processes of Mi'kmaw youth mental health in Mimikej and priorities for promoting mental health.

Spirituality is not necessarily equated with going to sweats, or going to church, but sweats and other traditional ceremonies have been increasingly identified in the

literature as a way of Aboriginal healing from grief, or loss of culture associated with the Residential School experience (Gagné, 2007; Hunter, Logan, Goulet, & Bolton, 2006; King, 2011; Kirmayer & McCormick, 2009; Lucero, 2011; Mental Health Commission of Canada, 2012; Waldram, 2013). During this study, sweats were being introduced to youth in Mimikej by an Elder, and the youth who attended were responding favourably, according to this Elder. Some youth in this study conveyed positive responses to participating in healing circles but did not discuss sweats. Sweats and ceremonies enhance youths' experiences in traditions of expressing Mi'kmaw spirituality. Indigenous people have a traditional unity with the environment and this tradition is reflected in songs, ceremonies, approaches to healing, birthing, and rituals associated with death (Couture, & McGowan, 2009). Ceremony is a part of understanding Indigenous spirituality and is expressed differently than practices found in Catholicism. Importantly, the adults in this study were concerned that the church, and the sweat lodges were not being attended by many youth in Mimikej. They viewed this as problematic, as these practices provide a way for youth to explore their spirituality, which they believed was integral to Mi'kmaw youth mental health.

Trusted Listener

The youth and adults participating in this study repeatedly presented the need for Mi'kmaw youth in Mimikej to have someone to listen to them or the need for youth to talk with someone whom they could trust. Trusted listener was a prominent theme in the analysis. The findings suggest the need to talk with someone centred on who they could trust in the community, or whether it has to be someone from the community, or someone that could relate to them, and if the listener was Aboriginal, and/or someone who was a

professional. Participants did not essentialize who would be considered a trusted listener. The youth identified that although they did not want to be told who they should talk with, having someone to talk with was vital to Mi'kmaw youth mental health.

The general literature on Aboriginal mental health consistently identifies that resources for counselling in rural First Nations communities are limited (Kirmayer, Tait, & Simpson, 2009; Native Mental Health Association of Canada, 2007; Vukic, Rudderham, & Martin-Misener, 2009), services are not culturally appropriate (Dell & Hopkins, 2011; McCormick, 2009; Musquash, & Bova, 2007; Stewart, 2008) and racism needs to be addressed (Health Council of Canada, 2012). An assessment of the Community Youth Initiative Project conducted by Adeleson and Libinski, (2008) in a New Brunswick Mi'kmaq community supports specific strategies for working with youth. These authors identified traditional healers, clinically trained therapists, and youth support staff as a beginning for integrating a range of social and community activities necessary for youth in the community. As the government has stopped funding for healing projects related to the residential school experience, the community is required to seek external multi-year sustainable funding for projects of this magnitude to continue. The Nova Scotia RHS (2008-2010) found that, when talking with someone about their emotions or mental health, 63.5% of Mi'kmaw youth talk with friends, 47.1% with parents, 43.5% with other family members, 12.5% with counselors, 9.5% with social workers, 8.5% with other health care professionals and 3.5% with traditional healers. The authors suggest that; "perhaps strategies to improve mental health services and information would do well to target friends and family" (p117).

In light of the findings in Mimikey, and other research with First Nations people on counselling in First Nations communities, the need to respond to having a trusted listener is paramount as youth work towards coming to know who they are. Understandably, most participants did not arrive at any one specific solution as the issue is multifaceted; however, in the open forum some did suggest that having volunteers in the community, who are trained in the ethics of confidentiality, should be available in the community for youth. This response is notable, builds on the values of the community working together, and would require someone to support the volunteers.

Summary

The findings from this study reveal how a strengths-based approach to working with youth to promote their wholistic and relational understanding of mental health requires a collective effort with youth. The youths' conceptualization of Mi'kmaw youth mental health is embedded in Mi'kmaw traditions and community. The need to engage, and support Mi'kmaw youth as they come to know who they are, and develop their own identity, inclusive of Mi'kmaw ways of knowing requires a decolonizing approach to practice. This current study in Mimikey has explicated some of the social, historical, political and economic realities facing Mi'kmaw youth as they strive to promote their mental health, and make meaning of their life in the context of these realities. The findings in this study reveal that many of the Mi'kmaw youth in Mimikey are young vibrant, thoughtful, knowledgeable youth who can work with the community to respond to the mental health issues Mi'kmaw youth face in Mimikey and beyond.

Chapter 9 Co-creation of an Action Plan to Promote Mi'kmaw Youth Mental Health in Mimikej

In this chapter I include youth and adult participants' responses for a potential action plan to promote rural Mi'kmaw youth mental health in Mimikej. Youth groups and sports in Mimikej were identified as positive activities for promoting Mi'kmaw youth mental health by most of the participants in this study. Many participants described the benefits of the youth groups and sports, and conveyed the importance of sustaining and enhancing these activities; however, youth and adult participants suggested more opportunities for youth are needed. The focus in this chapter is on priorities participants presented that could support Mi'kmaw youth as they strive to live life well. Although youth and adult participants spoke of the need for youth to leave the community as a process for gaining new perspectives, they also shared how changes in the community could enhance rural Mi'kmaw youth mental health.

Youth and adults in this study identified that strategies aimed at creating opportunities for Mi'kmaw youth to live life well in Mimikej must include community structures and relationships. It was generally agreed that opportunities to promote Mi'kmaw youth mental health ought to come from within the community. Strategies need to be inclusive of formal and informal leaders in the community, with resource expertise being invited in by the community, and that youth should be involved and included in any plans. The action plan consists of two sections and conveys what the youth and adult participants identified as priorities, except priorities 6 and 7, which were explained primarily by the adult participants. The first section focusses on actions with youth which include:

- 1) Enhancing workshops and programs

- 2) Connecting youth with Elders and Mi'kmaw culture
- 3) Creating a drop- in center
- 4) Addressing addictions

The second section is comprised of broader community action plans which include:

- 5) Promoting community involvement
- 6) Collaboration amongst existing services
- 7) Supporting parents

Actions with Youth

Enhancing workshops and programs. In the individual sessions many youth spoke of the need for workshops, and programs, as well as education on mental health to promote mental health. For example;

[I] think there needs to be more workshops dealing with like mental health and addiction issues and stuff like that. Erin

I guess we can do activities or something, stuff about it.....Yes, so people can understand about what it is and stuff. Kevin

Like what mental health is, and what schizophrenia or depression are. Like any of that. Like bipolar. Like any of that, they should just know what it is because their friend or their parent or anyone could be suffering from it and they don't know. And they should get help but they don't know they have it or none of them know they have it. And they should just know. Leah

Education on mental health all together. People with mental disabilities get alienated, you have to understand what they are going through, not everyone would get help, if you go to a friend and they'll say it is all in your head you could get the wrong advice. People are scared and don't know where to go what to do, with mental problems everyone knows where the doctor is, they might be scared to say anything is wrong with

them, education would make it better. David

Some youth suggested that the workshops do not have to focus on mental health education. For example;

Just workshops. Like it doesn't have to be on like depression or mental health or like anything like that. It could just be on like how to make moccasins or how to make dream catchers. And then like to bring back the tradition and also help everyone, and just like get everyone closer and stuff. Debbie

Keith was specific about a program he had participated in and the benefits of this program.

I: guess they could maybe get together and, you know, talk or something like that. Because like every... Well, I think it's starting back up but before the holiday, there was LOVE, I think. We have it every Tuesday at the school, after school. And it's like a talking thing and we discuss stuff. Not all people stay but maybe 5 or 10 stay. And then they'll have these questions. It's pretty nice.

I: What does... Does LOVE stand for something?

R: Leave Out Violence, I guess, Everywhere

Many youth in the individual storytelling sessions spoke of how they would welcome the opportunity to learn more about mental health. Offering education and doing other types of programs with youth was a common topic. The focus on workshops and programs was reaffirmed in the talking circles with youth as this youth confirms.

I was going to say more workshops. And like things to get the community together so people don't feel like they're an outcast or they're alone. Talking Circle #4

Although the need for workshops and programs was presented as important by most of the youth participating in this study, there were a few who suggested that workshops

“with teens” would not help the “kids that need help”. For example, this youth in talking circle #2 explained;

I'm going to say it's all wrong, other than the workshops with the parents. Because like I said, like you can have workshops with teens but they're just going to get off the reserve or it's not going to the kids that need the help. Talking Circle #2

He conveyed that workshops for parents would be important; however, he stated that some youth would not benefit from any workshops.

Some of the adult participants in the individual storytelling sessions also conveyed the importance of workshops and programs for the youth. For example, this teacher and Elder explain;

But we have no programs for them. None at all. I mean they have the gym open twice a week for basketball and volleyball but that's just another sport. You know, there's other stuff they could be doing. We have a homework program but none of the high school or junior high use it at all. Andrea

Like the workshops that we have with the kids. You know, explain things to them. Telling them different stories about how I was brought up or how this person was brought up, and what it's like today and what it was like back then. John

The topic of developing workshops and programs for youth was suggested as important for promoting the mental health of the youth in Mimikej by adults and youth participating in this study. Although one youth stated that workshops are not needed, because they would not reach the youth who need help, most adult and youth participants spoke of the value of education on mental health and for workshops for youth. Adults and youth presented the importance of providing Mi'kmaw youth with activities, and events that would enable youth to bring back Mi'kmaw traditions, and develop their life skills.

Connecting with Elders and with Mi'kmaw culture. Some youth participating in this study attended school outside of Mimikey and acknowledged that evidence of their culture or discussions about Mi'kmaw ways is not a part of the school they go to, as this youth suggested.

At school there isn't really much because I go off-reserve. So there's not really much of our culture there. Debbie

Debbie elaborated on how she would like to be able to have opportunities in Mimikey that would provide youth with more cultural knowledge.

Like something that brings their culture to them. Like being able to like make a small hand drum for example or learning how to dance.

Learning the language, and learning more about Mi'kmaw history and traditions and connecting with Elders was reinforced in the talking circles with youth as a way to promote Mi'kmaw youth mental health. For example;

I don't know about you guys but when I say I'm from [Mimikey], everyone is like they assume I speak native. And I think we should have a clinic for our youth to learn more about our culture. Because it's dying. We're getting older. You know, we're having young kids. They won't know anything about what our culture is. Talking Circle #1

Because nowadays... Like I personally don't know anything about my culture besides the fact that I am Mi'kmaq. And I lost that connection to Elders. So just rebuilding that. Talking Circle #4

Well, a clinic, as I was saying earlier for youth and old if they wanted to learn about their culture and what the Elders went through with the schools that they had to go to. That had been taken away from their family. They have to learn about that. And their culture, about what... Yes. Talking Circle #1

Many adult participants spoke about working with the Elders in the community and how important Elders are in promoting Mi'kmaw youth mental health in Mimikey.

The adults participating in the study shared their concerns and the need for Elders to be involved. The following quotes from these service providers and an Elder explain their concerns;

The Elders get to see the youth, and they would interact with each otherthere's a barrier there. Sam

We need to come back in touch with the Elders because they're the ones who know what the hell has been going on for the past 50, 60 years. We don't. We can read in a book or... But we as the youth are going to carry on all this stuff. And if we have no idea about it then how are we supposed to teach our children? Maxine

And they talk about the culture. Our culture is hanging on by a thread. And I have some kids that come to the sweat, young guys and girls. And they're starting to learn there's nothing wrong with it. John

In her individual session, this service provider talked about how Elders can contribute to Mi'kmaw youth getting back to their roots.

I have some too that are very much into the traditional. They love to drum. They love to sing. They like to be involved in pow-wows. If you can get kids back to their roots and their connections, and get them involved in their community. That's why I think you have to have it run by First Nation people. They have to be able to get the connections to people, to connect them to an Elder or connect them to the pow-wows. Because I have a lot of kids that they love to drum and they love to dance. And then getting them involved in those activities, it's so good for them. Cynthia

This parent shares the importance of Elders teaching local traditions and cultures and her concern of losing many of the Elders.

But I think one of the things I think is the influence, the lack of influence of our tradition and culture and traditions on our youth today. And we've lost so many of our Elders and our teachers. And it's very sad. Elizabeth

Elizabeth explained her concern of being assimilated as she talked about the need for youth in Mimikej to have more understanding of Mi'kmaw ways.

You know, we've been too busy, I think, being assimilated. We've been told to leave the reserve, go get a job, and we'll be better off blending in, you know, wherever, and just being Canadian. And everything...

A reintroduction to culture and sweats is looked upon positively by some of the participants as this Elder explains;

Oh, yeah. We brought the kids in them and they just loved them. And I brought it in. It was introduction to our culture and to the sweat. And it was mild. And I explained everything to them. And we got out and, "When's the next one?" Wow, when's the next one? You guys are just getting out of this one. "When's the next one? And can we bring our teachers?" John

In the community open forum, participants discussed the importance of youth going with Elders out on the land to learn how to survive on the land. They suggested these teachings are valuable for appreciating the land, building teamwork, bridging the generation gap and learning from the land and not just technology. Youth and adults perceived a reconnection with Mi'kmaw culture and local knowledge as significant in creating opportunities for youth in the community to live life well.

Creating a drop-in center. The opportunity to have a drop-in center for youth in the community was presented as an important initiative by many youth and adults participating in this study, and some youth and adults suggested it could be run by the youth. A drop-in center was not a unique idea but something community members have talked about for many years. The youth talked about the idea of having a place they could call their own, and some youth referred to other Mi'kmaw communities that had a drop-in center for youth in their communities. For example,

They have computers and like a pool table, and they like have a big TV, an XBOX and stuff like that. And they can like watch movies. Talking Circle #4

Although there is a multipurpose center in Mimikej, this center is used by community members of all ages for sports and other activities. The youth in this study discussed how they would like to have a separate place where they could all “hang out”. For example, Leah explained;

Probably just like somewhere that we can all just hang out and like talk and what not.

Many youth in the talking circles spoke about having a place where they could go. They did not offer where this place could be; however, many talked about the need to have their own space. They referred to this place as a drop-in center, or a clinic or somewhere to go that they could do workshops, or hang out to play pool, watch TV or to share ideas with each other.

To just have somewhere to go and do something. Because I'm not into sports. I'll admit it, I'm not into sports. But I do play pool because I have a pool [table] down in my basement. And that's just something that would be nice to start up. Talking Circle #3

They presented many ideas of activities and who could be involved and what could happen if they had a place to go. For example;

That drop-in center that you were talking about, and how you could just go and like talk to someone if you needed it, or just hang out. You wouldn't be doing drugs or anything. Talking Circle #1

Okay. What [Sandy] said, more programs and like a place where they can go so it's like drug-free and alcohol-free, and don't have the choice to do it. I guess Talking Circle #2

I think a drop-in center is a really good idea. I think a lot of people would actually go to it because, again, it's run by youth.

So it's peers..... And if there was a drop-in center, there'd definitely have to be an adult that was there. Definitely because in order to make that child feel comfortable in the space. Talking Circle #4

The youth in this talking circle were suggesting that youth should be instrumental in determining how the drop-in center functions and organizing certain events and that there should be an adult included to support the youth.

Similar to the youth, many adult participants discussed the importance of youth having a place of their own, like a drop-in center, or youth center where activities could take place and it could be their own space. Parents, teachers, Elders and service providers suggested where this drop-in center could be, the need to start small, and some activities that could be initiated. For example;

But in our reserve, it's just with the economics around here, like there's no money, no funding, no nothing for them. You know what I mean? But if it was a project or something... It's worth money spent on a youth building for them, even if it was just something small. We don't need a big old mansion for them. Carey

I mean you know when Father [Bill] moved out of that place next door that was supposed to be turned into a youth group or a youth home or a youth center of their own. So they still don't have a place. Even if they do have a meeting room in the community center, they're far from having a place of their own. Mary

Not just the building and nobody to do it. Yes, you need all of it. And there's a building up there. There's a kitchen in it that could be put to good use. And they've got chefs in our community that could be teaching the younger parents. You know, things like that. Make use of it. Catherine

Catherine, like Cary suggested the community could start small, and not build a new building.

Maybe they should have just went with a small, what do you call it? Small accomplishments first.... Because they're trying to go way big and we're into the big hole. Financially.

I would actually love to have a youth center up here. Like just a drop-in center where you can come and you can play pool, you can go play video games, you can read a book. You know, just somewhere for them to call their own. That's what I would love to have eventually. Maxine

Similar to the youth, this Elder explained there should be an adult involved if there was to be a drop-in center for youth;

We need someone there to do activities with them and to let them know there's other things to do instead of just standing around and becoming a bully or doing other things. You know, getting involved in drugs and things like that. John

In the open forum, community members supported the need for a drop-in center for youth. Some participants discussed how a few years ago they had an opportunity for funding from an organization to build a drop-in center which would have had two sections with bedrooms in the back if youth wanted to stay overnight, a kitchen and a counselor on site. Although funding was granted, the Chief and Council, at the time, vetoed this initiative. Participants in the open forum did not provide rationale for the Council's rejection.

The findings from this study suggest that a drop-in center for the youth in Mimikej is a vision for many of the participants in this study. The youth and adults have many ideas of how the youth center would function and for possibilities of the structure. With youth involvement, and collaboration within the community, this dream could be realized.

Addressing addictions. The youth talked about the issues of drug and alcohol abuse in their individual storytelling sessions and talking circles and how drug abuse and

how alcohol impacts their mental health. In this section I present how the youth conveyed the importance of resources to help members in the community who have an addiction and included the need to address adult community members as well. For example;

It can be kind of embarrassing. I mean I know people can't help it. It's their life choice, I guess. But sometimes they want to get off it but they can't. It would be more simpler if we had more people coming in helping them get through that so it's less embarrassing than saying you live in [Mimikej] and blah, blah, blah. Yeah. Talking Circle #1

Addiction is pretty big. And people say you can go to rehab but rehab only really works if you want to get better. And even if the people want to get better, it's kind of hard for them because they don't have the continuous positive reinforcement. So if you have more like workshops with parents or anyone who's troubled, that might work, I guess. Talking Circle #2

NADACA (Native Alcohol and Drug Abuse Counselling Association) is a service for alcohol and drugs abuse in the community; however, many participants did not talk about how this service promotes Mi'kmaw youth mental health in Mimikej. This service provider talked about services for the youth. She explained;

We have two addiction counselors in the community. And they'll service youth like right up, referring them to... And then there's a youth centre in Labrador. There's another youth centre in Maria, Quebec. And so they do offer, and they can provide detox and treatment for youth in that aspect. Susan

Another service provider explains how services should be more geared towards youth.

And we have a large percentage of alcohol and drug addictions. And they need a service here that they can get help. Because our Addiction Services, I know we have the NADACA workers and stuff but I just think that they need more of a program that's just geared towards youth, youth addictions. ... But then it's hard because then they go back to their homes and there could still be drugs in their home, you know. Kim

Later in her interview she explained;

Addictions in particular is one that I'm passionate about. We need to get something in these communities to help teens effectively deal with their addictions because addictions doesn't get better for a 30 day program. Kim

This Elder discussed the need to respond to the youth in the community who are suffering from addictions;

But what they need, they need a place for these kids. They need an addiction hospital. They need some place where they can go. And for someone to just be really true to them and let them know that, you know, there is a better life out there. And to get them off the drugs. John

This parent explains how in the past there was someone like a counselor involved with the youth but the initiative did not work.

Because they did have somebody up here off the reserve that came to the reserve to one of the buildings and... It didn't work. But I'm thinking it was a person that was off the reserve too. Maybe that didn't work. You know, maybe they weren't comfortable or you know what I mean. Carey

The youth in the individual sessions and talking circles spoke about the need to have resources for people with addictions but they did not talk about NADACA. Drug and alcohol abuse was discussed as an issue in the community by most of the youth and adult participants in many different contexts. The complexity of this issue cannot be resolved by offering addictions services alone. The participants did not expect that a 30 day program for addictions would be enough; they conveyed that a focus on offering services for youth and adults who are addicted requires a concerted effort of long-term resources.

Broader Community Action Plans

Promoting community involvement. The importance of involving families and community in gatherings to enhance community involvement and getting everyone

together was conveyed by the youth in the individual sessions, and talking circles. For example, Keith said, *I guess more places to do something* and Erin said, *I guess we can do activities or something*.

The youth did not talk about doing these activities for youth only. The need for activities which involved community members along with the youth was stressed in the talking circles. For example;

But if there's like a lot of fun activities and doing stuff, and stuff like that, then that would get a lot of people involved and stuff. That's what I think. Talking Circle #3

I like the idea of everyone getting together and like have like more activities for everybody to do. And like so the community can get more involved in everything. Talking Circle #4

Because when I was little, we always had pow-wows. Everyone used to go. It was enjoyable. Just having more of that. Talking circle #4

The adults focussed more on building relationships within the youth population in Mimikej, in keeping with their views that peers and friends are important for mental health. They did not talk about family fun days or community barbeques, and spoke more of how the adults would provide support for youths' events. There is a youth group in the community; however, the adults would like more involvement of the youth with each other, and the adults would provide support by establishing activities for the youth in the community. This service provider explains how the youth can increase their participation in the community, starting with a small group and the group grows as other youth see the benefits.

Yes, starting from a small group, say half a dozen, and they are helping each other and see the good and then the group gets bigger and they start doing some good things in the community. Sam

I think it has to be with everybody, with the parents and with the people that do have time to donate their time or whatever with the youth groups, the after school programs. I think everybody who can get involved should be involved because that helps out a lot. John

You know, they support each other. And that's so important. That group, if they had the right hand, that group would just mushroom like you wouldn't believe. But you've got to get somebody that cares and knows what they're doing. I'm getting too old for that. But if I[t] had been 25 years ago, I would have had a bunch of them going on. Elder talking circle

The emphasis of involving the community in more gatherings was not evident in the adult sessions as they conveyed understandings of promoting youth mental health in their community; however, the adults did present suggestions of the youth doing more together and adults supporting them.

There are barriers to youth being active in the community as suggested by the youth and adults participating in this study. The youth perceived there was a lack of awareness about or advertising of programs for youth, and expressed a concern that not all youth have access to transportation. They identified that these were barriers to youth getting together.

We have to get the word out that there's programs like this because not too many people know. Like me and [name] didn't know until like last year that like youth group and all that stuff was going on. Talking Circle #3

It's just the lack of advertising. And if you aren't connected with other people, like if you don't have internet to be able to find out about a certain event then it is really hard for you, or anybody, to know who doesn't use the internet often to get involved. Talking Circle#3

Debbie, in her individual session, was concerned that youth who did not live in the middle of the community would not be able to access programs or workshops. She stated;

But not a lot of people can get there. Because as before, they don't really have cars or anything. And it's in the middle of the community but still there's people down there and there's people up there.

The adults concurred with the youth that transportation within the community is problematic for many youth, and the adults regarded it to be unsafe for youth to be walking around in the evenings alone. For example, these two adults explain the issues that impede youth from getting together;

It's harder for them to get to the programming if you're, you know, x amount of kilometers away if you don't have a ride, if you don't have... I don't know, I guess one way would be some sort of a transit system. Jeff

And kids have to be able to get there. And it's hard for parents because a lot of the parents, they may live down in the [valley section] but they don't have a car to get them up either. And they don't want their kids walking home late at night if the program is over at 9:30. Like you know, that's being a responsible parent. Cynthia

Collaboration amongst existing services. Although there are services in the community, adult participants identified how the agencies could be working together to promote the mental health of youth in the community, and the need for these agencies to build trust with the youth and family in Mimikej. Mi'kmaq Family and Child Services is the child welfare agency mandated under the Children and Family Services Act to protect youth. The youth did not talk about Mi'kmaq Family and Child Services; however, most of the adults participating in the storytelling sessions talked about Mi'kmaq Family and

Child Services and the influences of this service in the community as it relates to youth and families.

... their reputation and their approach is not good. It's not inviting. They try really hard but they come off as just scary
Maxine

I think we need... I think there's a gap in family services. Susan

I hear it because people would say they would be afraid of Mi'kmaq Family because they could take my kids. And you're looking back in the years and years of residential school. So I don't think there's that trust. Cynthia

Some explained how they were afraid to seek help from Mi'kmaq Child and Family Service as youth would be taken from their families as this Elder explains;

Today it's we have Children's Services. If anything happens in a family, they're right there plopping the kids out of there. And sometimes it's good and sometimes it isn't. Margaret

According to teachers, parents, Elders and some service providers, Mi'kmaq Child and Family Service could be doing more to promote rural Mi'kmaw youth mental health if they worked together with other agencies in the community. The adult participants spoke of families being afraid to discuss concerns about youth in the community because of Family Services. Some teachers explained how they avoid Child and Family Services, yet are concerned about youth who are in families that are not necessarily healthy and are selling drugs to youth.

I don't think they should have to be under the Children's Services to get help there Andrea

This teacher explains in more detail her concern about Mi'kmaq Child and Family Services in the community;

It's a foreign service. And they're not welcome. They're actually intimidated... The people that do live here are

intimidated by them. I actually have no use for them myself personally. And I've had experiences with them. Very little at that, and thank God. But I don't want them..... And people don't like it because they've been taking our kids, and not from me but people in my family, and taken them and taken them out of the community. They stopped taking our kids and putting them in the residential schools and abusing them, and they did a 360 scoop and then they changed it. Now they're more foster First Nations kids in foster care than there ever was in residential schools or jails combined. And they're going out there and the same thing is happening to them. They're landing in homes of strangers, foster parents. Mary

Families who are concerned about their teenage children do not feel comfortable asking for help from Mi'kmaq Child and Family Services. This parent explains that the community can do better than having children grow up under the protection of the agency and is concerned that youth under Mi'kmaq Child and Family Services have access to services that are not necessarily having an impact on promoting health. She states;

Children that are growing up in care, I think that they have a lot of access, more access to services that are paid for and there's research for. I mean they've sent children to Utah and all over the place. And none of those services that I know have really made a big impact on that child's life..... Like I said, they grew up in care, in the agency. And it's very sad to see that that's the best that we could do with all the money that they could give towards that. Elizabeth

This Elder also spoke about her concerns with Mi'kmaq Family and Child Services

The parents are given false hope, I found. I have relatives that had their children taken away, and friends. And they were told, you know, if you straighten up, you'll get your kids back. But they never got them back until the children were old enough, or if they had a member that was in the political arena that would help them. But if they didn't have that political person to help them, they never got their kids back. And I found that pretty sad for some kids. Catherine

This service provider acknowledged there is a gap in services and would like to see more of a focus on mental health and that Mi'kmaq Child and Family Services could work together with other agencies in the community. She explains;

There are so many layers and layers of issues that we're asking people to look at. Which is why I think if we had like Mental Health, I think they would see it different than Mi'kmaq Family and Children Services. Because then their mandates are different. More community approach programs is I think what we need more of to help people so that they can come in and talk about it and not feel blamed, and feel supported to say we need to work together. Cynthia

Adult participants presented some concerns about Mi'kmaq Family and Child Services as it relates to Mi'kmaw youth mental health in Mimikeyj. They conveyed that youth who are having problems with family members who are drinking should not have to go to this agency to get help, and that Mi'kmaq Child and Family Services should collaborate more with other agencies in the community. Some participants also explained how other services in the community were instrumental in the issues surrounding rural Mi'kmaw youth mental health.

The RCMP service in the community was seen as important for youth but as one youth explained, he thought about calling the RCMP but realized the social ramifications.

No. No. Because people would be like, "Oh, he went to the cops. Don't tell him what you're going to do." Because if you're doing drugs or under-aged drinking, "Oh, don't go near him because he's going to tell the cops on us." Jim

Jim was explaining how he was thinking of going to the RCMP when he was being abused but realized he may be perceived as someone who would also report others who were drinking or abusing drugs. In other words, the RCMP were perceived as an agency that some youth kept away from as they did not want to get in trouble with the law. If

you were seen by other members of the community as someone who would seek help from the RCMP, you could be ostracized.

This parent shares another common concern expressed by some of the adult participants such as who the youth can call when a youth in the community needs help for whatever reason. She explained;

But they really don't have anybody. Usually it's just the RCMP. And this is where you get the, "Oh, you've got to go here. You've got to go to the hospital." You know what I mean? And sometimes it's not as bad as they make it. Carey

She was explaining how the RCMP are called when a youth is having trouble, and the RCMP would take the youth to the hospital, which this parent suggested was not the solution for some youth.

Many participants also discussed the poor financial state the community is in, and how this affects the resources in the community or the ability to create opportunities for youth to live life well. For example, youth shared about the need for fundraising for trips or for sports activities, as this youth explains;

And so I had to fundraise money. Luckily I have a lot of people around here that I know and that know that I would like...I wouldn't just go like spend it on smokes or something. I would actually go into the sport. And that's why I'm playing rugby now, is because I've raised that money. And thankfully I did have those people. Patrick

These service providers summed up the economic need in Mimikej and how it influences resources.

It's always a money thing, yes.....So no, it's a money issue for the Band or what have you. Kim

So there are so many resources that need to be here in [Mimikej] to make a difference for our kids. Because I hear their

stories all the time from the youth, the youth themselves, plus their friends. Cynthia

Economics in Mimikey was seen as a barrier to creating opportunities and as Jeff, a parent and service provider concurred, *It all boils down to the almighty dollar.*

A few participants spoke briefly about employment in the community.

But we want our youth to be working here too. Sam

This Elder spoke about work in general in Mimikey and the need to increase work in the community.

It's work. Work is what makes the community move. We don't have enough work. We need more work. Catherine

One parent concurred that work in the community is needed, and in particular in the field of mental health.

So we need more of our people that can work in our community, not non-native people. Our people don't feel that they're helping them... I would say for every story that I've heard of mental health, a person that asked for help __ or went for help, 95% would have said that they left it and they didn't get the help they need. And they're still suffering today.
Elizabeth

Selling drugs in the community is profitable and some participants acknowledged that poverty in the community has forced some members to earn money illegally. For example,

But for some... I've seen so many people like here, they'll say they were forced to do it because they didn't have no money.
Cynthia

Also, some adult participants talked about school in general, and promoting education for work for youth, as this teacher and Elder explain;

Oh, education has a big thing to do with it too, right. Allen

Yes, it's that school there. There's a few going back to the [local] school. So that's good. As long as they go to school, I don't care where they go. But we push education. It's so important to them. I always explain to them, you've got to have this education. I said the more education you get, the bigger purse or the bigger wallet you're going to need because the more money you're going to get. John

Other adults talked more specifically about what needs to happen in the school in Mimikey, such as having a local school board, offering more programs at the school, or involving the school more in discussions with other service providers in the community. As these two adult participants explain;

We don't have a school board and we don't have the chief and council at the school board. So we don't have anywhere to bring out concerns to about these things ... I wrote letters since last May to the school, to the chief and council about developing the school board and putting Elders in the school, and bringing these teachings into the school...So we actually need a school board. Elizabeth

I think that whether it takes involving the schools here, mom and dad, or the youth, or recognizing where there's a problem and not being scared to say do you need a counselor, do you want someone to talk to? Susan

Not many spoke about services at the health center related to Mi'kmaw youth mental health in Mimikey aside from speaking positively about the youth groups and youth council, which were identified earlier as important for promoting Mi'kmaw youth mental health. The youth groups and youth council are organized and offered by the health center. The mental health coordinator is seen as very busy with the youth groups and some participants believe another individual could be involved in working on other matters of mental health for youth, as this parent explains;

Like we do have a mental health coordinator but I think she does a lot already. But I think that it should be an individual

that puts on and takes on all this. You know what I mean?
Carey

Very few participants talked about how the agencies in the community are working together to promote Mi'kmaw youth mental health in Mimikej. As this Elder explains; *I think we need more infrastructure in our community*, [Margaret]. She was referring to infrastructure to develop opportunities within the community for Mi'kmaw youth to promote their mental health.

One service provider talked about working more closely with the school and how she is not involved in any meetings with other agencies.

Again, I haven't been involved in it but I think they do have community forums. Like they have community meetings here where the police get together and the Band and stuff. So I think it is happening. I'm just not involved in it. Cynthia

This service provider suggested;

It has to be run by First Nation people that know the community that people trust..... Trust is huge in this community.....People have to come together to put these services together for sure. Kim

Calling upon external resources when needed is also valued by the community, as this Elder explained in the Elder talking circle;

Like I say... You see, if we can't find the answer, we have to be able to branch out to find the answer out there or somebody to come in, like a resource person.

This parent's quote summarizes what is needed for Mimikej to move forward.

We can look at crime rate. We can look at those. We can look at suicide rates. We can look at family violence. We can look at separations. We can look at divorces. You can look at just about any area you want. They form different parts of mental health when it comes to any human being that lives within those confined areas. And in order for us to move forward with our youth, we need to find balance, we need to find harmony

amongst our people as families, as community and as service providers. Matthew

Supporting parents. The youth and adult participants in this study presented how parents are influential in affecting the mental health of Mi'kmaw youth in the community. In this section, I present how participants suggested that parents need support in their efforts to promote rural Mi'kmaw youth mental health. The youth participating in this study conveyed that parents need to care for the youth. For example;

I would like to see parents start caring for their children more than what they do, and actually spending time with them, and treating them all equally instead of favouritizing one. Talking Circle #1

On the other hand, adult participants were concerned that some parents are held hostage by their children; for example, some youth have threatened to call Mi'kmaq Child and Family Services. One parent explains;

The parents say, oh, no, you're not. "Oh, yes, I am." "Oh, no, you're not. You've got homework to do and you're doing your homework." "I am not. I'm going up the road." And a big argument starts over homework. Well, the mom puts her foot down, or the dad puts his foot down. "Come here, young man, come here, young lady," grabs her by the shoulder or by the arm. "Let me go. You touch me one more time like that and I'm calling Mi'kmaq Family on you or I'm calling child welfare on you. You have no right putting your hand on me." Matthew

Adults participating in this study identified other issues parents face in the community, such as having a child involved with addictions. This service provider explains the complexity of the issue;

I think as a parent, then you feel like how did this happen to me? How did this happen to my child? How did he get involved in addictions? You know, it's that guilt that comes with it shouldn't have happened to him, you know, and stuff. And then, you know, you could also have a parent that is still

*in a relationship with a partner that's still actively drinking...
Like you know, it gets complex. Kim*

Further, the adults participating in this study suggested parents should also be knowledgeable about mental health issues such as depression.

And parents need to understand how to treat, how to support children to live with anxiety, how do you live with depression, how to know signs if your kids are depressed, and when it becomes a major risk to their life or whether it's just living with depression. Cynthia

So you want to be able to provide support for the parents but you know what, what specific program is there for parents that are dealing with out of control teenagers, young adults? And it doesn't necessarily got to be a child that's addicted to drugs. And a lot of parents will say, you know what, it's sad because I'm not talking to my daughter or my son, I'm talking to the addict. Matthew

Another important concern raised by the adults participating in this study is that some adults are still grieving over the residential school experience and this issue has not been addressed. This teacher explains;

The adults that live with it, that were abused, they're still here. And their mental health regarding that abuse issue has not been addressed in any other way except a conference at residential school. Mary

Although the youth participating in this study did not discuss the issues parents are faced with, they did acknowledge the need for parents to demonstrate care and spend time with adolescents in the community. The adults participating in this study suggested that a priority for enhancing rural Mi'kmaw youth mental health would be to provide support for parents including education, and services that could help parents with adolescents with addictions and with addressing the grief some parents may be experiencing because of the residential school experience.

Discussion About the Action Plan

Youth and adults who participated in this study conveyed opportunities to promote rural Mi'kmaw youth mental in Mimikey that could be realized. The youth participants provided concrete examples of how to promote Mi'kmaw youth mental health in the community. The funding we received during the data collection phase of this research, for two weekend retreats on the land with 12 to 14 year old youth in Mimikey and Elders, monthly sessions with youth and Elders, or other informal leaders knowledgeable about Mi'kmaw traditions, and part time employment of two youth to coordinate the project is not sustainable. This project is supported by single year funding and is an example of the issues associated with sustainability of youth-focused community initiatives. The need for continuous on-going flexible programs with youth was a concern. However, the community continues to work with the youth groups and to promote sports within the community.

During the 18 months of data collection and meetings with the CAC, other events occurred that were a part of our discussion on mental health and health promotion. For example, the youth participating in the Mi'kmaq summer games now have their own team with Mimikey tee-shirts, some youth started having tea with Elders during Elder luncheons put on at the health center, a program helping the supervisors who work with youth after school respond to youth who were bullying other youth was established, community events were advertised on the Band website, and evening Mi'kmaw language classes planned. Further, the guidance counselor of the local school, the nurse at the health center, a representative from Mi'kmaq Child and Family Services, and a representative from the Native Alcohol and Drug Abuse Counselling Association

(NADACA) plan to meet regularly for case management of youth who may be under their care to ensure that services for these youth are not duplicated, are coordinated and provide continuity of care. These initiatives are examples of how the community is creating opportunities for youth to live life well. None of these initiatives can be attributed to being a direct outcome of this research; however, conversations in the community on the activities of this community-based participatory research, which was transparent, may have contributed to the community's ongoing discussions of what they perceived as important to promote Mi'kmaw youth mental health. It is also possible that these initiatives may have informed what participants conveyed in their interviews. The initiatives demonstrate that Mimikey is working on priorities to improve rural Mi'kmaw youth mental. These initiatives are a beginning and require commitment and resources to develop broader and more in depth sustainable opportunities in mental health promotion for the youth in Mimikey.

The initial work with the different agencies described above is important, and responds to the need for collaboration among existing services as described by the adult participants. Concerns expressed by the adult participants about Mi'kmaq Child and Family Services warrant revisiting this agency's mandate to determine how services can better align with the community's priorities for promoting opportunities for Mi'kmaw youth to live life well. As suggested by the adult participants in this study, individual organizations in the community respond to youth episodically with little cross-system communication resulting in seemingly random intermittent services for youth. Mimikey could develop a model of practice to be all-encompassing of the resources identified by participants and be inclusive of all levels of care. Kirmayer Whitley and Fauras (2009)

have written an extensive report for Health Canada First Nations and Inuit Health highlighting examples of community team approaches to mental health services and wellness promotion in urban, rural and remote Aboriginal communities. A fundamental concern in their report is that programs should not be parachuted in, and “that integrated health services require that mental health is incorporated into health policy and legislative frameworks, supported by senior leadership, adequate resources, and ongoing governance” (p.43). A health promotion model with professionals, integrated with other community organizations, Elders, informal care workers, and families is an opportunity for Mimikej to promote Mi’kmaw youth mental health. Figure 3 (p. 263) is a beginning resource planning model based on the ideas generated in this study. This model is adapted from Reading, Kmetz and Gideon’s (2007) First Nations Wholistic and Planning Model found in Appendix A (p.284). More input and involvement from the youth is needed to increase the comprehensiveness of the planning model. The benefits of the youth group, enhancing interactions between the youth and Elders, increasing activities such as sports, implementing workshops that are meaningful to the youth, having trusted listeners which may include youth helping youth are all actions which have been emphasized in the findings of this study. Youths’ voices are critical to the success of initiatives developed in Mimikej.

The findings in this study suggest that programs to address addictions in the community should be expanded. Many Mi’kmaw youth conveyed how alcohol misuse by adults in the community negatively impact Mi’kmaw youth mental health. Mimikej has a treatment center for adults, but they do not have any specific services for youth, aside from sending youth outside the community. There is a need to provide more counselling

for youth who have addictions, or who return to the community from a treatment center. Some adults in this study identified that treatment for addictions is ongoing, not just a thirty day program. Youth conveyed that youth who have addictions cannot always solve this issue on their own. One youth identified the benefits of healing circles, and other youth conveyed the importance for some youth to have someone they can talk with.

Lastly, the adults in this study identified that parents need support. In the open forum there was some discussion about how supports for parents with young children are already in existence and could be expanded to include parents with older children. Further investigation is needed to determine strategies for supporting parents who have adolescents in the family, and what supports parents would benefit from as opposed to providing prescriptive parenting tips.

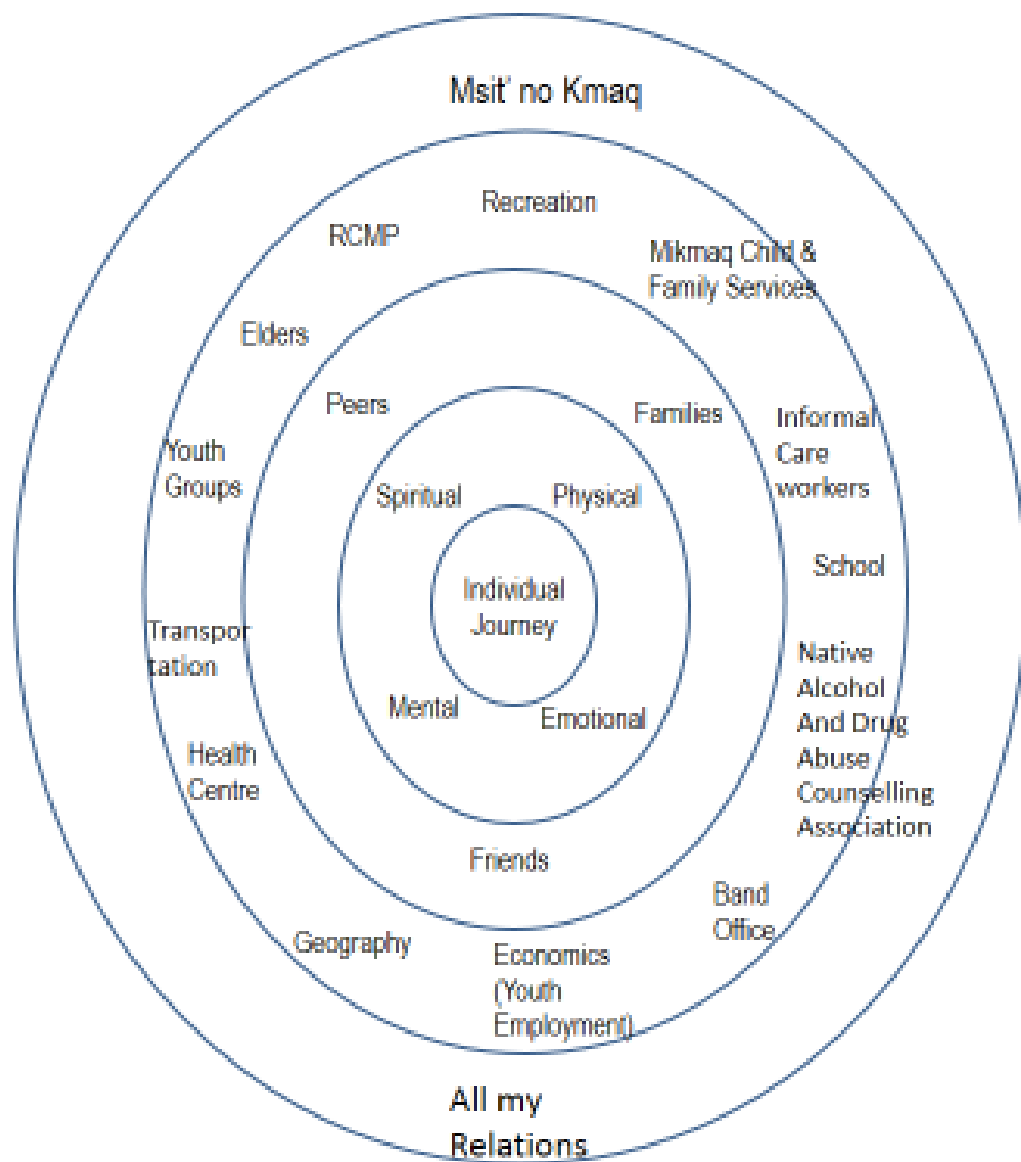
Although Mimikej may administer programs, and seek funding for initiatives that are short-lived, the ability to govern their health services could alleviate the barriers that prevent the community from advancing the mental health priorities of Mi'kmaw youth. This concern may be addressed as self-government in other First Nations communities is advancing toward this direction. For example, British Columbia has recently established self-government of health services (Tripartite Committee on First Nations Health, 2013); however, self-government of health in Mi'kmaw territory is far from being established. During the interim, health care professionals, including nurses, and the agencies and resources identified in this study can work collaboratively with each other, and with the youth in Mimikej, as they create and develop opportunities for Mi'kmaw youth that are commensurate with Mi'kmaw ways of knowing.

Summary

The youth participating in this study have demonstrated their understanding of what promotes their mental health. The youths' perspectives are meaningful and provide directions for priorities that matter to them. The adults in this study are more familiar with the agencies in the community and the need for these agencies to work together. Mi'kmaq Child and Family Services is not perceived as helpful. The need for all agencies including the School, RCMP, the Health Center, Mi'kmaq Child and Family Services and NADACA to work together was supported by the adults.

Although economic resources are an issue, as one Elder recommended, "*small accomplishments first*" are needed. Involving community members that have the time, and by building on the resources within the community could provide more opportunities for Mi'kmaw youth in Mimikey to live life well. The community has been working on promoting Mi'kmaw youth mental health and participants in this study have identified how to further promote rural Mi'kmaw youth mental health.

Figure 3 Resource Planning Model for Action Plan to Promote Mi'kmaw Youth Mental in Mimikeyj



Chapter 10 Conclusion

In this chapter I present implications for research, practice, education and policy; limitations of the research; a reflexive account about the research; and plans for dissemination. Further, I provide an analysis of the application of employing two-eyed seeing, ethical space and community based participatory research (CBPR) when conducting decolonizing research with Aboriginal people. This discussion is necessary in order to extend methodological knowledge of what it means to conduct research with Aboriginal people using processes that enable the co-creation of knowledge, and that do not perpetuate the colonial legacy. I end the chapter with concluding remarks about the overall study.

Research Implications

Research concerning Aboriginal youth mental health should be conducted with Aboriginal people, and with Aboriginal youth in particular, as this study identifies the importance of their involvement in research. The findings in this study demonstrate how research that focuses on a strengths-based approach, and on Aboriginal ways of knowing enhances knowledge development. The youth in this study presented their understanding of mental health, how they strive to achieve mental health, and the desire to have opportunities to reach their full potential. Investing in the inclusion of Aboriginal youth in research calls to attention their issues and may inform program development. Based on this study, future research with youth should focus on either young adolescent, middle adolescent or older adolescent age groups. This study included 14 to 18 year old youth, and although there were similarities in the findings, the younger youth found it more

difficult to articulate their understandings. It would be relevant to focus more attention with young adolescents as they come to know who they are.

King (2011), the Scientific Director of Canadian Institutes of Health Research, Institute of Aboriginal Peoples Health, calls for an emphasis on intervention research and knowledge translation that would enable communities to achieve their goals of health equity (p.74). Future Aboriginal youth mental health research is needed to evaluate interventions and programs aimed at promoting Aboriginal youth mental health from a strengths-based approach. For example, what initiatives currently support Aboriginal youth to develop their sense of self, and how would it be determined if these interventions are effective? Empirical evidence of effective programs and community development strategies are timely as Aboriginal people proceed in their efforts to promote Aboriginal youth mental health. For example, if the program in Mimikej that received funding from the Mental Health and Addictions Community Grants Program in Nova Scotia had long-term funding, meaningful evaluations over time would determine whether the objectives and plans were effective. A prospective study identifying the benefits of youth input, and youth participation would enhance future initiatives and provide direction for further development. A wholistic and relational understanding of Aboriginal youth mental health could advance research that goes beyond identifying Aboriginal individual youth risk factors.

Decolonizing research: theoretical implications. This qualitative inquiry was conducted by employing community based participatory research (CBPR), and the theoretical constructs of two-eyed seeing and ethical space. In recent years CBPR has been advocated in the Tri-Council Policy Statement (Canadian Institutes of Health

Research, (CIHR), Natural Sciences and Engineering Research Council of Canada, (NSERC), & Social Sciences and Humanities Research Council of Canada,(SSHRC) 2010) for conducting research with Indigenous peoples. In this section I discuss two-eyed seeing, ethical space and CBPR and the methods of storytelling and talking circles as a non-Aboriginal researcher with respect to methodological considerations for promoting decolonizing research. This discussion may help inform future research with Indigenous peoples

Martin (2012) suggests two-eyed seeing offers a way in which diverse perspectives might work together to answer our most pressing questions about the health of Indigenous people and communities. “Two-eyed seeing acknowledges the entrenched power imbalances between Indigenous groups and the dominant health-care system which has historically suppressed Indigenous world views and practices” (Vukic, Gregory, & Martin-Misener, 2012, p.149). Two-eyed seeing and ethical space challenged me as a researcher to build relationships based on mutuality, and to explore different understandings of rural Mi’kmaw youth mental health with participants in Mimikej. Ethical space created a framework during the interviews, and with the CAC during analysis and interpretation of the findings to discuss mental health in a mutual, respectful manner that included different perspectives of what it means to be mentally healthy, and how to promote Mi’kmaw rural mental health. However, two-eyed seeing remains a binary concept which limits the analysis and interpretation of the data. In a complex historical and sociocultural environment embedded in an era with the resurgence of Aboriginal traditions and the effects of colonization, two-eyed seeing does not take into account dynamic multiple perspectives. Two-eyed seeing was valuable in the initial

phases of the research as this construct was used to guide the research process. Two-eyed seeing lost its robustness in the analysis and interpretation as it was challenging to be inclusive of multiple ways of knowing mental health. Including participants' conceptions of Mi'kmaq youth mental health in order to develop potential health promotion action plans specific to their community was problematic as the intersections of colonization, social, historical and economic issues were not unveiled through two-eyed seeing. With respect to ethical space, this construct was instrumental for ensuring dialogue with participants and the CAC about intentions, values and assumptions, during the inception of the research, data collection, analysis of the data, and the co-construction of knowledge.

Staying true to Indigenous methods of storytelling and talking circles warrants consideration by researchers. The direction of the research stems from participants, more so than the researcher when employing these two methods of data collection. Participants chose to speak of their lived realities and what was meaningful to them. As these methods place an emphasis on participants' flow of discussion, they might restrict probing of potentially relevant topics. For example, in this study participants did not talk much about the influence of Catholicism on mental health and I did not pursue it.

Potentially, this may have been a lost opportunity. Decisions of employing storytelling and talking circles should stem from the research purpose and questions. Therefore, before embarking on research with Aboriginal peoples, researchers should determine if data from storytelling and talking circles would be consistent with meeting the objectives of the research. In this dissertation, data collected from the storytelling and talking circle sessions supported the purpose of the research and research questions.

Marginalized communities are often misrepresented, pathologised or problematized by research processes (McAreavey & Das, 2013). CBPR is a promising method for shifting the research process from participants being researched to being active partners in the research, leading to the co-construction of knowledge. Including a Community Advisory Committee (CAC) in this research helped to shape the research in a way that involved the community and informed the data collection and analysis that was not misrepresenting the community's understanding of rural Mi'kmaq youth mental health as the CAC was intimately involved throughout the research process. What becomes problematic in marginalized communities is the ability to share power and control of the research; however, sharing control of the research is more probable in CBPR where partnerships are established, than in other methodologies that may not engage community partners.

Mantoura and Potvin (2012) caution that participatory research in heterogeneous communities must be conscious of co-researchers' hidden agendas, politics, interests, projects and expectations, and rarely is this explicated in the research. The co-creation of knowledge with a CAC should be articulated in the write-up of the study. In order for CBPR to be recognized as a valid research method, the need for reflexivity on the part of all co-researchers is critical. In this dissertation, CAC members were not engaged in critical reflexivity in the write-up phase; however, the discussions and negotiations of the findings during the meetings were done in the spirit of mutual co-operation. Further, the multiple data collection methods facilitated multiple perspectives from the community. For example, the final data collection method, the community open forum, enabled community members with multiple interests and agendas to contribute to the data, and interpretation was done in mutual collaboration with the CAC. One of the findings

included the priority of connecting youth with Elders and Mi'kmaw culture for promoting rural Mi'kmaw youth mental health. This was conveyed by most participants in the individual storytelling and talking circle sessions and was supported in the final open forum. This priority was not an individual agenda of certain members on the CAC as many participants in the multiple methods of data collection identified this priority.

Kingsley and Chapman (2013) suggest achieving agreement between partners regarding data interpretation is one way for ensuring quality. Therefore, structuring the research process to provide opportunities for achieving agreement needs to be considered in the planning of the research. For CBPR to be recognized as valid within Indigenous communities, initial and ongoing negotiations of the research purpose, design, including the roles and responsibilities of CAC members, implementation, and write-up are fundamental. Working with a CAC can take many forms, and in this research the CAC's involvement was more than simply advising who to interview, and proper protocols for conducting research in the community. Engagement of CAC members necessitated initial discussion and negotiation of what roles and responsibilities were important to them as committee members. Conversations regarding what was relevant to the Committee with respect to their level of participation and the terms of reference for the Committee were crucial to the success of this research. The establishment of relationships that are committed to seeking truth built on the foundation of trust and open communication in the context of an equal playing field is not an easy task. Researchers can not underestimate the complexity of including a CAC in the entire research process if the CAC is to be involved in responding to the research purpose and questions.

There are institutional barriers to enacting CBPR that is proclaimed as decolonizing. Researchers must consider their positionality in the confines of doing research as an outsider. Castleden, Mulrennan and Godlewski, (2012) posit most university-based research concerning Indigenous people—considered “legitimate” by those in positions of power—is carried out by non-Indigenous researchers and informed by theory developed in the absence of Indigenous perspectives. Aboriginal research is conducted within a dominant Western society professing neoliberal ideologies that are difficult to disentangle. In the Indigenous Knowledge Translation Summit Report, summarized by Kaplan, Myrth and Smylie, Ermine (2006) presents four models of research demonstrating: A) perpetuation of Western ways of knowing , B) perpetuation of colonialism, C) appropriation of Indigenous knowledge and D) an Indigenous framework that works with institutions to facilitate change within the Indigenous community. Figure 4 below depicts the four models in more detail.

Figure 4: Ermine's Models of Research

Model A: Mono-culture

(Western) Research ⇒ Synthesis ⇒ Policy ⇒ Application (Masses)

Model B: Colonialism

(Western Knowledge) research ⇒ synthesis ⇒ policy ⇒ application
For example; translate knowledge ⇒ transfer (to Indigenous community)

Model C: Appropriation

(Indigenous knowledge) research ⇒ synthesis ⇒ policy ⇒ application
For example; translate ⇒ transfer (into Western system)

Model D: Indigenous framework

(Indigenous based development of knowledge / institutions)
research ⇒ synthesis ⇒ policy ⇒ application ⇒
(Within Indigenous community)

(Ermine, in Kaplan, Myrth & Smylie, 2006, p. 35).

Ermine claims that until communities reclaim their knowledge base, and recapture significant control of the institutions that govern their lives, inroads in the application of knowledge translation and transfer may not be realized to affect change within the community (p.36). To capture control of institutions that regulate Aboriginal lives may be hard to achieve, and would necessitate ongoing serious negotiations amongst many political organizations. Mutual discussions are important. Recruiting Indigenous People and Indigenous scholars to be involved in the review of research grants involving Indigenous People would promote research that is inclusive of an Indigenous framework. Further, knowledge created from within an Indigenous framework may inform Western practices and should be acknowledged when included in knowledge dissemination and translation. For example, Johnston, Vukic and Parker (2013) acknowledge that there is now a recognition that non-Aboriginal societies can learn from Aboriginal community-based end of life care practices.

CBPR and two-eyed seeing, employed with an understanding of ethical space may prompt future development in the field of Aboriginal research; however, along with the concerns presented above, there are challenges. Shea, Poudrier, Thomas, Jeffery and Kiskotagan, who do research with Aboriginal youth (2013), note challenges including the time required to develop and maintain relationships, negotiation of power differentials, complexity of data analysis, need for flexibility, and difficulty of finding time for non-academic partners to devote time to research while still delivering services and programs in their communities. The latter is critical as community members are called upon to participate in meaningful ways with researchers, taking them away from their other responsibilities within the community. In this study, coordinating regular meeting times with the CAC was ongoing. Community members often had to juggle their commitments in the community to work with me. It was difficult to find time for members to participate as they were often pulled in many directions to respond to family members and work, or school commitments that would take precedence. Although an honorarium was provided to support and acknowledge CAC members' work in this CBPR, members were motivated by their involvement in the research process more so than receiving the honorarium. Their commitment to being on this committee was based on the purpose of the research. Therefore, working with the CAC, clearly establishing the purpose, the design, members' roles and ongoing negotiations is important as the demands placed on a CAC to participate can be limitless. It is important to invest in creating ways that facilitate participation of community members in CBPR.

With respect to power differentials, it is critical to build a trusting relationship, develop processes to negotiate differences, and build capacity with all members including

the researcher. For example, the members learned about the research process, ethics and confidentiality in research, and I learned more about analyzing data with an advisory committee. Acknowledging power differentials enables research to be conducted in an ethical manner that does not perpetuate a Western hegemony of ontological and epistemological world views, and resists the propensity of a researcher to control the research. Unwittingly researchers may control the research process unbeknownst to the researcher and community members.

CBPR is a promising method, and value orientation for doing research with Aboriginal communities that supports a decolonizing approach to research practice. Debate and dialogue of the limitations, tensions and possibilities of CBPR are necessary to mitigate complacency of incorporating CBPR as the gold standard for doing research with Aboriginal communities. Ongoing discussions to explore and enhance policies and procedures to promote decolonizing Indigenous critical inquiry is necessary to affect change.

Practice Implications

There is a critical need for community health/public health nurses to work in collaboration with youth, other agencies in the community such as the school, informal leaders, Elders, volunteers, and other organizations, and other disciplines such as medicine, social work, and families as they develop and implement programs to promote Aboriginal youth mental. There are two main components of the practice implications. The first focuses on youth involvement, and the second focusses on promoting, developing and advancing programs that involve community members and resources within the community.

Youth involvement. Nurses can work with individual youth, acknowledging their strengths, but concurrently they need to be involved with the community's efforts in creating and providing opportunities for rural Aboriginal youth to live life well. This approach encompasses building relationships and communication strategies to discuss, implement and evaluate programs with youth in the community. Working with youth, involving them in affecting change, and supporting their ideas and creativity would enhance their journey. The Mi'kmaw youth in this study have identified their visions for promoting Mi'kmaw youth mental health and they want to be actively involved in creating and implementing programs, workshops and activities geared towards youth and the community. The youth group was identified as a strength in this study. Working with this group to foster and support future activities in Mimikey would benefit the community. Shantz (2010) has identified how the youth council in Tyendinaga Mohawk Territory has played a central role in reclaiming the traditional practices, spaces and culture in their community. Shantz claims that Tyendinaga once suffered the horrible burden of youth deaths and suicides. Participation of young people within the initiatives in Tyendinaga have sparked a resurgence of Mohawk cultural and social practices. The resurgence is reflected in part through the establishment of the territory's first functioning longhouse in over a hundred years, and the youth council played an active role in this accomplishment (p. 236). The benefits of the youth council in Tyendinaga and other Aboriginal youth movements are examples of youths' potential in promoting their mental health and in supporting the community.

Integration of services. It is most important for community health/ public health nurses to practice health promotion within a model that includes interdisciplinary

practice. Interventions require multisystem approaches to address the multifaceted and complex social topography of rural Mi'kmaw youth mental health as identified in this current study. For example, developing formal programs for peer support in the community would enable youth to respond to their friends and peers who need help. Developing programs that support mothers and fathers or guardians as they parent adolescents in their journey is another example that could be explored with a community. There are human resources, such as Aboriginal mental health workers, Elders, traditional healers in and outside the community that could be called upon. Also, there may be established prevention programs initiated in other Aboriginal communities that nurses working with community members could adapt to promote Aboriginal youth mental health. Engaging in local knowledge, and building on the capacities within the community are the cornerstones for an interdisciplinary approach to practice that builds on the strengths of the youth and the community.

Education Implications

All health professionals should be well versed in the historical, political, economic and cultural realities of Aboriginal people. This knowledge is particularly relevant for nurses as they are major providers of health services in the Canadian context. Curricula for all health professionals should be more inclusive of Aboriginal ways of knowing, and of Aboriginal health issues (Stansfields & Browne, 2013). Advocacy and negotiation skills would benefit health professionals as they build partnerships to promote Aboriginal youth mental health. These skills are supported by recommendations from the Canadian Association Schools of Nursing Education/Association Canadienne des écoles de science infirmières (CASN/ACESI) and the Aboriginal Nurses Association of Canada

(ANAC) to enhance nursing education to address the socio-historical, cultural and contextual determinants of Aboriginal health (CASN/ACESI, 2013, p.11). Based on the findings of this research, nurse educators are encouraged to employ the recommendations put forth by CASN/ACESI and ANAC. Further, nurse educators should include a strengths-based approach to Aboriginal youth mental health, a broader wholistic and relational component to understanding Aboriginal youth mental health, and an approach that is not limited to the biomedical model.

Recruitment and retention of Aboriginal health professionals would increase the presence of role models, and legitimization of Aboriginal people who could support Aboriginal youth, and would promote employment for Aboriginal people. There is an urgency of revisiting and evaluating current strategies of recruitment and retention of Aboriginal nurses. Universities would be wise in advancing Aboriginal nursing scholars at all levels of degrees from undergraduate to graduate levels. At the most recent ANAC conference I attended, there was a focus on ANAC and the Canadian Nurses Association (CNA) working towards strategies to enhance the recruitment and retention of Aboriginal nurses in Schools of Nursing (ANAC Annual Conference, Vancouver, B.C. November, 9-11, 2013). Further, ANAC is developing Memorandums of Understanding with specific Canadian Universities to build strategies to enhance the recruitment and retention of Aboriginal nurses (personal communication, Fjola Hart Wasekeesikaw, Executive Director of ANAC, September, 2012). As more Aboriginal students participate in university nursing education their involvement in Aboriginal health research skills could develop, as would their leadership abilities.

There was no definitive response from the youth in this study if they would seek care from Aboriginal or non-Aboriginal health professionals. Many of the Mi'kmaw youth in this study were concerned that care providers could relate to them. Some youth and adults did perceive Aboriginal care providers as important, and this option should be available. Similarly, some youth conveyed the importance of participating in traditional healing circles. Aboriginal health professionals could facilitate Aboriginal youth mental health promotions in ways that are commensurate with Aboriginal ways of knowing. A larger pool of Aboriginal health professionals would help shape Aboriginal mental health promotion that is in keeping with Aboriginal ways of knowing, and hence the need to increase the number of Aboriginal health professionals. The Aboriginal Health and Human Resource Initiative (AHHRI) has provided structure and support to promote Aboriginal health professionals (<http://www.apcfn.ca/en/health/ahhri.asp>). This resource and other supports such as bursaries and scholarships would provide opportunities for Aboriginal youth to pursue a health professional career.

Policy Implications

Investing in long-term sustainable and flexible funding for health promotion initiatives that support efforts to promote Aboriginal youth mental health in an environment inclusive of family and community is necessary. Long-term flexible funding would enable the community to modify program goals, objectives and strategies as they implement programs that are driven by the community. Aboriginal people need to take a lead role in promoting the mental health of Aboriginal youth; consequently, mental health policies should be part of health policy which is governed by Aboriginal people with adequate resources for successful outcomes. This remains problematic in the current

climate of fiscal restraint resulting in the abolishment of important organizations such as NAHO, AHF that have supported Aboriginal peoples in their efforts to address the effects of colonization. Another important and relevant policy consideration is that Mi'kmaq Child and Family Services revisit their policies to identify how their mandate to serve and protect Mi'kmaq youth could be aligned with the community's priorities. Collaborating with the community would strengthen the relations with parents, Elders, service providers and teachers as many identified the services are not helping Mi'kmaq youth in the community. MacDonald and MacDonald (2007) testify for the need "to challenge and change this system that continues to colonize First Nations people" (p.44). The concerns that the Child Welfare System for Aboriginal youth does not respond to the needs of Aboriginal youth is not unique to this community. Professionals in the field of Aboriginal youth health claim that child welfare services are responding to crisis situations rather than developing preventive interventions, and this has led to unacceptably high apprehension rates of Aboriginal youth in foster homes (Blackstock 2011; Tait, Henry, & Loewen Walker, 2013). This current study supports concerns that Mi'kmaq Child and Family Services need to work with the community so that fewer children are apprehended. Mental Health Services, Department of Health Services, and Community Services could co-operate and collaborate to support policies and funding that respond to the needs, and strengths of Aboriginal youth and families as determined by the Aboriginal community.

Limitations of the Research

A limitation of this study is that it took place in one rural community in one province. Interviewing youth in another rural community may have added more breadth

and depth to the findings and allowed for greater comparison and contrast of the findings. Despite this limitation, the number of youth and adults interviewed, and the multiple methods of data collection provided a rich data set for the co-creation of knowledge to respond to the research questions.

A Reflexive Account about the Research

Reflexivity is critical in this type of research as it enables the researcher to speak to the “crisis of misrepresentation” (Fonow & Cook, 2005, p. 2281). Crisis of misrepresentation is a term that is used to describe qualitative researchers’ presentation of data which does not necessarily represent the voices of participants, which may be problematic in the write-up of the research report. Oleson (2005) promotes the need for reflexivity and consideration of whose voices are being included and excluded, and why, or why not, recognizing that perspectives of participants are not void of different ideologies. Reflexivity provides the need for making explicit the researchers’ relationship to the voices. Absolon and Willet (2005), who are Aboriginal scholars, support the need for locating one’s history, gender, class, race and social attributes. They claim: “It is time that academics recognize the validity of research processes that account for the influence of the researcher’s reality. Locating self in research brings forward this reality. Location ensures that individual realities are not misrepresented as generalizable collectives” (Absolon, & Willet, p.123). History, gender, class, race and social attributes enter the research interaction and during the research process it was critical to evaluate how my location influenced the data collection and analysis. For example, although I argue that the Western world has imposed its values and beliefs on Indigenous Peoples and needs to be conscious of this imposition, I recognized at times how I insidiously imposed my ideas

on the CAC. For example, at a CAC meeting we were having a conversation about what to name the community to maintain confidentiality. I presented a name, the CAC asked questions of why this name. I provided them with a rationale, which they in turn accepted. Not until I was questioned by my thesis Committee did I come to the realization that I imposed a Western name on a First Nations community instead of asking the CAC what name they would create. This simple act reinforced to me how I, as a non-Aboriginal, could unconsciously impose my Western understandings of the data, findings and interpretations on the community and the research process. Although not done intentionally, the insidious nature of this imposition is a consequence of living different worldviews, and reinforced to me the need to reflect continuously on my location as a researcher and its impact on how decisions were made in the Committee. Two-eyed seeing requires constant reflection and learning with the community since the application of misguided assumptions, which are not clarified with partners in the research, are problematic. A lack of dialogue, or lack of ethical space can have the indirect effect of perpetuating the dominate ideology if researchers are immersed in Western epistemologies.

I believe overall that my relationship with the CAC was based on trust and mutual decision making. In many meetings, the Committee had lively discussions on the findings from the data. For example, the CAC discussed the findings about youth not speaking about the Indian Residential School (IRS) experience in relation to youth mental health. One committee member was surprised as she believed students learned about the IRS experience in school, and although this may be the case, youth in this study did not extend this history to how it may influence Mi'kmaw youth mental health.

My belief is that the health disparities witnessed in Mi'kmaw communities, as with many First Nations communities, are associated with social, historical, economic, and political inequities which extend beyond a bio-medical approach to health. I did not bracket my feelings or assumptions and included them in my data collection and analysis with the CAC and the writing up of the research. I needed to analyze my thoughts when participants talked about their experiences. Discussions were conversational as opposed to a list of questions and the relationships I had with participants was participatory and not hierarchical. Location of self and reflexivity is critical during data collection and analysis and I needed to reflect on how this influenced the data collection and analysis. A non-Aboriginal researcher, conducting research with a Mi'kmaw community is challenging, mainly from the stance of building trust, developing relationships, and establishing partnerships. Mimikey is weary of researchers embedded in Western institutions of higher learning, and values being in control of what is being researched, by whom, and for what purpose. Hence, I frequently reflected on the research process, my position and my purpose as a researcher. This activity was not a burden, but an opportunity for personal and professional growth as I recognized how I could unwittingly impose my Western world views.

Engaging with the community, investing in community capacity and working with the youth was a privilege. I learned, collaborated, negotiated with community members and respected members of Mimikey as a visitor. I was invited for meals, tea and events, which were important opportunities for the community to come to know me, and I them, as the CAC and I initiated research of a sensitive nature. By taking time to build relationships, I was taking a risk based on institutionally-imposed norms for completion

of the dissertation. I reflected on meeting the standards of the institution and rendering the research useful to the community by staying true to the ownership, control, access, and possession (OCAP) principles, the ethics of doing no harm, maintaining confidentiality and informed consent. The community own this research; for example, I discussed the findings with members of the community so they could use them for their purposes, such as to provide evidence for funding and direction for future work, the transcripts stayed with me for confidentiality, and will be destroyed. The community had control by assisting me in establishing a CAC who contributed to the research process and directed how the research was conducted. Completing research within a specific timeframe originates from a Western ideology for doing research, and was not the only quandary. For example, it is recommended in Western science that focus groups be homogenous (Krueger, 1994; Sim, 1999). However, the CAC felt strongly that youth in the talking circles should not be separated with respect to gender. Acknowledging that the groups would be homogenous in many other respects, such as age, economic status, living in Mimikej and being Mi'kmaq, I went along with the CAC, and in retrospect believe that not separating the youth by gender was a positive experience as the youth shared their understandings openly and honestly.

Communication and discussion that was reciprocal with the CAC was fundamental for the success of conducting research with this Aboriginal community. For example, members of the CAC suggested I seize an opportunity to conduct a talking circle with many youth who were employed for the summer. I declined as this could be perceived as not respecting youths' choice to participate. I may have been able to have assured the youth they did not have to participate; however, the youth were employed by

the Band and may have felt an obligation to participate. Recruitment of participants was designed to be by choice, invitation and desire to contribute. I shared my concern of the ethics around recruitment for participation in this study, and the CAC respected my decision. Negotiating with the community was integral to the research process. I could not assume as a researcher that the design was preset in a rigid way that would restrict active participation, engagement and mutual partnership with the CAC. As the research evolved, ideas needed to be mutually discussed with the CAC as to how changes may influence research ethics, processes, and outcomes.

Reflecting on being respectful, responsible, relevant and reciprocal, and building trust with community members in Mimikej as a non-Aboriginal was paramount. I found being transparent, explaining what I was doing and why, answering questions and actively listening to the community helped to establish trust; however, I recognized there were some in the community who would never trust me because I am non-Aboriginal. The CAC knew this too, as did other community members, yet they continued to be supportive of the research in the community. The respect and trust the CAC members had in Mimikej, and the CAC's trust in me, as well as the past relations I had established with other members in the community enabled this research to continue.

Following Aboriginal protocols of storytelling and talking circles for data collection methods is important. I was constantly humbled by the stories shared, and felt the need to respect the individual stories by re-presenting the findings with the intention and dignity that they were presented to me as participants shared their reflections of understanding. I struggled with how to express Indigenous concepts in Western academic constructs, such as deconstructing a wholistic and relational view of mental health into

themes. I was concerned that developing themes had the potential of diminishing the meaning and stifling the intent of their stories. Upon reflection, I appreciated it is sometimes necessary to break parts down so that the whole can be realized. This was not an easy task. The CAC was intricately involved initially in the analysis, and later in discussions with the interpretation of the findings. This gave me more comfort and confidence that I was representing their ideas in a way that they agreed with. Drawing an image of Mi'kmaw youths' understanding (Figure 2, p. 110) sharing this with the CAC, and having an artist refine the picture enabled me to present some of the findings in a way that did not compartmentalize youths' understanding. The drawing represents more than written words embedded in constructs and concepts that are much more in keeping with the Western scientific write-up of research findings.

Plans for Dissemination

I plan to return to Mimikey and formally present the findings of this research. Although many people there are familiar with the work to date, formally presenting the final product to the Chief and Council, and others members of the community would provide closure of the research, and provide the community with evidence and data for future initiatives. I will publish and present aspects of this study in collaboration with, and recognition of the CAC (although we struggle with how CAC members can be personally recognized without breaching the confidentiality of the community). The findings of this research may support other work in the field of Aboriginal youth mental health, hence I will present to health authorities, Aboriginal Nurses Association of Canada, organizations involved with Aboriginal youth mental health, and institutions that would benefit from the knowledge created from this work. I plan to publish in journals

that focus on qualitative health research and Aboriginal health. Knowledge translation is critical as Aboriginal people advance their initiatives to address the health disparities in rural Aboriginal communities. Although the context of this study was in a rural Aboriginal community, the knowledge created may be relevant for Aboriginal youth mental health in urban settings locally, regionally, nationally and internationally.

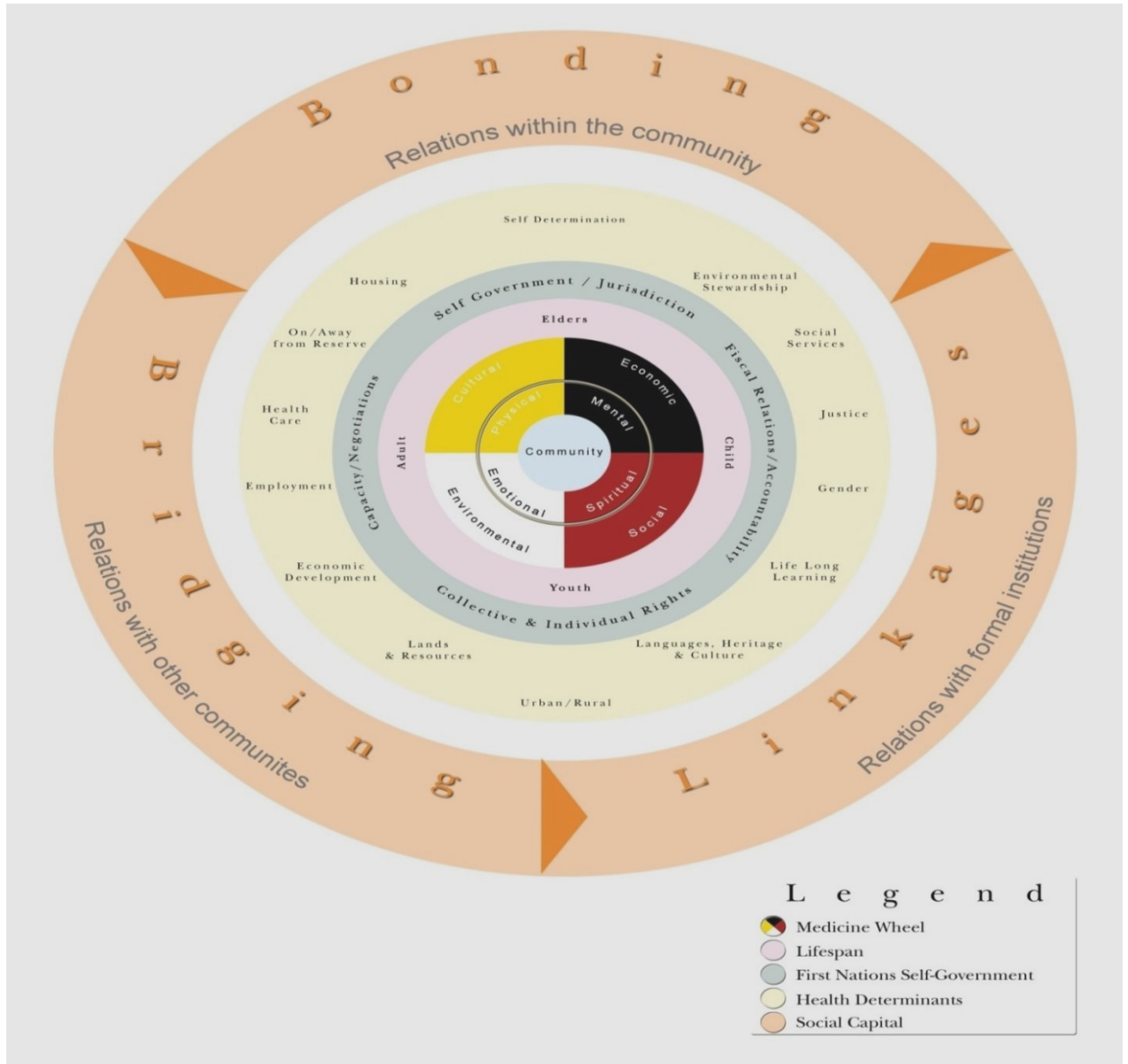
Concluding Remarks

Conceptualizing mental health as a wholistic and relational dynamic reinforces that mental health is understood as a social construct. As such, mental health rests in a socio-historical context, and is determined largely by those in power who govern what mental health will consist of, and how to promote mental health. The stories of personal agency and the active invisible processes of youths' journey, as told by the youth, challenge the stories of pathology that dominate the discourse of Aboriginal youth mental health. Redirecting the focus, by working with youths' strengths and understanding of mental health may help to inform health promotion program planning with rural Mi'kmaw youth. Overcoming the disparities in health resulting from historical, social, economic and political inequities requires an inclusion of multiple system interventions, partnerships and collaboration. Mi'kmaw peoples in Nova Scotia have identified Aboriginal youth mental health as a priority. Health professionals have the opportunity to work with Mi'kmaw communities from a wholistic perspective that is in keeping with Indigenous knowledge. Establishing practice based on Mi'kmaw youths' understanding of the processes necessary for rural Mi'kmaw youth mental health is relevant. Collaborating with Mi'kmaw youth, and recognizing their understanding of rural Mi'kmaw youth mental health may challenge the colonial legacy in Mi'kmaw

communities, and attend to the path of reconciliation. Mi'kmaw youths' voices to affect change are critical in the 21st century.

Appendix A

Wholistic Policy and Planning Model



Note: From *First Nations wholistic policy and planning model: Discussion paper for the World Health Organization Commission on Social Determinants of Health*. By J. Reading, A. Kmetz, & V. Gideon 2007, Ottawa: Assembly of First Nations. Copyright 2010 by Assembly of First Nations. Reprinted with permission.

Appendix B



Mental Health of Rural Mi'kmaq Youth: Community Based Participatory Action Research

Permission from the Chief and Council

Dear: Name of Chief

As per our discussions and my presentation to the band, I am writing this letter to confirm your permission to do this community based participatory research project with your community. My name is Adele Vukic. I am a PhD student from Dalhousie University School of Nursing. As a registered nurse, I have worked with First Nations communities for over thirty years. . The study has been reviewed by Dalhousie research ethics and Mi'kmaq Ethics Watch.

The Purpose of the Study:

Concerns about the mental health of Aboriginal youth are real. Aboriginal organizations like the Aboriginal Healing Foundation, the National Aboriginal Health Organization, the Regional Health Survey and the Royal Commission on Aboriginal Peoples agree. I did a study in 2005 with all 13 Mi'kmaw communities in Nova Scotia and the people participating said I should look at Mi'kmaw youth mental health concerns. This study will explore Mi'kmaw youth mental health and identify plans for how to make it better in your community.

Study Design:

This is a community-based participatory research project. It will be guided by a Community Advisory Committee. Individual storytelling and talking circles will take place with youth aged 14-19, parents, service providers, educators and Elders to understand Mi'kmaw youth mental health and to identify how to make it better. A community forum near the end of the project will make sure all community members have a chance to share their ideas. An Elder will open and close the talking circles and the forum. With your permission, I will be in the community to take part in community activities with youth. The Community Advisory Committee will guide me on what activities I should attend. The storytelling sessions, and talking circles may be audio taped if participants agree. What is said will be written up word for word. The tapes and notes will be stored in a locked drawer in my office. I will use a flip chart to take notes at the open forum. Electronic data will be stored on my computer. It will be protected with a user name and password. The material will be destroyed five years after the study is finished. All of the material will be studied with the help of the Community Advisory

Committee. When the work is done, I will share it with the Chief and Council and community members at a town hall meeting. I will share a feast to celebrate at the end of study organized by me and talk about what community members think about Mi'kmaw youth mental health and what can be done. The names of the people and the community in the study will not be shared.

Questions:

If you have any questions, concerns, or need more information about the study you can contact Adele Vukic at (902) 494 2207 or by email at adele.vukic@dal.ca or my supervisors; Dr Ruth Martin-Misener ruth.martin-misener@dal.ca Telephone – (902) 494-2250 or Dr David Gregory david.gregory@uregina.ca Telephone 306 585 5608

Summary:

I will be sure the people I talk with understand the study, the possible risks and benefits, and the precautions I will take so no one will know who took part in the study. People in the talking circles will be asked not to share any information about who took part in the circles or what they said. There is no guarantee they will not share this information with others. This study is expected to be finished in 12 to 16 months. Chief and Council will be given the results in writing and at a meeting if you like.

Problems or Concerns:

If you have any difficulties with or concerns about this study you may contact Catherine Connors, Director of Human Research Ethics at Dalhousie University, at (902) 494-1462 or by email at catherine.connors@dal.ca

We seek your permission for this study and welcome your ideas.

I _____, as the Chief representing band council and the community, approve this study.

Signature: _____ Date: _____

Researcher: _____ Date: _____

Contact Person:

Adele Vukic Ph D Student
School of Nursing
1459 Oxford \St
Halifax, N.S
B3H 4R2
Ph. 902 494 2207
Fax 902 494 3487

Email adele.vukic@dal.ca

Appendix C



Mental Health of Rural Mi'kmaq Youth: Community Based Participatory Action Research Terms of Reference for Community Advisory Committee

Purpose

The purpose of the Community Advisory Committee is to meet on a regular basis to inform the Community Based Participatory Research Project on Promoting the Mental Health of Mi'kmaq Youth Living in the community. The committee will develop the principles and values guiding their decision making. Initial meetings will map out the roles and responsibilities of the Advisory Committee.

Membership

Membership will consist of residents of the community who are of Aboriginal Ancestry and represent one of the following positions:

- 2 respected Elders of the community
- 4 youth aged 14 to 19 (two male; two female)
- 1 educator teaching youth aged 14 to 19
- 1 member of the health center involved with youth
- 2 representatives of the community involved in an organization responding to youth needs

Meeting Times and Focus

The committee will meet as needed. At first the committee will meet more often, possibly weekly, to inform the project regarding the research questions and data collection methods, and less often, once or twice a month, to include discussions and make decisions about the data collection, analysis and dissemination of research findings. The plan is that the CAC will take part with the data analysis as they will be given quotes without revealing identifying data. As data collection continues they will assist with the analysis of the summary of field and participant observation notes. CAC members who participate in the talking circle will be asked to maintain the confidentiality of participants within the group. The data collected from the open forum will also be shared with CAC members. Meetings will not exceed two hours unless all committee members agree.

Decision Making

Decisions will be based on consensus (I will discuss with the committee if consensus becomes problematic, how to resolve conflicts and contradictions that will be respectful of the work needed to complete this study).

Quorum:

A quorum of 8 members is required for decision making purposes

Honorarium:

An honorarium will be provided to the youth, parents and Elders in the committee. The amount would be \$50.00 for each meeting.

Appendix D



Mental Health of Rural Mi'kmaq Youth: Community Based Participatory Action Research

Script to Invite Potential Participant to Participate in Individual Storytelling Session

I invite you to take part in a study. A study done in 2005 found that Mi'kmaq community members in Nova Scotia want researchers to look at Mi'kmaq youth mental health. This study will explore Mi'kmaq youth mental health and identify how to make it better in your community. Taking part in the study is up to you. You may stop at any time without any problem. Taking part in the study will not likely benefit you, but we might learn things that will benefit others.

If you agree to take part in this study, you will meet with me for about 45 minutes to an hour to share your stories about youth mental health and how to make it better. If you agree, the session will be audio-taped. I will also take notes. A number will be put on the tape and notes. I will not use your actual name.

I will meet with you to hear your stories of what mental health means to you at a time and place that works for you. You can choose to stop talking at any time without any problems. You do not need to do anything before we meet.

This is only one part of the study. There will be talking circles and a community open forum where more opportunity is provided to share understandings of mental health and how to make it better in your community.

The purpose of the story telling is not to share your personal issues of mental illness but to discuss what mental health means to you, and what is needed in the community to promote mental health for youth. If you want to discuss personal problems a counselor is available.

**Mental Health of Rural Mi'kmaq Youth: Community Based Participatory Action
Research**

Guide for Individual Storytelling

Individual Storytelling Guide:

As talked about in the informed consent, the purpose of this study is to understand youth mental health and ways to make better the mental health of youth aged 14 to 19 in the community. Your privacy will be maintained as I will give your notes and tape a number. If you wish to stop at any time or not answer any question you may do so without any problem.

Demographic Data

Age:

Gender:

Student /parent/ educator/ role in the community:

Length of time in the community:

Would you share with me your stories of how have come to learn and understand youth mental health, along with experiences of how youth mental health can be made better in the community?

Probes:

Can you describe that in more detail?

What do you mean?

How do you explain that?

How does that connect with mental health?

Is this a major concern? Can you explain?

Is this a major positive influence?

How would that promote mental health?

How does this relate to mental health?

How would what you are sharing relate to promoting mental health?

How would that work in your community?

Appendix F



Mental Health of Rural Mi'kmaq Youth: Community Based Participatory Action Research

Recruitment Poster for Talking Circle

You are invited to participate in one of a series of talking circles. These talking circles are aimed at understanding Mi'kmaq youth mental health and to identify action plans to promote Mi'kmaq youth mental health in your community.

There will be talking circles for:

- Mi'kmaq youth aged 14-19
- Parents
- Elders
- Service providers
- School teachers

All talking circles will start and end with an Elder as we share our understanding and ideas.

Light refreshments will be served.

To find out more about the study and where and when the talking circles will be held please contact:

Adele Vukic RN PhD (student)
Dalhousie University School of Nursing
1459 Oxford St
Halifax, Nova Scotia
Canada B3H 4R2
Telephone – (902) 494-2207 email adele.vukic@dal.ca

Appendix G

Mental Health of Rural Mi'kmaq Youth: Community Based Participatory Action Research

Guide for Talking Circle

Introduction

The purpose of this study is to understand youth mental health and some ways to make the mental health of youth aged 14 to 19 in the community better. You will not be asked to share your own personal mental health issues. Your privacy will be maintained as I will give the tape and the notes a number. If you wish to leave at any time or not answer any question you may do so without any problem. I ask that what is discussed in the circle is not shared outside the circle and that no one discusses outside the circle who took part in the circle. Does everyone agree to that?

Demographic Data

Age:

Gender:

Length of time in the community:

Position in the community; Will be determined based on which talking circle participants participate in; youth, service provider, parent or Elder talking circle

From the individual storytelling we have learned..... about understanding of Mi'kmaq youth mental health. We would like to hear your thoughts about what we have learned so far and to hear if you have anything more you would like to add.

From the individual story telling we have learned.....about how Mi'kmaq youth mental health can be improved in the community. We would like to hear your thoughts about what we have learned so far and to hear if you have anything more you would like to add.

(Talking circle will be done in the traditional sense with a talking stick so probes are not needed)

Appendix H



**Mental Health of Rural Mi'kmaq Youth: Community Based
Participatory Action Research**

Community Open Forum Invite

You are invited to participate in a community open forum aimed at understanding Mi'kmaq youth mental health to identify action plans to promote Mi'kmaq youth mental health in your community.

(Date and time and place will be determined near the end of the study)

The open forum will start and end with an Elder as we share our understanding and ideas.

Light refreshments will be served.

To find out more about the study and where and when the open forum will be held please contact:

Adele Vukic RN PhD (student)
Dalhousie University School of Nursing
1459 Oxford Street
Halifax, Nova Scotia
Canada B3H 3J5
Telephone – (902) 494-2207
Fax – (902) 494-3487
E-mail – adele.vukic@dal.ca

Appendix I

Mental Health of Rural Mi'kmaq Youth: Community Based Participatory Action Research

Guide for Open Forum

Introduction

The purpose of this study is to understand youth mental health and some ways to make the mental health of youth aged 14 to 19 in the community better. I have done individual storytelling and talking circles with youth, Elders, service providers, parents and teachers which some of you may have already took part in. The CAC and I have looked at all the information. I want to share what I have learned so far and to hear what you think about it and to ask if there is something else we may be missing or something that is very important to you about youth mental health that you think we should know. I will be recording ideas on a flip chart. I will not use any direct quotes from this discussion in the final report. If you wish to leave the forum at any time you may do so without any problem. It is understood that by virtue of your attendance you are consenting to participate in this research project and contribute to the research process. The forum will be two hours long and I encourage active participation of all who are present.

I will ask for a show of hands of who are youth, parents, and service providers to have a sense of the demographics of participants.

We have learned..... about understanding of Mi'kmaq youth mental health. We would like to hear your thoughts about what we have learned so far and to hear if you have anything more you would like to add.

We have learned.....about how Mi'kmaq youth mental health can be improved in the community. We would like to hear your thoughts about what we have learned so far and to hear if you have anything more you would like to add.

Probes:

Can you describe that in more detail?

What do you mean?

Could you explain that a bit more for all of us?

How does that connect with mental health?

Is this a major concern? Can you explain?

Is this a major positive influence?

How would that promote mental health?

How does this relate to mental health?

How would what you are sharing relate to promoting mental health?

How would that work in your community?

Does anybody else have something to add to what was said?

Does anyone else have a something different to add to what was said?

Appendix J



Mental Health of Rural Mi'kmaq Youth: Community Based Participatory Action Research

Consent for Individual Storytelling

Local Principal Investigators:

Adele Vukic, RN PhD student

Dalhousie University
School of Nursing
1459 Oxford Street
Halifax, Nova Scotia, Canada
B3H 4R2
Telephone – (902) 494-2207
Fax – (902) 494-3487
E-mail – adele.vukic@dal.ca

Supervisors

Ruth Martin-Misener, NP, PhD,
Associate Professor
Dalhousie University School of Nursing
1459 Oxford Street
Halifax, Nova Scotia Canada
B3H 4R2
Telephone – (902) 494-2250
Fax – (902) 494-3487
E-mail – ruth.martin-misener@dal.ca

David Gregory RN PhD
Professor and Dean

Faculty of Nursing
Room 262 Laboratory Building
University of Regina
3737 Wascana Parkway
Regina Saskatchewan
S4S 0A2
Telephone 306 585 5608
E-mail david.gregory@uregina.ca

Contact Person: For more information about this study, at any time please contact:

Adele Vukic RN PhD student
Dalhousie University School of Nursing
1459 Oxford Street
Halifax, Nova Scotia Canada
B3H 4R2
Telephone – (902) 494-2207
Fax – (902) 494-3487
E-mail – adele.vukic@dal.ca

Introduction:

My name is Adele Vukic. I am working on my PhD in Nursing. I invite you to take part in this study. Taking part in the study is up to you. You may stop at any time without any problem. The study and the risks or discomforts you might face are described below. Taking part in the study will not likely benefit you, but we might learn things that will benefit others. You can talk with me or my supervisors, Dr. Ruth Martin-Misener Assistant Professor or Dr. David Gregory, Professor and Dean of Faculty of Nursing about any questions you have about the study.

The Purpose of the Study:

Concerns about the mental health of Aboriginal youth are real. Aboriginal organizations like the Aboriginal Healing Foundation, the National Aboriginal Health Organization, the Regional Health Survey and the Royal Commission on Aboriginal Peoples agree. A study done in 2005 found that Mi'kmaq community members in Nova Scotia want researchers to look at Mi'kmaq youth mental health. This study will explore Mi'kmaq youth mental health and identify how to make it better in your community.

Study Design:

This is a community based participatory research project. It will be guided by a Community Advisory Committee. Individual storytelling and talking circles will take place with youth aged 14-19, parents, service providers, educators and Elders. We will talk about Mi'kmaq youth mental health and how to make it better. A community forum near the end of the project will make sure all community members have a chance to share

their ideas. I will be in the community to take part in any community activities with youth. The Community Advisory Committee will guide me on what activities I should attend. Sessions will be audio-taped and will be written up word for word. This material will be stored in a locked drawer in my locked office. Electronic data will be stored on my computer and protected with a user name and password. The data will be destroyed five years after the study is finished. The material will be studied with the help of the Community Advisory Committee. When the work is finished, I will share it with the community. I will share a feast at the end of the study and talk about what community members think about Mi'kmaq youth mental health and what can be done to make it better. The feast will be organized by me and held at the bingo hall and will be open to all who can come. The names of the people who participate in the study and the community in the study will not be shared in any write up of the study.

Who Can Participate in the Study:

You may take part in this study if you are: a youth age 14-19, a parent of youth aged 14-19, a service provider or educator of youth aged 14-19, or an Elder in the community. Also you should have been living in the community for at least one year and speak and understand English.

Who Will be Conducting the Research:

I will be the person listening to your stories. I will work closely with the Community Advisory Committee to make sure that the community is involved.

What You Will be Asked to Do:

If you agree to take part in this study, you will meet with me for about 45 minutes to an hour to share your stories about youth mental health and how to make it better. You will not be asked to discuss your own personal mental health issues. If you agree, the session will be audio-taped. I will also take notes. A number will be put on the tape and notes. I will not use your actual name.

I will meet with you to hear your stories at a time and place that works for you. You can choose to stop talking at any time without any problems. You do not need to do anything before we meet.

Possible Risks and Discomforts:

There are no major risks to you if you take part in this research project. Some people may find sharing their stories about their understanding of mental health and what can make it better for youth in the community upsetting. Some people may wish to receive support after they share their stories. A contact name for a counselor will be provided to you if

you ask, or if the researcher thinks support is needed. You can choose not to answer questions or to stop the session at any time without problems. You can choose to withdraw the information you give until after it has been analyzed.

Possible Benefits:

There are no benefits to you by taking part in this study. It may benefit Mi'kmaq youth as a whole by adding to knowledge about Mi'kmaq youth mental health and what can be done to encourage positive youth mental health in the community. Sharing your stories with me may give you a better understanding of youth mental health, but this is not a guarantee.

Compensation:

A \$25.00 honorarium will be given to you for taking part in the storytelling. This will be provided to you following your participation in the storytelling to acknowledge your time and provide support for any expenses incurred by attending the session such as travel or babysitting.

Confidentiality and Anonymity:

Personal information you share will not be shared with others. But, if you report thoughts of harming yourself or someone else, or that someone is harming you, the researcher, by law, must report that information to the proper agency.

A number will be used for each person in the study. Information that you share with me will never be shared with others in a way that could identify you. Quotes and material will be shared with the Community Advisory Committee after I check it to make sure no one can identify who said what. All sessions that are taped will be written up word for word. The data will be stored in a locked drawer in my locked office. Electronic data will be stored on my computer and protected with a user name and password. Data will be destroyed five years after the study is finished.

Questions:

If you have any questions or want more information about the study you can reach me at (902) 494-2207 or by e-mail at adele.vukic@dal.ca

Summary:

You will receive a copy of this consent form before the storytelling session takes place. I will be sure you understand the purpose of the study, the possible risks and benefits... The study is expected to be finished in 12 to 16 months. If you wish, you will be sent a copy of the final report. Please fill out the attached form if you want to receive a copy.

Problems or Concerns:

If you have any difficulties with or concerns about this study you may contact Catherine Connors, Director of Human Research Ethics at Dalhousie University, at (902) 494-1462 or by email at catherine.connors@dal.ca

Signatures:

I have read the information about this study. I have been given a chance to talk about it and my questions have been answered. I agree to take part in this study. I realize that taking part in this study is up to me and that I am free to stop at any time without any problems.

I hereby give consent to use direct quotes in any published works with the understanding that no information will be included that will let people know who I am.

Yes _____ No _____

I hereby give consent to taping the storytelling sessions with the understanding that no information will be shared that will let people know who I am.

Yes _____ No _____

Signature: _____ Date: _____

Researcher: _____ Date: _____

Contact Information for Delivery of Study Findings

I wish to receive a summary of the study findings and am providing my contact information so that the researchers can share the results with me.

Signature: _____

Address:

Phone:

E-mail:

Appendix K



Mental Health of Rural Mi'kmaq Youth: Community Based Participatory Action Research

Consent Form for Talking Circles

Local Principal Investigators:

Adele Vukic, RN student

Dalhousie School of Nursing
1459 Oxford Street
Halifax, Nova Scotia, Canada
B3H 4R2
Telephone – (902) 494-2207
Fax – (902) 494-3487
E-mail – adele.vukic@dal.ca

Supervisors

Ruth Martin-Misener, NP PhD
Associate Professor
Dalhousie University School of Nursing
1459 Oxford Street
Halifax, Nova Scotia
Canada
B3H 4R2
Telephone – (902) 494-2250
Fax – (902) 494-3487
E-mail – ruth.martin-misener@dal.ca

David Gregory RN PhD
Professor and Dean
Faculty of Nursing
Room 262 Laboratory Building
University of Regina
3737 Wascana Parkway
Regina Saskatchewan
S4S 0A2
Telephone 306 585 5608
E-mail david.gregory@uregina.ca

Contact Person: For more information about this study, at any time please contact:

Adele Vukic, RN PhD (student)
Dalhousie University School of Nursing
1459 Oxford Street
Halifax, Nova Scotia Canada
B3H 4R2
Telephone – (902) 494-2207
Fax – (902) 494-3487
E-mail adele.vukic@dal.ca

Introduction:

My name is Adele Vukic. I am working on my PhD in Nursing. I invite you to take part in this study. Taking part in the study is up to you. You may stop at any time without any problem. The study and the risks or discomforts you might face are described below. Taking part in the study will not likely benefit you, but we might learn things that will benefit others. You can talk with me or my supervisors, Dr. Ruth Martin-Misener Assistant Professor or Dr. David Gregory, Professor and Dean of Faculty of Nursing about any questions you have about the study.

The Purpose of the Study:

Concerns about the mental health of Aboriginal youth are real. Aboriginal organizations like the Aboriginal Healing Foundation, the National Aboriginal Health Organization, the Regional Health Survey and the Royal Commission on Aboriginal Peoples agree. A study done in 2005 found that Mi'kmaq community members in Nova Scotia want researchers to look at Mi'kmaq youth mental health. This study will explore Mi'kmaq youth mental health and identify how to make it better in your community.

Study Design:

This is a community based participatory research project. It will be guided by a Community Advisory Committee. Individual storytelling and talking circles will take place with youth aged 14-19, parents, service providers, educators and Elders. We will talk about Mi'kmaq youth mental health and how to make it better. A community forum near the end of the project will make sure all community members have a chance to share their ideas. I will be in the community to take part in any community activities with youth. The Community Advisory Committee will guide me on what activities I should attend. Sessions will be audio taped and will be written up word for word. This material will be stored in a locked drawer in my office. Electronic data will be stored on my computer and protected with a user name and password. The data will be destroyed five years after the study is finished. The material will be studied with the help of the Community Advisory Committee. When the work is finished, I will share it with the community. I will share a feast at the end of the study and talk about what community

members think about Mi'kmaq youth mental health and what can be done. The feast will be organized by me and held at the bingo hall and will be open to all who can come. The names of the people and the community in the study will not be shared in any write up of the study.

Who Can Participate in the Study:

You may take part in this study if you are: a youth age 14-19, a parent of youth aged 14-19, a service provider or educator of youth aged 14-19, or an Elder in the community. Also you should have been living in the community for at least one year and speak and understand English.

Who Will be Conducting the Research:

I will be the person listening to your ideas and an Elder will open and close the talking circle. I will work closely with the Community Advisory Committee to make sure that the community is involved.

What You Will be Asked to Do:

If you agree to take part in this study, you will take part in a talking circle with an Elder and myself to talk about understandings of Mi'kmaq youth mental health and how to make better Mi'kmaq youth mental health in the community. You will not be asked to discuss your own personal mental health issues. If you agree, the talking circle will be taped. I may also take notes. A number will be put on the tape and notes. I will not use names. You can choose to leave the talking circle at any time without any problems. You do not need to do anything before we meet.

Possible Risks and Discomforts:

There are no major risks to you if you take part in this research project. Some people may wish to receive support after they share their stories. You may find sharing your ideas upsetting. A contact name for a counselor will be provided to you if you ask, or if I think support is needed. You can choose to stop the session at any time without problems.

Possible Benefits:

There are no benefits to you by taking part in this study. But it may benefit Mi'kmaq youth as a whole by adding to our knowledge about Mi'kmaq youth mental health and what can be done to encourage positive youth mental health in the community. Sharing your stories in the circle may give you a better understanding of youth mental health, but this is not a guarantee.

Compensation:

\$25.00 will be given to you for taking part in the study. This will be provided to you following your participation in the talking circle to acknowledge your time and provide support for any expenses incurred by attending the session such as travel or babysitting.

Confidentiality and Anonymity:

Personal information you share will not be shared with others. But, if you report thoughts of harming yourself or someone else, or that someone is harming you, the researcher, by law, must report that information to the proper agency.

A number will be used for each talking circle. Members in the talking circle will be asked not to let anyone else know who took part in the circle or what was said. There is no guarantee that this request will be honoured by all members in the talking circle. Information that you share with me in the talking circle will never be presented to others in a way that could identify you. Quotes and material will be shared with the Community Advisory Committee after I check it to make sure no one can identify who said what. All sessions that are taped will be written up word for word. The data will be stored in a locked drawer in my office. Electronic data will be stored on my computer and protected with a user name and password. Data will be destroyed five years after the study is finished.

Questions:

If you have any questions or want more information about the study you can reach me at (902) 494-2207 or by e-mail at adele.vukic@dal.ca

Summary:

You will receive a copy of this consent form before the talking circle takes place. I will be sure you understand the purpose of the study, the possible risks and benefits. . The study is expected to be finished in 12 to 16 months. If you wish, you will be sent a copy of the final report. Please fill out the attached form if you want to receive a copy.

Problems or Concerns:

If you have any difficulties with or concerns about this study you may contact Catherine Connors, Director of Human Research Ethics at Dalhousie University, at (902) 494-1462 or by email at catherine.connors@dal.ca

Signatures:

I have read the information about this study. I have been given a chance to talk about it and my questions have been answered. I agree to take part in this study. I realize that taking part in this study is up to me and that I am free to stop at any time without any problems.

I hereby give consent to use direct quotes in any published works with the understanding that no information will be included that will let people know who I am.

Yes _____ No _____

I hereby give consent to taping the talking circle with the understanding that no information will be shared that will let people know who I am.

Yes _____ No _____

Signature: _____ Date: _____

Researcher: _____ Date: _____

Contact Information for Delivery of Study Findings

I wish to receive a summary of the research study findings and am providing my contact information so that the researchers can share the results with me.

Signature: _____

Address:

Phone:

E-mail:

Appendix L



**Mental Health of Rural Mi'kmaq Youth: Community Based Participatory Action
Research**

Transcription Confidentiality Agreement

I, _____ have agreed to keep the information contained within the tapes for the above research strictly confidential. I will not relate any segment of this information to another person, nor will I discuss the contents with anyone other than the researcher for purposes of clarification in transcription.

Signature of Transcriber _____

Date _____

Signature of Researcher _____

Date _____

Appendix M

Permission Letter for the Wholistic Policy and Planning Model

Hi Adele;

I just received the confirmation - from our Assistant-Director of Health For the use of the attached document for your work.

It is already - translated (English/French).

Meegwetch, Thank-You, Merci

Arlene Lariviere
Administration & Communications Assistant Assembly of First Nations Health & Social
Development Secretariat 473, Albert Street, Suite 810 Ottawa Ontario K1R 5B4
Tel: 613-241-6789 ext: 218
Fax: 613-241-5808
Toll-Free: 1-866-869-6789
Email: alariviere@afn.ca
Website: www.afn.ca

-----Original Message-----

From: adele vukic [<mailto:vukica@DAL.CA>]
Sent: Thursday, November 04, 2010 1:28 PM
To: Arlene Lariviere
Subject: Fwd: wholistic planning model

Hi Arlene

I am forwarding the message I sent to you a while ago about permission to include the Wholistic Planning Model in my PhD.

I wonder if I missed your response.

Look forward to hearing from you.

Regards Adele

Assistant Professor
Dalhousie University
School of Nursing
902 494 2207 (Office)

References

- Abelson, J., Forest, P., Eyles, J., Casebeer, A., Martin, E., & Mackean, G. (2007). Examining the role of context in implementation of a deliberative public participation experiment: Results from a Canadian comparative study. *Social Science & Medicine*, 64, 2115-2128.
- Abelson, J., Forest, P., Eyles, J., Casebeer, A., & Mackean, G. (2004). Will it make a difference if I show up here? A citizen's perspective on improving public involvement for health care decision making. *Journal of Health Services Research & Policy*, 9(4), 205-212.
- Aboriginal Healing Foundation (AHF). (2005). *Reclaiming connectedness: Understanding residential school trauma among Aboriginal people*. Ottawa: Aboriginal Healing Foundation.
- Aboriginal Healing Foundation (AHF). (2006). *A healing journey: Reclaiming wellness. The Final report of the Aboriginal Healing Foundation*. Ottawa: Aboriginal Healing Foundation.
- Aboriginal Healing Foundation (AHF). (2007). *Suicide among Aboriginal People in Canada*. Ottawa: Aboriginal Healing Foundation Research Series.
- Aboriginal Healing Foundation (AHF). (2008). *Aboriginal healing in Canada: Studies in therapeutic meaning and practice*. J. Waldram (Ed.). Ottawa: Aboriginal Healing Foundation Research Series.
- Adelson, N. (2005). The embodiment of inequity: Health disparities in Aboriginal Canada. *Canadian Journal of Public Health*, 96(Supp. 2), 545-561.
- Adelson, N. (2007). Biomedical approach a poor fit with aboriginal views on health and healing. *Canadian Psychiatry Journal*, 3(1), 7-10.
- Adelson, N., & Lipinski, A. (2008). The community youth initiative project. In J. Waldram (Ed.). *Aboriginal healing in Canada: Studies in therapeutic meaning and practice* (pp. 9- 30). Ottawa: Aboriginal Healing Foundation Research Series.
- Aboriginal Nurses Association of Canada. (2008). *British Columbia hires twenty native mental health workers*. Retrieved from Aboriginal Nurse Association of Canada. Retrieved from <http://www.anac.on.ca/publications>
- Aboriginal Nurses Association of Canada. (2009). *Cultural competence and cultural safety in nursing education: A framework for First Nations, Inuit and Métis nursing*. Retrieved from Aboriginal Nurses Association of Canada Retrieved from <http://www.anac.on.ca/Documents/Making%20It%20Happen%20Curriculum%20Project/FINALFRAMEWORK.pdf>

- Absolon, K., & Willet, C. (2005). Putting ourselves forward: Location in Aboriginal research. In L. Brown & S. Strega (Eds.), *Research as resistance: Critical, Indigenous, and anti-oppressive approaches* (pp. 97-126). Toronto: Canadian Scholars Press.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th Ed.). Washington: American Psychiatric Association.
- Anderson, J. M., Rodney, P., Reimer-Kirkham, S., Browne, A. J., Khan, K. B., & Lynam, M. J. (2009). Inequities in health and healthcare viewed through the ethical lens of critical social justice: Contextual knowledge for the global priorities ahead. *Advances in Nursing Science*, 32(4), 282–229.
doi:10.1097/ANS.0b013e3181bd6955
- Archibald, J., Jovel, E., McCormick, R., Vedan, R., & Thira, D. (2006). Creating transformative Aboriginal health research: The BC ACADRE at three years. *Canadian Journal of Native Education*, 29(1), 4-11.
- Assembly of First Nations. (1998). *Tradition and education: Towards a vision of our future* (Vol. 1). Ottawa: Assembly of First Nations Education Secretariat.
- Averill, J. (2005). Studies of rural elderly individuals: Merging critical ethnography with community-based action research. *Journal of Gerontological Nursing*, 31(12), 11-18.
- Aston, M., Meagher-Stewart, D., Sheppard-LeMoine, D., Vukic, A., & Chircop, A. (2006). Family health nursing and empowering relations. *Pediatric Nursing*, 32(1), 61-67.
- Barry, M., & Jenkins, R. (2007). *Implementing mental health promotion*. Philadelphia: Elsevier Publishing Co.
- Barry, M., Patel, V., Jane-Llopis, S., Raeburn, J., & Mittlemark, M. (2007). Strengthening the evidence base for mental health promotion. In D. McQueen & C. Jones (Eds.), *Global perspectives on health promotion effectiveness* (pp. 67-86). New York: Springer.
- Bartlett, J., Iwasaki, Y., Gottlieb, B., Hall, D., & Mannell, R. (2007). Framework for Aboriginal-guided decolonizing research involving Métis and First Nations persons with diabetes. *Social Science & Medicine*, 65, 2371-2382.
doi.org/10.1016/j.socscimed.2007.06.011
- Baskin, C. (2011). *Strong helpers' teachings: The value of Indigenous knowledges in the helping professions*. Toronto: Canadian Scholars Press.

- Battiste, M. (2000). Unfolding the lessons of colonization. In M. Battiste (Ed.), *Reclaiming Indigenous voice and vision* (pp. xvi-xxx). Vancouver: UBC Press.
- Battiste, M. (2005). Research ethics for protecting Indigenous knowledge and heritage: Institutional and researcher responsibilities. In N. Denzin, Y. Lincoln, & L. Tuhiwani Smith (Eds.), *Handbook of critical and Indigenous methodologies* (pp. 497-509). London: Sage.
- Blackstock, C. (2011). The Canadian Human Rights Tribunal on First Nations Child Welfare: Why if Canada wins, equality and justice lose. *Children and Youth Service Review*, 33(1), 187-94. doi.org/10.1016/j.childyouth.2010.09.002
- Bloomberg, L., & Volpe, M. (2008). *Completing your qualitative dissertation: A roadmap from beginning to end*. London: Sage.
- Bombay, A., Matheson, & Anisman (2011). The impact of stressors on second generation Indian residential school survivors. *Transcultural Psychiatry*, 48(4), 367-391. doi: 10.1177/1363461511410240
- Brant, C. (1990). Native ethics and rules of behaviour. *Canadian Journal of Psychiatry*, 35(6), 534-539.
- Brant, C. (1993). Suicide in Canadian Aboriginal peoples: Causes and prevention. In *The path to healing: Report of the national roundtable on Aboriginal health and social issues. Royal commission on Aboriginal peoples*. Ottawa: Ministry of Supplies and Services.
- Brant Castellano, M. (2004). Ethics of Aboriginal research. *Journal of Aboriginal Health*, 1 (1), 98-114.
- Brant Castellano, M. (2008). A Holistic Approach to Reconciliation: Insights From Research of the Aboriginal Healing Foundation. In M. Brant Castellano, L. Archibald, M. DeGagné (Eds.). *From truth to reconciliation* (pp.383-403). Ottawa: Aboriginal Healing Foundation.
- Browne, A. (2000). The potential contributions of critical social theory to nursing science. *Canadian Journal of Nursing Research*, 33(2), 35-55.
- Browne, A., & Fiske, J. (2001). First Nations women's encounters with mainstream health care services. *Western Journal of Nursing Research*, 23(2), 126-147.
- Browne, A., Smye, V., & Varcoe, C. (2005). The relevance of postcolonial theoretical perspectives to research in Aboriginal communities. *Canadian Journal of Nursing Research*, 37 (4), 16-37.

- Briggs, S. (2009). Risks and opportunities in adolescence: Understanding adolescent mental health difficulties. *Journal of Social Work Practice*, 23(1), 49-64. doi: 10.1080/02650530902723316
- Bullock, M., Nadeau, L., & Renaud, J. (2012). Spirituality and Religion in Youth Suicide Attempters' Trajectories of Mental Health Service Utilization: The Year before a Suicide Attempt *Journal of Canadian Academy of Child Adolescent Psychiatry*, 21(3), 186-193.
- Burns, C., Dunn, A., Brady, M., Starr, N., & Blosser, C. (2004). *Pediatric primary care: A handbook for nurse practitioners* (3rd Ed.). St. Louis: Saunders.
- Canadian Association of University Schools of Nursing. (2013). *Educating nurses to address socio-cultural, historical and contextual determinants of health among Aboriginal Peoples*. Retrieved from <http://www.casn.ca/vm/newvisual/attachments/856/Media/ENAHHRIKnowledgeProductFINAL.pdf>
- Canadian Institute for Health Information (CIHI). (2004). Aboriginal Peoples Health. In *Improving the health of Canadians* (pp. 75-104). Ottawa: CIHI.
- Canadian Institute for Health Information (CIHI). (2007). Health Indicators 2007. Retrieved from http://secure.cihi.ca/cihiweb/products/hi07_health_indicators_2007_e.pdf
- Canadian Institutes of Health Research (CIHR) (2008) *CIHR guidelines for health research involving Aboriginal People* Retrieved from <http://www.cihr-irsc.gc.ca/e/29134.html>
- Capp, K., Deane, F., & Lambert, G. (2001). Suicide prevention in Aboriginal communities: Application of gatekeeper training. *Australian and New Zealand Journal of Public Health*, 25(4), 315-321.
- Castleden, H., Garvin, T., & Huu-ay-aht First Nation. (2008). Modifying photo voice for community-based participatory Indigenous research. *Social Science & Medicine*, 66(6), 1393-1405. doi:10.1016/j.socscimed.2007.11.030
- Castleden, H., Mulrennan, M. & Codlewska, A. (2012). Community-based participatory research involving Indigenous peoples in Canadian geography: Progress? An editorial introduction. *The Canadian Geographer / Le G'eographe canadien*. 56(2), 155–159. doi: 10.1111/j.1541-0064.2012.00430.x
- Collins, P., Abelson, J., & Eyles, J. (2007). Knowledge into action? Understanding ideological barriers to addressing health inequalities at the local level. *Health Policy*, 80, 158-171.

- Community Health Nurses Association of Canada. (2003). *Canadian community health nursing standards of practice*. Ottawa: Community Health Nurses Association of Canada.
- Chandler, M., & Lalonde, C. (2004). Transferring whose knowledge? Exchanging whose best practices? On knowing about Indigenous knowledge and Aboriginal suicide. In J. White, P. Maxim, & D. Beavon (Eds.), *Aboriginal policy research: Setting the agenda for change* (pp. 111-123). Toronto: Thompson Educational Publishing Inc.
- Chandler, M., & Lalonde, C. (2008). Cultural continuity as a protective factor against suicide in First Nations youth. *Horizons*, 10(1), 68-88.
- Chief Public Health Officer's Report on the State of Public Health in Canada. (2011) *Youth and Young Adults – Life in Transition*. Retrieved from <http://www.phac-aspc.gc.ca/cphorsphc-respcacsp/2011/index-eng.php>
- Clifford, J. (1986). Introduction: Partial truths. In J. Clifford & G. Marcus (Eds.), *Writing Culture: The Poetics and Politics of Ethnography* (pp. 51-76). Berkeley: University of California Press.
- Coffey, A., & Atkinson, P. (1996). *Making sense of qualitative data: Complementary research strategies*. London: Sage.
- Collins, P. (2006). The politics of Black feminist thought. In E. Hackett & S. Haslanger (Eds.), *Theorizing feminisms* (pp. 51-61). New York: Oxford Press.
- Confederacy of Mainland Mi'kmaq. (2008). *Organizational objectives*. Retrieved from <http://www.cmmns.com>.
- Cote, C. (2007). Canada's first female aboriginal psychiatrist: Charting a new course for First Nations mental health research. *Canadian Psychiatry Journal*, 3(1), 6-10.
- Couture, R., & McGowan, M. (Eds.), (2013). *A metaphoric mind; Selected writings of Joseph Couture*. Edmonton: AU Press.
- Creswell, J. (2003). *Research design: Qualitative, quantitative and mixed methods approach* (2nd Ed.). London: Sage.
- Cross, T., Friesen, B., Jivanjee, P., Gowen, K., Bandurraga, A., Matthew, C., & Maher, N. (2012). Defining youth success using culturally appropriate community-based participatory research methods. *Best Practices in Mental Health*, 7(1), 94-114.
- Dadich, A. (2007). Is spirituality important to young people in recovery? Insights from participants of self-help support groups. *Southern Medical Journal*, (100)4, 421-425.

- DeGagné, M. (2007). Toward an Aboriginal paradigm of healing: Addressing the legacy of residential schools. *Australian Psychiatry*, 15 Supp. doi: 10.1080/10398560701701114
- Dell, C., & Hopkins, C. (2011). Residential volatile substance misuse: Treatment for Indigenous youth in Canada. *Substance Use & Misuse*, 46, 107–113, doi: 10.3109/10826084.2011.580225
- Dell, C., Seguin, M., Hopkins, C., Tempier, R., Mehl-Madrona, L., Dell, D., Duncan, D. & Mosier, K. (2011). From Benzos to Berries: Treatment offered at an Aboriginal youth solvent abuse treatment centre relays the importance of culture. *The Canadian Journal of Psychiatry*, 56(2), 75-83.
- Denzin, N., & Lincoln, Y. (2005). The discipline and practice of qualitative research. In N. Denzin & Y. Lincoln (Eds.), *The sage handbook of qualitative research* (3rd Ed.). London: Sage Publications.
- Denzin, N., & Lincoln, Y. (2008). Critical methodologies and Indigenous inquiry. In N. Denzin, Y. Lincoln, & L. Tuhiwani Smith (Eds.), *Handbook of critical and Indigenous methodologies*. London: Sage Publications
- Dixon, S., & Stein, M. (2006). *Encounters with children: Pediatric behaviour and development* (4th Ed.). Philadelphia: Elsevier.
- Dooris, M. (2005). Health settings: Challenges to generating evidence of effectiveness. *Health Promotion International*, 21 (1), 55-65. doi: 10.1093/heapro/dai030
- DuHamel, P. (2003). Aboriginal youth: Risk & resilience. *Native Social Work Journal*, 5, 213-242.
- EchoHawk, M. (2006). Suicide prevention efforts in one area of Indian Health Service, USA. *Archives of Suicide Research*, 10(2), 169-176.
- Elias, B., Mignone, J., Hall, M., Hong, S., Hart, L., & Sareen, J. (2012). Trauma and suicide behaviour histories among a Canadian indigenous population: An empirical exploration of the potential role of Canada's residential school system. *Social Science and Medicine*, 74, 1560-1569. doi:10.1016/j.socscimed.2012.01.026
- Emerson, R., Fretz, R., & Shaw, L. (2007). Participant observation and fieldnotes. In P. Atkinson, A. Coffey, S. Delamont, J. Lofland, & L. Lofland (Eds.), *Handbook of ethnography* (pp. 352-368). London: Sage Publications.
- Epp, J. (1986). *Achieving health for all: A framework for health promotion*. Ottawa: Health and Welfare Canada.

- Ermine, W. (2005) *Ethical space: Transforming relations*. Retrieved from http://www.pch.gc.ca/progs/pa-app/rassamblement-national/gathering/indigenous_traditions_e.cfm
- Ermine, W. (2007). The ethical space of engagement. *Indigenous Law Journal*, 6(1), 193–203.
- Estey, E., Kmetc, A., & Reading, J. (2008). Knowledge translation in the context of Aboriginal health. *Canadian Journal of Nursing Research*, 40(2), 24-39.
- Etowa, J., Thomas Bernard, W., Oyinsn, B., & Clow, B. (2007). Participatory action research: An approach for improving Black women’s health in rural and remote communities. *Journal of Transcultural Nursing*, 18(4), 349-357.
- Eaude, T. (2009) Happiness, emotional wellbeing and mental health – what has children’s spirituality to offer? *International Journal of Children’s Spirituality*, 14(3), 185–196. doi: 10.1080/13644360903086455
- First Nations Centre. (2007). *OCAP: Ownership, Control, Access and Possession*. Sanctioned by the First Nations Information Governance Committee, Assembly of First Nations. Ottawa: National Aboriginal Health Organization.
- First Nations Regional Longitudinal Health Survey (RHS) (2005). *2002/03: Results for adults, youth and children living in First Nations communities*. Retrieved from <http://rhs-ers.ca/english/pdf/rhs2002-03reports/rhs2002-03-technicalreport-afn.pdf>
- Fisher, P., & Ball, T. (2002). The Indian family wellness project: An application of the tribal participatory research model. *Prevention Science*, 3(3), 235-240.
- Fleming, J., & Ledogar, R. (2009). Social Capital and resilience: A review of concepts and selected literature relevant to Aboriginal youth resilience research. *Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health*, 6(2) 25-46.
- Fonow, M., & Cook, J. (2005). Feminist methodology: New applications in the academy and public health. *Signs*, 30(4), 2281-2286.
- Fontana, A., & Frey, J. (2008). The interview: From neutral stance to political involvement. In N. Denzin & Y. Lincoln (Eds.), *Collecting and interpreting qualitative materials* (3rd ed., pp. 115-160). Thousand Islands: Sage Publications.
- Friere, P. (2000). *Pedagogy of the oppressed*. New York: Seabury Press.
- Garwick, A., & Auger, S. (2003). Participatory action research: The Indian family stories project. *Nursing Outlook*, 51(6), 261-266. doi:10.1016/j.outlook.2003.09.006

- Getty, G. (2010). The journey between Western and Indigenous research paradigms. *Journal of Transcultural Nursing*, 21(5), 5-14. doi:10.1177/1043659609349062
- Goldner, E., Jenkins, E., Palma, J., & Bilsker, D. (2011). *A concise introduction to mental health in Canada*. Toronto: Canadian Scholars Press Inc.
- Gone, J. (2009). Encountering professional psychology: Re-envisioning mental health services for Native North America. In E. Kirmayer & V. Guthrie Valaskakis (Eds.), *Healing traditions: The mental health of Aboriginal Peoples in Canada* (pp. 419-439). Vancouver: UBC Press.
- Gone, J. (2013) Redressing First Nations historical trauma: Theorizing mechanisms for indigenous culture as mental health treatment. *Transcultural Psychiatry*, 50(5), 683–706. doi: 10.1177/1363461513487669
- Good, M., & Willoughby, T. (2008). Adolescence as a Sensitive Period for Spiritual Development. *Child Development Perspectives*, 2(1), 32–37. doi: 10.1111/j.1750-8606.2008.00038.x
- Goodkind, J., Hess, J., Gorman, B., & Parker, D. (2012). “We’re still in a struggle”: Diné resilience, survival, historical trauma, and healing. *Qualitative Health Research*, 22(8) 1019– 1036. doi: 10.1177/1049732312450324
- Goodwill, A., & McCormick, R. (2012). Giibinenimidizomin: Owning Ourselves—Critical Incidents in the Attainment of Aboriginal Identity. *Canadian Journal of Counselling and Psychotherapy*, 46(1), 21–34.
- Gordano, P. (2007). *Personality psychology, 21st century psychology: A reference handbook*. Retrieved from http://sageereference.com/psychology/Article_n43.html
- Goulet, L., Linds, W., Episkenew, J., & Schmidt, K. (2011) Creating a space for decolonization: Health through theatre with Indigenous youth. *Native Studies Review*, 20(1), 89-116.
- Gregory, D., Harrowing, J., Lee, B., Doolittle, L., & O’Sullivan, P. (2010). Pedagogy as influencing nursing students’ essentialized understanding of culture. *International Journal of Nursing Education Scholarship*, 7(1), 1–17. doi:10.2202/1548–923X.2025
- Greenwood, D., & Levin, M. (1998). *Introduction to action research: Social research for social change*. Thousand Oaks: Sage.

- Hallet, D., Chandler, M., & Lalonde, C. (2007). Aboriginal language knowledge development and youth suicide. *Cognitive Development, 22*, 392-399. doi:10.1016/j.cogdev.2007.02.001
- Hamilton, N., & Bhatti, T. (1996). *Population health and health promotion: An integrated model of population health and health promotion*. Ottawa: Health Canada.
- Hancock, T., Labonté, R., & Edwards, R. (1999). Indicators that count! Measuring population health at the community level. *Canadian Journal of Public Health, 90* (Supp. 1), S22-S26.
- Harper, G., & Cetin, F.C. (2008). Child and adolescent mental health policy: Promise to provision. *International Review of Psychiatry, 20*(3), 217-224. doi: 10.1080/09540260802030559
- Hatcher, A., Bartlett, C., Marshall, A., & Marshall, M. (2009). Two-eyed seeing in the classroom environment: Concepts, approaches, and challenges. *Canadian Journal of Science, Mathematics and Technology Education, 9*(3), 141-153. doi: 10.1080/14926150903118342
- Hayward, S., Ciliska, D., DiCenso, A., Thomas, H., Underwood, J., & Rafael, A. (1996). Evaluation research in public health: Barriers to the production and dissemination of outcomes data. *Canadian Journal of Public Health, 8*(6), 413-417.
- Health Canada. (2003). *A Statistical Profile on the Health of First Nations in Canada - Determinants of Health, 1999 to 2003*. Retrieved from <http://www.hc-sc.gc.ca/fniah-spnia/pubs/aborig-autoch/2009-stats-profil/index-eng.php>
- Health Canada. (2009). *Statistical Profile on the Health of First Nations in Canada: Self-rated Health and Selected Conditions, 2002 to 2005*. Retrieved from www.hc-sc.gc.ca/fniah-spnia/pubs/aborig-autoch/2009-stats-profil/index-eng.php
- Health Council of Canada (2012). *Empathy Dignity and Respect; Creating cultural safety for Aboriginal People in Health Care*. Retrieved from <http://www.healthcouncilcanada.ca/>
- HHR Planning Subcommittee of the Advisory Committee on Health Delivery and Human Resources (ACHDHR). (2005, revised 2007). *A framework for collaborative pan-Canadian health and human resources planning*. Prepared for the Conference of Deputy Ministers of Health. Halifax: Tomlin-Murphy Consulting Inc. Retrieved from http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/hhr/2007-frame-cadre/2007-frame-cadre-eng.pdf
- Hofrichter, R. (2003). The politics of health inequities: Contested terrain. In R. Hofrichter (Ed.), *Health and Social Justice* (pp. 1-56). San Francisco: Jossey-Bass Press.

- Hohenemser, L., & Marshall, B. (2002). Utilizing a youth development framework to establish and maintain a youth advisory committee. *Health Promotion Practice*, 3(5), 155-165. doi:10.1177/152483990200300211
- hooks, b. (2006). Postmodern blackness. In E. Hacket, & S. Haslanger (Eds.), *Theorizing feminisms* (pp. 51-61). New York: Oxford Press.
- Hunter, L. Logan, J., Goulet, Barton, S. (2006) Aboriginal healing: Regaining balance and culture. *Journal of Transcultural Nursing*, 17(1), 13-22.
doi: 10.1177/1043659605278937
- Interagency Advisory Panel on Research Ethics. (2008). Research involving Aboriginal peoples. Retrieved from <http://www.pre.ethics.gc.ca/eng/policy-politique/initiatives/draft-preliminaire/>
- Israel, B., Eng, E., Schulz, A., Parker, E. (2005). *Methods in community-based participatory research for health*. San Francisco: John Wiley & Sons.
- Iwama, M., Marshall, M., Marshall, A. & Bartlett, C. (2009). Two-eyed seeing and the language of healing in community-based research. *Canadian Journal of Native Education*, 32 (2), 3-23.
- Jacano, J., & Jacano, B. (2008). The use of puppetry for health promotion suicide prevention among Mi'kmaq youth. *Journal of Holistic Nursing*, 26(1), 50-55. doi:10.1177/0898010107306201
- Jackson, L., Schmutzer, P., Wenzel, A., & Tyler, J. (2006). Applicability of cognitive behavior therapy with American Indian individuals. *Psychotherapy, Theory Research Practice, Training*, 43(4), 506-517. doi: 10.1037/0033-3204.43.4.506
- Johnston G., Vukic A., & Parker, S. (2013) Cultural understanding in the provision of supportive and palliative care: perspectives in relation to an indigenous population *British Medical Journal Supportive & Palliative Care*, 3, 61–68. doi: 10.1136/bmjspcare-2011-000122
- Jones, M. & Galliher, R. (2007). Ethnic Identity and Psychosocial Functioning in Navajo Adolescents. *Journal of Research on Adolescence*, 17(4), 683–696 doi: 10.1111/j.1532-7795.2007.00541.x
- Juneau, C., Jones, C., McQueen, D., & Potvin, L. (2011) Evidence-based health promotion: an emerging field. *Global Health Promotion*, 18(1), 79-81. doi: 10.1177/1757975910394035

- Kaplan, D., & Love-Osborne, K. (2009). Chapter 3: Adolescence. In W.W. Hay, Jr., M.J. Levin, J.M. Sondheimer, R.R. Deterding (Eds.), *CURRENT Diagnosis & Treatment: Pediatrics* (19th Ed.). Retrieved from: <http://www.accessmedicine.com/content.aspx?aID=3398049>
- Kaplan-Myrth, N., & Smylie, J. (2006). *Summit Report: Indigenous Knowledge Translation Summit*. Regina: First Nations University of Canada.
- Katz, L., Elias, B., O'Neil, J., Enns, M., Cox, B., Belik, S.L., & Sareen, J. (2006). Aboriginal suicidal behaviour research: From risk factors to culturally-sensitive interventions. *Journal of Canadian Academy of Child Adolescent Psychiatry*, 15(4), 159-167.
- Kaufman, M. (2006). Role of adolescent development in the transition process. *Progress in transplantation*, 16, 286-296.
- Kemmis, S., & McTaggart, R. (2005). Participatory action research. In N. Denzin & Y. Lincoln (Eds.), *The sage handbook of qualitative research* (3rd ed., pp. 567- 608). London: Sage Publications.
- Kim, S., & Esquivel, G. (2011). Adolescent spirituality and resilience: Theory research and educational practices. *Psychology in the Schools*, 48(7), 755-765. doi: 10.1002/pits.20582
- Kincheloe, J., & McLaren, P. (2005). Rethinking critical theory and qualitative research. In N. Denzin & Y. Lincoln (Eds.), *The sage handbook of qualitative research* (3rd ed., pp. 303- 342). London: Sage Publications.
- King, J. (2011). Reclaiming our Roots: Accomplishments and Challenges. *Journal of Psychoactive Drugs*, 43(4), 297-301. doi: 10.1080/02791072.2011.628921.
- King, M. (2011). Scaling Up the Knowledge to Achieve Aboriginal Wellness. *The Canadian Journal of Psychiatry*, 56(2), 73-74.
- Kingsley, B., & Chapman, S. (2013). Questioning the meaningfulness of rigour in community-based research: Navigating a dilemma. *International Journal of Qualitative Methods*, 12, 551-569.
- Kirby, M., & Keon, J. (2006). *Out of the shadows at last: Transforming mental health, mental illness, and addictions*. Final report of the Standing Committee in Social Affairs, Science and Technology. Retrieved from <http://www.parl.gc.ca/39/1/parlbus/commbus/senate/com-e/soci-e/rep-e/rep02may06-e.htm>.

- Kirk M., Tomm-Bonde, L., & Schreiber, R. (2014). Public health reform and health promotion in Canada. *Global Health Promotion*, Advance online publication. doi:10.1177/1757975913512157
- Kirmayer, L. (2012). Changing patterns in suicide among young people. *Canadian Medical Association Journal*, 184(9), 1015-1016. doi:10.1503/cmaj.120509
- Kirmayer, L., Boothroyd, L., Laliberto, A., Laronde-Simpson, B. (1999). *Suicide prevention & Mental Health Promotion in First Nations Communities. Cultural and Mental Health Research Unit Report No.9*. Montreal: Institute of Community & Family Psychiatry, Sir Mortimer B. Davis-Jewish General Hospital.
- Kirmayer, L., Boothroyd, L., Tanner, A., Adelson, N., & Robinson, E. (2000) Psychological distress among the Cree of James Bay. *Transcultural Psychiatry*, 37(1), 35-56. doi:10.1177/136346150003700102
- Kirmayer, L., Fraser, L., Faurus, V., & Whitley, R. (2009). *Current Approaches to Youth Suicide Prevention: A Report Prepared for Health Canada, First Nations and Inuit Health Branch*. Montreal: Culture and Mental Health Research Unit.
- Kirmayer, L., Tait, C., & Simpson, C. (2009). The mental health of Aboriginal peoples in Canada: Transformation of identity and community. In E. Kirmayer & V. Guthrie Valaskakis (Eds.), *Healing traditions: The mental health of Aboriginal Peoples in Canada* (pp. 3-35). Vancouver: UBC Press.
- Kirmayer, L., Sedhev, M., Whitley, W., Dandeneau, S., & Issac, C. (2009). Community resilience: Models, metaphors and measures. *Journal of Aboriginal Health*, Nov. 2009, 62-117.
- Kirmayer, L., Whitley, R., & Faurus, V. (2010). *Community Team Approaches to Mental Health Services and Wellness Promotion; A Report Prepared for Health Canada, First Nations and Inuit Health Branch*. Montreal: Institute of Community & Family Psychiatry.
- Kirmayer, L. Dandeneau, S., Marshall, E., Phillips, M., & Williamson, K. (2011). Rethinking resilience from Indigenous perspectives. *Canadian Journal of Psychiatry*, 56(2), 84-91.
- Kovach, M. (2005). Emerging from the margins: Indigenous methodologies. In L. Brown & S. Strega (Eds.), *Research as resistance: Critical, Indigenous, and anti-oppressive approaches* (pp. 19-36). Toronto: Canadian Scholars Press.
- Kovach, M. (2009). *Indigenous methodologies: Characteristics, conversations and contexts*. Toronto: University of Toronto Press.

- Kral, M., Idlout, L., Minore, J. Dyck, R., & Kirmayer, L. (2011). Unikkaartuit: Meanings of wellbeing, unhappiness, health and community change among Inuit in Nunavut, Canada. *American Journal of Community Psychology*, 48,426–438. doi: 10.1007/s10464-011-9431-4
- Kroch, T. & Kralik, D. (2006). *Participatory action research in health care*. Retrieved from <http://lib.mylibrary.com/Browse/open.asp?ID+74809&loc=Cover>
- Krueger, R.A. (1994). *Focus groups: A practical guide for applied research*. (2nd Ed.), Thousand Oaks: Sage.
- Kutcher, S., Murphy, A., & Gardner, D. (2008). Psychopharmacological treatment options for global child and adolescent mental health: The WHO essential medicines list. *Journal of American Academy of Child and Adolescent Psychiatry*, 47(10), 1105-1113.
- Kyle, J. (2013). Spirituality: Its role as a mediating protective factor in youth at risk for suicide. *Journal of Spirituality in Mental Health*, 15(1), 47-67. doi:[10.1080/19349637.2012.744620](https://doi.org/10.1080/19349637.2012.744620)
- LaFramboise, T., Hoyt, D., Oliver, L., & Whitbeck, L. (2006). Family community and school influence on resilience among American Indian adolescents in the Upper Midwest. *Journal of Community Psychology*, 34(2), 193-209. doi: 10.1002/jcop.20090
- LaFramboise, T., Medoff, L., Lee, C., & Harris, A. (2007). Psychosocial and cultural correlates of suicide ideation among early adolescents on a northern plains reservation. *Research in Human Development*, 4(1-2), 119-143. doi:[10.1080/15427600701481020](https://doi.org/10.1080/15427600701481020)
- Leftwich, M. (2007). *Abnormal psychology, 21st century psychology: A reference handbook*. Retrieved from http://sage-reference.com/psychology/Article_n77.html
- Legha, R., & Novins, D. (2012). The role of culture in substance abuse treatment programs for American Indian and Alaska native communities. *Psychiatric Services*, 63(7), 686-692. doi: 10.1176/appi.ps.201100399
- Lemstra, M., Neudorf, C., Mackenbach, J., D'Arcy, C., Scott, C., Kershaw, T., & Maunapanemi, I. (2008). Risk indicators for depressed mood in youth: Limited association with Aboriginal cultural status. *Pediatric Child Health*, 13(4), 285-290.

- Lemstra, M., Rogers, M., Thompson, A., Redgate, L., Garner, M., Tempier, R., & Moraros, J. (2011). Prevalence and Risk Indicators of Depressed Mood in On-Reserve First Nations Youth. *Canadian Journal of Public Health*, 102(4), 258-263.
- Liebenberg, L. (2009). The visual image as discussion point: Increasing validity in boundary crossing research. *Qualitative Research*, 9(4), 441–467. Retrieved from <http://qrj.sagepub.com/cgi/content/9/4/441.abstract>
- Lincoln, Y., & Guba, E. (1985). *Naturalistic inquiry*. London: Sage
- Little Bear, L. (2000). Jagged worldviews colliding. In M. Battiste (Ed.), *Reclaiming Indigenous voice and vision* (pp. 77-85). Vancouver: UBC Press.
- Longboat, C. (2008). Ethical space in the intellectual terrain: A cultural perspective. *Canadian Journal of Native Education*, 31(1), 72- 83.
- Loppie, C., & Wien, F. (2007). *The health of the on reserve Mi'kmaq population in Nova Scotia: Data from 2002-2003*. Halifax: Atlantic Aboriginal Health Research Program for The Mi'kmaq Health Research Working Group & Union of Nova Scotia Indians. Retrieved from <http://www.unsi.ns.ca/upload/reports/ns%20rhs%20report%2007.pdf>
- Loppie, C. (2007). Learning from the grandmothers: Incorporating Indigenous principles into qualitative research. *Qualitative Health Research*, 17(2), 276-284. doi: 10.1177/1049732306297905
- Lucero, E. (2011). From tradition to evidence: Decolonization of the evidence-based practice system. *Journal of Psychoactive Drugs*, 43(4), 319–324. doi:10.1080/02791072.2011.628925
- MacAulay, A., Commanda, L., Freeman, W., Gibon, N., McCabe, C., Robbins, M., & Twohig, P. (1999). Participatory research maximizes community and lay involvement. *British Medical Journal*, 319, 774-778.
- MacDonald, N., & MacDonald, J. (2007). Reflections of a Mi'kmaq social worker on a quarter century work in First Nations Child Welfare. *First Peoples Child and Family Review*, 3(1), 34-45.
- MacNeil, M. (2008). An epidemiologic study of Aboriginal adolescent risk in Canada: The meaning of suicide. *Journal of Child and Adolescent Psychiatric Nursing*, 21(1), 3-12.
- Madriz, E. (2003). Focus groups in feminist research. In N. Denzin & Y. Lincoln (Eds.), *Collecting and interpreting qualitative materials* (2nd ed., pp. 363-388). Thousand Islands: Sage.

- Mantoura, P., & Potvin, L. (2012). A realist-constructionist perspective on participatory research in health promotion. *Health Promotion International*, 28(1), 61- 71.
Doi:10.1093/heapro/das037
- Martin, D. (2012). Two-Eyed Seeing: A Framework for understanding Indigenous and Non-Indigenous approaches to Indigenous Health Research. *Canadian Journal of Nursing Research*, 44(2), 20-42.
- McAreavey, R., & Das, C. (2013). A Delicate Balancing Act: Negotiating with Gatekeepers for Ethical Research When Researching Minority Communities. *International Journal of Qualitative methods*, 12, 113-131.
- McCabe, G. (2008). Mind, body, emotions and spirit: Reaching to the ancestors for healing. *Counselling Psychology Quarterly*, 21(2), 143-152.
- McCormick, R. (1997). Healing through interdependence: The role of connecting in First Nations healing practices. *Canadian Journal of Counselling*, 31(3), 172-184.
- McCormick, R. (2009). Aboriginal approaches to counseling. In E. Kirmayer & V. Guthrie Valaskakis (Eds.), *Healing traditions: The mental health of Aboriginal peoples in Canada* (pp. 337-354). Vancouver: UBC Press.
- McCreary Centre Society. (2008). *Trends in adolescent health: Survey of British Columbia youth*. British Columbia: McCreary Centre Society.
- McHugh, T. (2011). Physical activity experiences of Aboriginal youth. *Native Studies Review*, (20)1, 7-26.
- McIntyre, L., Wien, F., Rudderham, S., Etter, L., Moore, C., MacDonald, N., Johnson, S., & Gottschal, A. (2003). A gender analysis of the stress experience of young Mi'kmaq women. *Centre of Excellence for Women's Health: Research Bulletin*, 4(1), 8-10.
- McMillan, J. (2010). Family violence and Aboriginal communities: Building our knowledge and direction through community-based research and community forums. In *Atlantic Aboriginal Health Research Program: Community-Based Research Publications* (pp. 37-43). Truro: Eastern Woodlands Publishing Inc.
- McNiff, J., & Whitehead, J. (2006). *All you need to know about action research*. Thousand Oaks: Sage.
- McQueen, D., & Jones, C. (2007). Global perspectives on health promotion effectiveness. In D. McQueen & C. Jones (Eds.), *Global perspectives on health promotion effectiveness* (pp. 3-11). New York: Springer.

- McQueen, D. (2007). Critical issues in theory development for health promotion. In D. McQueen & I. Kickbush (Eds.), *Health and modernity: The role of theory in health promotion* (pp. 21-42). Toronto: University of Toronto Press.
- Meagher-Stewart, D., Aston, M., Edwards, N., Young, L., & Smith, D. (2007). Managements' perspective on Canadian public health nurses' primary health care practices. *Primary Health Care Research & Development*, 8, 170-182. doi:10.1017/S1463423607000199
- Mental Health Commission of Canada. (2012). *Changing directions, changing lives: The mental health strategy for Canada*. Calgary, AB: Author
- Mignone, J., & O'Neil, J. (2005). Social capital and youth suicide risk factors in First Nations communities. *Canadian Journal of Public Health*, 96 (Supp. 1), S51-S54.
- Mi'kmaq Health Research Group. (1999). *The health of the Nova Scotia Mi'kmaq population*. Sydney: Union of Nova Scotia Indians.
- Miller, C., Pearce, M., Moniruzzaman, A., Thomas, V. Christian, W. Martin T....Spittal, P. (2011). The Cedar Project: risk factors for transition to injection drug use among young, urban Aboriginal people. *Canadian Medical Association Journal*, 183(10), 1147-53. doi:10.1503/cmaj.101257
- Miles, M., & Huberman, A. (1994). *Qualitative data analysis*. Thousand Oaks: Sage.
- Minde, R., & Minde, K. (1995). Socio-cultural determinants of psychiatric symptomatology in James Bay Cree children and adolescence. *Canadian Journal of Psychiatry*, 40, 304-312.
- Minkler, M., & Wallerstein, N. (2003). *Community-based participatory research for health*. M. Minkler & N. Wallerstein (Eds.), San Francisco: John Wiley & Sons.
- Mitchell, T., & Maracle, D. (2005) Healing the generations: Post-traumatic stress and the health status of Aboriginal populations in Canada. *Journal of Aboriginal Health*, 2(1), 14-23.
- Mittlemark, M. (2007). Shaping the future of health promotion: Priorities for action. *Health Promotion International*, 23(1), 98-102 . doi:10.1093/heapro/dam
- Mohammed, S. (2006). Scientific inquiry: (Re) examining health disparities: Critical social theory in pediatric nursing. *Journal for Specialists in Pediatric Nursing*, 11(1), 68-71.

- Morris, K. (2007). (A Literature review) Re-examining issues behind the loss of family & culture & the impact on Aboriginal youth suicide. *First Peoples Child & Family Review*, 3(1), 133-142.
- Morrisey, K., & Werner-Wilson, R. (2005). The relationship between out of school activities and positive youth development: An investigation of communities and families. *Adolescence*, 40(157), 65-85.
- Morse, J., & Richards, L. (2002). *Read me first, for a user's guide to qualitative methods*. Thousand Oaks: Sage Publication.
- Mota, M. Elias, B., Tefft, B., Medved, M., Munro, B. & Sareen, J. (2012). Correlates of suicidality: Investigation of a representative sample of Manitoba First Nations adolescents. *American Journal of Public Health*, 102(7), 1353-61
doi:10.2105/AJPH.2011.300385
- Musquash, C., & Bova, D. (2007). Cross cultural assessment and measurement issues. *Journal of Developmental Disabilities*, 13(1), 53-65.
- Mussell, B., Cardiff, K., & White, J. (2004). *The mental health and wellbeing of Aboriginal children and youth: Guidance for new approaches and services*. Chilliwack: Sal'I'shan Institute.
- Mussell, B. (2005). *Warrior-Caregivers: Understanding the healing and challenges of First Nations men*. Ottawa: National Aboriginal Healing Organization.
- National Aboriginal Health Organization (NAHO). (2002). *Improving population health, health promotion disease prevention and health protection services and programs for Aboriginal people*. Ottawa: Kinnon Consulting.
- National Aboriginal Health Organization (NAHO). (2007). *Facilitators Report on FNIMHHRI Advisory Committee Roundtable October 2007*. Retrieved from http://www.naho.ca/documents/naho/english/pdf/hhr_facilitatorsReport.pdf
- Native Council of Nova Scotia, Union of Nova Scotia Indians & Confederacy of Mainland Micmacs. (1997). *Mi'kmaw resource guide*. Truro: Eastern Woodland Publishing.
- Native Mental Health Association. (2007). *Charting the future of Native mental health in Canada: Ten year strategic plan 2007–2017*. Chilliwack: Native Mental Health Association of Canada.
- Newhouse, D. (2004). All singing/all dancing 24/7. The Center for Research and Information on Canada (CRIC):Government of Canada.

- Oleson, V. (2005). Early millennium feminist qualitative research. In N. Denzin & Y. Lincoln (Eds.), *The sage handbook of qualitative research* (3rd ed., pp. 235-278). London: Sage Publications.
- O'Neill, M., Pederson, A., Dupère, S., & Rootman, I. (2007). Introduction: An evolution in perspectives. In M. O'Neill, A. Pederson, S. Dupère, & I. Rootman (Eds.), *Health promotion in Canada: Critical perspectives* (2nd ed., pp. 1-15). Toronto: Canadian Scholars' Press Inc.
- Park, P. (1993). Participatory Action Research. In P. Park, M. Brydon-Miller, B. Hall, & T. Jackson (Eds.), *Voices of change: Participatory research in the United States and Canada* (pp. 1-19), Toronto: OISE.
- Peters, R., & Demerai, L. (1997). Improving mental health services for urban First Nations: Policy issues relevant to health care reform. *Canadian Journal of Community Mental Health*, 16(2), 29-36.
- Poliandri, S. (2011). *First Nations identity and reserve life: The Mi'kmaq of Nova Scotia*. Lincoln: University of Nebraska Press.
- Raeburn, J., & Rootman, I. (2007). A new appraisal of the concept of health. In M. O'Neill, A. Pederson, S. Dupère, & I. Rootman (Eds.), *Health promotion in Canada* (pp. 19-31). Toronto: Canadian Scholars' Press Inc.
- Raphael, D. (2000). The question of evidence in health promotion. *Health Promotion International*, 15(4), 355-367. doi: 10.1093/heapro/15.4.355
- Raphael, D., & Bryant, T. (2000) Putting the population into population health. *Canadian Journal of Public Health*, 91(1), 9-12.
- Reading, J., Kmetz, A., & Gideon, V. (2007). *First Nations wholistic policy and planning model: Discussion paper for the World Health Organization Commission on Social Determinants of Health*. Ottawa: Assembly of First Nations.
- Reading, C. L., & Wien, F. (2009). Health inequalities and social determinants of Aboriginal peoples' health (pp. 1-38). Ottawa: National Collaborating Centre for Aboriginal health.
- Report of the Royal Commission on Aboriginal Peoples. (1995). *Choosing life: Special report on suicide among Aboriginal people*. Ottawa: Ministry of Health.
- Report of the Royal Commission on Aboriginal Peoples. (1996). *Volume 3: Gathering Strength*. Ottawa: Ministry of Supply and Services.

- Riecken, T., Tanaka, M., & Scott, T. (2006). First Nations youth reframing the focus: Cultural knowledge as a site for health education. *Canadian Journal of Native Education*, 29(1), 29-41.
- Rieckmann, T., Wadsworth, M., & Deyhle, D. (2004). Cultural identity, explanatory style, and depression in Navajo adolescents. *Cultural Diversity and Ethnic Minority Psychology*, 10(4) 365-382. doi: 10.1037/1099-9809.10.4.365
- Ryan, G., & Bernard, R. (2003). Techniques to identify themes. *Field Methods*, 15(1), 85-109. doi: 10.1177/1525822X02239569
- Sable, T. & Francis, B. (2012). *The language of this land, Mi'Kma'ki*. Sydney, N.S.: Cape Breton University Press.
- Schnarch, B. (2004). Ownership, control, access and possession (OCAP) or self-determination applied to research. *Journal of Aboriginal Health*, January, 80-95.
- Schmidt, G. (2000). Barriers to recovery in a First Nations community. *Canadian Journal of Community Mental Health*, 19(2), 75-87.
- Shantz, J. (2010). 'The foundation of our community': cultural restoration, reclaiming children and youth in an indigenous community. *Journal of Social Welfare & Family Law*, 32(3), 229-236. doi: 10.1080/09649069.2010.520515
- Shea, J., Poudrier, J., Chad, K., Jeffery, B., Thomas, R., & Burnouf, K. (2011). In their own words: First Nations girls' resilience as reflected through their understandings of health. *Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health*, 11(1), 1-15.
- Shea, J. Poudrier, J., Thomas, R., Jeffery, B. & Kiskotagan. L. (2013). Reflections from a creative community-based participatory research project exploring health and body image with First Nations girls. *International Journal of Qualitative Methods*, 12, 273-93.
- Sim, J. (1998). Collecting and analyzing qualitative data: Issues raised by the focus group. *Journal of Advanced Nursing*, 28(2), 345-352. 10.1046/j.1365-2648.1998.00692.x.
- Skinner, R. & McFaull, S. (2012). Suicide among children and adolescents in Canada: trends and sex differences, 1980-2008. *Canadian Medical Association Journal*, 184(9), 1029-1034. doi:10.1503 /cmaj.111867
- Smith, L.T. (2000). Kaupapa Maori research. In M. Battiste (Ed.), *Reclaiming Indigenous voice and vision* (pp.225-247). Vancouver: UBC Press.

- Smye, V., & Browne, A. (2002) 'Cultural safety' and the analysis of health policy affecting aboriginal people. *Nurse Researcher*, 9(3), 42-56.
- Smye, V. (2004). *The nature of the tensions and disjunctures between Aboriginal understandings of and responses to mental health and illness and the current mental health system* (Unpublished doctoral dissertation). University of British Columbia, British Columbia, Canada
- Smylie, J., Anderson, I., Ratina, M., Crengle, S., & Anderson, M. (2006). Indigenous health performance measurement systems in Canada. *Lancet*, 367, 2029-2031.
- Smylie, J., Marin, C.M., Kaplin-Mryth, N., Steele, L., Tait, C., & Hogg, W. (2003). Knowledge translation and Indigenous knowledge. *Circumpolar Health*, 139-143.
- Stansfields, D., & Browne, A. (2013). The relevance of Indigenous Knowledge for nursing curriculum. *International Journal of Nursing Education Scholarship*, 10(1), 1–9. doi: 10.1515/ijnes-2012-0041
- Statistics Canada. (2006). Census of population, Statistics Canada catalogue no. 97-558-XCB2006010. Release date: January 15, 2008. <http://www12.statcan.ca/census-recensement/2006/dp-pd/index-eng.cfm>
- Statistics Canada. (2006). Aboriginal Community Profiles. Retrieved from <http://www12.statcan.ca/english/census06/data/profiles/aboriginal/Index.cfm>
- Stewart, S. (2008). Promoting Indigenous mental health: Cultural perspectives on healing from Native counselors in Canada. *International Journal of Health Promotion & Education*, 48(2), 49-56.
- Stiffman, A., Brown, E., Freedenthal, L., House, E., Ostmann, S., & Soo Yu, M. (2007). American Indian youth: Personal, familial, and environmental strengths. *Journal of Child and Family Studies*, 16, 331–346. doi: 10.1007/s10826-006-9089-y
- Stirling, A., & O'Neill, M. (2007). The promotion of health or health promotion? In M. O'Neill, A. Pederson, S. Dupère, & I. Rootman (Eds.), *Health promotion in Canada* (pp. 32-45). Toronto: Canadian Scholars' Press Inc.
- Strickland, C. (1999). Conducting focus groups cross-culturally: Experiences with Pacific Northwest Indian People. *Public Health Nursing*, 16(3), 190–197.
- Suicide Prevention Advisory Group. (2002) *Acting on what we know: Preventing youth suicide in First Nations*. Ottawa: Assembly of First Nations and Health Canada.

- Sword, W. (1997). Enabling health promotion for low-income single mothers: An integrative perspective. *Clinical Excellence for Nurse Practitioners*, 1(5), 324-332.
- Szala-Meneck, K., & Lohfeld, L. (2003). The charms and challenges of an academic qualitative researcher doing participatory research (PAR). In D. Pawluch, W. Shaffir, C. Miall (Eds.), *Doing ethnography: Studying everyday life* (pp. 52-65). Toronto: Canadian Scholars' Press.
- Tait, C. (2008). Ethical programming: Towards a community-centred approach to mental health and addiction programming in Aboriginal communities. *Pimatisiwin: A Journal of Aboriginal & Indigenous Community Health*, 6(1), 29-59.
- Tait, C. (2009). Disruptions in nature: Disruptions in society: Aboriginal Peoples of Canada and the making of Fetal Alcohol Syndrome. In E. Kirmayer & V. Guthrie Valaskakis (Eds.), *Healing traditions: The mental health of Aboriginal Peoples in Canada* (pp. 196-220). Vancouver: UBC Press.
- Tait, C., & Whiteman, E. (2011) Introduction: Indigenous youth, resilience, and decolonizing research. *Native Studies Review*, 20(1), 1-5.
- Tait, C., Henry, R., & Loewen Walker, R. (2013). Child welfare: A social determinant of health for Canadian First Nations and Métis Children. *Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health*, 11(1), 39-53.
- Tedlock, B. (2008). The observation of participation and the emergence of public ethnography. In N. Denzin & Y. Lincoln (Eds.), *Strategies of qualitative inquiry* (3rd ed., pp. 151-172). London: Sage Publication.
- Tomblin-Murphy, G., & Maddalena, V. (2007). *Establishing a minimum data set to support the advancement of NAHO's Aboriginal Health Human Resource Initiative: Next steps*. Retrieved from http://www.naho.ca/documents/naho/english/pdf/hhr_MDS_Report.pdf
- Tousignant, M., & Sioui, N. (2009) Resilience and Aboriginal communities in crisis: Theory and interventions. *Journal of Aboriginal Health*, Nov. 2009, 43-61.
- Tripartite Committee on First Nations Health. (2013). *Tripartite Committee on First Nations Health: Annual Report*. Retrieved from <http://www.health.gov.bc.ca/library/publications/year/2013/Together-in-Wellness.pdf>
- Truth and Reconciliation Commission of Canada. (2012) *Truth and Reconciliation Commission of Canada: Interim report*. Retrieved from http://www.attendancemarketing.com/~attmk/TRC_jd/Interim_report_English_electronic_copy.pdf

- Ulin, P., Robinson, E., & Tolley, E. (2005). *Qualitative methods in public health: A field guide for applied research*. San Francisco: Jossey-Bass.
- Ungar, M. (2005). *Handbook for working with children and youth: Pathways to resilience across cultures and contexts*. Thousand Oaks: Sage.
- Ungar, M. (2010). What is resilience across cultures and contexts? Advances to the theory of positive development among individuals and families under stress. *Journal of Family Psychotherapy*, 21, 1–16. doi: 10.1080/08975351003618494
- Union of Nova Scotia Indians. (2013). *The Health of the Nova Scotia Mi'kmaq Population: Results from the 2008-10 Regional Health Survey for the On Reserve Population*. Author: Sydney Nova Scotia. Retrieved from <http://www.unsi.ns.ca/departments/first-nations-regional-longitudinal-health-survey/4/>
- Vukic, A., & Keddy, B. (2002). Northern nursing practice in a primary health care setting. *Journal of Advanced Nursing*, 40(5), 542-548. doi: 10.1046/j.1365-2648.2002.02411.x.
- Vukic, A., Rudderham, S., & Martin-Misener, R. (2009). A Community partnership to explore gaps in mental health services in First Nations communities in Nova Scotia. *Canadian Journal of Public Health*, 100(6), 432-435.
- Vukic, A., Gregory, D., Martin-Misener, R., & Etowa, J. (2011) Aboriginal and Western conceptions of mental health and illness. *Pimatisiwin: Journal of Indigenous and Aboriginal Community Health*, 9(1), 65-86.
- Vukic, A., Gregory, D., Martin-Misener, R. (2012). Indigenous Health Research: Theoretical and Methodological Perspectives. *Canadian Journal of Nursing Research*, 44(2), 146-61.
- Waldram, J., Herring, A., & Young, T.K. (2006). *Aboriginal health in Canada: Historical, cultural, and epidemiological perspectives* (2nd Ed.). Toronto: University of Toronto Press.
- Waldram, J. (2008). *Aboriginal healing in Canada: Studies in therapeutic meaning and practice*. Ottawa: Aboriginal Healing Foundation Research Series.
- Waldram, J. (2009). Culture and Aboriginality in the study of mental health. In E. Kirmayer & V. Guthrie Valaskakis (Eds.), *Healing traditions: The mental health of Aboriginal peoples in Canada* (pp. 56-79). Vancouver: UBC Press.
- Waldram, J. (2013) Transformative and Restorative Processes: Revisiting the Question of Efficacy of Indigenous Healing. *Medical Anthropology: Cross-Cultural Studies in Health and Illness*, 32(3), 191-207. doi:10.1080/01459740.2012.714822

- Walkup, J., & Working Group on Quality of Issues. (2009). Practice parameters on the uses of psychotropic medication in children and adolescents. *Journal of American Academy of Child and Adolescent Psychiatry*, 48(9), 961-973.
- Wallerstein, N., & Duran, B.M. (2003). The conceptual, historical, and practical roots of community based-based participatory research and related participatory traditions. In M. Minkler & N. Wallerstein (Eds.), *Community-based participatory research for health* (pp. 24-48), San Francisco: John Wiley & Sons.
- Walls, M., Hautala, D., & Hurley, J. (2014). "Rebuilding our community": Hearing silenced voices on Aboriginal youth suicide. *Transcultural Psychiatry*, 51(1), 47-72. doi: 10.1177/1363461513506458
- Walters, K., & Simoni, J. (2009). Decolonizing strategies for mentoring American Indians and Alaska Natives in HIV and mental health research. *American Journal of Public Health*, 99(Supp. 1), 71-76. DOI: 10.2105/AJPH.2008.136127
- Warry, W. (2007). *Ending denial: Understanding Aboriginal issues*. Peterborough: Broad View Press.
- Wendt, G., & Gone, J. (2011). Rethinking cultural competence: Insights from indigenous community treatment settings. *Transcultural Psychiatry*, 49(2), 206–222. doi: 10.1177/13634615111425622
- Wheeler, K. (2008). *Psychotherapy for the advanced practice psychiatric nurse*. St.Louis: Mosby, Elsevier.
- Whitbeck, L. (2006). Some guiding assumptions and a theoretical model for developing culturally specific preventions with Native American people. *Journal of Community Psychology*, 34(2), 183-192. doi: 10.1002/jcop.20094
- White, J., & Joidin, N. (2007). Promising strategies: Aboriginal youth: A manual of promising suicide preventing strategies. Retrieved from Centre for Suicide Prevention: http://www.suicideinfo.ca/csp/assets/prom_stat_en.pdf
- Wieman, C. (2009). Six Nations mental health services: A model of care for Aboriginal communities. In E. Kirmayer & V. Guthrie Valaskakis (Eds.), *Healing traditions: The mental health of Aboriginal Peoples in Canada* (pp.401-410). Vancouver: UBC Press.
- Williams, L. (2007). Health promotion in Saskatchewan: Three developing approaches. In M. O'Neill, A. Pederson, S. Dupère, & I. Rootman (Eds.), *Health promotion in Canada: Critical perspectives* (2nd ed., pp. 171-175). Toronto: Canadian Scholars' Press Inc.

- Wilson, K., & Rosenberg, M. (2002). Exploring the determinants of health for First Nations people in Canada: Can existing frameworks accommodate traditional activities? *Social Science & Medicine*, 55(11), 2017-2031.
- World Health Organization. (1986). *Ottawa charter for health promotion*. Ottawa: World Health Organization, health and Welfare Canada, Canadian Public Health Association.
- Wright, L., & Leahy, M. (2005). *Nurses and families: A guide to family assessment and intervention* (4th Ed.). Philadelphia: F. A. Davis Company.
- Youngblade, L., Theokas, C., Schulenberg, J., Curry, L., Huang, I., & Novak, M. (2007). Risk and promoting factors in families, schools and communities: A contextual model of positive youth development in adolescence. *Pediatrics*, (119, Supp 1), 47-53. doi: 10.1542/peds.2006-2089H
- Zahradnik, M., Stewart, S., Stevens, D., & Wekerle, C. (2009). Knowledge translation in a community-based study of the relations among violence exposure, post traumatic stress and alcohol misuse in Mi'kmaq youth. *First Peoples Child and Family Review*, 4(2), 106-117.
- Zahradnik, M. (2010). A community-based, collaborative investigation of trauma, its mental health consequences, alcohol misuse and resilience in a school attending sample of Mi'kmaq adolescents. In *Atlantic Aboriginal Health Research Program: Community-Based Research Publication* (pp. 44-50). Truro: Eastern Woodlands Publishing Inc.
- Zahradnik, M., Stewart, S., O'Connor, Stevens, D., Ungar, M., & Wekerle, C. (2010). Resilience moderates the relationship between exposure to violence and posttraumatic re-experiencing in Mi'kmaq youth. *International Journal Mental Health Addiction*, 8, 408-420. doi: 10.1007/s11469-009-9228-y