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Indigenous Wise Practices

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Abstract

The Indigenous Wise Practices research study emerged for the Ministry of Children and Family Development (MCFD) to understand the journeys of Child Youth and Mental Health (CYMH) clinicians in integrating Indigenous Wise Practices and culturally safe approaches in their work with Indigenous clients. Through this research, MCFD intended to explore the areas in which additional support could be provided on structural levels, including policy changes, for CYMH clinicians to seamlessly integrate Indigenous Wise Practices and culturally safe approaches. Moreover, this research study anticipated discovering which Indigenous Wise Practices are currently being implemented in the practices of CYMH clinicians. This research study aimed to explore the various barriers, gaps, and challenges that hinder the ability of clinicians to integrate such practices in their interactions with Indigenous clients. In this final report, there will be an introduction to discuss the goals and purpose of this research study. The research study and the methodology were guided by trauma-informed, strengths-based, and decolonization theories. Although the report provides a more thorough explanation, this research study utilized non-probability research methods inducing selective and convenience sampling methods. Indigenous Elders and CYMH clinicians were interviewed to gain in-depth insight regarding the most effective practices with Indigenous children, youth, and families. Through these interviews, student researcher's derived similar themes that emerged from Elders and clinicians. The meeting with the Elders offered five key themes including, 1) The holistic understanding of self, 2) Listen to understand, 3) Creating a safe space, 4) The Medicine Wheel, and 5) Spirituality and ceremony. Moreover, the clinician interviews provided nine themes including, 1) Clinicians' understanding of Indigenous Wise Practices, 2) Journey towards incorporating Indigenous Wise Practices, 3) Clinicians' willingness to learn and remain open-minded, 4) Cultivating whole system relationships, 5) Time and patience for fostering a genuine connection, 6) Barriers in relationship building with Indigenous communities, 7) Indigenous-led Service Delivery that brings Change to Practices and Policies, 8) The need to increase culturally sensitive practices, and 9) Acknowledgement of past and current harm created by the system. In this research study, it was discovered that developing meaningful relationships with no time constraints and increasing Indigenous-led services is a pertinent practice that should be incorporated largely into the MCFD services. These findings were explored in the context of the literature utilized to support the development of this research study. The limitations of this research study included a small sample size with a discredited ability to generalize the findings, time constraints for clinician interviews and circle meetings, and the strictly virtual setting of this study. The final section explores implications for future areas of research, policy implementation, and changes in practice.

Keywords: Indigenous, Elders, Wise Practices, Cultural Safety, Children and Youth Mental Health (CYMH)

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Introduction

The Ministry of Children and Family Development (MCFD) is the governing child protection body throughout the province of British Columbia (BC). MCFD currently uses six Structured Decision Making (SDM) Tools to assess child protection concerns. The safety assessment is one of these six tools. It is designed to provide guidance through the use of clear descriptors to social workers when determining the immediate safety of children. This information guides the decision regarding whether the child may remain in the home without safety interventions, may remain in the home with safety interventions in place, or must be placed out of the home to ensure safety.

The purpose of this research study is to identify whether the safety assessment tool is being completed as intended by child protection teams across BC. Teams within the Vancouver/Richmond SDA have been engaged in a model fidelity approach (using the tools when and how they were intended) using the SDM Tools over the past year. This project has included providing refreshers on each of the tools to teams within the SDA. One issue that has been identified by workers who use the safety assessment tool is that social workers are not always gathering information about every question on the safety assessment. This issue was raised by social workers during SDM Tool refresher training. The safety assessment is a crucial portion of the SDM Tools, as it determines if a child may remain in their home. In order to ensure that the safety of children is assessed thoroughly and consistently across all families, it is critical to understand if the safety assessment tool is being used as intended. If the tool is not being used as intended, supporting staff to increase their capacity to use the tool properly is warranted. This shift in practice is important to ensure that all social workers are modeling best practice approaches in child welfare. The questions associated with this research are as follows: 1) Are social workers asking or gathering information for all the questions in the safety assessment, regardless of the reported concerns? 2) If not, why not? What are the challenges and barriers? 3) How can staff be better supported to use the safety assessment as intended? The goals of this research include identifying how social workers are completing the safety assessment, current gaps within the safety assessment practice across BC, and recommendations on how practice can be improved to support model fidelity and align with best practice approaches within the child welfare system.

Additionally, researchers should be aware of the traumatization of the Western approach to research with Indigenous communities (Windchief & Cummins, 2021). It is essential to not appropriate and generalize Indigenous ways of knowing, and to approach knowledge with curiosity and respect (Windchief & Cummins, 2021). In an attempt to not further perpetuate colonial practices, the principles of OCAP (ownership, control, access and possession) need to be upheld throughout any research process (First Nations Centre, 2007). These principles recognize the necessity for Indigenous peoples and communities to determine how research studies will be conducted, used, safeguarded and shared at every stage of a study (First Nations Centre, 2007). Thus, decolonizing the approach to conducting research is a fundamental component when engaging with Indigenous communities.

Before researching Indigenous Wise Practices, it is essential to understand what this term entails. Indigenous Wise Practices are approaches that acknowledge the traditional knowledge and the contextual nature of Indigenous communities' experiences (Aboriginal Policy and Practice Framework, 2015). Indigenous Wise Practices harbour decolonization, reconciliation, and anti-racism towards Indigenous communities (Wesley-Esquimaux & Snowball, 2010). It is also important to note that Indigenous Wise Practices are unique to each community, and practices should not be generalized to all communities. Indigenous Wise Practices are grounded in traditional knowledge of the Kwantlen First Nations' Seven Laws, storytelling, the Medicine Wheel, and the Circle. The seven laws, spirits entrusted by the Creator to watch over humanity, shared seven values. These values include humbleness, forgiveness and understanding. Next, storytelling is a vital component for many Indigenous communities. Storytelling is an essential aspect of

Indigenous culture that provides connections to ancestral experiences, new experiences, guidance on becoming a better human being, and preserving culture (Lawrence & Paige, 2016). Moreover, the Circle is used by Indigenous Elders to share important teachings through listening and sharing by creating a space where everyone is treated with respect and equality (Raven Speaks, 2012). The Circle is a way to begin the healing process, promote understanding, prevent or solve problems, build trust, share common experiences, create connections, learn from others, and identify ways to grow (Stevenson, 1999). Indigenous cultures approach health, wellness, and healing through the medicine wheel. The balance of all four spheres of humanity is required: the mental, physical, emotional, and spiritual (Kemppainen et al., 2008).

For Indigenous communities in Canada, the most fundamental definition of sovereignty stems from "the natural right of all human beings to define, sustain and perpetuate their identities as individuals, communities and nations" (Report of the Royal Commission on Aboriginal Peoples, 1996, p. 105). Sovereignty is an innate human characteristic that can be expressed through the principle of self-determination for Indigenous peoples to find power in the freedom to make their own choices (Report of the Royal Commission on Aboriginal Peoples, 1996). The strong connection that Indigenous peoples maintain with their homelands and territories existed long before Canada formed as an independent country.

Through this literature review, recommended practices, gaps in the literature, limitations, and implications for future research emerged. An essential recommended practice by Richardson and Murphy (2018) included training non-Indigenous staff to practice Indigenous Wise Practices. That is, non-Indigenous staff should be thoroughly educated and trained on the history of colonization, its impacts on Indigenous communities, Indigenous traditions, practices, and trauma-informed theory.

The implementation of Indigenous Wise Practices should be implemented in collaboration with Indigenous communities. Collaboration could encompass aspects such as hiring Indigenous staff for all levels of an organization, elevating Indigenous voices when developing programs, and incorporating Indigenous traditions in consultation with Indigenous communities (Richardson & Murphy, 2018).

Researchers must learn about Indigenous traditions and practices, and they must involve Indigenous members in all stages of the research process (Maar et al., 2019). Due to the belief that Indigenous ways of practice are not scientific and scholarly, there is limited research available on the implementation of Indigenous research frameworks and Indigenous Wise Practices (Mercer et al., 2010). As reflected by Wesley-Esquimaux and Snowball (2010), Indigenous Wise Practices enhance Western approaches by fostering culturally sensitive practices that are utilized by clinicians when engaging with Indigenous communities. At the conclusion of this research study, the results will attempt to inform and navigate the implementation of Indigenous Wise Practices.

Theoretical Framework

Throughout this research study, various theories informed and guided the research methodology. To begin, trauma-informed theories ensure safety, collaboration, choice, and empowerment to share the individual's interpreted narrative (Levenson, 2017). Trauma-informed practices highlight the significance of collaboration to ensure a reduction in power imbalances between the client and the clinician (Levenson, 2017). Moreover, this research is guided by strengths-based theories in social work practice. The strengths-based theory emphasizes an individual's inherent strengths that allow them to overcome challenges (Askew et al., 2020). The strengths-based theory disentangles the beliefs that individuals are responsible for the deficits in their situation and shifts the focus on the individuals' resiliency (Askew et al., 2020).

The decolonization theory is utilized to inform the implementation of effective practices with Indigenous populations. Decolonization detaches colonial practices when engaging with Indigenous and racialized communities (Gaudry & Lorenz, 2018). Decolonization provides space for self-determination, and economic and cultural freedom (Gaudry & Lorenz, 2018). The

theories outlined above guide this research by providing frameworks to incorporate in research question development and analysis. The theoretical frameworks offer insight into how the methodology could be constructed to answer our research questions.

Conceptual Framework

This research study aims to explore pivotal components of Indigenous Wise Practices in the development and implementation of CYMH services for Indigenous children and youth in British Columbia (BC). Specifically, the term Indigenous is deliberately used throughout the research study about this population group over the synonymous term Aboriginal. Although both are similar terms, Indigenous is associated more with activism, whereas Aboriginal is related more with legal discussions in government policy (University of British Columbia, 2021). The negative affiliation that historical and present government policies often possess for many Indigenous peoples has led to the use of the term Indigenous (University of British Columbia, 2021). The application of Indigenous resonated more strongly for this research as it is a collective term that refers to First Nations, Métis, and the Inuit in Canada. This research study uses Indigenous as it does not focus on any specific community, rather, it is applied as an inclusive term. However, it is essential to be aware that each Indigenous community has their own unique Indigenous Wise Practices that this research study may not be able to address. The methodology section presents the process for conducting interviews with CYMH clinicians, DAA clinicians, and Indigenous Elders.

This research study aims to increase knowledge of the tools and resources utilized by clinicians with Indigenous children and youth in their transition from Western models to wise practices. Additionally, it will be used to inform the continued integration of successful models of wise practices for clinicians.

Research Methods

The student researchers used non-probability (i.e., selective and convenience) sampling methods for this research. The Elders were selected for their knowledge, teachings, leadership in the Indigenous communities and willingness to participate. The purpose of speaking to Elders was to obtain information that is connected to Indigenous cultures. As Elders have a connection to cultural roots and lived experiences of Indigenous cultures before forced assimilation, it was critical to directly converse with Elders to gather learning that is authentic and respectful of traditional knowledge. The teachings provided by Elders aided student researchers in verifying, correcting and incorporating information regarding Indigenous cultures and practices within MCFD. The clinicians were selected for their knowledge and application of wise practices in their work, willingness to participate and availability during the scheduled interviewing period. Criteria for inclusion were: Current CYMH and DAA clinicians who self-identified to incorporate wise practices in their work. Those who do not meet the criteria described were not included in this research study.

The Elders were invited by Marlena Kaltsidis, the Aboriginal Policy and Program Analyst of the MCFD Aboriginal Policy and Program Team (APPT). Five Elders participated in the Elder Circle. In consultation with APPT, student researchers appropriately obtained consent, generated respectful interview questions, presented Elders with suitable honorariums and gifts and harboured cultural safety during the Elder Circle. The clinicians were recruited through an Invitation to Participate email sent by a student researcher and forwarded by Kali Love, through the internal MCFD email contact list. Kali is a MCFD Program Evaluation Analyst. Interested clinicians contacted student researchers via email and then were sent a link to provide consent and fill out the demographic survey. Student researchers then proceed to arrange the meeting. There was no response from DAA, therefore, only CYMH clinicians were interviewed. Seven clinicians participated in the interviews. There was minimal risk for the research participants. The clinicians had varying cultural backgrounds, years of experience with MCFD, and educational levels (see Appendix A).

Six out of seven clinicians had Master's degrees and one clinician had their Bachelor's degree. The clinicians had varying levels of experiences with MCFD. The most experience one clinician had was twenty-two years. The clinician with the least

experience was five years. The remaining clinicians had varying experience from five to fifteen years.

For data collection, student researchers spoke with the Elders and CYMH clinicians. The circle with the Elders and interviews with the clinicians were held over Zoom due to COVID-19. The circle and interviews were also recorded and transcribed through Zoom, with one interview being professionally transcribed. Student researchers manually omitted all identifiers from the transcripts. The circle with the five Elders was four and a half hours long, and student researchers asked the Elders three questions.

Student researchers used semi-structured interviews for consistency and validity. The interviews with clinicians were about 45 minutes each, and clinicians were asked eleven questions. As part of the research process, student researchers met with the MCFD sponsors bi-weekly for support throughout. These meetings were also used for student researchers to gain knowledge on how to best engage with the Elders most respectfully and appropriately. In consultation with APPT, especially with Marlena Kaltsidis, student researchers received guidance on protocols for engagement with Elders.

The primary qualitative data for this research study was obtained through interviews with clinicians and the circle with Elders. Student researchers utilized triangulation methods with collaborative group meetings to collect data, analyze the interviews and circle meetings, and code the themes.

Triangulation in qualitative research involves the use of multiple methods or data sources to establish validity and credibility (Peersman, 2010). Data, investigator, and theory triangulation methods were used in this research study. Data triangulation is the use of a variety of data sources (Peersman, 2010). Student researchers used the data from the circle with the Elders and interviews with clinicians. Investigator triangulation involves using multiple researchers in collecting and analyzing data (Peersman, 2010). All five student researchers were involved in collecting, coding and analyzing data. Theory triangulation uses various theoretical perspectives in the research (Peersman, 2010). Additionally, trauma-informed practice, strengths-based theory, and decolonization theory guided this research and the findings.

An inductive approach was used for coding and codes were generated as data was analyzed. The NVivo program was used to code the data. To begin, structural coding was used in the initial coding stage to break down the data of the interviews by each question. The student researchers then continued with line-by-line descriptive coding, summarizing data by using a few words that capture the theme from the data. The student researchers then grouped the codes together that have similarities, and looked for patterns to emerge. After the individual student researchers completed the coding for their interviews, the group met together to conduct intercoder reliability to find the central themes from all the interviews.

The last step in gaining data was the optional closing circle where the five Elders and even clinicians were invited to reconnect as a group with the student researchers so that student researchers could share the research findings from the circle and interviews before the final presentation and report. The purpose of this circle was to verify findings and receive. It was also an opportunity to give thanks and close these relationships. This component is critical to closing relationships in good ways while instilling decolonizing methods.

Findings

Findings from Elders Circle

During the circle with the Elders, the student researchers had the opportunity to ask three questions (Appendix B). There were five key themes that emerged from the knowledge shared by the Elders. The themes were: 1) The holistic understanding of self, 2) Listen to understand, 3) Creating a safe space, 4) The Medicine Wheel, and 5) Spirituality and ceremony.

The Holistic Understanding of Self. The Elders spoke about the importance of clinicians and clients having a holistic understanding of self. This means having self-awareness, self-love, and self-care. Starting with self-awareness, it is not only important for clinicians to recognize who they are and where they come from, but also to ensure they are creating safe spaces for clients to do the same. Elder E3

suggested asking these questions, “How can I be the person that I want to be? How am I damaged and what does my trauma look like?”

Knowing the answers to these questions and understanding oneself enables healing, which leads to self-belief and self-love. The Elders emphasize having love for oneself to prioritize mental well being. As one Elder stated:

> We need to first love ourselves. The thing about mental health is that we first have to, when we're working with someone, make sure that they have a good grasp of love for themselves, and a good sense of self worthiness. The difference for me from the time was youth right up to the Elderhood, or walking that path, was… learning to love myself, I was learning to care for myself, protect myself and share it right taking healthy chances (E3).

A way to love oneself is through self-care as it is a protective factor. When an individual is fatigued, it affects how they think, feel, and behave. Elder E4 said:

> It dawned on me that in those low periods, where I get mad and do things, because I'm hugely tired, and those dark entities come into me and make me feel that way, making me become irrational, not true to who I am, and not balanced (E4).

Elder E2 said, “When you embrace yourself with something that's healthy, it’s gonna get you to different places.” In speaking with all Elders, it was evident that taking care of oneself is important when providing support to clients but also for clinician’s mental well being.

Listen to Understand. Next, the Elders highlighted the importance of listening to understand. Elder E3 said, “A person can really make a difference in someone’s life by listening to them, by paying attention to them, and not just once but time and again, until finally when they finish telling their story.”

To support a client, the clinician must have the ability to patiently and carefully listen to the client talk about where they are from, what their culture is, and what their story is. Elder E3 suggested:

> Looking at a drug addict, one must ask, why is he or she a drug addict? There's pain, there's trauma. They're using drugs as a band aid. They're using sex as a band aid. If they’re working all the time, they use work as a band-aid. We need to go back, find out where the issue is through their story (E3).

Creating a Safe Space. It is integral for clinicians to create a safe space in order for the clients to share their stories. For Indigenous clients, clinicians must provide a space that is welcoming for Indigenous clients. If clients have not shared their stories, perhaps it is because they have not felt safe.

Clients will not open up and start the healing process until they feel comfortable and safe. Elder E2 said, “All we were there is to create a safe place for them to do what they need to do for themselves. They're doing the work.” Elder E4 shared an example of an unsafe space. They said, “Too many times a child is taken out of the classroom to be interviewed by a social worker. They’re put into an office. How scary is that? How much more trauma are we creating because of that?”

The Medicine Wheel. Another key component highlighted by all the Elders was the Medicine Wheel. The Medicine Wheel represents balance. Elder E5 said, “If we were to look at the medicine wheel, as a tool of self-reflection, we look at defining health as a balance between mind, body, spirit and emotions.” Elder E4 shared that they ground themselves in the Medicine Wheel through balancing all the quadrants. Elder E2 stated that the medicine wheel can help one understand where they actually come from. Elder E2 also asked, “How many of you guys actually have your wheel with you? [laughs] I’m just kidding, I’m just kidding. It’s inside you, it’s inside you. So whatever you get from here [points to heart], is good medicine.”

Spirituality and Ceremony. Finally, the Elders emphasized spirituality as it has been neglected and dismissed in the mental health and healthcare fields. Elder E3 said, “You need to include spirituality into the healing practices if you are working with Western medicine. If you don't include spirituality, you're missing the mark.” Many practice spirituality through ceremony. Elder E3 said,

> We have many tools in the sense of ceremony. Ceremony is what will help save people. What is the spirituality of these people? The tool is going and attending functions like a pow-wow or going to a sweat lodge, or going to a drumming circle, or learning how to sing and dance for that particular culture that you're living at, or doing a full-moon

ceremony.

Other ceremonies the Elders spoke about included praying, fasting, taking spirit baths, and smudging.

Findings from Interviews with CYMH Clinicians

The interviews with clinicians included eleven interview questions (Appendix C). The clinicians were of various ethnic backgrounds. Five clinicians identified as Caucasian, one identified as Asian, and one as Indigenous (Appendix A). With these diverse cultural backgrounds of clinicians, it should be noted that there is an element of cross-cultural work. Nine themes emerged from the analysis of data from the information provided by the MCFD clinicians: 1) Clinicians' understanding of Indigenous Wise Practices, 2) Journey towards incorporating Indigenous Wise Practices 3) Clinicians' willingness to learn and remain open-minded, 4) Cultivating whole system relationships, 5) Time and patience for fostering a genuine connection, 6) Barriers in relationship building with Indigenous communities, 7) Indigenous-led Service Delivery that brings Change to Practices and Policies, 8) The need to increase culturally sensitive practices, and 9) Acknowledgement of past and current harm created by the system.

Clinicians' Understanding of Indigenous Wise Practices. When speaking with CYMH clinicians about the term Indigenous Wise Practices, some clinicians had not heard of this specific term, while others had various definitions. However, the common understanding was that Indigenous Wise Practices referred to the use of traditional ways of healing. The clinicians shared their awareness that these traditional or Wise Practices were most effective when supporting Indigenous clients. One clinician stated, "My definition of Indigenous Wise Practices is essentially Indigenous-led practices, where it should be and needs to be informed by Indigenous Elders, leaders, members, in that particular area, in the land, in the territory" (P03). Clinicians were also aware that every client is unique, and their needs will be different. Clinicians use creativity and flexibility to support clients in accessing traditional ways of healing.

Journey Towards Incorporating Indigenous Wise Practices. While all the clinicians had differences in their journeys towards incorporating Indigenous Wise Practices, there were common elements. A few clinicians acknowledged their lack of knowledge about Indigenous people and their history in Canada. However, these same clinicians found themselves gaining valuable insight from Indigenous-led training taken at the workplace. The San'yas training was felt to be very effective for a few clinicians. One clinician stated "well the San'yas as I mentioned that was life altering, there's no other way to put it for me" (P06). Another clinician also stated "the biggest one would be the San'yas training through" (P03).

Other clinicians started their journey of learning about Indigenous Wise Practices when they enrolled in Indigenous courses in post-secondary, while others had their interest peaked when travelling abroad and engaging with Indigenous people in different countries. There were commonalities for all clinicians when speaking about their journey and use of Indigenous Wise Practices.

A similarity found across all clinicians was the continued interest in learning and their openness to work with Indigenous people in the most supportive and culturally safe way. Every clinician shared a passion and interest through their openness to engage with every article, training or community activity that could progress their journey. There was also a shared attitude and perspective from all clinicians when incorporating Indigenous Wise Practices, and the importance of relationships was highlighted which will be spoken about next.

The Clinicians' Willingness to Learn and Remain Open-Minded. Clinicians shared that being open to learning about Indigenous ways can lay the foundation for incorporating Indigenous Wise Practices in CYMH practice. Being curious will lead to better initiation. One clinician noted the art of questioning and listening while listing some examples, "approach it in a more peaceful manner, to be quiet more, to be able to ask questions and kind of know when not to. Because there's various, there's really subtle things that can be really disrespectful" (P02). As first impressions are crucial and potentially lasting, it is essential to attempt engagement using a suitable approach that comes from a place of respect in the eyes of Indigenous communities.

Cultivating Whole System Relationships. As differences exist between every Indigenous

community, researchers have been mindful not to perceive each community in a generalized context. In spite of this, the emphasis on valuing community and family, and viewing situations through a holistic lens appeared to be a consistent shared value. The dynamics of an intervention will inevitably differ when working with a single individual versus a group or more than one client. Hence, many Western-based interventions may not be as suitable if they were designed for practice with an exclusive focus on the client. To quote a clinician in their interview, they said:

> I've been encouraged to use a different approach when you're working with an Indigenous family because they're not going to necessarily want to fill out a checklist online. Instead, it may involve meeting over a cup of coffee or going for a walk or throwing rocks into the river or any of those ways of engagement. It's going to be based on what they are needing, and it could look like five meetings before we get actual concrete assessment data gathered (P06).

This particular approach towards gradual relationship building is relevant to the subsequent themes as well.

Time and Patience for Fostering a Genuine Connection. Clinicians have noted timeline constraints as a presenting systemic challenge within the current colonized system they are embedded. For clinicians to provide the space to foster a genuine connection with Indigenous clients, time and patience in building trust are important. It is often the case that this cannot be done meaningfully within the expectation of within the expectation of time which many Western-based assessments and interventions are limited. There must be a shift in focus on valuing the relationships more than capturing the objectives and numbers of system-led designs. A clinician shared an example that taught her to recognize the differences in what Indigenous clients value when engaging with the system:

> We have a really laid out intake process that is meant to sort of, like, do a quick snapshot of where people are at and determine their criteria for services. And um, for some folks that feels like that process takes forever when it's like, you know, could be up to two hours appointment. But, um, the message that I hear a lot through my work, front and center or out in community is that- that actually is no time at all… for somebody to warm up and open up and feel comfortable talking about their deep struggles (P04).

Barriers in Relationship Building with Indigenous communities. During the interviews, several MCFD clinicians identified the need to implement outreach services and engage with Indigenous people by meeting clients in their home communities to promote a sense of safety. This can strengthen the relationship with Indigenous clients and families. Indigenous children and families often do not come to MCFD offices due to the lack of culturally safe services. A clinician stated that “it could be that you're going to meet clients at the friendship center because the MCFD building is terrifying” (P07). The clinicians have identified the need for MCFD leaders to connect with Indigenous leaders as they need to learn about how to appropriately integrate wise practices within the MCFD framework. Additionally, clinicians spoke about the need to foster ongoing relationships with Indigenous communities. The purpose of these ongoing relationships is to promote Indigenous-led changes or the development of policies and procedures.

Indigenous-led Service Delivery that Brings Change to Practices and Policies. Practices, policies, and frameworks are shaped from a colonized, Western, and medical model approach. Clinicians have identified the need to have Indigenous-led practices and service delivery shaped and formed by Indigenous Elders, leaders, and community members. A clinician stated, “I would say that kind of goes back to what I was saying earlier about if our leadership, our leaders in the ministry are connected to the [Indigenous] leaders in communities that would have a big impact” (P07). It is also vital to ensure that Indigenous children, youth, and families are involved in developing practices and policies as well. The partnership is essential to promote the self-determination of Indigenous communities and demonstrate how to integrate wise practices appropriately and safely by clinicians.

Clinicians shared that they do not have the flexibility to work with Indigenous clients in ways that go outside the parameters of current policies and practices. As shared by a clinician, “I find that I value

our structure and I value our process and I value our policy. But I also know that we need flexibility to work outside of that and be creative" (P06). For instance, sharing food and drink together is a part of the ceremonial aspects of Indigenous cultural values, so it is an accommodating and organic way of engaging with clients in the community. This includes critical aspects such as building relationships with clients. There is a lack of policies and procedures that encourage and support clinicians in their journey towards learning how to use Indigenous Wise Practices.

Need to Increase Culturally Sensitive Practices. Practices within CYMH should focus on traditional ways of healing. Clinicians shared that there are not enough opportunities for them to learn what Indigenous Wise Practices would look like and how they can use them in their practice to better support Indigenous clients. Clinicians should be provided opportunities to learn what traditional ways of healing are and how they can be implemented. These teachings should come directly from the Indigenous communities the clinicians are working in. Current practices should move away from checklists and standardized procedures and look to what the client needs. There should be an opportunity for clients to access cultural support and for clinicians to have the knowledge to assist with this. As one clinician shared, "we need to do more than learning about it… we need the capacity and the flexibility and the resources to implement it" (P06).

Acknowledgement of Past and Current Harm Created by the System. Lastly, clinicians spoke of the need for MCFD as an organization to acknowledge the harm that has been caused. There needs to be an acknowledgement of how the organization has caused harm in the past, and how in some ways the continuation of that harm. When interacting with Indigenous individuals, CYMH clinicians should be aware of the intergenerational trauma experienced by Indigenous peoples. There is a real fear of Indigenous children being taken away and MCFD is not the first place many Indigenous people turn to for support. A clinician stated, "They wouldn't come to us for help because we haven't done the bridging. We haven't acknowledged our mistakes, we haven't acknowledged our impact on them enough. We haven't… essentially we haven't repaired the damaged relationship" (P03). To conclude, steps need to be taken toward repairing relationships and cultivating ongoing relationships between MCFD and Indigenous communities. Additionally, there is a dire need to create space for Indigenous leaders and elevate Indigenous voices.

Discussion and Limitations

The findings of this study indicate the need for the ongoing shift from Western-based models of practice to integrating Indigenous Wise Practices into CYMH services. In learning about sharing from Elders and each clinician's journey in incorporating Indigenous Wise Practices into their practice, various aspects of what encouraged their learning were identified. The results are informed by a trauma-informed lens, strengths-based theory, and decolonization theory. An analysis will be provided to explain how the literature supports our findings.

In this manner, there were firsthand encounters in recognizing how the circle transcends into a healing process by sharing common experiences, creating connections, and a sense of community (Raven Speaks, 2012). Many teachings related by the Elders through means of storytelling centered on messages of self-love and self-care for guidance on becoming a better human being (Lawrence & Paige, 2016). The medicine wheel is a prominent tool that can be utilized to visualize wholeness and self-reflection, as well. This can be used in part with storytelling for an Indigenous client to reflect on every four quadrants of the wheel in how it impacts their life, and identify which aspect may be off-balance. The medicine wheel can also be seen as an educational tool for the Indigenous belief that striving for balance in all four spheres – mental, physical, emotional, and spiritual – is necessary for healing (Kemppainen et al., 2008). In consideration of Indigenous children and youth attempting to access mental health services for various needs, such teachings that highlight the wellness of the whole person are a valuable source in aiding their healing journey. Moreover, clinicians who are open to using healing circles as a space for

storytelling provide a suitable environment where they can purposefully listen to understand the finer details of their client's lives. Indigenous clients identify the circle as an outlet where, through intimate sharing, they can build trust and share common experiences (Stevenson, 1999).

The notion of what characterizes a safe space for an Indigenous client may differ in ways from that of a non-Indigenous client. A trauma-informed lens can impart understanding to clinicians that simply upholding professional values such as confidentiality, competence and a non-judgmental attitude are not enough because of the damaging impact caused by system-led professionals in the past towards Indigenous clients and their families.

Within the framework of Indigenous Wise Practices, facilitating ways of engagement that are Indigenous-led resonate with the value of sovereignty and self-determination (Report of the Royal Commission on Aboriginal Peoples, 1996). For this reason, collaborating and involving Indigenous Elders as part of therapeutic interventions are a means of creating a safe space for Indigenous clients.

Spirituality and ceremony are key components that Indigenous Elders advocate for to integrate as part of Indigenous Wise Practices. In accordance with Mercer et al.'s (2010) findings, spiritual practices may differ from what can be derived in a scientific and scholarly manner which attests to the lack of existing research in this domain. Subsequently, there may be a lack of therapeutic interventions that pertain to spirituality and ceremony today. Therefore, future implementation of Indigenous Wise Practices in CYMH organizations should consider incorporating more diverse approaches that entail these components in engagement and delivery. The varying definitions of what Indigenous Wise Practices could mean based on each clinician's interpretation of the term showed a lack of uniform theory coupled with a foundational knowledge of the decolonized practice. This research aims to add to the understanding of what Indigenous Wise Practices are by collaborating with Indigenous community members such as Elders, which is part and parcel of decolonizing research practice (Windchief & Cummins, 2021).

Adopting an open-minded willingness to learn is a key theme that participants expressed in encouraging the incorporation of Indigenous Wise Practices. Possessing this mindset in seeking to learn about Indigenous ways and knowledge that participants may not have previously been aware of is recognized as a significant contributor to building relationships the right way. This is an important step towards steering away from colonized ways of practice. A narrative approach can be utilized in practice with Indigenous clients to allow space for storytelling, sharing of history, learning about Indigenous perspectives, and being mindful of the trauma that is spoken about. As noted by Lawrence and Paige (2016), using storytelling as a form of narrative therapy supports connection to culture and promotes the holistic wellness of an individual. In addition, this theme aligns with some of the values of the Seven Laws of Kwantlen Nation which have been elaborated upon by previously documented learning. Particularly, the virtue of Humbleness in recognizing and valuing the knowledge of another culture and the virtue of Understanding that needs to be upheld is integral for exercising Indigenous Wise Practices as part of this theme.

Building relationships with the community and whole family systems as opposed to a single individual is a vital component of Indigenous Wise Practices. Participants have shared that regardless of which Indigenous community they work with as every community is different, there has been a consistent emphasis on integrating whole systems for an Indigenous client's mental health journey. According to Stevenson (1999), helping professionals such as social workers or counsellors, have been able to provide the necessary support to Indigenous communities and individuals through the usage of healing circles, talking circles, or sharing circles. To effectively engage with members of Indigenous communities, there is a fine-tuned and careful way to approach that needs to come from a place of respect, honouring time and space, and safety. Participants have related how vital it is to not re-traumatize people who are attempting to come to engage in a system that has essentially traumatized them in the

past and had continually done this.

The Aboriginal Policy Framework in British Columbia (2015) stated that components of building strong relationships rely on collaborating and striving for collective decision-making. This relates to how family and community coming together in the circle is part of a restorative process for the Indigenous client. There is also a need to take time and have patience for fostering a genuine connection between clinicians and clients.

Western-based practices tend to be confined by structural limitations such as time constraints that hinder the process of establishing meaningful and trusting relationships with Indigenous clients. This has also been provided as feedback from Indigenous partners as working against meeting the scope of Indigenous Wise Practices. Aligning with the Teachings of the Seven Laws of Kwantlen Nation, virtues such as Understanding, Humbleness and Generosity need to be upheld, and this means allowing the space and time for a sincere therapeutic relationship to be developed in the right way. From a trauma-informed approach, it leads to the understanding that the Indigenous population has suffered from severely damaging relationships in the past with the Western systems as a result of historical events. Therefore, it is imperative that clinicians provide time and patience without conditions to sincerely bridge this gap, and cultivate relationships in a paced and careful manner.

Outreach work and community involvement from the clinicians were identified as common and effective ways to address barriers in establishing relationships with Indigenous clients and communities. Interventions that typically take place within an organization building with the client entering the workplace can be modified and implemented in another place of a client's choosing. Offering Indigenous clients the choice to voice what constitutes a safe space to them and accommodating their needs in this regard, can eliminate some looming barriers in relationship building. In accordance with Wesley-Esquimaux and Snowball's (2010) understanding of Indigenous Wise Practices, they consist of culturally sensitive practices that can work collaboratively towards enhancing Western approaches that already exist. In addition, the discussion that future CYMH program development and revisions should involve collaboration with Indigenous community members and hiring Indigenous staff at all levels of the organization supports the decolonizing theory of this research's framework.

Indigenous communities need to establish Indigenous-led service delivery that can lead to changes in existing practices and policies. Sovereignty and the principle of self-determination is an innate part of Indigenous identity in its expression of freedom in making their own choices for the good of their own community (Report of the Royal Commission on Aboriginal Peoples, 1996). Relating to the strengths-based theory, creating Indigenous-led service delivery is a way of emphasizing an Indigenous community's presenting strengths and sense of resiliency as opposed to deficits (Askew et al., 2020). This also ties into the subsequent theme of increasing culturally sensitive practices. In order to address the dearth of traditional ways of healing, the direction should be geared towards hiring Indigenous staff who can elevate Indigenous voices in aspects such as policy development or necessary practices changes. Moreover, Indigenous-led services can increase the collaboration between Indigenous communities for further guidance on the appropriate implementations of Indigenous Wise Practices.

Acknowledgement of historical wrongdoings committed against Indigenous populations is another necessary step towards incorporating Indigenous Wise Practices in the right way. Beyond this, clinicians need to be mindful in considering how past harm may still persist in the present system. In particular, child protection and child removal characterizes how system-led institutions in Canada had addressed perceived issues within Indigenous families. Among various reasons, this may be one aspect as to why many Indigenous clients retain a deep sense of mistrust and apprehension in engaging with CYMH services. Overall, practice must be trauma-informed to recognize and reduce any power imbalances between the clinician and client (Levenson, 2017).

There were several limitations identified in this research study. The research criteria aimed to survey British Columbian CYMH clinicians working in various agencies across the province. However, limited access in recruiting respondents from DAA means that the sample size consisted exclusively of CYMH clinicians from MCFD. Therefore, this limits the generalizability of the findings and diminishes overall external validity. Another limitation is time constraints and mismatched availability between researchers and participants.

If time constraints had not been a factor, it may have led to an increased sample as there were instances of interested participants responding after the window of time that data collection was completed. Additional participants may have had distinct experiences to share within their own practice that could have contributed to the themes differently. As a result, this research was subject to under coverage bias as it inadequately represented some members of the population within the sample. Another limitation is the purely virtual format of the data collection process which was a shift away from how this evaluation was originally planned to be facilitated. Indigenous Elders were included among our participant sample, and traditional ways of connecting with these Indigenous Elders were unable to be accommodated due to COVID-19-related public health restrictions, timeline constraints, and geographical barriers. This is especially relevant given that many Indigenous Wise Practices pertain to sharing of knowledge and information through traditional ways in the space of a physical circle. Along with technical difficulties that resulted in critical loss of time in the midst of some interviews, the lack of flexibility in options for conducting interviews could have inadvertently influenced the outcome of the provided data and the collection process. In spite of these given limitations, this evaluation has been able to identify what Indigenous Wise Practices are presently integrated into BC CYMH services.

Implications for Future Directions

Provide MCFD Clinicians with Education to Support them with Using Indigenous Wise Practices.

The clinicians acknowledged several training opportunities, such as San'yas Indigenous Cultural Safety Training, Brief Child and Family Interview Intake Training, and the Kairos' Blanket Exercise.

The clinicians found these trainings beneficial and gained information that they could implement into practices with CYMH services. Educational training and classes can be used to support Indigenous clients by providing cultural safety and awareness of how to speak with Indigenous clients with safety and awareness of the trauma and historical challenges they may have experienced. A clinician stated they participated in personal education such as attending workshops outside of MCFD, community events, traditional feasts, and reading books from Indigenous authors (P05, research interview, March 16, 2022). They also recommended, "localized training" which includes learning about Indigenous groups where the MCFD office is located (P05, research interview, March 16, 2022). Education on the historical, and political contexts of Indigenous colonization was important and identified in many of the interviews with clinicians as it shaped their practice with Indigenous clients and families. The need for continuous and ongoing teaching, training, and learning that comes directly from Indigenous communities, leaders and Elders were identified in the research as clinicians expressed that they did not have the knowledge on how to best support Indigenous clients in traditional ways. Being creative and flexible in the opportunities provided for clinicians can support their journey with implementing Indigenous Wise Practices.

Further Research can be Completed to Determine How to Create Partnerships with Indigenous Communities.

Clinicians have identified the gap between the MCFD leadership and the Indigenous leaders in the community. A clinician stated, "if our directors are not connected with the leaders in Aboriginal communities that's a problem. So that to me is a tool like when our leaders and the leaders in those communities [connect] (P07, research interview, March 17, 2022). This demonstrates that the partnership between Indigenous communities and MCFD needs continual improvement. Further

research on how to mend the strained relationship between MCFD and Indigenous communities can be completed to identify areas of improvement to better support Indigenous children and families. As identified from this research, the definition of mental wellness in Indigenous communities is very different from the medical model. To bridge this gap, there must be a relationship that respects the Indigenous worldview, to appropriately implement Indigenous Wise Practices within service delivery. There is limited research in this area, and formal plans to mend the relationship are needed. This must be done using a trauma-informed and community-centered approach which starts with an understanding of trauma and its impact on relationship building with Indigenous communities. The research from the literature review indicated that community participation, collaboration and engagement empowered Indigenous individuals and communities. It promoted self-determination and equitable involvement in Indigenous communities to influence programs and policies using transformative change (Petrucka et al., 2016). This demonstrates the power of amplifying Indigenous voices and valuing their contributions to service delivery.

Further Research can be Completed to Understand Service Users' Perspectives.

There is a lack of research available that is committed to understanding the perspective of Indigenous children, youth, and families in relation to receiving Indigenous Wise Practices within the child youth and mental health service framework. The Aboriginal Policy and Practice Model focuses on supporting the involvement of Indigenous children and families, extended families, Elders, traditional knowledge keepers and communities in decision making, inclusive of Indigenous Wise Practices, values, and traditions (Aboriginal Policy Framework in British Columbia, 2015). Shaping the policy dialogue and service implementation can be done by allowing Indigenous communities to self-direct and be involved in decision-making with a community engagement approach (Ryan et al., 2006). Speaking to the children, youth, and families about what is helpful for them and determining which Indigenous Wise Practices resonate with them is essential to understanding the needs of the service users.

Indigenous-led Service Delivery that Brings Change to Practices and Policies.

Current research indicates the lack of policies and frameworks within Western agencies that directly involve Indigenous communities. Most Westernized models only consult Indigenous Elders, leaders, and communities but do not provide the opportunity to create and implement programs and policies (Ryan et al., 2006). During this research, it was evident that knowledge provided by Elders on the traditions, cultures, and practices can be implemented into service delivery. These include engaging in self-awareness, self-love, and self-care. It is essential to listen to understand, create safe spaces to provide autonomy for clients and integrate spirituality and ceremony within practices. The medicine where provides an opportunity for clinicians to support Indigenous children, youth and families to find balance using the four quadrants. As one Elder stated, "if we were to look at the medicine wheel, we look at defining health as a balance between mind, body, spirit, and emotions" (E5). It can be vital to continue these conversations with Elders and meetings to promote relationship building. The knowledge from the Elders can be used to provide improved services for Indigenous clinicians and could benefit Indigenous children, youth, and families. Research indicates incorporating Indigenous wise practices into agencies has proven benefits for Indigenous people. Using wise practices can encourage connections to Indigenous culture, language, and self-identity. Each wise practice is unique to a distinct Indigenous community, and the cultural practices can be included in a way that reflects the values, beliefs, and desires of the community (Ryan et al., 2006).

Conclusion

Overall, this research study provided significant insight into the current experiences of CYMH clinicians integrating Indigenous Wise Practices. Indigenous Elders offered thorough knowledge on aspects such as the self, relationship building, and traditional and cultural practices. Additionally, CYMH clinicians highlighted the barriers that hinder the implementation of Indigenous Wise Practices and

provided insight into how these challenges could be overcome. Thus, the findings shared by Indigenous Elders and CYMH clinicians can be utilized to inform MCFD policies and practices to encompass the various changes necessary to harbour and cultivate safe spaces for Indigenous clients and CYMH clinicians. MCFD must continue to heal the relationships with Indigenous communities by acknowledging the past and current wrongdoings of the organization. Incorporating the valuable information gathered in this research study can work toward elevating Indigenous voices and providing Indigenous communities with the autonomy to guide Indigenous Wise Practices into MCFD services.

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Appendix A

Clinicians' demographic information

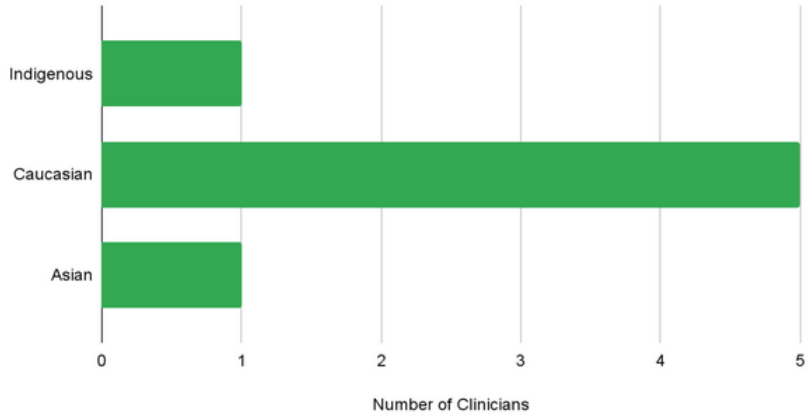

Figure A1. *Clinicians' Cultural Background*

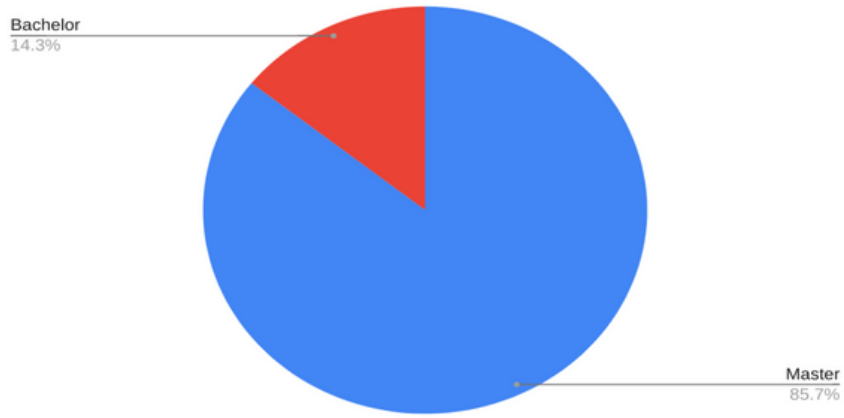

Figure A2. *Clinicians' Education Level*

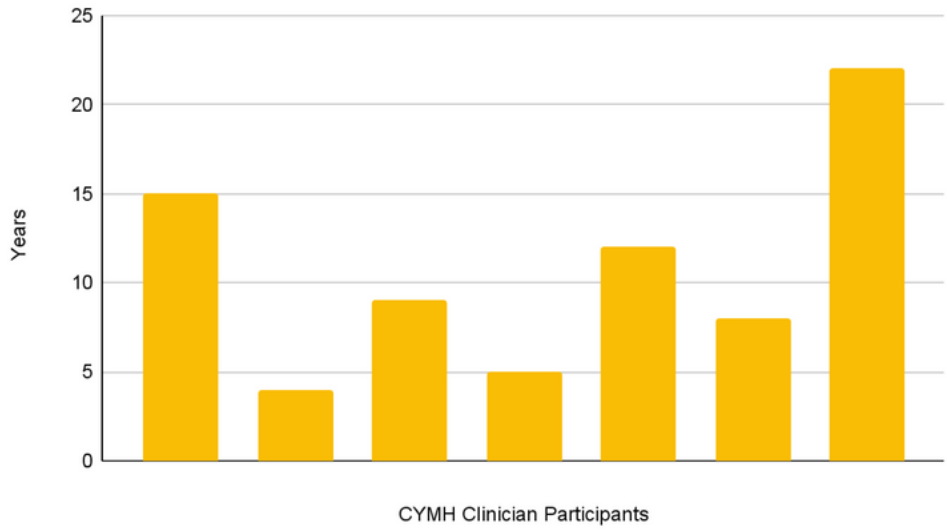

Figure A3*. Clinicians' Years of Experience at MCFD*

Appendix B

Questions for Elders

1. How do you describe mental health and wellness?
2. What are some of the traditional ways or teachings that you or your community use to support mental wellness? What do these look like in your lives?
3. From your perspective, how could clinicians support the inclusion of traditional and cultural ways in professional practice?

Appendix C

Interview Questions for CYMH Clinicians

1. Can you tell me about your role in MCFD?
2. How do you define Indigenous Wise Practices?
3. What were the circumstances that started and led your journey towards incorporating Indigenous Wise Practices?
4. How and why do you incorporate Indigenous Wise Practices?
5. How do you ensure these practices are delivered in a culturally safe way?
6. What training, learning, or connections have fostered the implementation of Indigenous Wise Practices into your work? (for example, specific MCFD training, relationships with Indigenous communities, training outside of MCFD, etc.)
7. What challenges do you experience using Indigenous Wise Practices with children, youth and families? Were there any systemic challenges?
8. What would be some useful tools or further training that would have helped you learn about integrating Indigenous Wise Practices into your work?
9. How did the use of Indigenous Wise Practices provide different outcomes for children, youth and or family?
10. Do you have any additional thoughts about the integration of Indigenous Wise Practices into CYMH that you think would be useful for us to note?
11. Would you like your name stated on the “acknowledgement” section of the final report? The acknowledgment section will be at the end of the report thanking research participants for their involvement by name. You may remain anonymous if you chose to.