

Negotiating Change: Community Mental Health and Addiction Practice in the Northwest
Territories of Canada

by

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BSc (Health Education), Dalhousie University, 2003

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of the Requirements for the Degree of

MASTERS OF ARTS

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Abstract

The purpose of this study was to explore the experiences and support needs of community mental health and addiction services providers in the context of rapid social and economic change in communities in the Northwest Territories (NWT) of Canada. Two main questions guiding this inquiry were: *How do community mental health and addictions workers experience and respond to rapid socio-economic change in relation to their professional practice? What are the support needs of practitioners in light of continued change in the region?* Primary data consisted of personal interviews with 15 community-based mental health and addictions practitioners throughout the NWT. Findings drawn from the thematic analysis of these interviews highlight the positive and negative changes taking place in communities with respect to mental health and addictions, the significant impact of organizational change on front-line practice, and the possibilities that exist for the future of mental health and addiction service delivery in the NWT. In the discussion chapter, community-based practitioners' views are related to key themes within the literature and recommendations to improve the NWT mental health and addiction services policies and practices are made.

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Chapter 1: Introduction

Modern Arctic societies are facing “an unprecedented combination of rapid and stressful changes” (Arctic Human Development Report (ADHR), 2004, p.10). Major shifts in social, political, economic, geo-political and environmental landscapes of Canada’s north began in the 1950s but have intensified in recent years (Csonka & Schweitzer, 2004). This thesis explores the experiences of community-based mental health and addiction practitioners working in the midst of intense and sustained social and economic transformation.

I conducted field research in the Northwest Territories (NWT) of Canada. Though the NWT was colonized recently in relative terms, several large-scale natural resource extraction projects have been developed with others slated for the future. This economic "boom" may be directly or indirectly affecting mental health and substance use trends in the NWT (Chalmers, Cayen, Bradbury & Snowshoe et al., 2005; Mackenzie Valley Environmental Impact Review Board (MVEIRB), 2005). Land-claim settlements, self-government agreements, and devolution further affect the political context in which health care providers operate. This Masters thesis documents how mental health and addictions practitioners experience and perceive their practice in light of significant social and economic change. This research will also identify practitioner support needs in light of continued change in the region.

1.1 Research Interest and Scope

Studies in the north and elsewhere have shown how rapid change has multiple impacts on communities (Koneru, Weisman di Mamani, Flynn & Betancourt, 2007) and has negatively affected the health of Aboriginal Canadians (Kirmayer, Brass & Tait,

2000). Understanding and mitigating the impacts of rapid change in the north is an identified research need (Csonka & Schweitzer, 2004). Preparing for the social impacts of new resource development has been identified as a major priority by northern residents (Aurora Research Institute (ARI), 2001; Miltenberger, 2006; Salokangas, 2005), government (GNWT 2006b; Miltenberger, 2006) and industry regulators (Mackenzie Valley Impact Review Board (MVEIRB), 2005). Community health and social services are considered a key area affected by accelerated development (MVEIRB, 2005). Given that significant social change occurs in communities during the preparatory phase of new industrial activity (Freudenburg & Gramling, 1992), upcoming projects may already be affecting health practice.

Past research links large-scale change over a short period of time to social and cultural distress, mental health and addictions-related problems in northern communities (Csonka & Schweitzer, 2004) and mental health service utilization in resource boom-towns (Bacigalupi & Freudenburg, 1983). The front-line practitioners have valuable and underutilized knowledge on community wellness (Lock, 2000; Scott-Samuel, 1996), yet their voices are largely absent in current research on mental health and addiction service provision in the NWT (Chalmers et al., 2005). The voices of Aboriginal practitioners are heard even less frequently (McCallum, 2005). This is problematic, not only because mental health and addiction workers offer a unique window into the relationship between economic growth and community health, but because practitioners' beliefs about prospective change are a strong predictor of actual responses (Csonka & Schweitzer, 2004).

1.2 Thesis Overview

This thesis is made up of five chapters. Following this introductory chapter, the second chapter is the literature review where prior research and background information pertaining to social and economic change and health practice in the North are reviewed and synthesized. The third chapter presents the research design and discusses methodologies that were influential to the research process as well as the processes of theory building and conceptual development that took place prior to data collection. This chapter also describes the ethical approvals obtained for this study, the participant recruitment and data collection procedures as well as the process by which the information collected was analyzed. The research findings are contained in chapter four. Beginning with a description of the research participant sample, this chapter outlines the key findings emerging from this research. Findings are grouped under three subheadings: (1) practitioner perspectives on community change; (2) practitioner perspectives on organizational change; and (3) change for the future. The fifth and final chapter provides a more in-depth discussion of these findings as they relate to the literature and ends with some positive thoughts for the future on what possibilities exist for policy, practice and future research.

A note on structure and language in this thesis: In an effort to be clear, I have tried to present this thesis in a logical, sequential fashion, although the actual research process was far from seamless. As is the case with many new researchers, I found the project evolved along the way. Through this experience, I have come to see research as a journey and my role, as the researcher, as an explorer. I have written my thesis in the first person to reflect the personal learning experience that this truly was, as well as to help

those who read this thesis in remaining mindful of the role that the researcher has as an active participant in the research process, not a passive or impartial observer.

Chapter 2: Literature Review

All societies and cultures change, but is there such a thing as too much change, too fast? Many northern researchers are asking themselves this question as they observe how colonization has influenced the politics, cultures, environments, and economies of the circumpolar north. This chapter presents a review of literature focused on rapid change in the North and its potential impact on mental health and substance use and on Northwest Territories (NWT) health and social service professionals tasked with the responsibility of providing mental health and addiction services.

This literature review focuses on two themes: first, the impact of social and economic change on individuals and communities in the NWT. Here I offer a brief synopsis of the recent social and economic changes in the territory. Many health and social impacts result from natural resource development, the single greatest driver of social and economic change in the NWT. I discuss the rates of mental health and substance use in the territory and review research on the overall stress of rapid change on communities.

The second section of this literature review chapter looks at what is known about the role of helping professionals in the delivery of health care in these rural or remote regions, paying specific attention to the role of the Aboriginal paraprofessional - a group highly represented in the NWT mental health and addiction professions. Exploring the realities of northern mental health and social service practitioners illuminates what issues workers face on a daily basis in their practice. Understanding the everyday realities of community-based health and social service practitioners prepares us to examine whether

rapid change has any bearing on the work of mental health and addiction service providers in the Northwest Territories.

2.1 Social and Economic Change in the Northwest Territories

Since the 16th century, processes of colonization and resource exploitation have deeply affected the course of social change for Canada's First Peoples (Kirmayer, Brass & Tait, 2000). These impacts are arguably even more pronounced in the Northwest Territories (NWT), where the colonial presence and subsequent waves of change are far more recent. Prior to the early 1950s, there was relatively little outsider presence in the traditional lifestyles of the region's Aboriginal (Dene, Métis, and Inuit) people (Dickerson, 1992). Although petroleum and mineral extraction has occurred in the region since the 1920s, these activities were concentrated in a few select communities and did not involve local people (Hamilton, 1994). At that time, the Federal Government only concerned itself with resource extraction activities and left the delivery of health and social services to church missions, trading posts, and the RCMP. As Dickerson (1992) describes, "schools were provided where church missions existed. Health care was available in hospitals at mission sites or mining towns. Relief rations were administered, sparingly, if one in need happened to be close to a mission, trading post, or RCMP detachment" (p.56).

In 1953, the Federal Government began to focus on "northern development", a move driven by sovereignty concerns, the Cold War, and Canadian public pressure to improve the social and economic conditions of northern Aboriginal peoples (Hamilton, 1994). The northern development agenda was a priority for federal governments throughout the 1950s to 1960s and included a concentrated effort to make education,

health services, and the formal economy accessible to Aboriginal peoples in the region. Permanent settlements were established where health services, non-residential day schools, and vocational training were administered. Like most other Aboriginal settlements in Canada (Kirmayer, Brass & Tait, 2000), the location of virtually all of these communities was dictated by government and commercial interests rather than by Aboriginal peoples. The decline of the fur trade left Aboriginal people who were living the traditional hunting lifestyle with no means to participate in the formal economy and buy supplies. By the 1960s, economic marginalization forced most families to take up residence in the communities (Ironside, 2000). There are now 33 permanent settlements in the NWT with a total of 42,940 residents (NWT Bureau of Statistics, 2009). Communities range in size from the capital city with a population of 19,155 to hamlets with as few as 71 people (GNWT, 2008). See appendix A for a map of the NWT.

Many of the most substantial recent changes in the NWT have resulted from political movements within the territory. The emergence of Aboriginal political organizations in the 1970's was a powerful voice during the Berger Inquiry of 1974-1976¹, when the Mackenzie Valley Gas Pipeline was first being considered. The coming of responsible government to the NWT just one year later brought a fully elected legislature to the North (Prince of Wales Northern Heritage Centre, n.d.). Other political

¹ The Berger Inquiry was a public impact assessment process commissioned by the Government of Canada, which took place between 1974 and 1976. It was spearheaded by Justice Thomas Berger in communities across the Yukon and Northwest Territories, as well as some southern Canadian communities. The purpose of this inquiry was to examine the social, environmental and economic impacts of a proposed gas pipeline to run through the Yukon and the Mackenzie River Valley of the Northwest Territories (CBC, 2001). As Scott (2007) recounts, this process was transformative for Canada's Northern Aboriginal peoples as it was an opportunity for them to have their stories and viewpoints on the development of a pipeline heard. The widespread media attention given to the hearings provided an opportunity for those in southern Canada to hear the concerns of northern Aboriginal people as expressed by the people themselves. In the report issued at the end of the hearing process, Justice Berger recommended a 10-year moratorium on any pipeline developments, until such time as Aboriginal land claim settlements could be reached (Scott, 2007).

processes, such as land-claim settlements, self-government agreements, and devolution of federal responsibilities to the territorial government have also contributed to a socio-economic shift within the territory. Since 1984, four comprehensive land claim and self-government agreements have been signed in the NWT and several others are in the process of negotiation (Indian and Northern Affairs Canada (INAC), 2007).

The exploration for and extraction of non-renewable resources represents another key force of socio-economic change. Numerous mines excavating base and precious metals have been in operation over the years although, since the early 1990's, there has been a shift towards diamond exploration and diamond mining. There are currently four mines operating in the NWT: CanTung Tungsten Mine and the Ekati, Diavik, and Snap Lake Diamond Mines (GNWT, 2007). Oil and gas have been extracted on a small scale in the Norman Wells region of the NWT since the 1930s, and there are once again proposals to develop the vast oil and gas resources of the Mackenzie Valley and Delta. The Mackenzie Gas Project, one of the largest energy projects ever proposed in Canada, is currently undergoing a regulatory review (GNWT, 2006a). Increases in commodity prices, especially uranium and base metals, lead the territorial government to project more exploration projects in the future (GNWT, 2007).

Accompanying political and resource developments has been an expansion in the transportation and communications systems. Air travel, ice roads, and all-season highways now largely replace the waterway transportation systems that historically sustained the north. Communication systems have also evolved to connect most communities to the Internet, as well as through telephone, television, and radio (INAC, 2001 as cited in Wonders, 2003). Government programs such as "telehealth" are now

using these information and communications technologies to deliver health and social service information, services, and expertise virtually in some communities (GNWT, 2009). In many ways, communities are more connected to each other and to southern Canada than ever before.

Environmental change greatly affects the social and economic wellbeing of Northerners. Already in the NWT, climate change has contributed to a decline in certain species, such as barren land caribou populations. These negative impacts are felt in the local economies and the traditional diets of individuals and communities who depend on this resource as a main source of food (GNWT, 2006d). Comprehensive studies on the impacts of warming in the Western Canadian Arctic project further declines in biological diversity as the climate continues to warm (Arctic Climate Impact Assessment, 2004). This will undoubtedly intensify the social and cultural impacts being felt in the region today (Trainor et. al, 2007).

2.2 Rapid Change, Community Mental Health and Substance Use

So much has changed within the lifetimes of many Northerners. What is the effect of such rapid change on the north's people? In researching the effect of rapid change on communities, one useful concept is "acculturative stress." Acculturation has been defined as culture change that results from continuous, first hand contact between two distinct cultural groups (Berry, 1992). Acculturative *stress* is a reduction in the health status (psychological or physical) of individuals who are undergoing acculturation (Berry, Kim, Minde & Mok, 1987).

Links between acculturative stress, mental health, and substance use have been established in studies in Canada and internationally. Koneru et al. (2007) conducted an

extensive scan of the literature on the health impacts of acculturative stress on a wide range of populations who have experienced rapid cultural change. Drawing on the findings from 86 separate studies on the health impacts of acculturation, they concluded acculturative stress is frequently associated with elevated levels of depression in people and consistently associated with increases in alcohol and drug use among groups.

In one of the largest studies on acculturative stress in Canada, Berry, Kim, Minde and Mok (1987), measured stress levels among 1,197 individuals in Canada who have recently experienced rapid cultural change, including immigrants, refugees, visiting foreign students, and Aboriginal peoples. They measured psychological indicators associated with acculturative stress, including lowered mental health status (i.e., anxiety, depression), feelings of marginality and alienation, and identity confusion. They concluded the process of rapid cultural change has unavoidable costs in terms of acculturative stress, but that the degree of stress can vary depending on a number of factors. Groups who are voluntarily involved in the acculturation process, such as immigrants, experienced less difficulty adapting than those forced into situations of cultural change, such as refugees and Aboriginal communities. Predictably, groups who are more socially marginalized (i.e., those with no formal education, facing language barriers, or unemployed) also experienced more acculturative stress.

Some researchers (O'Neil, 1986) argue that discussing the impacts of colonization on Canada's Aboriginal peoples in terms of acculturative stress does not adequately capture the full impact and involuntary nature of colonial policies and government interventions such as residential schools, forced settlement, and out-adoption of Canadian Aboriginal children. O'Neil (1986) and other researchers since (Alexander, 2000; Kirmayer, Simpson & Cargo, 2003; Wesley-Esquimaux & Smolewski, 2004) have

employed other concepts such as *cultural discontinuity*, *historic trauma*, *internal colonialism*, and *social dislocation* to explicate the devastating impacts that systematic social and cultural destruction have had on Aboriginal Communities. Indeed, as Kirmayer, Brass and Tait (2000) point out, the term *trauma* has become a particularly powerful way to discuss the “personal and collective injuries suffered by Aboriginal peoples as a whole” (p. 613). Irrespective of the terminology or conceptual lens that is used, similar connections have been drawn between a legacy of forced assimilation and cultural suppression and the high rates of depression, alcoholism, suicide, and violence experienced in many Canadian Aboriginal communities.

2.3 Resource Development, Mental Health and Substance Use

Compounding the general stresses associated with rapid social and cultural change is the particular impact that extractive industries may be having in the NWT. Some of the most compelling evidence linking rapid change to community health in the NWT has been a result of social impact assessments conducted on behalf of the diamond mining industry. Since 2002, communities deemed most affected by the territory's diamond mines have been closely monitored to identify possible socio-economic impacts of mining in the region (GNWT, 2006c). These studies revealed a number of health trends related to mental health and addictions. Negative impacts include increased rates of substance abuse, gambling, sexually transmitted infections, violent crime, and income disparity (GNWT, 2006c). Positive impacts include a decrease in teen births; increases in average income, employment, and education; and an increase in trapping, hunting, and fishing in small communities (GNWT). Similar trends have been reported in research

analyzing the impact of mining on other Aboriginal communities in Canada (Gibson & Klinck, 2005).

The experience of northerners supports the link between resource development and mental health and addictions. Community-based research conducted by Aboriginal groups in the NWT indicate that many residents perceive that the money generated from resource development projects can fuel substance abuse, violence, and gambling addictions (North Slave Métis Alliance, 2002; Salokangas, 2005). Numerous territorial residents have spoken out at recent community consultations on the Mackenzie Gas Project to express concern over a perceived increase in social problems due to greater substance use (MVEIRB, 2005). These concerns are consistent with the past experience of communities and local health and social service organizations (Brockman & Argue, 1995). Research in other northern/remote locations also indicates a link between substance use and resource development. Numerous studies have shown that an influx of newcomers attracted by potential work in new industry corresponds with increases in community consumption of alcohol and other substances (Ritter, 2001; Freudenburg & Gramling, 1992; Dean, 1995). A study conducted in remote northern communities in BC found there to be significant problems with alcohol and other substance use in remote work sites to a degree that negatively affects employee health and safety on the job (Barton, 2002).

While the relationship between rapid industrial development and mental health is not as direct, there is evidence to suggest that rapid socio-economic change brought on by resource development has implications for community mental health services. A longitudinal study conducted in a small boomtown community in the western United

States in the 1980's found mental health service utilization increased dramatically during a resource boom. The majority of the increase in caseload was due to a rise in service utilization by local residents, rather than industry-related workers, leading the authors to speculate that significant social changes are stressful on pre-boom residents (Bacigalupi & Freudenburg, 1983).

Increasingly, resource extraction is taking place in remote regions separate from established communities. Fly-in, fly-out arrangements facilitate employment of northerners in these projects, where they live on-site for the duration of their shift (usually two weeks on, two weeks off). This approach helps to avoid the boom-and-bust pitfalls of establishing single-sector mining towns (Ritter, 2001); however, community-based research conducted with women in the NWT indicates that the long distance commuting as well as the long periods of time away from home necessitated by a rotational work schedule can be extremely stressful on spousal relationships (Brockman & Argue, 1995). Other researchers found a rotational work schedule reduces families' reported ability to co-parent and time spent teaching land-based skills to children (Baffin Region Inuit Association, 1986). Many miners report difficulty adjusting to the change in pace of life in their communities to two weeks of 12-hour shifts at the mine (Brockman & Argue, 1995). All of these factors add stress to individuals and families and can negatively affect mental health.

2.4 Health Practice in the North

In reviewing the literature on community health practice in northern or rural/remote regions, I was struck by the difficulty and obstacles faced by health service providers. This is no doubt a reflection of the realities of the job, but perhaps also on the

deficiency-oriented approach taken by researchers who study these issues. An interesting commentary on this can be found in McCallum (2005), who analyzed medical research over a 60 year period in Canada (1910-1970) to explore how Aboriginal health is depicted in academic discourse. Drawing on an unspecified number of articles from five major Canadian health journals, McCallum concluded that during this 60-year time frame, the academic literature overwhelmingly framed Aboriginal health issues in terms of isolation and hardship, presenting Aboriginal peoples as "primitive" and "susceptible" (p. 117). The author also noted that the articles she analysed did not generally incorporate the perspectives of local health care workers or provide details on the lived experiences of the participants or researchers. The absence of this personal voice might help in part to explain why even today, northern health research tends to be oriented towards the deficiencies in health care and/or the hardships faced by those who provide services.

The negative portrayal of northern life in academic literature had significant repercussions for Montgomery (2003) whose graduate research explored community, workplace, and social issues faced by human service professionals working in rural communities. Using a theoretical "rurality" model based on the research of 55 rural experts as his guide, Montgomery developed a mixed-method interview instrument for his own study with rural professionals in eight rural communities in British Columbia. To his surprise, during data collection there was only weak agreement with the issues outlined in his survey tool. Some respondents took exception to the negative emphasis his survey tool placed on rural practice. The discord between the theoretical model underpinning his survey and the experiences of rural practitioners was too great to ignore. Montgomery returned to the literature, re-analysed his base assumptions and reworked his survey tool

in a way that framed rural as ‘different’ rather than ‘deficient’. With this cautionary note against overemphasizing the hardships and deficiencies of northern health practice, the following section presents an overview of the overarching themes emerging from current research.

2.4.1 Northern Mental Health and Addictions Practice

There are unique challenges to providing mental health and addictions services. In a rural or remote context, the foremost issue mentioned in the literature is the challenge of guaranteeing confidentiality. Not surprisingly, in small communities, privacy concerns can prevent people from connecting with practitioners (Minore & Boone, 2002).

Numerous researchers have found that because confidentiality in smaller communities is recognized as a challenge, practitioners do not always share information with each other, even when it is appropriate and beneficial, such as in an interprofessional team context (Blank et al., 1995). This lack of appropriate information-sharing can result in practitioners internalizing all that they hear and has been found to contribute towards practitioner feelings of isolation and burn-out (Roberts, Battaglia & Epstein, 1999).

Another issue linked to small population numbers and geographic isolation in rural or remote locations is the limitations this places on the number of practitioners serving in a given field or location. There may be only one counsellor or case worker available to attend to a crisis or traumatic situation in a community. As McIssac (2006) points out, this also creates a situation of dual roles or relationships. For example, the same counsellor may be responsible to meet with both a victim and a perpetrator, or could be related to one or the other. There are divergent opinions on whether dual roles are a positive or negative thing (for a complete discussion, see Scopelliti et al., 2004).

Regardless, the situation is essentially unavoidable in small, northern communities with limited human resources.

Cultural competency remains a big challenge for the many northern health practitioners who are not from the territory or community they serve, including mental health and addiction professionals. As Kirmayer, Simpson, and Cargo (2003) explain, in addition to the language barriers and cultural nuances, socioeconomic and power discrepancies between clients and practitioners can be a barrier to effective practice. Understanding of and sensitivity to the history of colonization, as well as ongoing issues of structural violence, racism, and marginalization, are all critical when non-Aboriginal health and social services professionals work within the Canadian Aboriginal context (Kirmayer, Simpson, & Cargo).

Culture and language affect Aboriginal paraprofessionals serving in their own communities as well. As Minore and Boone (2002) note, Aboriginal paraprofessionals are often seen as “insiders” by their non-Aboriginal co-workers, offering a valuable link to the local language and culture. However, professional colleagues can be resistant to the idea that they offer an “equal-but-different” expertise. Hierarchy, racism and interprofessional exclusion can affect team practice and impede the ability of Aboriginal paraprofessionals to be effective in their work (Minore & Boone).

Counsellor turnover is an ongoing problem for many organizations. One of the main reasons cited for this is worker “burnout” is emotional exhaustion, leading to illness, fatigue and depression (Knudsen, Ducharme & Roman, 2006). Interviews with 812 substance abuse treatment counsellors in the United States suggest that some of the

reasons for burnout are unevenly distributed caseloads, working within top-down organizations in which there is a hierarchy of decision-makers, and feelings of inequity or unfairness in the workplace (Knudsen, Ducharme & Roman). Similar findings emerged from a recent survey measuring burnout, vicarious trauma, and secondary traumatic stress disorder in 152 mental health practitioners in Australia. Researchers determined that burnout due to work-related stressors, including being new to the profession, concerns about safety, and concerns about relationships with others were the best predictors of therapist stress rather than exposure to vicarious or secondary trauma in the therapeutic counseling setting (Deville, Wright & Varker, 2009).

There is a shortage of health and social service professionals in Canada's Aboriginal communities (Health Canada, 2007). In the NWT, this problem extends to mental health and addiction practitioners, where the average employee leaves after 1.8 years (Chalmers et al., 2005). A contributing factor to the rapid turnover of health care workers cited by Kinch, Katt, Boone and Minore (1993), is that the majority of professional recruits to these communities are not indigenous to the region they work in. Increasing the number of indigenous service providers has been achieved, in part, by the inclusion of paraprofessionals in the delivery of community health and social services.

In the NWT, paraprofessionals now make up more than half of the community-based counseling program. Therefore, understanding the role of the paraprofessional is particularly important to grasping the challenges of mental health and addictions practice in the region. The next section reviews the literature on the specific role of paraprofessionals in health and social service delivery.

2.4.2 Paraprofessionals in Health and Social Service Provision

As described in Minore and Boone (2002), the role of “paraprofessional” as it relates to health practice includes a wide range of salaried workers who are recruited locally to perform various supporting roles in the delivery of health care services. Paraprofessionals typically do not possess the same formal education credentials of their professional counterparts, but most have completed some degree of training and have practical experience and a familiarity with local resources (Hiatt, Sampson & Baird, 1997). Paraprofessionals are referred to by a host of other titles, including nonprofessionals, preprofessionals, workers, helpers, caretakers, attendants, and aides (Bayes & Neill, 1978).

Despite heavy reliance on paraprofessionals in small communities, there is little information on the paraprofessional experience in northern, rural or remote health practice. Most of the literature on rural or remote healthcare issues focuses on medical care and on physicians’ experience of practice. A scan of the literature conducted for this review using the terms "northern" "rural" or "remote" in combination with "mental health and addictions practice" generated information on physicians, psychiatrists, nurses and other professional roles rather than the paraprofessional positions of interest to this study. Williams and Cutchin (2002) discuss the lack of research focused on paraprofessionals, pointing out the irony of this situation given the widespread difficulty in attracting and maintaining physician care in rural settings.

The wide range of professional titles and reference terms used to describe paraprofessionals also makes it challenging to conduct an exhaustive search of the

literature. A search using over ten different keywords² to describe paraprofessionals in any facet of healthcare generated a bit more information on this subset of practice, although the literature focused on the interactions between professional and paraprofessional staff in the health care setting (i.e. Minore & Boone, 2002; Purden, 2005). Other studies focus on the service delivery models that utilize paraprofessional staff (Musser-Granski & Carillo, 1997) and supervisory issues (Lambert, 1999, Siang-Yang, 1997).

An exception was Kinch, Katt, Boone and Minore's (1993) article titled "On Being Everything and Nothing: The Retention of Health Care Workers in Northern Communities." This research focused on the experiences in paraprofessional practice from the perspectives of workers themselves. The authors conducted an exploratory study in three Aboriginal communities in northern Ontario to determine what factors affect the retention of Aboriginal paraprofessionals in their jobs. Using a qualitative interview approach, the authors spoke to 48 current and former Aboriginal paraprofessionals working as Community Health Representatives (CHRs) and mental health and addictions workers. The authors were interested in knowing about their experiences as Aboriginal members of the health care teams in their communities.

The researchers found that paraprofessionals frequently face the dilemma of being "everything and nothing" in their communities. Although they play an essential role in the health care setting, complementing outsider health professionals' clinical knowledge with their insider cultural knowledge and community awareness, much confusion and

² Keywords included paraprofessional, nonprofessional, preprofessional, indigenous or aboriginal health worker, community health representative, community counselor, health aide, outreach worker, support worker, home visitor, and advocate, among others.

uncertainty exists among other health professionals about the part they can and should play. They also found paraprofessionals' "role congruence" tensions stem from community expectations of what they should be doing that are different from the actual terms of their employment and official job description. Although they are "everything" in terms of being an essential liaison between outsider health professionals and the communities they serve, paraprofessionals often cited feeling misunderstood or unappreciated as a legitimate member of the health care team.

The researchers found that there was a wide range of expectations of paraprofessionals who were supposed to be working in similar positions. Some paraprofessionals reported working outside of their scope of practice by performing nursing duties while others said their primary role was administrative or to translate for nursing staff. Positive relations and emotional support with other members of the health care team were widely cited as extremely important and a major determinant of how well a paraprofessional handled the stress associated with their job. Interpersonal difficulties with other members of the community also affected the work of some respondents. Despite these issues, most respondents emphasized that they derived great personal satisfaction from helping people in their own communities and they felt they could be even more effective in their roles if they were more clearly defined.

A study by Hamrosi, Taylor and Aslani (2006) stands out as a rare example of researchers tapping into the knowledge of paraprofessionals to better understand health issues in Aboriginal communities. Using an in-depth qualitative interview approach, the authors spoke to 11 Aboriginal health workers to identify the type of and reasons for inappropriate use of prescribed medications within Aboriginal communities. Given their in-depth understanding of the community they serve as well as their familiarity with

clinic patients and families, the workers were well positioned to shed light on some of the reasons medications were being used in ways other than intended. The researchers were told by the health workers that there is limited understanding among some Aboriginal patients of their medication's intended purpose, in part because of miscommunications between some Aboriginal patients and pharmacists. The researchers also gained insight into a cultural norm of medication sharing in some Aboriginal communities. This study exemplifies the benefits of tapping into the knowledge of a local paraprofessional as someone who understands the cultural factors at play and can access sensitive health information where other professionals cannot.

A short, informal opinion piece by McIssac (2006) in the BC Medical Journal entitled "A First Nations perspective on mental health and addictions" provides an insightful commentary on one paraprofessional's experience as a community-based counsellor in northern Aboriginal communities. In it, McIsaac spoke of the issues involved with providing mental health services based on an urban, Euro-American model for diagnosing and treating mental illnesses. He argues psychiatry must incorporate the cultures and traditions of Aboriginal service users into its approach to mental health services, make better use of local elders and traditional healers, and be responsive to the unique circumstances of individuals living in small, isolated regions which pose real challenges to those seeking treatment.

2.5 Health and Social Services in the Northwest Territories

The impacts of rapid change on northern mental health and addiction practitioners in the NWT must be understood in the context of the organizational framework for health and social services in the territory. This section provides an overview of the governance

structure of health and social service delivery in the NWT and background information on mental health and addiction services structure and delivery.

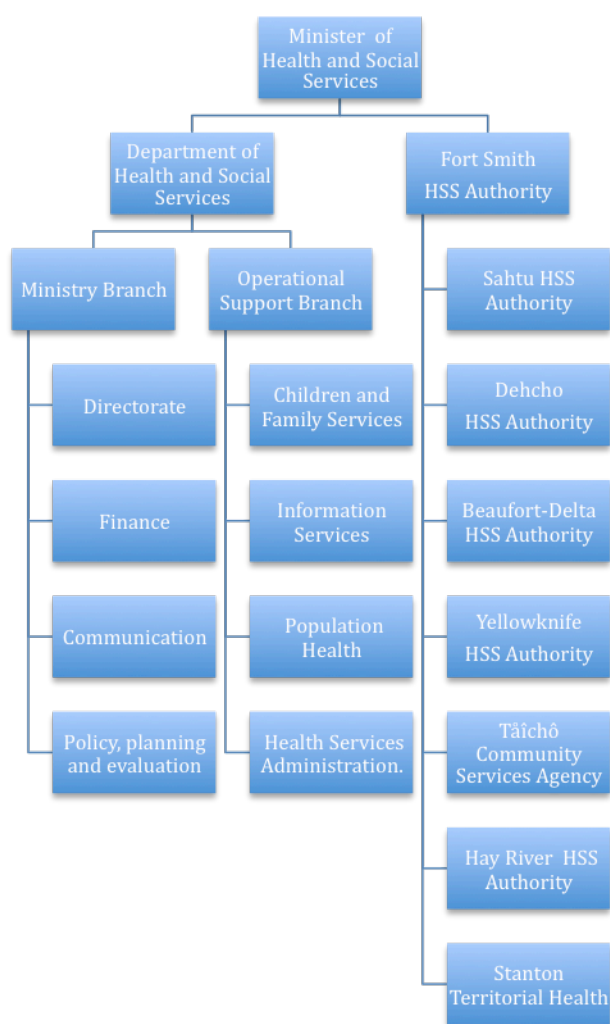
2.5.1 NWT Health and Social Service System

The NWT health and social services system is made up of the territory-wide Department of Health and Social Services (DHSS) and eight regional health authorities (see appendix A). The DHSS consists of two branches: the ministry branch and the operational support branch. The ministry branch includes several divisions responsible for financial management, communication, policy, planning and evaluation, and a directorate providing overall leadership spearheaded by the Deputy Minister of Health and Social Services and a Senior Management team. The operational support branch consists of four divisions: Children and Family Services, Information Services, Population Health, and Health Services Administration. Within each of these divisions, the Department is responsible for program planning, development and monitoring of standards and quality assurance, and providing support to Regional Health Authorities in the management of direct program delivery.

Managed by an appointed local board of trustees (Cuff et al., 2001), the regional health authorities are responsible for a number of different health and social program and services in communities within their jurisdiction. The health services they are responsible for include public health clinics, home care, school health programs and educational programs. There are two regional hospitals in Inuvik and Hay River and one territorial hospital in Yellowknife. Physicians and specialists regularly visit other communities in outlying areas. Social service programs under the mandate of the regional health and social service authorities include child protection services, adoption services, family

violence prevention, mental health, addictions, and corrections. Non-government organizations and private professionals (i.e., dentists) provide supplementary services through agreements with the Department and/or Authorities. The organizational chart in figure 1 below illustrates the organizational divisions of the DHSS. For a map of the NWT delineating the regional health authorities, see appendix A.

Figure 1: Organizational Structure of the Government of the Northwest Territories (GNWT) Department of Health and Social Services (DHSS)



2.5.2 NWT Mental Health and Addiction Services

Mental health and addiction services in the NWT have undergone substantial changes over the past few years. In 2001, the Department of Health and Social Services (DHSS) contracted a private consulting firm called “Chalmers and Associates” to complete an evaluation of all the Community Addiction Programs in the NWT. At that time, community non-governmental organizations (NGOs) or Community Councils provided these services with funding from the DHSS. The evaluation also looked at a mobile addiction treatment program that had been piloted the previous year. The Chalmers report, entitled *A State of Emergency: Community Addiction Program Evaluation* was issued in May 2002. Later that same year, the DHSS restructured the system of health and social service delivery to become the Integrated Service Delivery Model (ISDM). The ISDM grouped territorial Mental Health and Addiction Services together as one of six core groups of programs and services.

Chalmers, Cayen, and Snowshoe (2002) found addiction services seriously inadequate in many NWT communities and concluded there was a lack of capacity at the community level to deal with the problems presented by substance abuse. The report made 48 recommendations on how the system could be improved. In response to this evaluation the DHSS, in consultation with a working group of community representatives, decided to phase out the funding previously provided directly to local NGOs and Band Councils to deliver community addiction services. Instead, they assigned regional health authorities the role of delivering both mental health and addiction services (Chalmers et al., 2005).

Since 2003/2004, GNWT mental health and addiction services have been in place in all NWT communities. Services consist of a territory-wide Community Counseling Program (CCP) as well as one residential addiction treatment facility located on the Hay River Reserve. Access to services varies by community, with some services available at the community level and other services only at the regional or territorial level. For the most part, therapeutic counseling, home and community care, and limited psychiatric services and crisis supports can be accessed within the smaller communities while clinical psychiatric, hospital, and specialized team treatment services are only available at the regional or territorial level (Government of the Northwest Territories (GNWT), 2004). Most of the CCP positions are housed within the regional departments of health and social services, with the exception being one community in the NWT where an NGO provides these services on behalf of the regional health authority through a contribution agreement.

The CCP is comprised of three positions: the Community Wellness Worker, the Mental Health and Addictions Counselor, and the Clinical Supervisor (Chalmers et al., 2005). The Clinical Supervisor provides both clinical supervision and administrative supervision while the Mental Health/Addictions Counselor (MHAC) position is responsible for providing the therapeutic counseling element of the team's services. Both positions require a bachelor's degree and at least 2 years of previous counseling experience. The community wellness worker (CWW) is a paraprofessional role dedicated to providing education, health promotion, and prevention activities in the community in the areas of addiction, mental health, and family violence. CWWs may also be the first point of contact for intake and aftercare for counseling and do basic counseling (Chalmers

et al.). As part of the re-structuring, staff employed as addiction workers by an NGO or Community Council were given additional training through a GNWT partnership with Keyano College and then directly appointed to CWW positions. As of 2005, 77 people had gone through the training to become CWWs (Chalmers et al.)

Currently there are 72 positions funded directly by the GNWT for the regional Community Counselling Programs. This includes 26 CWW positions, 34 counsellor positions and six clinical supervisor positions as well as six Manager positions. At the time of writing, most of these positions were filled with the exception of two CWW, four counsellor, two clinical counselor, and 2 management positions (S. Chorostkowski, personal communication, August 31, 2009). These figures do not include the eight counselling and community wellness worker positions that are paid through contribution agreements with one non-profit organization also providing this service.

A subsequent evaluation by Chalmers et al. (2005) reviewed the impact of the changes made to the system. The report applauded the move to a territory-wide standardized CCP, particularly highlighting increase in the level of training and professional qualifications now required for the counseling-level positions as an improvement. A notable limitation of this evaluation was that there was minimal input from front-line practitioners themselves on the impact of these changes on their work (Chalmers et al., 2005).

2.6 Conclusion

I conducted this literature review in two stages. The first stage linked literature on recent change in the north with key concepts and research pertaining to the impacts of

rapid change on community and individual mental health and substance use. Special focus was given to literature examining potential implications on mental health and substance use in areas undergoing new resource development, as this is a form of social and economic change currently occurring in the NWT. The second section focused on northern mental health and addiction practice and provided a brief overview of the structure and function of mental health and addiction services in the NWT.

Together, this literature paints a picture of the realities in which mental health and addictions practitioners in the NWT are carrying out their work. To recap, it is a situation in which much change has taken place in the region over a very short period of time, very possibly putting stress on communities. Mental health and addiction practitioners, including many paraprofessionals, are being challenged to meet a multitude of community needs related to mental health and addiction issues and are operating under a relatively new community counselling program structure. The next chapter describes how, using the literature, I conceptually linked the diverse issues of rapid change, mental health and addictions, and practice to design a study focused on the views, experiences and support needs of NWT mental health and addiction practitioners in light of continued social and economic change.

Chapter 3: Research Design

This chapter addresses the many facets of thesis research design and describes the rationale that informed my approach to the inquiry. I begin with a description of the research methodology and data collection methods followed by a discussion of the theoretical underpinnings of this project, including the conceptual framework and preliminary field research that shaped the research focus. Subsequent sections describe the process of creating an interview guide along with sampling strategies and the participant recruitment process. An explanation of the data collection and analysis procedures are also included in the chapter. Confidentiality and other ethical concerns were important considerations in this research and the steps taken to ensure that participants were protected throughout the research process are discussed here as well. The final sections of this chapter outline the strengths and limitations of the research design, as well as my views on issues of validity and reliability with respect to the research design.

3.1 Research Methodology

As Maxwell (2005) explains, connecting with a research paradigm is not entirely a matter of choice; you must find a tradition that aligns with your own values and assumptions about the world. Critical reflection through journaling about my ideas on the research topic and reading about various approaches to research helped me to identify my personal orientation within the established paradigms. Additionally, as Nelson, Treichler, and Grossberg (1992) state, “the choice of research practices depends upon the questions that are asked, and the questions depend on their context” (p. 2). Accordingly, in addition to my personal research philosophy, the choice of which methodology to employ was

dictated to a degree by my research questions and the northern community context in which I was conducting this research.

Through this process of research and reflection, I drew on useful components from several complementary, qualitative methodologies grounded in both interpretive and critical theory. Elements of phenomenology, critical hermeneutics (a subset of phenomenology), and Indigenous research methodology all informed my thinking on how to conduct this exploratory qualitative study. The following sections identify which components of each methodology I considered particularly influential to this research process. I will also address aspects of these methodologies that I have not taken up and explain why. First, though, because a mixed methodological approach is controversial for some researchers, I share a few thoughts on my decision to draw on different qualitative traditions rather than adhering to only one.

3.1.1 Multiples Methodologies and "Generic" Qualitative Research

Drawing on elements of different research methodologies is not a simple matter. Research methodologies come with their own underlying assumptions about what constitutes knowledge and can be considered “good” research, as well as specific codes of conduct and modes of analysis. Within the qualitative traditions alone, there is a wide range of approaches specifying how research should be conducted and what the goal of the research should be. However, as qualitative researchers and theorists (Lincoln & Guba, 2003) have pointed out, the methodological genres are blended all the time. My perspective is aligned with Denzin and Lincoln (2003), who state “all research is interpretive” (p. 33) in that it is an act guided by our beliefs and feelings about the world and how it should be understood and studied. If we accept Denzin and Lincoln’s (2003)

assertion that “objective reality can never be captured...we can know a thing only through it’s representations” (p. 8), then the practice of combining methodologies becomes not a question of how to validate the tools or strategies used in research, but “a strategy in and of itself that adds rigor, breadth, complexity, richness, and depth to any inquiry” (Flick, 1998, p. 231). Drawing on different methodologies forces us to understand clearly how we are orienting ourselves within the research, what we are tuning into and what we are leaving behind.

Stepping away for a moment from the philosophical question of whether it is better to blend methodologies or use just one, it is important to point out that many methodologies we are presented with cannot be taken up fully by a student. Community-based research is a good example. There are plenty of reasons why it is important to engage local communities in the research process, but to do so well requires a larger commitment, both in terms of time and resources than most students can offer. Similarly, the indigenous methodological approach as described by Tuhiwai-Smith (1999) cannot be enacted by a non-Indigenous outsider in the way it can by an Indigenous insider researcher. Does that mean that non-Indigenous researchers should avoid referencing this approach altogether? Researchers like Walsham (1993) advise not to completely avoid a methodology when it is not a perfect fit. Rather, we should understand all of the possible approaches relevant to our inquiry and be open to fusing interesting concepts from complementary research approaches together. Of course, it is important to be clear on the philosophies underlying the methodologies being invoked to ensure they are not in conflict (Dootson, 1995).

Within the qualitative traditions, there are distinct differences, but also shared values, such as a mutual interest in rich, detailed descriptions of the social world (Denzin & Lincoln, 2003). Unlike quantitative research, there are no objective data to be quantified, but rather meaningful relationships to be considered (Kvale, 1996). Where qualitative methodologies differ is in the specific processes of data collection and modes of analyses to create these descriptions and understand these relationships. There is no doubt that different qualitative lenses can lead to different interpretations of the data, but if we accept that there are many correct understandings of reality than this ceases to be so problematic because there is no “right” answer to arrive at.

Lincoln and Guba (2003) suggest that “to argue that paradigms are in contention is probably less useful than to probe where and how paradigms exhibit confluence and where and how they exhibit differences, controversies, and contradictions” (p. 254). The task of the researcher is therefore to understand the methodological tools being employed to ensure they work well together. I also agree with Caelli, Ray and Mill (2003) when they state that researchers who do not adhere to one established methodological approach should be prepared to clearly articulate their rationale for their chosen approach and outline the steps they took to ensure their findings are valid. With this in mind, I next explain the specific components of the qualitative methodologies I have found to be useful guides in designing and carrying out my thesis research. I describe how each has been influential in this study and how they fit together to support the analysis of my findings.

3.1.2 Phenomenology

In many ways, this research is a phenomenological study. Phenomenological studies are primarily interested in the “lived experiences” of people in relation to a specific concept or phenomenon (Creswell, 1998). Phenomenology aims to capture an understanding of those experiences as interpreted by participants themselves (Kirby, Greaves & Reid, 2006). In this study, the purpose is to explore the experiences and support needs of community mental health and addiction services providers in the context of the phenomenon of rapid social and economic change in northern communities. I believe phenomenology is a particularly appropriate approach to use in this study because, in exploring this phenomenon, I am focusing on the interpretations of a specific group in society (mental health and addiction practitioners) with the goal of understanding what social and economic change means to them in their work. While I have conducted background research to better understand the context of the work mental health and addiction practitioners do and the types of social and economic changes that have been noted in northern communities, the perceptions of practitioners themselves of the phenomenon of social and economic change is the focus of the study. Additionally, the research methods and analytical approach, described later in this chapter, were also very much in line with standard phenomenological techniques. I relied heavily on phenomenologist Kvale (1996) for instruction on how to proceed with these phases of the research process.

There is, however, one major way in which my philosophical orientation departs from phenomenology; it is my disbelief in the possibility of “bracketing” ones own experiences in order to enter the life world of interview participants. In this regard, my

epistemological orientation is more closely aligned with critical hermeneutics, a subset of phenomenology. This and other aspects of critical hermeneutics that influenced my research approach are described next.

3.1.3 Critical Hermeneutics

Critical hermeneutics is a qualitative methodology that blends elements of critical social theory with the hermeneutic phenomenological tradition (Kinsella, 2006).

Although newly emergent, critical hermeneutics is a methodological approach used increasingly by health researchers (Allen, 1995; Venturato, Kellett, & Windsor, 2007; Spirig, 2002; Milligan, 2001) seeking to understand the lived experience of people while at the same time considering how history, culture, power and authority factors into the interpretations of their meanings (Kinsella, 2006). Three elements of this methodology were particularly influential to my research project, namely the importance of context, stories as text, and critical perspectives.

Importance of Context

Hermeneutic methodology resonates with me in part because of the emphasis placed on context in order to understand people's lived experience. People's stories must be interpreted with the social, historical, and cultural factors in mind that have helped to shape their reality (Lavery, 2003). Unlike phenomenology, the hermeneutic approach believes it is impossible for the researcher to "bracket" or set aside her or his own position or experiences in order to better relate the perspective of the knower to the issues being researched (Lavery, 2003). The hermeneutic tradition views interpretation as an act bound up in history or "pre-understanding" (Jones, 1975 as cited in Lavery, 2003) and

cultural context, therefore the idea of bracketing is viewed as impossible. Instead, it is argued that the interpretive processes should be considered a dynamic exchange between the researcher and participants, who work together through dialogue to determine what they think is happening.

I have difficulty imagining a scenario in which sensitivity to context is not valuable but would argue that it is particularly crucial in the NWT, a vast region that is home to several distinct Aboriginal groups as well as to non-Aboriginal settlers. As a lifelong northerner of Euro-Canadian descent, I recognize I carry a certain set of social, political, and historical assumptions. The conclusions I draw from my research participant's words are consciously and unconsciously filtered through these pre-understandings, so I appreciate that the hermeneutic approach views both the researcher and participant as active participants in the act of interpretation and the emphasis that is placed on the act of understanding across differences.

Stories as Text

Hermeneutics is often associated with textual analysis, but as Kvale (1996) explains, this does not just refer to books. The hermeneutic approach can also treat human activity as "texts" with intended or expressed meanings (Kvale, 1996). Human activity texts can come in many forms, including written or verbal communication, visual arts, and music. The value that hermeneutics places on conversation and storytelling was relevant to this project as it is reflective of the oral history and traditions of the northern communities of focus in this research. In my interview design, I encouraged storytelling through open-ended questions and a relaxed, conversational approach to the interview process. More details on my interviewing technique will follow in a subsequent section of this chapter.

Critical Perspectives within Hermeneutics

As discussed in depth by Kinsella (2006), many researchers and theorists who work within the hermeneutic tradition have sought ways to extend the hermeneutics approach to examine critically the ways that power and authority factor into people's lives. One way that critical hermeneutics accomplishes this is by paying attention to how power relations affect communication. This can include an awareness of how meaning is derived from people's experiences (i.e., what is deemed important) and the social implications of research interpretations (Allen, 1995). Many critical hermeneutic researchers are also concerned with whose voice is being privileged in the dialogue and focus their research on voices they perceive to be marginalized by dominant social forces (Terhune, 2008), while others focus on "democratic communication" (Allen, 1995, p. 180), in which a range of people with diverse perspectives on an issue are able to present their views in a more balanced fashion. Thinking about the importance of whose voice is being privileged helped me to determine my own participant sampling approach.

On a broad level, the discussion of "who's voice?" aided the process of choosing to focus on community-level mental health and addictions practitioners, a group whose perspectives are largely absent in current research on mental health and addiction service provision in the NWT (Chalmers et al., 2005). Given that front-line practitioners have valuable and underutilized knowledge on community wellness (Lock, 2000; Scott-Samuel, 1996), it was my goal to tap into the collective expertise of these workers so that others may hear about their experiences and views of the phenomena of social and economic change. Within this group, a democratic approach to practitioner perspectives was sought, with representation from mental health and addiction practitioners in both

small and large communities, male and female, Aboriginal and non-Aboriginal, in both professional and paraprofessional service provision roles.

With its emphasis on voice and co-construction of meaning, a research project fully committed to the critical hermeneutic tradition would heavily involve research participants themselves in the analysis of research findings. In this inquiry, the time and resources of a graduate-level thesis reduced the degree of participant collaboration in this study to three specific points in the analytical process. This type of member checking is not collaborative enough to consider this study an example of critical hermeneutics, but this methodological tradition shaped my views on the importance of context, the value of story-telling, and the importance of considering whose voices are being heard. As a result, I built in as many opportunities as possible to get participant feedback on my interpretations of their words, carefully selected a diverse group of practitioners to include in the study, and remained conscious throughout the process of data collection and analysis of my own reactions, interpretations, and emotions, keeping track of all of these things through a detailed log book as I moved through the research process. Considering the critical hermeneutic perspective on “whose voice” also led to some deeper considerations about the ways in which my research was sensitive to the viewpoints of Aboriginal practitioners.

3.1.4 Indigenous Methodology

As my research involved speaking with Aboriginal people and conducting fieldwork in a region where Aboriginal people make up the majority of the population, it was also imperative that my approach is consistent with Indigenous methodology. On a theoretical level, this meant consciously supporting the goals of healing, mobilization,

transformation, and decolonization described by Linda Tuhiwai-Smith (1999, p. 117) as a non-Aboriginal ally, continually questioning how my research supports the goal of decolonization (Porsanger, 2004). In tangible terms, this meant working closely with Aboriginal communities to make certain that I had their support and involvement throughout the research process. Support for research on mental health and addiction services in principle was obtained at the outset of the study through preliminary consultation over the summer of 2007 with Aboriginal groups on whose traditional territory this research was occurring. Support from individual Aboriginal mental health and addiction practitioners was obtained through the participant recruitment and consent process. Balanced representation of Aboriginal practitioners and non-Aboriginal practitioners was important to the study to ensure that the perspectives of Aboriginal practitioners was heard loud and clear. As described later in this chapter, during participant recruitment a special effort was made to ensure at least half of participants were Aboriginal practitioners.

Indigenous methodologies contributed to my thinking about possible implications my research could have in terms of deconstructing or reinforcing colonial attitudes and negative stereotypes about the North and its people. For example, there is a widespread public perception that small northern communities are troubled places. In my preliminary consultation with Aboriginal leaders and helping professionals, it was expressed to me that more research focusing on the negative aspects of community life was not helpful. In response to this, I purposely designed the interview guide to include questions that would encourage practitioners the opportunity to talk about positive aspects of their experiences in communities. Additionally, in the interpretation and presentation of the data, it was

important to consider how findings could be misread or misappropriated by others to further the oppression of Aboriginal peoples. In coding the data, I uncovered some themes related to practitioner observations on community life that I did not feel I had the cultural competence or understanding to delve into, nor the space within the thesis to do them justice. In consultation with participants and my thesis supervisor, I decided that presenting these data in the thesis and community report would not do justice to their complexity.

3.2 Research Methods

In accordance with these qualitative methodologies, the research method selected for data collection was in-depth personal interviews. I chose this method primarily because of my interest in hearing people's stories. Storytelling is a mode of information-sharing that is widely used and culturally appropriate in the Aboriginal context (Tuhiwai-Smith, 1999) and thus was deemed appropriate for this northern community context. Interviews are an appropriate research method in qualitative research because they "emphasize the constructive nature of the knowledge created through the interaction of the partners in the interview conversation" (Kvale, 1996, p.11). In this way, new knowledge can be created as both parties involved examine the research subject matter together. Semi-structured interviews are particularly appropriate as the conversational open-ended nature of these methods allows research participants flexibility to share what they feel is most significant (Creswell, 1998).

Interviews took place at a time of day and in a location chosen by participants. The relaxed nature of these interactions meant participants could share as much or as little as they wanted and return to subject matters to expand on points, which led to multiple

interpretations of the phenomenon of social and economic change. This benefit of storytelling is noted by Bishop (1994) who suggests storytelling is “a useful and culturally appropriate way of representing the ‘diversities of truth’ with the story teller” (p. 175).

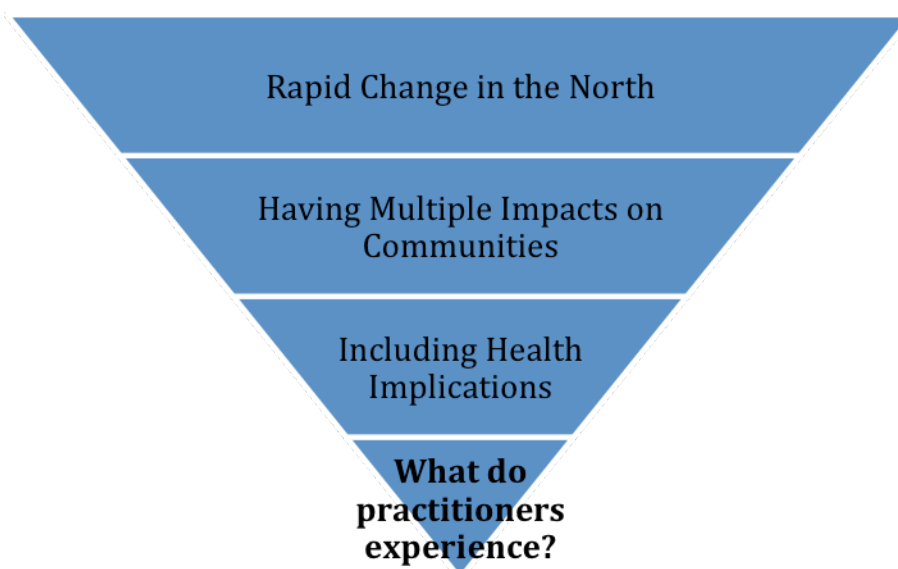
The audio transcripts and detailed research notes resulting from these conversations were linked to broader issues of change, community, and northern health practice through the academic and grey literature presented in the literature review. The words of participants, my own log notes and the secondary data together formed the basis for my analysis on the views and experiences of mental health and addiction practitioners working in a rapidly changing northern community context.

3.3 Theory Building and Conceptual Development

Creating a conceptual framework, described by Maxwell (2005) as “a system of concepts, expectations, beliefs and theories that supports and informs the research” (p. 33), allows the researcher to organize personal experiences and prior reading on the subject in way that flows logically. Since my project is exploratory in nature, this process could also be considered an exercise in theory building for my thesis as it has helped me to determine what I already knew (or thought I knew) about my research interest and what I wanted to find out. With the understanding that theory is “a set of concepts and the proposed relationships among these...A structure that is intended to represent or model something about the world” (Maxwell, 2005, p. 42), I determined the connections I perceived between social and economic change in the NWT and its impact on mental health and addictions practice. These connections were informed by the literature I reviewed as well as my own personal experiences as a northerner. Figure 1.1 below

illustrates the relationship between the concepts of change, health and practice that led to a specific focus on the community-based mental health and addiction practitioner's experience of change in relation to practice. This figure depicts the funneling process that occurred beginning with the broadest and most general ideas that led to a more specific and particular focus for the thesis.

Figure 2: Thesis Focus



3.4 Preliminary Field Research

To ensure my research ideas were of interest to and supported by relevant community stakeholders, I commenced a preliminary consultation process in the NWT. Conversations with stakeholders began as early as September 2006, although the bulk of community consultation took place in July and August of 2007. This included meetings with over 25 community-based health practitioners and health administrators familiar with mental health and addictions-related work in the NWT. Consultations also took

place with leaders representing Aboriginal communities where my research was taking place. The comments and feedback I received were integrated into the research focus and design.

As a result of these discussions, my research scope was simultaneously broadened and refined. It was refined in the sense that I determined the most appropriate subset of health practice to focus on would be the work of community-based mental health and addictions practitioners. It was also broadened in a way because I realized that although my personal interest in rapid change and its impact on health was derived from a concern with the impacts of resource development in communities, there are many other types of change – both positive and negative - taking place simultaneously that could be affecting the work of practitioners. I also concluded that it was important not to assume that their work was necessarily changing at all. Consequently, I broadened my project so that the primary focus of the thesis was on the experiences and perceptions of community-based mental health and addictions practitioners, with one element of my inquiry looking at their perspectives on various changes within practice.

3.5 Further Conceptual Development

Further conceptual development was necessary to begin generating some research questions. To this end, I used what Shield and Tajilli (2006) refer to as a "conceptual framework table". Within Shield and Tajilli's approach, conceptual frameworks are classified into five distinct categories. The first and most relevant category to my inquiry is their *working hypothesis* approach, suitable for exploratory studies. Working hypotheses are essentially concrete statements about what one *expects* to uncover through the research process based on one's own knowledge/experience as well as the academic

literature on your topic. In my case this information was also derived from conversations I had with community stakeholders during my preliminary field research and other secondary source data I had read, such as government reports. Shield and Tajilli (2006) stress it must be possible to gather evidence that either supports or challenges each individual hypothesis within the conceptual framework.

One modification I made to the working hypothesis approach was replace “hypothesis” with the more fitting term “concept”. As described by Becker (1997), concepts are "empirical generalizations, which need to be tested and refined" (p. 128). Becker suggests that these generalizations or concepts are developed "in a continuous dialogue with the empirical data" (p. 109), but in early writings (Becker, 1986) he also warned researchers not to lean too heavily on the literature. Academic literature has the advantage of what he calls "ideological hegemony" (Becker, 1986, p. 146). Relying too heavily on the literature puts you at risk for missing phenomena that is not represented or different from what was established by previous researchers. I found this a particularly relevant point, having identified several gaps in the literature on northern health practice in preparation for my field research.

Drawing jointly on Becker's (1986) definition of concepts and Shield and Tajilli's (2005) "working hypothesis" approach, I created a table linking concepts central to my inquiry to the literature and other forms of knowledge, as well as to related research questions one might ask. This latter category was in response to Shield and Tajilli's recommendation that each sub-hypothesis should have at least one interview question dedicated to it. The resultant conceptual framework table is depicted in table 1 below.

Table 1: Conceptual Framework Table

Central Concepts	Sources of Scholarly and other Forms of Knowledge	General Research Questions
Rapid change is occurring in the Canadian north.	<ul style="list-style-type: none"> • News media • Reflections of Northerners during the Mackenzie Valley Pipeline Review Process • Academic literature (i.e., Arctic Human Development Report, 2004; Buell, 2006) 	<ul style="list-style-type: none"> • How (if at all) is rapid change affecting communities in the Canadian North?
Rapid change is having multiple impacts on communities.	<ul style="list-style-type: none"> • The academic literature and government reports (i.e., the Arctic Human Development Report, 2004; Freudenburg & Gramling, 1992; GNWT, 2006b) 	<ul style="list-style-type: none"> • What (if any) impacts do these changes have on communities?
Rapid change and the related impacts are affecting health outcomes in northern communities, including mental health and addiction issues.	<ul style="list-style-type: none"> • Government reports (i.e., Mackenzie Valley Environmental Impact Review Board (MVEIRB), 2005; Chalmers et al., 2005) • The academic literature (i.e., Csonka & Schweitzer, 2004; Dean, 1995; Ritter 2001) • Comments of northerners during my preliminary field research. 	<ul style="list-style-type: none"> • If community change is noted, has there been an impact on population health, and in particular, mental health and addictions in communities?
Rapid change is affecting the work of community mental health and addictions practitioners.	<ul style="list-style-type: none"> • Reflections of northerners during my preliminary field and a limited amount of academic literature (i.e., Bacigalupi & Freudenburg, 1983) 	<ul style="list-style-type: none"> • If change's impact on community mental health and addictions is noted, does this affect the work of front-line community mental health and addition practitioners?

This systematic approach linking my central concepts to the literature and broad research questions was helpful to a degree. However, after reading additional literature on mental health and addictions practice in northern Canada and other rural/remote settings, it became clear that there is a significant lack of information about what community-based mental health and addictions practitioners actually do in their daily work. The roles and responsibilities seem to vary greatly in the literature, especially in relation to paraprofessional positions. It did not seem possible that one could reasonably conduct a study on changes to practice without knowing first what the job entailed. Moreover, asking practitioners about the impacts of rapid social and economic change on their

practice without asking about the ways in which they could be supported in their role in communities stopped short of potentially productive recommendations for improvements to the way services are provided in communities. Therefore, I added two additional concepts to address these issues (see table 2).

Table 2: Other Important Concepts

Additional Concepts	Scholarly Support and other Forms of Knowledge ³	Research Questions
Delivering community mental health and addictions practice in the rural and remote regions is unique in terms of challenges and rewards.	<ul style="list-style-type: none"> • Reflections of Northerners during my preliminary field research • Some academic literature (i.e., Minore & Boone, 2002; McIssac, 2006); • Government reports (Chalmers et al., 2005) 	What are the current practices of long-serving community mental health and addictions workers in the NWT?
Changes to the work of community mental health and addictions professionals could result in new support needs.	<ul style="list-style-type: none"> • Government report (Chalmers et al., 2005) • Reflections of Northerners during my preliminary field research • My own experience 	What are the support needs of these workers in light of continued change in the region?

3.6 Building an Interview Guide

To recap, the focus of the thesis is on NWT community mental health and addiction practitioner perceptions and experiences of social and economic change in relation to their professional practice. While Tables 3.1 and 3.2 present broad research questions that are relevant to this thesis focus, the task remained to turn these general questions into specific interview questions. Maxwell (2005) recommends self-reflection as a first step to developing an interview guide; thus, I first considered how I myself

³ I've added "other forms of knowledge" to the table that Shield & Tajilli (2006) recommend because it this line of reasoning came about, not only from my review of academic literature, but also from conversations with health practitioners and other key informants during my preliminary field research.

would respond to questions on the research topic. My thesis supervisor and I conducted an informal interview where I spoke of my own experience working in the area of mental health and addictions in the north and what I perceived as the impacts of social and economic change on practice. This self-interview was an important first step in building a project that is “reflexive” (Hammersley & Atkinson, 1995). In accordance with the principles of hermeneutic phenomenology, the point of the self-interview is to better understand how my own viewpoints inform my approach to the research and/or the way that I interpret the information I gather.

The second step was to draft some proposed interview questions based upon my personal reflections and the broad research questions outlined in the conceptual framework tables. I pilot-tested this first set of interview questions with two classmates, who answered the questions on mental health and addictions practice from their perspectives as health service providers in other capacities. I adapted my questions based on their responses to improve clarity and focus. I then conducted a third pilot test with a community-based health professional from the NWT. His answers gave me confidence that I was more or less on the right track with my research questions, although he appeared to be confused about my questions related to the concept of change. In response to this, I restructured my interview guide at this point to make it easier for me to proceed with the interview if people did not have anything to say with respect to change in their work over time or in their community. By leaving such questions open-ended, I avoided putting people in a position where they felt the need to make up answers in order to satisfy my interest in how social and economic changes influence practice. The interview was intended to be a satisfying experience whether or not this issue of change resonated with people.

I also decided to alter some of the language I was using in my interview guide. The main change was that throughout my interview guide I used the word “practice”. Initially this word was used because I did not have a firm idea of who I would be interviewing and I wanted to leave room for people, such as elders, traditional healers, volunteers, and others who are involved in the area of mental health and addictions to participate potentially. However, as explained below, circumstances led to a narrowing of focus to community wellness workers and mental health and addiction counselors. Once it was clear that this was the group I would be able to access, it made more sense to occasionally use the word “work” in addition to the word “practice”.

My interview guide evolved to include questions centered around five main areas. They were: (1) personal history, (2) practice today, (3) reflections on change, (4) challenges and rewards of practice, and (5) support needs. Following this semi-structured line of questioning, I had an open-ended question asking participants if there was anything more they would like to share with me about the work that they do. The final version of the interview guide is included in Appendix B.

In summary, the process I followed to design the interview questions was one of focusing and re-visioning, using a conceptual framework that was grounded in my methodological influence and informed by the literature, preliminary field research findings, and personal experience. The interview guide was amended along the way through pilot tests with volunteers whose responses helped to determine what made sense to ask, how to order the questions, and what language to use to set participants at ease in sharing their knowledge and experiences with me.

3.7 Ethical Considerations and Approvals

Whenever a researcher involves other people in a study, there are many ethical issues to consider. Recognizing the moral and institutional imperative to conduct my inquiry in an ethical matter, I have made every effort to comply with the University of Victoria and Tri-Council Guidelines on Ethics (Tri-Council, 1998), the University of Victoria's Protocols and Principles for Conducting Research in an Indigenous Context (University of Victoria, 2003), as well as the ethical standards set forth for conducting research in the NWT (Aurora Research Institute, 2005). To ensure ethical integrity, I consulted with community stakeholders, ethics committees both at the university and community level, and my thesis supervisor and committee.

My project required several ethical approvals to proceed. The first necessary approval was from the University of Victoria Human Research Ethics Board. The second level of approval was the Department of Health and Social Services, Government of the NWT via the Aurora Research Institute. Approval at this level was conditionally granted, contingent on approval through a *third* review process by the Chief Executive Officer and/or an ethical review committee at the health authority level in each jurisdiction in which I planned to conduct research. I went through the approval process at the regional health authority level for each of the different regions I conducted interviews in. The University of Victoria Human Research Ethics Board approvals are included as Appendix C and the NWT Aurora Research Licence as Appendix D.

At each stage of the ethical review process, approval was granted with the condition that I share my findings with the permission-granting institutions. Consequently, a major ethical issue I identified with my project was related to the issue of

maintaining the confidentiality of participants. Due to the small population base in the NWT and the even fewer number of mental health and addictions workers in the territory, it was impossible to assure participants confidentiality. One way I have dealt with this issue has been not to reveal the identity of the communities or even regions involved in my thesis. Careful proofreading also occurred to ensure that use of quotes or demographic information does not inadvertently identify an individual participant. The presentation of research findings in a thematic format, rather than using individual narratives for example, is another confidentiality safeguard. This approach may also serve to reframe the discussion so that any information that is shared does not reflect a specific community, but instead speaks broadly to health and social wellbeing in the north as a whole.

3.8 Participant Selection and Recruitment

This study adopted a “purposive” (Maxwell, 2005) approach to participant selection, as I specifically sought out mental health and addiction practitioners in NWT communities. The positions of interest were the community mental health/addiction counsellor and community wellness worker. I decided to focus on practitioners working in these roles based on the selection criteria outlined in Kirby, Greaves and Reid (2006) who cite relevant experience, willingness, contactability, responsiveness, identity, diversity, and communicative compatibility as key factors. Although people in the counselling and community wellness positions are by no means the only people whose work relates to mental health and addictions, they occupy the community-based positions funded under the Mental Health and Addiction division of GNWT Department of Health and Social Services who make up the territory-wide Community Counselling Program.

The two positions are supportive and complementary. Mental health and addiction counsellors have clinical training and/or post-secondary studies related to therapeutic counselling. Community Wellness Workers are paraprofessionals who coordinate health promotion activities at the community level specific to mental health promotion and addiction prevention. They are also able to counsel people on a limited basis and help residents connect with supportive resources, including the community Mental Health and Addiction Counsellor.

Another key factor in the decision to focus on these two positions was familiarity with the community. In most instances, counsellors and wellness workers live full-time in communities. Community Wellness Workers in particular are often indigenous to the communities they serve. This is not the case with all health professionals; for example, it is common for nurses and physicians to visit on a rotational basis rather than live full-time in NWT communities. Yet, prior research on mental health and addiction services in the territory has focused on the perspectives of clinicians and administrators rather than on those of the community-level practitioners (Chalmers et al., 2005). Community-level practitioners have valuable and underutilized knowledge on community wellness (Minore & Boone, 2002). By documenting their perspectives and experiences, this research project aimed to augment existing research and gain further insight into what mental health and addictions practice looks like in the NWT.

Ethical considerations solidified the decision to focus on counselors and community wellness workers. The small population of many NWT communities dictated that I carefully select participants who could not easily be identified by the description of their work. Since the counseling and wellness worker positions are found in nearly every community in the territory, focusing on this population was one way to protect the

individual identities of research participants while linking the experiences and perspectives of individual practitioners from different communities separated by great distances.

Since the selection criteria centered on specific positions of employment, participant recruitment required the involvement of the employer. In a broad sense, the employer is the territorial government's Department of Health and Social Services, but each Regional Health Authority is primarily responsible for workers within their jurisdiction. In one jurisdiction, mental health and addictions services are also provided by a non-profit organization funded on a contractual basis by the Regional Health Authority. Staff from this non-profit organization have been included in this research as well.

The first point of contact was with senior management at the GNWT Department of Health and Social Services. Through a key contact at the Department of Health and Social Services, I was able to make contact with all of the Regional Health Authority managers responsible for overseeing the work of mental health and addiction counselors and community wellness workers. I presented an outline of my study to the managers via a conference call and then followed up with those who expressed interest in the project with further information. This included a letter of invitation to participate for distribution to community-based mental health and addictions counselors and wellness workers (see Appendix E). In two communities, I was permitted to attend regional staff meetings to speak directly to counselors and wellness workers about my study and invite their participation. This direct approach worked much better than the indirect invitation to participate through the Regional Health Authority Managers, because I was able to field questions and better express my interest and enthusiasm for the project to prospective

participants. However, direct access to workers was not possible without the permission and support of managers. Protocol around how staff meetings operated and whether outsiders were able to participate varied among different health authorities.

In the regions where my invitation to participate was distributed through email by managers, I relied on counselors or wellness workers to contact me directly themselves if they were interested in participating. In regions where I had been able to present the information in person to staff, I was able to follow up by telephone or email with individual staff member to ask them if they were interested in participating. I was careful to emphasize during this follow-up that participation was optional and voluntary, while conveying my deep interest in their work. Nearly everyone I contacted personally agreed to take part in the study.

3.9 Data Collection Procedures

Data collection occurred in the spring and summer of 2008 in communities throughout the NWT. As previously described, primary data collection consisted of in-depth personal interviews with 15 community-based mental health and addictions counsellors. Secondary data such as government reports, newspapers and other media articles, as well as additional conversations with relevant government and non-governmental representatives served to deepen my understanding of the history and current context of mental health and addictions service delivery in the NWT.

All of the primary interviews took place in person in the community of residence for the participant and I travelled by vehicle or plane to meet with them there on a date of their choosing. The interview times were scheduled outside of regular work hours, so as not to interfere with the participant's roles and responsibilities at his or her place of

employment and to maintain confidentiality. In acknowledgement of the participant's time and shared expertise, I offered an honorarium of fifty dollars to each individual prior to commencing the interview. The amount of the honorarium was set based on GNWT hourly wage information and in consultation with the Aurora Research Institute. The physical location of the interview meetings in participant's communities were diverse and depended on the participant's expressed preference. They included the participant's home or office, a private meeting space in a public library, a café, and my hotel or place of residence. The interview began with a review of the interview consent form (Appendix F) and both the participant and researcher received a copy of the signed form. The length of an interview ranged from forty-five minutes to two and a half hours, with most interviews lasting a little more than an hour.

My interview approach was influenced by Kvale's (1996) description of the interview situation as a conversation between two people "in which knowledge evolves through a dialogue" (p.125). As Kvale (1996) describes it, this conversation is ideally reciprocal and non-hierarchical, with the researcher maintaining a careful balance between the task of gathering information while remaining sensitive to emotional aspects of human interaction. I tried to accomplish this by keeping the interview atmosphere friendly, familiar, and fairly informal. Many of the interviews occurred over a pot of tea or a light meal since, as previously described, the interview location was chosen by the interview participant.

In keeping with what Kvale (1996) refers to as the pre-interview "briefing" (p. 128), I began the interview with a short personal biography so that participants knew a bit about me before I asked them to share about themselves. Prior to turning on the audio recorder, I always explained why I was hoping to record the interview and asked their

permission to do so. I answered any questions they had prior to turning the tape recorder on and when I did turn it on, I placed it in an inconspicuous location to help alleviate the self-conscious feeling some people get when they know they are being recorded. If the participant was interested, I would go over a simplified version of the interview guide with them so they knew the general themes and overall flow of the interview questions beforehand.

Conversations often diverged from the interview guide. When this occurred, rather than immediately trying to bring the conversation back to my intended question right away, I attempted to follow the participant's train of thought. I learned from the pilot interviews and reflection that if the relevance of what the participant was sharing was not obvious to me, it was important to probe the speaker about the topic they had introduced to better understand its intended meaning. If I did not understand something that was being shared, I asked for clarification or a story or example of what they were discussing.

In some respects, the interview was the beginning of the analysis phase of the research. While participants were speaking, I would often summarize what I understood them to be saying in my own words and ask if I understood them correctly. In some instances, I added questions into the interview guide related to information that had been shared with me in previous interviews to get a sense of what others believed about the same issue. For example, after a few individuals mentioned a certain policy they saw as problematic, I asked others about their thoughts on this policy to gauge whether they held a similar or different viewpoint. As with the questions contained in the interview guide, I was careful not to frame these additional inquiries in a leading manner; I was as interested in tensions and contradictions as I was in similarities and trends across the interviews.

Before ending the interview, I followed Kvale's (1996) direction of including a short debriefing component to the discussion. As part of this, I asked participants if there were other aspects of their practice that they would like to talk about or points we covered that they would like to expand upon. I also outlined the next steps in the research process, explaining that I would be in touch again with a copy of the interview transcript and a summary of key points I have taken from our conversation for their review and comments. Recognizing that some people may feel somewhat vulnerable after sharing their personal experiences, I also emphasized again that the information I collect from other interviews would be combined to identify overarching themes. In this way, their story becomes part of a collective story of mental health and addiction workers from across the NWT. People seemed to respond well to this description of the end product and most expressed that they enjoyed the experience of speaking with me. I always made sure to let them know I appreciated their time and followed up with a hand-written thank you card within a week of the interview.

As previously noted, while in the field I also kept a personal journal where I logged my own reflections on the research process and my thoughts and reactions to the interview conversations I was having with counsellors and wellness workers. I set time aside after each interview to consider what was shared with me and to write my field notes. I also used the audio recorder to talk to myself about what stood out from the interview. Additional time in communities was spent visiting other service providers and community members and accessing local library collections and newspapers, noting stories and reference items related to mental health and addiction issues in the community. These experiences all fed into my personal log notes and eventually, my data analysis.

3.10 Data Analysis Procedures

The approach to data analysis considered key elements of both interpretive and critical methodological traditions (Venturato, Kellett & Windsor, 2007). In phenomenology and critical hermeneutics, meaning is derived from the interpretation of texts (in this case, “texts” would include transcripts and interview notes) through several close readings and the identification of key themes and ideas. In both of these methodologies, as well as Indigenous methodology, critical consideration is also given to the overall context under which these texts are produced, including the political/power conditions (Allen, 1995). This has been described as a dialectic (Kvale, 1996) or multi-stage (Laverty, 2003) process in which the reader moves back and forth between the actual words in the text and other data pertaining to the overall context to determine its meaning. As Allen (1995) puts it, “one understands a sentence in part by understanding the context within which it occurs, and, similarly, one understands the context by understanding individual sentences. Each can modify the other” (p. 179).

The next section describes the specifics of interview analysis and outlines the ways I adhered to these methodological ideals through participant feedback at different stages in the interpretive process and by carefully combining interview transcripts and notes, my personal log notes and secondary data through thematic “categorizing” and narrative “connecting” strategies for data codification (Maxwell, 2005 p.96). Specifically, Kvale’s (1996) “meaning condensation” and “meaning categorization” analytical approaches were useful categorizing tools. Meaning condensation involves summarizing the words of the participant into short statements, which retain the main sense of what is being expressed; meaning categorization is a process of coding the interview into themes or categories.

3.10.1 Interview Analysis

The first stage of analysis in most qualitative studies is a careful review of the primary data that is to be interpreted (Maxwell, 2005). In this case, primary data consisted of 15 personal interviews with NWT mental health and addiction practitioners. Detailed interview notes were used in place of transcripts for the three interviews that were not audio recorded. However, the other 12 interviews were audio recorded and transcribed verbatim by a professional typist. I purposely selected an individual who was not from the NWT to transcribe as an added measure to protect the identities of research participants. I also ensured that this individual signed a confidentiality agreement upon my receipt of the transcripts and erased her copy of the audio file and all the related transcription word processing files once the transcript was completed. After receiving a transcript, I reviewed it for accuracy. I listened to each interview a second time from beginning to end, noting any points of emphasis, pauses or expressions I saw as important to the overall context of the interview. As recommended by Maxwell (2005), during these initial reviews of the transcripts, I kept personal log notes pertaining to what I was hearing in the data, including some tentative ideas on possible themes or categories emerging from the interview. These notes and reflections were essentially the first stage of the analytical process. Interesting quotes or key words in the transcript text were highlighted. Interviews were then ‘cleaned’ in the manner described by Kvale (1996) to remove or disguise any possible identifiers that could compromise participant confidentiality.

All of the methodologies I have drawn on for this study emphasize ongoing researcher-participant communication as part of the analytical process (Laverly, 2003; Tuhiwai-Smith, 1999; Kvale, 1996). However, time and resource limitations of a

graduate-level thesis limited participant collaboration in this study to two main junctures in the analytical process. The first opportunity for participant feedback and collaboration was in a review of cleaned interview transcripts and interview summaries. As explained by Kvale (1996), returning transcripts to participants provides them with an opportunity to clarify any statements that were made, delete statements they do not want included, or add additional thoughts on the subject matter.

Along with the interview transcript, participants were provided with a “summary” version of our interview. Summaries are a good way to break the data down into a manageable size, while still retaining a well-rounded account of an individual’s unique perspective or experience (Maxwell, 2005). To create these summaries, I condensed each interview transcript into a series of shorter statements. The purpose of creating these interview summaries and providing them to participants was so that they could get a sense of how I heard and understood their experiences as mental health and addictions practitioners, based on the information they shared with me, and give them a chance to respond if they did not agree with my interpretation. As well, I wanted participants to see that their individual ideas and experiences had been heard before I moved into the phase of combining the emergent themes from their interview with data from the other interviews I conducted. Participants who did not consent to have their interview audio-recorded only received the interview summary, so this was viewed as a particularly important feedback opportunity for them.

I sent each participant their transcript and interview summary by email with a personal note encouraging their thoughts and comments on these documents, including their thoughts on changes, points requiring clarification, or additional ideas. While several participants responded indicating their interest or appreciation and interest in

reading their transcript and/or summary, no one requested any changes or made any additional comments as a result of receiving it. This was somewhat disappointing, as I had anticipated more involvement from participants in this stage of the analytical process. However, this process did lead me to engage really with the content of each interview, some of which I felt I had almost memorized by the end of creating a summary. A more successful dialogue between me as researcher and many of the participants is described later in this section during a second opportunity for participant feedback.

Each of the interview summaries was then further shortened to a series of one or two word descriptors or “topics” that captured the key issue or concept being described in each of the interview statements. Like McMillian and Schumacher (2001), I refer to these descriptors as topics although have been referred to by others as “meaning categories” (Kvale, 1996) and “organizational categories” (Maxwell, 2005). The purpose of coding the interview summaries in this manner was primarily to organize the data in simple terms that would make it easier to compare and contrast interviews.

Analysis of the data occurred both within and between participant transcripts to ensure that both commonalities and differences within the sample were examined. Overarching findings or “themes” were determined by comparing the categories from all 15 interviews. I have called these categories “themes” rather than “findings” as I perceive the latter implies a conclusiveness that is not in line with the multiple versions of truth that my guiding methodologies suggest research is capable of producing. Overarching themes are what Maxwell (2005) refers to as “etic categories” (p.98), in that they are substantive concepts emerging from the researcher’s macro-level thinking on a given topic and not necessarily concepts that the participant would have used in the individual experience. In identifying the overarching themes, special attention was paid to points of

contradiction or tension within and between the interview texts, as this could signify an important issue (Kvale, 1996). In addition to the interview transcripts, relevant excerpts from my log notes and secondary data related to the interview discussion topics assisted in the identification of key theoretical concepts. Table 1.1 illustrates this process with an excerpt from one of the interviews.

Table 3: Example of Analytical Process

Participant Pseudonym	Full Text of Conversation	Meaning Summary	Emergent Themes	Researcher Notes/Reactions
Mary	<p>As a government employee working for the government, I have always had a challenge with the protocols...the policies in place. You have to work around them, but sometimes they prove very stressful for local workers, community wellness workers, mental health workers, or new staff when they do not know how to do a proper referral.</p> <p>You need to know how to talk to the next person, that is very challenging. Because sometimes it could be your tone of voice or the way you pose your questions to them or what – I am not too sure what it is; but sometimes maybe they are having a bad day but things do not run smoothly.</p>	<p>A challenge this practitioner cites in her job is navigating government policies and protocols. For example, she says that referring clients to other services can be really stressful. One of the reasons she says this is stressful is negotiating relationships with other staff who are also involved in the referral process. Things like bad moods or not everyone involved understanding the process can be problematic. The paperwork involved can also be a barrier in the referral process.</p>	<p>Navigating government policies and referral protocols can be stressful on practitioners</p> <p>Positive inter-professional relationships key to effective service provision.</p>	<p>Her words indicate she sees inefficiencies in the way other people do their jobs (“they don’t know how to do a proper referral”)</p> <p>Yet, complaints of the referral process “not running smoothly” were interesting to compare alongside her earlier story of dragging her heels purposely for someone she perceived to be abusing the referral system.</p>

This process of condensing the meaning of the interview data had a synthesizing effect that allowed me to bring together the emerging thematic categories from 15 different mental health and addiction practitioners while still remaining close to the individual context in which it was shared. I often found, when summarizing an interview

text that my mind would jump to another participant's words, my log or source from my literature review, which either supported, contrasted, or in some other way had a nuanced connection to the interview text I was reading. A conversation of sorts would take place in my head among the various sources. I would make note of these mental intersections within the "research notes/reactions" section of my interview analysis table.

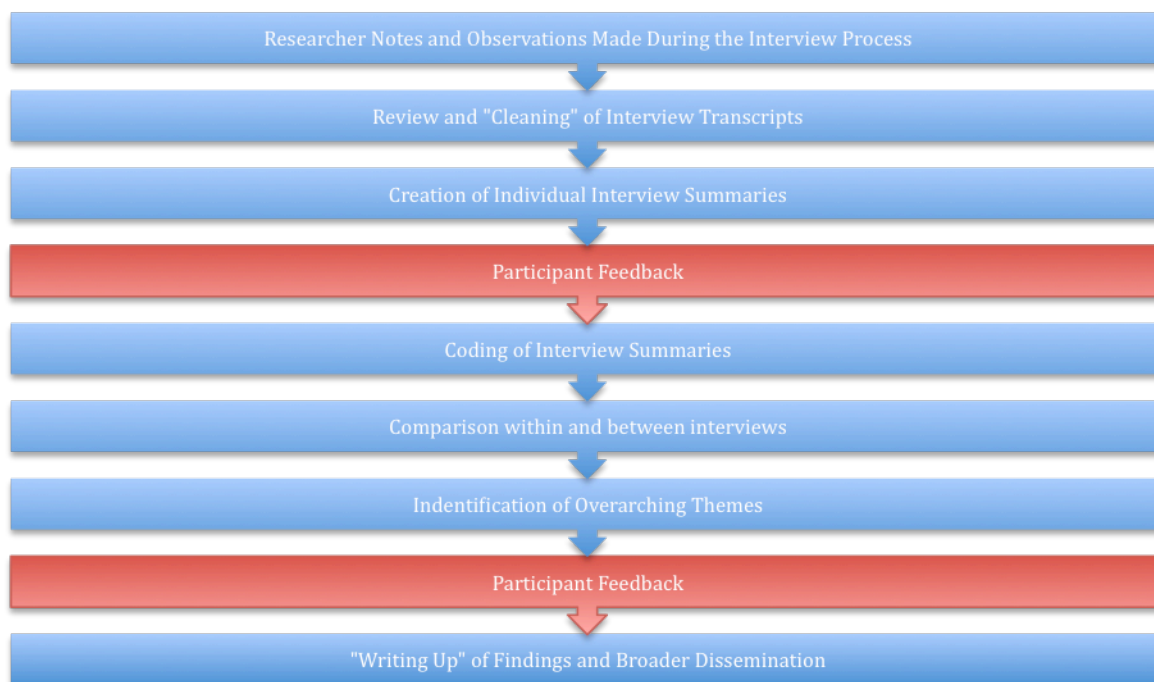
Many of the emergent themes appeared multiple times within and between interviews, while others stood out as contrasting examples, contradictions, or tensions in the interview data. Both similarities and differences in the various interview texts were considered important during this review of the data and were noted within the categories that were being identified. Saturation, described by Guest, Bunce, and Johnson (2006) as "the point at which no new information or themes are observed in the data", was reached after 10 interviews were analysed. The subsequent five interviews served to expand and reinforce the categories and themes that had already been identified. I produced individual interview summaries for these final five interviews, but rather producing a description of themes for each interview, I concentrated on noting new concepts, disconfirming evidence from the previous 10 interviews and identifying appropriate quotes.

A second and final opportunity for participant feedback came at the end-point of the analytical process when I attended in-person and teleconference Community Counseling Program staff meetings to report back to all staff on the overarching themes prior to releasing this information to the general public. Giving participants and other staff an "advance preview" of the study's findings was an opportunity to gauge their reactions to the overarching themes and ensure that no findings breached participant

confidentiality in the minds of participants. The final feedback sessions also allowed participants to advise on which findings they saw as important to communicate to territorial decision-makers or the general public during wider community reporting/dissemination of the research results. Two meetings were conducted in major centres in the NWT, and practitioners who did not reside in these communities were able to participate by telephone.

In total, 10 of the 15 participants were present at these feedback sessions alongside their colleagues. Those who participated in the study were not singled out or identified and all of the Community Counselling Program staff were invited to comment on the findings. The presentation of the preliminary findings evolved into group discussions of the trends and issues that were raised as a result of this territory-wide research. Those who did not feel comfortable expressing their views or opinions in the group setting were encouraged to email or call me to talk one-on-one about their reactions to the findings, and two practitioners who were also participants in this research opted to do this instead. I noted all the comments that were made in my research log and based on the group and individual discussions that followed these presentations, concluded that the overarching themes I was proposing were acceptable and viewed as important and reflective of the NWT mental health and addiction practitioner experience. I viewed this final series of consultations as the final “go ahead” to proceed with writing up the findings as they were presented to practitioners. The entire analytical process is depicted below in Figure 2.

Figure 2: Data Analysis Process



3.10.2 Strengths and Limitations the Research Design

There is incredible value in exploring a rather abstract phenomenon like “social and economic change” from the concrete and applied perspective of a community-based mental health and addictions practitioner. Exploring this conceptual issue through in-depth interviews with these professionals has served a dual role of making the abstract meaning of change become more concrete while at the same time effectively linked the experiences and ideas of individual workers in a manner that tells a collective story of the work that they do in northern communities. Having spoken to individuals in communities across the territory, this research is neither community nor agency specific and thus can facilitate our understanding of NWT mental health and addiction practitioners experience overall. Ideally, this sort of information could lead to changes in the policies and standards of practice governing their work so that practitioners can better serve

communities' mental health and addiction needs. Drawing on the methodologies of phenomenology, critical hermeneutics and Indigenous methodology has provided me with the critical lens with which to factor the unique social, cultural, historical, political and economic context of the NWT into my examination of mental health and addiction practitioner views and experiences on the phenomenon of social and economic change. This approach has also allowed me to stay true to my belief that my findings are as much a product of my own understandings of these issues as they are the perspectives of the participants in the study.

Another strength of this research design is that there were several safeguards in place to ensure that the story that is being told is an accurate reflection of NWT community mental health and addiction practitioner's views and experiences with respect to the impacts of social and economic change on practice. Assessment of a project's validity at the community level is based on what Kvale (1996) refers to as "critical common sense" (p. 218). In this project, research participant's thoughts and feedback were central to the interpretive process. This concern was demonstrated in the preliminary community consultation phase, during which stakeholders shaped the research focus, the multi-stage ethics approval process at the territorial and regional health authority level, as well as two consultations with participants at different points in the data analysis.

This commitment to community feedback and engagement continues. Past and upcoming presentations at research conferences related to northern and community-based research are opportunities to dialogue with others experienced in this type of research about my preliminary research findings and issues of analysis. As well, in an effort to make this research accessible to everyone who might want to know about the project and

its outcomes, a plain language community report outlining the research design and key findings will be prepared and distributed to various northern stakeholders.

To establish validity, qualitative research is typically generalized to theory (Creswell, 1998). However, since this research was exploratory in nature, there was no one established theory to generalize towards. For some, this might be considered a limitation of the research design. But for critical interpretive researchers, generalizable research findings are not viewed as necessary, or even desirable, as these methodologies contest the idea that there is only one valid and true interpretation of research findings (Kvale, 1996). Given this subjective nature of reality, Kvale (1996) suggests that validation of research findings must come from several different sources including the research participants, general public, and the theoretical community.

In this study, validating the research with a wide range of sources occurred throughout the research process. In addition to the community and participant consultations detailed above, the development early on of a conceptual framework process was an opportunity to generate meaningful interview questions based on prior research and theory on related subject matters. The subsequent pilot testing of the interview questions helped to ensure they were understandable and generated the sorts of conversations I was looking to have with practitioners. Then, a systematic analytical process of first summarizing and then coding each interview led to an in-depth understanding of each practitioner's viewpoints. This ensured that while the findings were grounded in the words of practitioners themselves, they were contextualized by other sources of data, including my research log notes and the literature.

3.11 Conclusion

This chapter has outlined the influential methodologies, data collection methods, procedures, and introduced the analytical process that led to the identification of research findings. The rationale for using a blended qualitative approach for this exploratory research has been presented and the tensions, strengths and weaknesses of this decision were discussed. The next chapter demonstrates how the analysis procedure worked in practice using examples from the data and also outlines the key research themes or findings, with supporting quotes from practitioners themselves.

Chapter 4: Research Findings

A review of the literature and preliminary field research suggested that social and economic changes occurring in the north have implications for mental health and substance use in communities. Accordingly, my subsequent research sought to document the experiences and support needs of individuals tasked with the provision of mental health and addiction services in communities. Two main questions guided this inquiry: *How do community mental health and addictions workers experience and respond to rapid socio-economic change in relation to their professional practice? What are the support needs of practitioners in light of continued change in the region?* This chapter therefore presents findings from the interviews with community-based mental health and addiction practitioners in the NWT.

In the process of investigating and analyzing the data, important themes emerged, not all of which directly related to my initial research focus. While practitioner's views on social and economic change were touched on in all of the interviews, the conversations included a more general discussion of the challenges and rewards of mental health and addictions practice in the north. To "stay close to the data" therefore, the findings presented in this chapter extend to consider broader conceptions of change, such as practitioner viewpoints on institutional changes that have been made to the way services are structured and delivered in northern communities. I also wanted to make space in this thesis for recording the types of change practitioners would like to see in the future. This chapter, therefore is an account of not only what I set out to discover about the impacts of social and economic change on community-based mental health and addiction practitioners, but also a launching point for a discussion on the kinds of change that

practitioners see as significant and their recommendations for change in the future. Heeding Richardson's (1990, p.39) advice to "let the words provide the evidence and the analysis frame the experience", practitioners' anecdotes and stories have shaped my ideas about the significance of rapid social and economic changes on the work of mental health and addiction practice.

Using the process of data analysis described in the methodology chapter, findings were grouped into three analytical categories: (1) practitioner perspectives on community change; (2) practitioner perspectives on organizational change; and (3) changes needed for the future of mental health and addiction services in the NWT. Within these three broad categories, several key findings are presented. Most of this chapter is dedicated to presenting the key findings, whenever possible drawing directly on the words of practitioners themselves to illustrate the points that are being made. Before diving into what practitioners had to say, it is important to set the context. First, a demographic overview of research participants provides general information on the group of practitioners I interviewed for this study. This is followed by an account of how the process of data analysis described in the methodology chapter worked in practice and informed the findings presented here.

4.1 Description of Participants

In 2008, in-depth qualitative interviews were completed with 15 community-based mental health and addiction counselors and community wellness workers, an allied paraprofessional position, in the Northwest Territories (NWT). These individuals live and work in 12 of the 33 communities in the NWT, and three of the eight health authority regions. All participants were interviewed in person in their community of residence.

Due to the sensitive nature of mental health and addiction issues, and the fact that research participants were being asked to speak about their work life, ensuring participant confidentiality was important. However, the small population of the Northwest Territories and even smaller number of community-based mental health and addiction practitioners made this particularly challenging. The steps being taken to safeguard participant confidentiality were explained to participants in the invitation to participate, the Interview Consent Form, and verbally prior to the interview. Through this process of informed consent, research participants were assured that no information that easily identified them would be presented in the thesis, community report, or other publications resulting from this research. As there is typically only one mental health and addiction counselor or wellness worker per community, this means keeping not only participant names confidential, but also their professional titles and the names of the communities and regions in which they work. Nevertheless, it is important to the findings to describe some of the general characteristics of participants.

Participants were divided between the two professional positions of interest: nine participants were community wellness workers and seven participants were mental health and addiction counselors. Four of the 15 in the sample have been in their current position for less than two years, while the majority of others have been in their position (or a similar position in the region) for five or more years. The fact that there were mainly long-term employees in the participant sample was considered beneficial because of the focus on “change” in the interview questions. Four of the research participants were male and twelve were female. While not equally balanced, the gender distribution of this sample is representative of helping professions as a whole, which are disproportionately

female. Half of participants were of Aboriginal (First Nation, Inuit or Métis) descent. This is representative of the NWT population as a whole, where the Aboriginal population in 2006 was 50.3 percent of residents (Statistics Canada, 2006).

Although participant locations are not identified, individuals who were interviewed for this project represented a diverse range of communities in the NWT, ranging in population from less than 200 people to several thousand. These communities were in the northern arctic regions as well as the southern sub-arctic regions of the territory. Participants were recruited only from regions where permission for conducting this study had been granted by the Aurora Research Institute, the NWT's licensing body for research taking place in the territory, and the appropriate GNWT Regional Health Authority.

4.2 Change, Practice and Support: Key Findings

The categories and themes from each of the 15 practitioner interviews are presented here under three broad topics: practitioner expressions of *external changes* related to the communities they serve, *internal changes* related to the structure and function of mental health and addiction services in the NWT, and *practitioner views on what is needed for the future related to mental health and addictions services* in light of all of these changes. Within these three overarching topics, several key findings have been identified as significant.

In brief, community-related themes include practitioner reflections on changes in substance use patterns in northern communities, changes in community attitudes towards abuse disclosure, and the impacts of economic booms on people with mental health and

substance use issues. Organizational themes include practitioner reflections on how recent changes to the way mental health and addiction services are structured and delivered to communities has impacted their work. Themes related to practitioner-identified needs for the future include the need for choice and flexibility in how services are delivered and the need for trauma-specific training and referral options. Figure 4 below visually depicts these thematic categories and the sub-themes.

Figure 4: Key Thesis Findings Grouped Thematically

Changes in Community	Organizational Change	Change for the Future
<ul style="list-style-type: none"> • substance use patterns • abuse disclosure • impacts of economic booms on mental health and substance use. 	<ul style="list-style-type: none"> • government restructuring of services • government protocols in the community context • creative approaches to service delivery 	<ul style="list-style-type: none"> • importance of choice • both insiders and outsiders have roles • addressing trauma

Theme #1: Practitioner Perspectives on Community Change

There are several ways that practitioners see their communities changing. In the interviews, this was a particularly lengthy topic of discussion among longer serving practitioners who are local to the communities they serve. Three key areas of community change highlighted by several practitioners - substance use, abuse disclosure and changing economic circumstances - are discussed here.

Substance Use Changing in Some Communities

The face of substance use in NWT communities is changing. Yet, the degree to which substance use is changing and the distribution of this change across the territory is uneven. Practitioners from larger regional centres spoke of changes they have observed about trends in street drug use, such as the suspected introduction of methamphetamines as an additive to crack cocaine and the overall increase in crack cocaine usage:

[There is]...a lot of crack cocaine. Marijuana is still there. Prescription drugs – some are taking prescription drugs. Not so much crystal meth up here but I hear now that crack is just crystal meth is part of crack now too. ^{p13}

We are seeing that there's been a big change. Originally the Northwest Territories was known for their alcohol addiction...now we are seeing crack cocaine huge ^{p12}

At the same time, many community-based mental health and addiction practitioners maintain that alcohol abuse in northern communities – a long-standing problem - remains the primary substance use issue faced in their communities. Practitioners in smaller communities spoke of the substantial increase in marijuana use over recent years, but characterized the ongoing struggles that exist for communities associated with alcohol use as much more problematic. One practitioner said “*I almost think more people do weed than drink, but when they drink that's when all the trouble happens.*” ^{p7}

When asked for their thoughts on why these changes are taking place, practitioners said they thought that improvements in transportation routes are making it easier for people to come and go from communities. One practitioner simply said, “*Once the road is open, it's open to everything.*” ^{p2} Increased employment and training opportunities outside of small communities were also reasons cited for more access to

alcohol and drugs. As expressed by this practitioner, the attitude of practitioners was that this trend was part of an inevitable “trickling up” effect of many outside influences that northerners are now exposed to: *“I think because we’re in traffic lanes, because people have more money, some of the southern stuff has started to move north.”* ^{p5}

People from smaller communities still may come in contact with harder substances even when they are not available locally. Frequently, people from smaller northern communities come to the city and get involved with harder street drugs available there. A practitioner from a larger center said *“They jump from the frying pan to the fire. A lot times they’ve come in, say, for medical reasons. And they don’t end up going back to the community...they get into another form of a drug and away they go.”* ^{p14}

Some practitioners expressed that changes in the types of substances that are used in the north is disconcerting to them because they are not always sure what they are dealing with. However, many others said that the type of substance use that is occurring in the territory is not as relevant to their work as it may seem, since the primary focus in counselling and community wellness work is the underlying emotional and psychological factors motivating the use of these substances. One practitioner summarized the reasons for substance use as *“sexual abuse, financial rejection, abandonment, guilt, grief, anger, fear, relationship issues, education issues.”* ^{p12} A similar sentiment was expressed by another practitioner, who said *“basically the using all these alcohol and drugs and these different types of pills or whatever, those are just usually symptoms of something that has happened in a person’s past or is just currently happening in their lives. It is a stress source of some sort....alcohol and drugs are just the surface.”* ^{p13}

Over and over again, practitioners emphasized the fact that the real issues they face are not the substance abuse itself, but the emotional and psychological reasons for their presence in people's lives. Ironically, though, substance abuse often plays a role in bringing people to the door of the practitioner. One practitioner explains:

Very often, my relationships with clients have started...because of some violation that has happened. Like probation has referred the client to me. And it is often an alcohol-related violence. And that's it. From the entry point, alcohol or violence act often is not the discussion. I mean they'll tell me what happened and then of course I do the assessment of whether they're going to be at risk to harm someone else because of their behaviors but most often the conversations are about their lives in general on how painful their lives have been and are. And alcohol is just one of the factors that come into play. ^{p5}

Reduced Stigma Surround Discussion of Abuse

A really positive change that several practitioners noted is a shift towards more open discussion of mental health issues, including the sensitive topics of historical abuse and trauma. As this practitioner shares, the stigma of talking about past abuse seems to be more acceptable now than ever before: *“People are starting to deal with it [abuse] more and I think that's going to be a really positive thing because it's been so secret, hush-hush.”* ^{p7}

Specifically, practitioners observe that more men are seeking counseling for historical abuse and talking openly in their community about the fact that they themselves were abused in the past. One practitioner hypothesized that the residential school

compensation payments⁴ have been helpful in terms of shedding light on the fact that abuse occurred in communities and removing the stigma attached to the issue:

One of my clients did say that because the residential school idea has been treated the way it is, we've been told that it's OK to tell it now....I think to some extent maybe the context of, the present context has maybe reduced the shame to some extent because (1) the people are realizing how many people got abused and (2) is that the government is paying money so obviously there is some sense that it was wrong. Whereas people never talked about it because it was something they did wrong or they were dirty now that they've been abused....But at least we've provided a context where people can actually acknowledge that they were abused.^{p5}

Still, while strides are being made towards removing the shame and stigma surrounding talking about past experiences of abuse, some practitioners cautioned against thinking about these issues in the past tense. Issues around disclosure remain a barrier towards helping people in some communities who are experiencing violence or abuse. Practitioners spoke of ongoing struggles in some communities to get people to use the counselor or other services that are in place to help them address abuse issues in their past or current situation. In explaining why this is, one practitioner offered this insight:

“People are afraid that when they tell their story, it's going to go back to their husband or family and they'll get beat up again, you know. So that's the problem.”^{p15}

In terms of how practitioners are responding to these needs and encouraging community members to continue to speak out and seek help in healing from abuse, almost every practitioner spoke of the importance of trust. Building a foundation of trust with clients is considered the most crucial aspect of being an effective helping professional.

⁴ The Common Experience Payment (CEP) is a compensation payment related to the Indian Residential Schools Settlement Agreement. Recipients were paid \$10,000 for the first school year (or partial school year) of residence at one or more residential schools, plus an additional \$3,000 for each subsequent school year (or partial school year) of residence at one or more residential schools (Service Canada, 2009).

One practitioner spoke of the value of relating their personal story as a way to accomplish this:

There's a lot of...abuse up here. A lot of violence, family violence that a lot of them have experienced and hang on to... But, you know, to get there, you have to establish trust. Quite often, the way I do that is I relate some of my story, you know, to them and say, 'You know, look, this is what happened to me.' You know, if they're new I'll say, 'Before we go on, I just want to let you know who I am and something of where I come from.'^{p13}

Another practitioner spoke of the importance of simply listening, without an agenda as to what should or should not be the focus of the counseling session:

Sometimes the mental health work is shelved just so that I can make the kind of connection that they're looking for. And then, of course, we move onto more professional kinds of arrangements. But, yes, some of them, it's just... A lot of them, they just need a shoulder to come and cry on. Or somebody just to vent to and nothing else and there's nothing else that they might need at that point and time.^{p6}

Still others spoke of their efforts to build trust through ensuring people were able to access counseling services in a discrete manner and by taking part in the community's social activities outside of work hours. Practitioners from smaller communities especially emphasized the value of community involvement. One practitioner offered this advice:

"You need to be out there. People need to see you, they need to get the feel of you or they won't trust you. So I mean that's really key for any helping professional in the small communities. You need to go out and be present, take part, have fun."^{p7}

Economic "Booms" Affect People Differently

An aspect of community change that has been the subject of much debate in the Northwest Territories and other northern regions discussed in the literature is the potential for resource development "booms" to cause stress on community services. However,

these concerns were not reflected in research participant views on the matter, perhaps because major resource development initiatives have not come to fruition and there has been no “boom” to speak of. Consequently, mental health and addiction service practitioners from smaller communities generally did not see resource development adversely affecting their services...yet. Many speculated that should major resource development projects like the Mackenzie Valley Pipeline go through, they would see some social impacts and a rise in demand for mental health and addiction services.

Speculation on what may still be to come was sometimes based on past experience working in other communities where resource development projects have gone through:

I think we'll be busier. Based on my past experience, I imagine we would be busier. There would be more people referred. Like I said, in the previous community where I was, where people were getting mining jobs, you know, that certainly had an impact. So, I anticipate it will here. ^{p3}

The overwhelming attitude of many in these smaller communities where development has not yet taken place is that major social and economic change in the region is inevitable and just a matter of time. Several practitioners stressed *preparedness* and expressed the sentiment that it is up to communities themselves to prepare for the social impacts of change. One small-community practitioner expressed her views on the matter in this way:

Politicians are politicians they're taking care of politics and I think as caregivers [as well as other] people within the communities, elders, youth, we have to start saying what our needs are. We have to start helping one another and we need to -- because before the development comes, we have to be prepared for it. ^{p1}

Practitioners in communities where extractive industries are currently operating indicated that while the mining activities in the region has negatively impacted substance

use for some people in their community, that this is not the case for everyone. They suggested that additional income generated from working in these industries could fuel substance abuse in people who are already engaged in these behaviors but did not suggest that it is creating new dependencies. In fact, several practitioners noted how many people in the community have benefited from the economic opportunities. As illustrated by the quote below, many practitioners felt that any influx of cash – whatever the source – would have a similar effect:

I can definitely say a lot of my clients who have, especially the younger ones that have addictions issues do work at those camps, and I do know that they come back with the money, any type of money they get, a lot of it - I mean I hate to say and judge - does go towards alcohol, drug use...habits. So I mean, it's good for some people. I'm not saying this is for everybody, but for a lot of people...just like people getting the residential money. We've seen the drinking go up, we've seen the violence go up. There is a connection there with any type of money that people get. ^{p7}

What this practitioner is referring to by “residential money” is the *Common Experience Payments*. During the period when interviews were conducted, all of the communities were in the midst of receiving this compensation. The preliminary field research of 2007 took place *prior to* the bulk of the payouts. At that time, practitioners expressed concern as to whether community counseling services would be overwhelmed when people started to receive their compensation cheques. Practitioners worried these payments would trigger painful memories and that they would not have the capacity for larger case-loads.

During the main field research period following the residential school compensation payouts, feedback from practitioners about the impact of the program on their work was quite varied. Some practitioners maintained that the program has

contributed to a rise in mental health and addiction problems in their communities. For example, one practitioner said *“If there has been a major change over the last year, it’s definitely been [residential school compensation] ...People who have had some healthy recovery and some significant time that have ended up going back because of that particular issue.”* ^{p13}

Others spoke of ripple effects on the community. An example of a practitioner drawing an indirect connection between compensation and social problems within her community is this:

It’s affected my work negatively because there were some deaths in the family, in the community, and the thing is they can’t link it but it’s part of the system....I know for sure. This youth, another went to residential school, the mother got it, gave money to her child, the child buys booze. She says what happened, one is in jail, one is in the hospital, and they don’t see that as impact from residential school. Because he didn’t go to residential school, but his mother did. But I know the mother gave him money ^{p2}

Many other practitioners had a less definitive interpretation of the compensation’s impact on community mental health and addictions. The following practitioner’s viewpoint was echoed by others: *“Certainly since residential school money has come in, we’ve been getting some stories of people who have been drinking more than usual, and there have been repercussions from that. I think many many people have used it more wisely, but of course there are people who haven’t.”* ^{p3} Indeed, several practitioners mentioned the positive ways they have seen people use their compensation funds. Practitioners also applauded additional counseling services and healing workshops the Aboriginal Healing Foundation provided to communities. These additional services focused specifically on the residential school experience, which eased the burden on community-based counseling services.

In summary, practitioners expressed that whether money came in the form of a government compensation handout, an industry-fueled boom, or another source, large sums of money do not make things better for those who have problems with substance abuse. While the majority of people in a community take advantage of these financial opportunities, more money for those already struggling with substance abuse problems can just lead to more problems. Practitioners appreciate additional counseling supports and programs during these “boom” periods to mitigate the impact they have on vulnerable members of the community.

Theme #2: Practitioner Perspectives on Organizational Change

The initial purpose of this research was to explore how mental health and addiction practitioners’ experience and respond to social and economic change in relation to their professional practice. However, a surprising number of practitioners took up the discussion on change to focus on the internal organizational changes that have taken place in recent years, which have altered the way that mental health and addiction services are structured and delivered in NWT communities. This section shares practitioner’s perspectives on organizational change in terms of five themes: government restructuring, practitioner perspectives on organizational change, professional requirements, government protocol, and creative approaches to service delivery.

Government Restructuring

As described at length in chapter two of this thesis, a number of changes took place between 2003/2004 about the way that mental health and addiction services in the Northwest Territories are administered and funded. A main shift that occurred during this

period was that the GNWT assumed the role as service provider for almost all of the mental health and addiction-related services in NWT communities and phased out funding it was previously providing to NGOs and Community Councils to fulfill this role. Most of the practitioners interviewed for this thesis worked in communities under both systems. For the majority of participants, our interview was the first opportunity they have had to discuss the effects of this organizational change on their work.

On a positive note, practitioners working within the government-run system who were previously employed by a community organization expressed appreciation for the structure that government regulation provides regarding personal safety and defining personal and professional boundaries. Government policies and protocols make it easier to avoid potentially unsafe situations, such as intervening during a conflict in someone's home or receiving work-related requests while off-duty. These sorts of activities were common requests for some workers when they worked directly for their community but are strictly prohibited now that they are government employees. Local practitioners who transferred over from community-based positions also expressed appreciation for the training that accompanied the move as well as for the wage increase and personal health benefits.

At the same time, in some practitioner's minds there have been drawbacks related to the move away from a community-run approach to mental health and addiction services to one designed and implemented by government. As illustrated by the quote below, for some practitioners the current model of service delivery does not meet community expectations:

So to some degree because it is a 'Southern Based' idea; what counseling is and it has been imposed. So service being provided, you know, whether, and it's being accessed to some degree. We've done some education around what we provide but I still think that community norms we don't fit into what the community expectation is.^{p3}

Specific examples of ways that the current government model of service delivery fails to meet community expectations includes the barriers that many practitioners said they face in terms of flexing their work schedule to accommodate counseling sessions with people who work during the days or to participate in a professional capacity in community gatherings that take place in the evening. One practitioner explains:

We can only flex our hours until 6. So, 9 to 6. After 6 it would be overtime. Well, you know, the government doesn't like doing overtime....So, okay so fair enough. But, a lot of the people that want to come see you, well they're working during the day, or you get invited to a lot of things to present and it's in the evening. A lot of things here happen on the evening and weekends. So, that can be difficult, challenging whereas you know, it's just not conducive to the 9 to 6....Without the government, it would be more like, okay having the flexibility to say, okay, you know what? Today maybe I'm going to work 12 to 8:30 because there is an event going on, it's important that I be there, I'm invited to be there and it is within my professional capacity. Just having that leeway rather than just the set, you can't work past 6. And if you work past 5 you have to get your boss' approval even for like, staying until 5:30. So just having that flexibility alone would be huge.^{p7}

One community event for which practitioner non-attendance is particularly problematic is community funerals. In most small northern communities, not to participate in a community funeral is disrespectful and thus completely inappropriate. This is particularly so for a helping professional tasked with the responsibility of promoting community mental health. Yet, as this practitioner explains, government employees are expected to use personal leave time if they want to attend a funeral. Some practitioners, like the one quoted below, disregard this rule and attend anyway. As her story indicates, these gestures are noted and appreciated by the community:

I was shocked when it was found out that I would have to take time off to go (to the funeral)...I thought it would be disrespectful for me not to go and second of all, the whole community closed down. Stores closed...I mean nothing was open, and I'm like 'this is dumb', so. You know, [my manager] felt bad because she understood, I'm like 'whatever I'm going anyhow, and I'm not booking off time for it', you know? I told [my manager] afterwards I went; she just left it at that. But at the same time, talking about rewarding is that during the eulogy when [a community member] got up...(he) actually paid respect to me and [the social worker] in front of the whole community... giving thanks to all the support that we provided. But things like that I think are part of the job, because you're going, you're paying your respects, you know. ^{p7}

Professional Requirements Presents Staffing Issues

The level of education required for the counseling position, in particular, prohibits most local people from being able even to apply for the job and given the isolated nature of many northern communities, it is a constant struggle to keep these positions filled. As this practitioner explains, *"Staffing issues can be a challenge. So you know, we're constantly working against the stream, upstream because two people are kind of handling the workload which is supposed to be for four. So staffing issue is definitely one of the challenges which then become hard in terms of support."* ^{p14}

Vacancies in the counseling positions can sometimes mean Wellness Workers are the sole mental health/addiction-related professional in some communities. This can lead to them providing therapeutic counseling services, essentially filling the role of a mental health and addiction counsellor as well. Some Community Wellness Workers, like this individual, indicate that they feel positively about the opportunity to act in a counseling role: *"I really like being a wellness worker. But I also get to do meaningful counseling because there's not a counselor here. And I feel confident doing that. So, I get to do both."* ^{p2} Meanwhile, other community wellness workers do not want this responsibility: *"Since ...I changed positions from [a community-based counseling position] to*

community wellness worker, it was a relief. But since then, I'm still doing the role of a counselor. I tell them I can't because my position is different now."^{p4} These quotes illustrate a couple of practitioner realities. First, despite the CCP's best efforts to professionalize and standardize mental health and addiction services in communities, some degree of 'making do with what exists' still occurs. Second, there are some who are comfortable with that and others who are not. This finding illustrates the pressure that practitioners are under to meet the support needs of their community, irrespective of their position, title, or qualifications.

Government Protocols in the Community Context

The formality of a government-run system also impacts how quickly practitioners are able to respond to client needs. In comparing her past experience working as a counselor in the non-profit sector to her current situation working in government, one practitioner said "*There was a little bit of more elbow room in working with a non-profit organization in a sense that you respond to crisis more quickly. Or you respond to any kind of situation more quickly. There are less steps to go through, getting approval.*"^{p6}

For practitioners who used to work under the old community-run system, the slower process and structured protocol associated with being a government-run service can be especially trying. Whether it is waiting for the go-ahead from a manager located in regional head office in another community or obtaining permission slips from friends and family to participate in a workshop, the norms of government practice are not always in line with community norms. One practitioner summed it up by saying, "*People here are*

very informal whereas with the government, they're quite formal. So there's a clash....the government isn't conducive for working in a small community.”^{p7}

Yet, contradictions exist. In the same breath as expressing these frustrations, practitioners expressed that they understand the need for policies and regulations and see merit in formal processes as a way to maintain a professional operation at the community level that will inspire the trust and confidence of community members. This is especially true when it comes to referral processes between helping professionals in the community. Some practitioners said that they have had problems with other helping professionals (nurses, RCMP, for example) just sending someone over to talk, without following the proper referral channels. This is viewed to be problematic, as it does not respect the confidential nature of the counseling relationship. In this way, practitioner concerns around gaining community trust surfaced again as a key concern, central to their ideas on effective community practice.

Creative Approaches to Service Delivery

In their effort to build relationships in communities, the tensions between informal community approaches to service delivery and more formal government protocols require a creative response from practitioners. This creativity is clearly illustrated when the discussion turns to how practitioners operate in practice. For example, in explaining how he circumvents the problem of not having private office space, one practitioner spoke of how he wanders the streets and grocery store aisles of the community, striking up conversations in a more informal manner with people. They find that this can often lead into meaningful counseling opportunities.

A regular part of my day [is being out and about in the community] and people must think 'oh God does he ever work?' or sometimes the health staff - not the ones here right now - but they are like 'where are you going?' (and I say) 'oh I'm just going to the store...I'm just going for a walk'. But quite often, that's where I get approached. I've done so much counseling walking down the street with somebody who just comes up to me or in the store they'll make an appointment with me, because they're so not used to having to call up and make an appointment, or physically come in. It's when you're walking downtown during your own business, during the day, that's when you get approached so much...especially by the youth. ^{p7}

Similarly, this practitioner spoke of the informal ways in which he connects with people in his community:

So, there are people I know where I know how and where I can meet them. I mean a lot of them are these kind of casual counseling relationships. That's what I would call them. Although I would never call them that to them, if you know what I mean. But like, for example, when I was setting up the tables for the feast, I knew the guy I would be setting them up there with. And I knew that that would be his opportunity to talk to me if he wanted to, you know what I mean? So yeah, I'm setting up for the feast and that's all good, but I'm also there as a counselor and I'm kind of ready for that. And it happened like I thought it would. And so we stopped and stood and talked for about 20 minutes. He talked mostly. And that was meaningful in some way. So there's a freedom there, like, you know, if I was working in an office in [a larger community] that might not be there. ^{p4}

Additionally, when it comes to accommodating people whose schedules don't allow them to meet for counseling between the regular 9-5 government hours, practitioners implied they are "getting creative" with their office hours: *"I had a client who worked and they, you know, obviously you're going to work it out. If you can only come at 5:30 then come at 5:30. I'll be here. So I flex as I have to...I shouldn't be saying that."* ^{p4}

Bending the rules is not something all practitioners are willing to do even when they know it would enhance their relationship with the community. One practitioner related a story about being told by her government employer that she was not allowed to

drop in uninvited to people's homes. She indicates she felt awkward abiding by this rule when she knew she was going against community expectations.

We're not allowed to do 'Home Visits' unless we're invited. So an expectation from the community for me when I first went to [my community of practice] I had all kinds of people coming in and saying 'when are you going to come and visit?' And I was told very definitely that I was not allowed to go to anyone's house unless I was specifically invited. And that's not a community norm. ^{p3}

Mental health and addiction practitioners not only have people's problems to contend with, but also their fear and shame in seeking help. In northern communities, like other small places, people gossip. Simply entering a building that contains services related to health or social issues carries stigma and is enough of a deterrent to keep some people from utilizing counseling services. Coming up with creative ways to connect with community members in need outside of an office setting may well be the most effective way to carry out the delivery of services in remote communities. The next section discusses changes that could be made to the way that mental health and addiction services are currently provided that would help practitioners adapt to the community and organizational changes and improve service delivery overall.

Theme #3: Change for the Future: How Services Could Be Strengthened and Improved

What would Mental Health and Addiction Practitioners like to see done differently with respect to mental health and addictions practice in the NWT? This section relates to the issue of support needs of practitioners in light of continued change in the region. Practitioner's responses reflect the passion they have for the work that they do and their desire to see NWT mental health and addiction services grow and change to be more responsive to the needs of all northerners. Specific areas where practitioners see room for

improvement are: ensuring there are a range of options in terms of mental health and addiction programs and services, increasing the capacity for local people to take on counseling positions and for communities in general to be more involved in the direction of mental health and addiction services overall, and making trauma-specific treatment programs available.

One Size Does Not Fit All: Choice in Service Provision

Choice is a theme that came up time and time again in practitioner interviews in relation to their visions for the future of mental health and addiction services in the NWT. Practitioners recognize that funding for mental health and addiction programs and services is finite. In determining what programs and services to fund and how effective existing programs are, they would like to see more community consultation and input from practitioners working at the community level. As this practitioner expresses, statistics alone do not capture whether or not a program or service is being well received or achieving its intended purpose:

You've got these, what they call 'statistics.' More number you get the better it is. Right – statistics. Okay, we'll give you so much money for this and that. People up in government or whatever, they're not listening to what people are saying. They are not listening to us out there, frontline workers are saying. They're not. Bottom line. You know, the, well people fall through the cracks. To the higher ups, they're just numbers. Statistics. And like we were talking about, it's more that western way of thinking, that serious scientific, that knowledge based way of presenting these programs or something and they'll continue providing a certain program even though it's not working. But the numbers say, 'oh so and so are attending. Look at that!'^{p13}

Also demonstrated in the quote above is practitioner concern over privileging a system that relies on western or scientific ways of knowing and does not reflect the values and traditional healing ways of the people of the north. People seeking mental health and

addictions services come with different backgrounds and needs, and practitioners would like to see a variety of approaches to mental health promotion and addiction treatment offered in the NWT to give clients some options as to how they approach mental health and wellness and healing from substance abuse. The implication in the above statement is that if frontline practitioners had more input into program planning, they could present ideas on how to tailor services to be more reflective of traditional northern approaches to healing and thus more meaningful and effective for some clients whose needs are not currently being met.

Recognizing that the provision of even one type of mental health or addiction service in each of the 32 communities across a vast region like the NWT is a daunting task, practitioners also cautioned that healing from abuse or addressing a substance problem is not something where a one-size-fits-all approach can be used. Even the best counselor may not be the appropriate fit for each individual in a community who needs to talk. While some people need the support of their family and community around them while they make changes in their lives, others need distance and separation from these influences in order for healing to take place. It is certainly not the case that all Aboriginal people want to head into the bush to do their healing, but some do. One practitioner summed up the range of needs that people have for mental health and addiction services in this way:

We are very different First Nation people... some of us are very traditional, some of us are contemporary meaning we're part traditional, we're part into the western society, some of us have gone into western society and we want to be little white man. So those are the people that are going to want to go to the [southern treatment facility] and all those other places run by white people. And I respect that. That's their way of healing. Whatever works for each one of us is different and I support that. We all have to remember that. Not everybody is going to like to go on the land... cause they're not

used to the land, they're not hunters or trappers. They were in the community working government jobs, driving their vehicles, going in taxis, and you put them out on the land? We're all very different. So there is going to be a need for some of the clients to still go to treatment programs^{p1}

Many practitioners believe strongly in locally based healing programs and drawing on community resources. This practitioner spoke of the value of involving the entire family in the entire healing process when she said "*Why take a client away from their home? You're not meeting the need of the client. Sure they wanted to run away from home and take care of their problems but they have to deal with their family. Do the whole family.*"^{p2} Meanwhile, other practitioners said they think some people can only heal outside of the community, where they can get perspective on their issues.

Both "Insiders" and "Outsiders" Have a Role to Play

For these practitioners, a supportive system is one in which the onus for healing does not lie on a handful of helping professionals alone; communities and local governments are also fully engaged. In some parts of the NWT, this is already happening and practitioners are excited about it. Practitioners from all backgrounds expressed the importance of having more counselors who come from northern communities themselves as opposed to importing healers from the south. As one practitioner stated, "*Aboriginal counselors need to come back and take charge of the healing.*"^{p15} The main reason practitioners said that it is important to have more Aboriginal counselors is the need they see to bring more cultural understanding to the work. As this non-Aboriginal practitioner expresses, the opportunity to be counseled by someone from one's own cultural background is an experience that, in and of itself, can be healing to people:

What would that be like if a person went to see a counselor and it was from their own culture? I mean just to, just to have that experience would be so... kind of like, I don't know there's something very healing just in that. You know, when you walk in and you say, 'OK. This woman is just like me. She knows my history. She knows everything.' I know how many times I've had people come to me who are from my background, cultural background, and they'll say, 'That's what I've always wanted' because then they don't have to explain anything.^{p5}

Other reasons practitioners said having more local people in these helping roles included: opening up employment opportunities for people within their own communities and promoting continuity of care by investing in people who are not going to leave the community after only a short while. Still, in the minds of other practitioners, there still appears to a role for the outsider professional. One non-Aboriginal practitioner said, *"People have told me, I like to come and see you because I'm white. I'm not from here, I don't know their history, so they feel safe."*^{p7}

This was echoed by Aboriginal practitioners as well who said that some community members have a hard time with the dual roles that they play in communities. They are seen as aunty, sister, friend, and neighbor, making it difficult for people to also view them as mental health professionals who keep confidential information to themselves. The process of gaining community confidence in each other to fill the counseling role is one that may take more time to overcome:

Some people in the community think its not working; we can do our own thing, we can help our own people, we just have to start empowering. That's good. That's good they can see that. But people have to start trusting each other. It's going to take a long time to get to there. However, there is still a need for confidentiality and I know that within the community we can't address it because there's still that trust issue.^{p1}

In addition to the struggles Aboriginal practitioners described around bridging the dual roles they play and inspiring people's confidence in their professionalism around

confidential issues, one practitioner's comments suggested that colonial systems of power, which have privileged white people as the "experts", has impacted how Aboriginal communities view their own helping professionals. She explained, "*If I said the same thing to them as you, they will not believe me but they will believe you...that's the way they were taught, who taught me? Someone from the European, I mean, there's a lot of that.*"^{p2}

Addressing Trauma

Practitioners emphasized the impact of trauma on communities. The term "trauma" was sometimes used explicitly and sometimes implied through other descriptors to explain the psychological impacts of overwhelming life experiences on clients. Specific issues raised by practitioners with respect to trauma included the effects of residential school violence in many communities that is deep and still fresh. One Aboriginal practitioner I interviewed emphasized that while much abuse occurred in the residential school system, it has occurred as well in other outside agencies such as the church, law enforcement agencies, and medical stations. The legacy of violence continues today within some families and communities. One practitioner shared "*One community I worked in, almost 100% of the women had been sexually abused*"^{p3}. Other times, the word "trauma" was not used, but the overall description references a pain that can be interpreted in those terms.

I was struck by the sheer intensity of the suffering that exists in the community. The inter-generational transfer of that shocked me as well. I was shocked by the, almost hopelessness that prevails. People come to you for help and they want help but they don't necessarily think that there is anything that could help them. They know something isn't working but they don't see their future as being anything other than it is. You know. And

I was shocked by that. ^{p3}

Practitioners expressed the need for ongoing training opportunities to equip them to meet the clinical issues effectively that confront them in their work. There is a real need for counseling and treatment specifically addressing physical and sexual abuse and other forms of trauma. Repeatedly, practitioners spoke of the need for a trauma-specific healing program. In one practitioner's words:

We need a trauma program. Trauma program is different from addictions, you know, because that's mental. Many times trauma is a contributing factor. But still I always say, 'You cut your finger, you put a Band-Aid and it heals.' What's broken is here is your spirit. ^{p15}

The current structure of mental health and addiction services aims to combine mental health promotion and personal counseling, and substance abuse treatment all together. Yet, according to practitioners, treatment services are focused first and foremost on substance abuse. With the exception of a couple of community-based professionals with training specific to trauma, there is little to offer those who need intensive counseling to address trauma they have experienced or violence they are currently experiencing. One worker spoke of the challenges she faced in getting a client the help she needed to process traumatic events in her past. She did not feel she had the skills herself to work with her on her issues and the only treatment options available to her were addiction-related. Even though this client had not engaged in any substance use in years, she needed to indicate on referral forms that she abused alcohol in order to get her the counseling she needed. This anecdote speaks to a crucial gap in service right now: current mental health and addiction policies and practices do not appear to adequately prepare

community-level workers to address trauma. More support is desperately needed in this area.

4.3 Conclusion

This chapter has presented some of the many important issues that community mental health and addiction practitioners in the Northwest Territories addressed in our conversations about change, communities, and practice. The subsequent discussion chapter will weave these findings together with my field notes and the academic literature to consider the implications for community-based mental health and addiction policy, research and practice in the NWT.

Chapter 5: Discussion of Findings and Concluding Observations

The thesis set out to explore how community mental health and addictions practitioners experience and respond to rapid socio-economic change in their professional practice. Research has concentrated on the views and experiences of counselors and community wellness workers. As the front-line service providers within the Community Counselling Program (CCP), these practitioners were considered to have special access and insight into community life and trends in health and wellness.

Preliminary field research and literature reviewed in chapter two suggested that social and economic changes taking place in northern communities could have notable implications for community health practice. This exploratory study confirmed that this is indeed true for NWT mental health and addictions practitioners. However, practitioner perceptions of change seemed less pronounced than the effects of rapid change on mental health and addictions described in the literature. Instead, practitioners emphasized the significant effects of internal organizational change on practice. This finding was not explored in the literature and presents another angle from which to consider the effects of rapid change on health in the north.

In this chapter, I discuss three key “lessons” I believe we can extract from the research findings. These lessons focus on how social and economic changes affect NWT mental health and addictions practitioners and how to best move forward in light of these changes. Where possible, these lessons are directly compared and contrasted with the literature on change and practice reviewed earlier in chapter two.

5.1 Lesson #1: Social and Economic Change Affects Mental Health and Addictions in Northern Communities

An important lesson drawn from the research is that social and economic change is not always negative and that community experiences of change do not necessarily affect people in the same way. Practitioners' observations of community changes with respect to substance use patterns, social norms around abuse disclosure and the effects of economic booms were a combination of both positive or negative insights on changes taking place in community that affects their practice. Practitioners indicated that the issues are much more nuanced and may occur at the individual rather than community level. These are the most tangible expressions of rapid social and economic change on community mental health and addictions. Based on these findings alone, it may seem as though the effects of rapid change are too minor or inconsistent to be considered to significantly impact the work of mental health and addiction practitioners.

There are, however, many ways to interpret and understand change and change-related stress. While my literature review focused on the concept of *acculturative stress* (Berry, 1992), the practitioners I interviewed did not talk about change in those terms. They did, however, speak at length about the effects of *trauma* on their clients. When probed on what was meant by trauma, some practitioners identified specific stressors, such as experiences of domestic violence or sexual abuse. Others were less specific about the root causes of the trauma they observed, suggesting what they have witnessed was a pervasive sense of pain or brokenness. Almost everyone interviewed emphasized that unresolved pain or trauma is a root cause of problematic substance use or addictions. Does some of this pain stem from a sense of social or cultural loss related to the many

social and cultural changes that have occurred in the last half-century? Might we also attribute the trauma experienced by residential school survivors as an impact of socio-economic change? The practitioners I interviewed did not explicitly make the connection between rapid social and economic change and their observations of trauma. But other researchers (Kirmayer, Brass & Tait, 2000) have made this theoretical link, suggesting that trauma in the Canadian Indigenous context stems from the rapid culture change, cultural oppression, and social marginalization. Practitioners' observations of trauma can be more clearly understood when related to the phenomenon of rapid change and its impact on mental health and addictions practice in this way.

5.2 Lesson #2: Internal Organizational Changes are an Expression of Socio-Economic Change and Affect Practitioner Interactions with Community

Overshadowing the discussion of socio-economic change, at times, was the emphasis many practitioners placed on *internal organizational change*. This discussion was related to the structure and function of mental health and addiction services and the effect these organizational changes have had on their practice. The focus on internal organizational issues demonstrates the significant impact that policy has on practice. It also suggests practitioners' experience on the job is more a product of the workplace environment than the community environment. As described in chapter two, Knudsen, Ducharme and Roman's (2006) findings that internal politics, including working relationships, workload, and changes to the way that the services are delivered are among the leading causes of burnout for many workers. My research suggests that northern practitioners are in a similar position: while outside forces of change may greatly impact their clients, it is practitioners' interactions with internal organizational change that really

shapes their experiences as helping professionals. This is perhaps because internal organizational changes, such as restructuring of programs and services, are so much closer to them and their “real lives” than some of the larger system changes brought about by shifts in the social and economic landscape. Practitioners are directly affected by these sorts of changes, so they are the ones that first come to mind as influencing practice when asked about change.

Practitioner discussions of organizational change reveal how standardizing mental health and addiction services changes the role of the practitioner vis-à-vis the community. Prior to the implementation of the GNWT Community Counseling Program, practitioners working for NGOs and Community Council responded to community needs to the best of their ability, though not all communities had access to adequate resources. In recent years, the GNWT has achieved their goal of creating a standardized mental health and addiction program across the territory and in the process have ensured that a basic level of service is available in all communities. By standardizing this front-line occupation the GNWT has placed boundaries on this role, which practitioners conceived in both positive and negative ways. Internal organizational change, it seems, is having just as much of a mixed effect on practitioners as external community changes are having on northern residents.

Before delving too deeply into the effects of this internal change on practitioners, it is interesting to consider why the GNWT would centralize community-based mental health and addiction services at a time when most other governments are moving away from being directly involved in front-line health and social service provision. According to Chalmers, Cayen and Snowshoe’s (2002) report, this move was motivated by a perceived need for a standardized counseling program with formally educated counselors

and paraprofessionals in each community. These goals are themselves a reflection of a changing northern landscape – one in which meeting southern standards for health and social service provision is increasingly important. The experiences and responses of community mental health and addictions practitioners are shaped not only by the individual policies and procedures of their workplace but by a shift in what is considered appropriate and essential community mental health and addiction services. This, I would argue, is a philosophy influenced by outside or “southern” ways of knowing. In this way, a reliance on the opinions of external consultants to guide the direction of mental health and addiction services rather than local practitioners or community leaders as well as the goal of a professional, standardized counseling program itself is an expression of changing times in the north. Reflecting back on Montgomery’s (2003) commentary on the tendency to see the north’s differences as deficiencies, the CCP demonstrates how the GNWT currently values a southern approach to healing.

5.3 Lesson #3: There are Ways to Move Forward Together

The CCP may be an outsider’s invention, but there are ways for NWT communities to make it their own. Practitioners spoke of the need for more local involvement in community-based service delivery; several mentioning how they would like to see more local people trained as counselors. They also see room for greater community direction in terms of how services are structured and delivered, such as the inclusion of more on-the-land type of activities. Together, these findings create a picture of a system that is looking for more community engagement. Kirmayer, Brass, and Tait (2000) reached similar conclusions in their discussion of recent research on the mental health of the First Nations, Inuit, and Métis in Canada. Kirmayer et al. (2000) argue that

mental health services need to be integrated into the community development process, with local control of the health care system needed, to make services reflective of local needs and priorities and “to promote the sense of individual and collective efficacy and pride that contribute to positive mental health” (p. 614).

Comments made by practitioners indicate that in addition to helping professionals who are local to the community they serve, those that are from elsewhere have important roles to play. A diversity of practitioners is valuable in terms of providing residents with options as to who they can interact with. It is also necessary given the current paucity of skilled helping professionals from the smaller communities. This mixed workforce needs to be supported to (1) increase the cultural competency of those who are not indigenous to the communities they serve, and (2) continue their professional development so that eventually, those working in a paraprofessional community wellness worker role might be equipped to take on more counselling responsibilities. The goal of greater Aboriginal leadership in these areas of healing was a goal expressed several times by participants in this research and as discussed in Kinch, Katt, Boone & Minore (1993), the only long-term solution to the constant issue of staff-turnover.

To be relevant and effective, the CCP also needs to take into consideration local culture and context. This sentiment was expressed repeatedly by practitioners interviewed for this thesis and the underlying assumption behind research such as Hamrosi, Taylor and Aslani’s (2006) study, which relied on the knowledge of local paraprofessionals. Improvements will be seen in a practitioners’ familiarity with emerging issues in their communities and their ability to outreach to a variety of residents if they are encouraged to have a flexible work environment. This includes being able to meet people on their

own terms, at a variety of different locations, at a variety of times throughout the day. This also could mean providing more cultural competency training for those individuals working in northern communities who are not Indigenous to the region so that they can better understand the social and historical context of they are working in.

The importance of understanding culture and context is apparent when one considers the practitioners' role as a dual citizen, occupying the space between the GNWT and the community they serve. An unwritten requirement of this role is the ability to interpret the meaning of certain words and actions; being too much of one world may permit the intended meaning to be "lost in translation." I experienced this myself with the term 'trauma.' Initially, I assumed that when practitioners spoke of trauma they meant specific events such as sexual or physical abuse. Repeated use of this term in varying contexts led me to realize that some practitioners were also using this word to refer to a more general experience of loss, possibly related to colonization. Another example highlighting the importance of local context in language was one practitioner who told me in her community, a "shot" referred to a full glass of alcohol. For months after arriving in the community she hadn't known this and it had resulted in misunderstanding and confusion in counselling people with substance use issues. These are two examples from my own research of how a lack of cultural citizenship may compromise the ability to effectively interpret meaning, a challenge that many practitioners must face on an ongoing basis.

Practitioners must navigate two worlds. They must be bureaucrats, meeting set standards and regulations. Yet to be effective, they must also gain the trust of clients by engaging in the community life. Performing the role of bureaucrat too well may prove a

handicap in meeting community needs. Among the practitioners I interviewed, there was a noticeable difference in the experiences of those who work for the one non-profit organization working at arms length from government policies and those who worked directly for a health authority. The non-profit practitioners expressed less anxiety about organizational protocol and internal organizational change than their government colleagues. The non-profit practitioners, as well as those government employees who openly stated they disregard GNWT policies when they think it is necessary to connect with community members, exhibited a higher level of awareness of community needs, talking with comfort and familiarity about the external social and economic changes affecting community life than other practitioners who were interviewed.

Practitioners also emphasized the critical importance of earning the community's trust and respect. They saw this as the foundation of effective counseling in the north. This view is consistent with research conducted on health care provision in other northern Canadian Aboriginal communities (Kirmayer, Simpson & Cargo, 2003; Minore & Boone, 2002). It follows then that practitioners take every opportunity to establish themselves, giving people a chance to get to know them. In the northern Aboriginal community context, this means being visible at community events and in some cases, making unsolicited house calls. Given the importance of trust and cultural competency in the effective delivery of health and social services to northern communities, should we not be doing everything we can to get our mental health and addiction professionals integrated into community life? Mental health and addiction services can be professionally and accountably delivered, but also responsive and sensitive to the unique traditions and context of life in small communities in the north.

The practitioners I interviewed said the CCP is falling short of community norms and expectations because of inflexible government policies and procedures. Yet, it is clear that certain aspects of the CCP are appealing to practitioners. In particular, policies on client confidentiality, clear expectations outlined in job descriptions, set number of work hours per week, funding for professional development, and clear safety standards were highlighted as important and valued by staff. Additionally, the fact that services are now available in all NWT communities is an improvement on the inconsistent service provision of the past. In general, it seems as though government-run mental health and addiction services are an improvement over previous community-run systems in terms of their own practitioner supports, but that these supports have come at the cost of practitioner flexibility, creativity and responsiveness to community needs. One is left to wonder, is there a way to “have your cake and eat it too”? That is, have government run the service with appropriate policies and processes in place, but relax those regulations that are impinging on practitioner effectiveness, such as rules against home visiting, attending community events as part of work, and flexing work hours? A more flexible government-run arrangement could provide the best of both worlds for practitioners.

If the GNWT is interested in promoting a CCP that is in touch with community needs, cultural norms and local context, they could make room for more personal discretion in terms of how practitioners connect with clients. As discussed by Wharf and McKenzie (2004), the tendency these days within policy-making in the human services is to limit the discretion of practitioners. Clearly though, some practitioners are taking advantage of what Wharf and McKenzie refer to as the “autonomy afforded by distance” (p.94) and there is an uneven application of policies and procedures as a result. Allowing

practitioners more flexibility in their work hours, changing the policy on funerals to allow counselors and wellness workers attend a community funeral on work time, and encouraging interaction with people outside of the formal office setting are three changes that would go a long ways towards bridging the practitioner-community barriers that currently exist for some workers.

Providing opportunities for feedback on policies and procedures is also crucial. For the majority of the practitioners I interviewed, our meeting was the first opportunity for feedback on the CCP that they have ever had. The GNWT Community Counselling Program is now entering its fifth year of operation and fittingly, the Department of Health and Social Services is in the midst of planning a review of mental health and addictions services (S. Chorostkowski, personal communication, August 31, 2009). A more inclusive approach than past reviews of the system (i.e., Chalmers, Cayen & Snowshoe, 2002) needs to take place so that the valuable perspectives of the community-based counselling and community wellness worker practitioners – including those who are working on a contractual basis with non-profit organizations – are heard in this process.

If consulted, counselors and wellness workers will tell the review panel about the fulfilling nature of the work and the encouraging changes that are being made in terms of people accessing counseling who have never done so before. The review panel would also learn about ways the CPP could be improved. This research has confirmed that community-based counselors and community wellness workers have a great deal of insight and perspective on community needs and priorities. Simple changes to operational policy could improve their integration into community life and, by extension, their effectiveness on the job. Informed by first-hand experience, the knowledge of these

practitioners should be more heavily considered when planning the direction of mental health and addictions programs for the future.

There is also a need for further academic inquiry on the broader issues of rapid change and its impact on mental health and addictions practice. In particular, it appears there is a need for more research on the possible relationship between rapid change and trauma as well as the relationship between trauma, mental health, and addiction issues in the territory. Another interesting research possibility, stemming from the emphasis on trauma in this study, would be to look at how policies and programs oriented towards addressing addictions issues could be changed to focus more heavily on wellness and healing from trauma. It would be interesting to explore how this type of shift in focus could reorient mental health and addiction services in the NWT to more effectively get at the root of the issues practitioners are observing in communities.

Future research could focus on community visions for how traditional northern healing practices might be incorporated or developed alongside the CCP. In the long term, however, I would suggest it is also worth asking whether the territorial government is the appropriate agency to provide direct counseling and addictions services. Counseling is a sacred space, as is “wellness work” when it involves helping people to address and prevent mental health and substance abuse issues. For those on the receiving end of government services, what is to distinguish the social worker, capable of child apprehension, from the wellness worker, who claims to offer confidential services? Government-run services may never be safe place for those residents who perceive the government as recently and completely violating their trust. For some, even working for the government appears to imply complicity in the trauma that colonialism has brought to

the north. In these cases and to varying degrees of success, wellness workers must negotiate a relationship between the trauma instigator and the traumatized. It should be a goal of the GNWT to engage communities in the process of visioning a future where local leadership provides the direction for mental health and addiction services and programming and work towards the goal of more northerners in the practitioner positions so that the people themselves set the course for mental health and addiction services.

References

- Arctic Climate Impact Assessment (2004). *Executive Summary*. New York: Cambridge University Press.
- Arctic Human Development Report (2004). *Arctic Human Development Report*. Akureyri: Steffanson Arctic Institute.
- Allen, D. G. (1995). Hermeneutics: philosophical traditions and nursing practice research. *Nursing Science Quarterly*, 8(4), 174-182.
- Alexander, B. K. (2000). The globalization of addiction. *Addiction Research*, 8(6), 501-526.
- Antonesa, M., Fallon, H., Ryan, A.B., Ryan, A. & Walsh, T. (2006). Methodology: Analysing qualitative data and writing up your findings. In *Researching and writing your thesis: A guide for postgraduate students* (pp. 92-109). Maynooth: MACE.
- Aurora Research Institute (2005). *Doing Research in the Northwest Territories: A Guide for Researchers*. Inuvik: Aurora Research Institute.
- Baffin Region Association. (1985). Socio-economic impacts of the nanisivik mine on Northern Baffin communities. In *The Effects of Rotational Wage Employment on Families and Workers in the Beaufort-Mackenzie Delta Area*. Northwest Territories: Department of Social Services.
- Bacigalupi, L. & Freudenburg, W.R. (1983). Increased mental health caseloads in an energy boomtown. *Administration in Mental Health*, 10(4): 306-322.
- Barton, S. S. (2002). Aspects of the effect of substance use on health, wellness and safety of employees and families in northern remote work sites. *Social Indicators Research*, 60 (1), 263-274.
- Bayes, M. & Neill, T. K. (1978). Problems for paraprofessionals in mental health services. *Administration in Mental Health*, 6(2), 133-146.
- Becker, H.S. (1997). *Tricks of the trade: How to Think About Your Research While You're Doing It*. Chicago: University of Chicago Press.
- Berry, J. W. (1992). Acculturation and adaptation in a new society. *International Migration*, 30(1): 69-85.
- Berry, J. W., Kim, U., Minde, T., & Mok, D. (1987). Comparative studies of acculturative stress. *International Migration Review*, 21, 491-511.
- Bishop, R. (1996) *Whakawhanaungatanga: Collaborative Research Stories*. Dunmore Press, Palmerston North.

- Blank, M., Fox, J., Hargrove, D., & Turner, J. (1995). Critical issues in reforming rural mental health service delivery. *Community Mental Health Journal*, 31: 511-523.
- Brockman, A. & Argue, M. (1995). *Review of the NWT diamonds project environmental impact statement: Socio-economic impacts on women* (Issue Brief). Yellowknife: NWT Status of Women Council. Retrieved November 23, 2006 from www.statusofwomen.nt.ca/download/review_BHP.pdf
- Caelli, K., Ray, L., & Mill, J. (2003). 'Clear as mud': Toward greater clarity in generic qualitative research. *International Journal of Qualitative Methods*, 2(2), 1-23.
- Canadian Broadcasting Corporation (CBC). (2001). Natives speak out: Native people air long-held grievances at the Berger commission. In *Canada: A People's History*. Retrieved online October 15, 2009 from http://history.cbc.ca/history/?MIval=Section.html&series_id=1&episode_id=17&chapter_id=2&lang=E.
- Chalmers, J., Cayen, L., Snowshoe, S. (2002, May). *A State of Emergency: Evaluation of Addiction Services in the NWT*. Retrieved October 21, 2008 from <http://www.hlthss.gov.nt.ca/content/publication/reports>
- Chalmers, J., Cayen, L., Bradbury, C., & Snowshoe, S. (2005). *Stay the Course... Together we can secure the foundation that has been built: An interim report on mental health and addictions services in the NWT*. Retrieved October 10, 2007 from <http://www.hlthss.gov.nt.ca/content/publication/reports>
- Creswell, J. (1998). *Qualitative inquiry and Research design: Choosing among the five traditions*. London: Sage.
- Csonka, Y. & Schweitzer, P. (2004). Societies and Cultures: Change and Persistence. In *Arctic Human Development Report* (pp. 45-68). Akureyri: Steffanson Arctic Institute.
- Cuff, G. B. (2001). *It's Time To Act: A Report on the Health and Social Services System of the Northwest Territories*. Retrieved January 13, 2009 from <http://www.hlthss.gov.nt.ca/content/publication/reports>
- Dean, A. (1995). Space and substance misuse in rural communities. *International Journal of Sociology and Social Policy*, 15, 134-155.
- Dickerson, M. (1992). *Whose North?: Political change, political development, and self-government in the Northwest Territories*. Vancouver: UBC Press.
- Denzin, N. K. and Y. S. Lincoln (2003). *Strategies of Qualitative Inquiry*. California: Sage.
- Devilley, G. J., Wright, R. & Varker T. (2009). Vicarious trauma, secondary traumatic stress or simply burnout? Effect of trauma therapy on mental health professionals. *The Australian and New Zealand Journal of Psychiatry*, 43(4), 373-85.

- Dootson, S. (1995). An in-depth study of triangulation. *Journal of Advanced Nursing*, 22:183-187.
- Flick, U. (1998). *An Introduction to Qualitative Research*. London: Sage Publication.
- Freudenburg, W.F. and Gramling, R. (1992). Community impacts of technological change: Toward a longitudinal perspective. *Social Forces* 70(4): 937-955.
- Gibson, G. & Klinck, J. (2005). Canada's resilient north: The impact of mining on Aboriginal communities. *Pimatisiwin*, 3(1), 116–139.
- Government of the Northwest Territories (GNWT) (2004). *Integrated Service Delivery Model for the NWT Health and Social Services System: A Detailed Description*. Yellowknife, NT: GNWT.
- Government of the Northwest Territories (GNWT) (2005). *GNWT Dehcho Regional Workshop on the Social Impacts of the Mackenzie Valley Gas Project: May 30 & June 1, 2005*. Prepared by GNWT Health and Social Services, Planning, Accountability and Reporting Division. Retrieved June 12, 2007 from <http://www.hlthss.gov.nt.ca/content/Publications/Reports/reportresult.asp?ID=107>
- Government of the Northwest Territories (GNWT) (2006a). *About the Mackenzie Valley Gas Pipeline Project*. Retrieved June 4, 2007 from http://www.iti.gov.nt.ca/pipeline/about_mvpo.htm
- Government of the Northwest Territories (GNWT) (2006b). *Communities and Diamonds. Socio-economic Impacts in the Communities of: Behchoko, Gameti, Whati, Wekweeti, Detah, Ndilo, Lutsel K'e, and Yellowknife. 2005 Annual Report of the GNWT under the BHP Billiton, Diavik and De Beers Socio-economic Agreements*. Yellowknife: GNWT.
- Government of the Northwest Territories (GNWT) (2006c). *2006 NWT Socio-Economic Scan*. Prepared by the Strategic Planning Branch. Retrieved June 12, 2007 from <http://www.stats.gov.nt.ca/Stainfo/Generalstats/Scan/scan.html>
- Government of the Northwest Territories (GNWT) (2006d) *Caribou Forever - Our Heritage, Our Responsibility: A Barren-ground Caribou Management Strategy for the Northwest Territories 2006 – 2010*. Retrieved August 30, 2009 from <http://www.enr.gov.nt.ca>
- Government of the Northwest Territories (GNWT) 2007. *Mining and Exploration in the Northwest Territories: 2007 Overview*. Retrieved online August 30, 2009 from <http://www.iti.gov.nt.ca>
- Government of the Northwest Territories (GNWT) (2008). *Summary of NWT Community Statistics*. Retrieved August 30, 2009 from [http://www.stats.gov.nt.ca/Profile/NWT%20Community%20Stats%20\(2008\).pdf](http://www.stats.gov.nt.ca/Profile/NWT%20Community%20Stats%20(2008).pdf)

- Government of the Northwest Territories (GNWT) (2009). *Telehealth: Background*. Retrieved August 30, 2009 from <http://www.hlthss.gov.nt.ca/english/services/telehealth/background.htm>
- Guest, G., Bunce, A. & Johnson, L. (2006). How many interviews are enough?: An experiment with data saturation and variability. *Field Methods*, 18, 59-58.
- Hamilton, J.D. (1994). *Arctic Revolution: Social Change in the Northwest Territories, 1935-1994*. Toronto: Dundurn Press.
- Hamrosi, K., Taylor, S. J., & Aslani, P. (2006). Issues with prescribed medications in Aboriginal communities: Aboriginal health workers' perspectives. *Rural and Remote Health*, 6: 557-569.
- Hammersley, M. & Atkinson, P. (1995). *Ethnography: Principles in practice* (2nd ed). London: Routledge.
- Health Canada (2007). *Aboriginal Health Human Resources Fact Sheet*. Retrieved online February 24, 2008 from http://www.hc-sc.gc.ca/ahc-asc/media/nrcp/2007/2007_12bk1_e.html
- Hiatt, S. W., Sampson, D., & Baird, D. (1997) Paraprofessional home visitation: Conceptual and pragmatic considerations. *Journal of Community Psychology*, 25(1), 77-93.
- Ironside, R.G. (2000). Canadian northern settlements: top-down and bottom-up influences. *Geography Annual* 82(2), pp. 103–114.
- Indian and Northern Affairs Canada (INAC) (2007, March). Plain Facts on Land and Self-government . Retrieved November 28, 2008 from http://www.ainc-inac.gc.ca/ai/scr/nt/pdf/pfov_eng.pdf
- Kirby, S. Greaves, L., & Reid, C. (2006). *Experience Research Social Change: Methods Beyond the Mainstream* (2nd ed.) Toronto: University of Toronto Press.
- Kirmayer L, Simpson C, Cargo M. (2003). Healing traditions: Culture, community and mental health promotion with Canadian Aboriginal Peoples. *Australasian Psychiatry*, 11, S15-23.
- Knudsen, H. K., Ducharme, L. J., & Roman, P. M. (2006). Counselor emotional exhaustion and turnover intention in therapeutic communities. *Journal of Substance Abuse Treatment*, 31, 173–180.
- Kvale, S. (1996). *InterViews—An Introduction to Qualitative Research Interviewing*. Thousand Oaks: Sage.
- Kinch, P., Katt, M., Boone, M., & Minore, B. (1993). On being everything and nothing: The retention of native health care workers in northern communities. *Arctic Medical Research*, 53(suppl.2): 92-97.

- Kinsella, E. A. (2006). Hermeneutics and critical hermeneutics: Exploring possibilities within the art of interpretation. *Qualitative Social Research*, 7(19) 217-223.
- Kirmayer, L. J., Brass, G. M., Tait, C.L. (2000). The Mental Health of Aboriginal Peoples: Transformations of Identity and Community. *Canadian Journal of Psychiatry*, 45, 607- 616.
- Kirmayer L., Simpson C. & Cargo M. (2003). Healing traditions: Culture, community and mental health promotion with Canadian Aboriginal Peoples. *Australasian Psychiatry*, 11, S15-23.
- Koneru, V.K., Weisman de Mamani, A.G., Flynn, P.M., & Betancourt, H. (2007). Acculturation and mental health: Current findings and recommendations for future research. *Applied and Preventive Psychology*, 12, 76-96.
- Lambert, S (1999). Providing consultation about boundary dilemmas to paraprofessionals working with people with severe psychiatric disabilities. *Journal of Education & Psychological Consultation*, 10(4), 377-384
- Laverty, S. (2003). Hermeneutic phenomenology and phenomenology: A comparison of historical and methodological considerations. *International Journal of Qualitative Method*, 2(3), 1-29.
- Lincoln, Y.S., & Guba, E.G. (2003). Ethics: the failure of positivist science. In Y.S. Lincoln & N.K. Denzin (Eds.), *Turning points in qualitative research: tying knots in a handkerchief* (pp. 219-238). Walnut Creek, CA: AltaMira Press.
- Lock, K. (2000). Health Impact Assessment. *British Medical Journal*, 320: 1395-1398.
- Mackenzie Valley Environmental Impact Review Board (MVIERB) (2005). *Raising the bar for socio-economic impact: Report on what communities told us*. Yellowknife: Mackenzie Valley Environmental Impact Review Board.
- Maxwell, J. A. (2005). *Qualitative Research Design: An Interactive Approach* (2nd ed.). Sage: London.
- McCallum, M. J. (2005). This last frontier: Isolation and Aboriginal health. *Canadian Bulletin of Medical History*, 22(1): 103-120.
- McIssac, M. K. (2006). A First Nations perspective on mental health in the north. *BC Medical Journal*, 48(4): 178-179.
- McMillan, J. A. & Schumacher, S. (2001). *Research in education: A conceptual introduction*. New York: Longman.
- Milligan, Frank (2001). The concept of care in male nurse work: an ontological hermeneutic study in acute hospitals. *Journal of Advanced Nursing* 35 (1), 7-16.

- Minore, B. & Boone, M. (2002). Realizing potential: Improving interdisciplinary professional/paraprofessional health care teams in Canada's northern Aboriginal communities through education. *Journal of Interprofessional Care*, 16(2): 139-147
- Miltenberger, M. (2006). *Social Impacts: Mackenzie Gas Project*. Presentation June 14, 2006 on behalf of GNWT Health and Social Services, Inuvik Petroleum Show, June 14, 2006. Retrieved June 4, 2007 from <http://www.inuvik.ca/events/ipsspeakers.html>
- Montgomery, J. C. (2003). The issues shared by professionals living and working in rural communities in British Columbia. *Canadian Journal of Rural Medicine*, 6(3): 255-260.
- Musser-Granski, J. & Carrillo, D. F. (1997). The use of bilingual, bicultural paraprofessionals in mental health services: Issues for hiring, training, and supervision. *Community Mental Health Journal*, 33(1): 51-60.
- Nelson, C., Treichler, P. A. & Grossberg, L. (1992). *Cultural Studies*. New York: Routledge.
- Neuman, W. (1997). *Social research methods: Qualitative and quantitative approaches* (3rd ed.). Needham Heights, MA: Allyn & Bacon.
- North Slave Métis Association (2002). *Can't Live Without Work: North Slave Métis Alliance Environmental, Social, Economic and Cultural Concerns*. Yellowknife: North Slave Métis Association
- Northwest Territories (NWT) Bureau of Statistics (2009). *NWT Population Estimates - January 2009*. Retrieved December 9, 2009 from <http://www.stats.gov.nt.ca/Statinfo/Demographics/population/quarterlyestimates/2009/Jan2009.html>
- O'Neil, J. D. (1986). Colonial Stress in the Canadian Arctic: An Ethnography of Young Adults Changing (pp. 249-274). In Janes C.R. et. al (eds.) *Anthropology and Epidemiology*. Kluwer Academic Publishers
- Prince of Wales Northern Heritage Centre (no date). *Online exhibits: Virtual Timeline of the NWT*. Retrieved December 4, 2006 from <http://pwnhc.learnnet.nt.ca/exhibits/index.htm>
- Porsanger, J. (2004). An essay in Indigenous methodology. *Nordlit Working Papers in Literature: Special Issue on Northern Minorities*. University of Tromsø: Faculty of Humanities 15:105-120.
- Purden, M. (2005). Cultural considerations in interprofessional education and practice. *Journal of Interprofessional Care*, (Suppl. 1), 224-234.
- Ritter, A. R. (2001). Canada: From fly-in, fly-out to mining metropolis. In G. McMahon, & F. Remy (Eds.), *Large mines and the community: Socioeconomic and*

- environmental effects in Latin America, Canada, and Spain* (pp. 125-158). Geneva: IRDC/World Bank.
- Roberts, L., Battaglia, J. & Epstein, R.S. (1999). Frontier ethics: Mental health care needs and ethical dilemmas in rural communities. *Psychiatric Services*, 50(4): 497-503.
- Salokangas, R. (2005). *Gwich'in Views of the Mackenzie Gas Project*. Inuvik: Aurora Research Institute & Gwich'in Renewable Resource Board
- Scopelliti, J., Judd, F., Grigg, M., Hodgins, G., Fraser, C., Hulbert, C., Endacott, R., & Wood, A. (2004). Dual relationships in mental health practice: Issues for clinicians in rural settings. *Australian and New Zealand Journal of Psychiatry*, 38: 953-959.
- Scott-Samuel, A. (1996). Health impact assessment: An idea whose time has come. *British Medical Journal* 313(27): 183-184.
- Shield, P. & Tajilli, H. (2006). Intermediate theory: The missing link in successful student scholarship," *Journal of Public Affairs Education* 12(3): 313-334.
- Siang-Yang, T. (1997). The role of the psychologist in paraprofessional helping. *Professional psychology: Research and Practice*, 28(4): 368-372.
- Smith, L. T. (1999). *Decolonizing methodologies: Research and Indigenous Peoples*. London: Zed
- Spirig, R. (2002). In invisibility and isolation: The experience of HIV-affected families in German-speaking Switzerland. *Qualitative Health Research* 12(10), 1323-1337
- Statistics Canada, 2006. *Percentage reporting Aboriginal identity for Canada, provinces and territories, 2006, 2001 and 1996 censuses*. Retrieved online August 30, 2009 from <http://www12.statcan.ca/census-recensement/2006/rt-td/ap-pa-eng.cfm>
- Strand, K., Marullo, S., Cutforth, N., Stoecker, R., & Donohue, P. (2003). *Community-based research and higher education: Principles and practices*. San Francisco, CA: Jossey-Bass.
- Trainor, S.F., Chapin III, F. S., Huntington, H. P., Natcher, D. C., & Kofinas G. (2007). Arctic Climate Impacts: Environmental Injustice in Canada and the United States. *Local Environment* 12(6), 627 – 643
- Terhune, C. P. (2008). Coping in isolation: The experiences of black women in white communities. *Journal of Black Studies*, 38 (4), 547-564.
- University of Victoria, Faculty of Human and Social Development. (2003). *Protocols and Principles for Conducting Research in an Indigenous Context*. Retrieved online February 14, 2007 from http://web.uvic.ca/igov/programs/masters/igov_598/protocol.pdf.

- Venturato L., Kellett, U. & Windsor C. (2007). Nurses' experiences of practice and political reform in long-term aged care in Australia: implications for the retention of nursing personnel. *Journal of Nursing Management* 15, 4-11.
- Walsham, G. (1993) *Interpreting Information Systems in Organizations*. Wiley: Chichester.
- Wharf, B. & McKenzie, B. (2004). *Connecting Policy to Practice in the Health Services* (2nd ed.). Canada: Oxford.
- Wesley-Esquimaux C. & Smolewski M. (2004). *Historic Trauma and Aboriginal Healing*. Retrieved online April 17 2009 from www.ahf.ca/assets/pdf/english/historic_trauma.pdf.
- Williams, A.M. & Cutchin, M.P. (2002). The rural context of health care provision. *Journal of Interprofessional Care*, 16(2): 107-115.
- Wonders, W. (2003). *Canada's Changing North*. Montreal: McGill-Queens University Press

Appendix A: Map of the NWT Health and Social Services Authorities



Source: Government of the Northwest Territories, Department of Health and Social Services

Appendix B: Interview Guide

The following script/questions is a general guideline intended to assist the Student Researcher by offering the interviewee specific topics to address. As this is a semi-structured interview, the script and questions may be adjusted during the interview itself to ensure maximum clarity and conversational flow.

Consent

- Have you read the consent form I gave you?
- Do you agree to its content?
- Do you understand that you can stop this interview or ask me to turn off the tape recorder at any time?
- Are you ready to start?

Interviewee Personal Background

- Tell me about yourself.
- How long have you been in your position?
- What got you interested in this sort of work?

Looking Back

- When you first started working in the mental health/addictions field ____ years ago, what did you find most interesting or rewarding about the work?
- Back then, what did you find most difficult/challenging?

Practice Today

- Could you tell me about your current mental health/addictions practice?
 - What do you see as your main roles and responsibilities?
 - Do you see your role as mental practitioner as separate from other roles (i.e. mother/relative/elder) in your community?
 - Are you originally from [the community of practice]? If so, what is it like practicing in a community where you have roots?
 - Does the work you do as a mental health/addictions practitioner have any bearing on your personal life in the community?
 - What does a typical week look like in your practice?
 - Does this change with the seasons/time of year or remain pretty much the same all year around?
 - Does your work happen between 9-5 or at other times?
 - What is the work environment like?

Experiences of Change

- So, since you first started working in this field, has your practice changed?

- If it has changed, how has it changed?
 - Are you working with the same groups of people you saw ____ years ago?
 - Are the people you help in your community coming to you with the same sorts of problems/issues in your community?
 - If not, why do you think you are seeing these different problems/issues in your community?
- How are you responding to this change?
 - Have you had to adapt your work style/approach?
 - What's worked for you?
 - What hasn't?
- Are there (other) changes on the horizon that you expect will influence your practice?
 - If yes, how?

Challenges and Rewards Today

- Would you say that the rewards and challenges in your work are the same or different than they were when you first started in the mental health/addictions field?

Support Needs and Other

- Is there anything more (for example, resources or training) that you think would help you in your practice?
- I understand that about 5 years ago there were major changes made in order to improve the way mental health and addictions services were provided in the NWT. In your opinion, how is the current system working in your community?
- Are there other aspects of your work that you would like to speak to?

Bringing the Interview to an End

- Well I think that is it.
- Thank you for your time
- I will contact you next week to see if there is anything else you might want to add or that you thought of. If you would like to review the transcript from this interview, I can also provide you with the opportunity to look it over and edit the content.
- Do you have any questions for me?



Appendix C and Appendix D (p. 118-119) removed from digital edition for protection of privacy. Originals held on file in UVic Libraries Technical Services.

Appendix E: Participant Letter of Invitation

Hello, my name is Alana Kronstal and I am a NWT resident currently completing a Masters degree in the Studies in Policy and Practice at the University of Victoria.

As part of my studies, I am conducting research on mental health and addictions practice in the NWT. I am speaking to community-based counselors and wellness workers about their work. In particular, I am interested in what community-based practitioners see as the biggest challenges and rewards to their work. I am also curious as to how long-term community-based professionals perceive social and economic change in their communities and whether they think these changes affect their professional practice.

As a professional in this field of mental health or addictions service provision, I would like to interview you about your views and experiences. My interview questions are general questions about your experiences as a health practitioner. I will not be asking any questions about confidential aspects of your work.

My research is being supervised by Dr. Marge Reitsma-Street, Studies in Policy and Practice Program, Faculty of Human and Social Development at the University of Victoria. She can be reached by phone at (250) 721-6468 or email mreitsma@uvic.ca.

Although I have the support of the GNWT Department of Health and Social Services, the Stanton Territorial Health Authority to conduct this research, my project is independent of government. My I have also obtained a research license from the Aurora Research Institute.

If you agree to be interviewed, I promise the following:

- To provide a cash honorarium of fifty (\$50.00) dollars in recognition of your time and valuable knowledge and experience. If applicable, child care expenses will also be covered.
- To protect your privacy and confidentiality by not attaching your name, community of practice, or other identifying information to the research findings.
- That participation is limited to this one interview and that I will only contact you about clarification or follow-up with your permission.
- To provide you with the opportunity to review a transcript of our interview so that you may edit (add or delete) any information before I compile the results of my research.
- To make available my findings and the final results and later, to those in charge of health policy and administration in the NWT.

If you agree to be interviewed, you have the right to do the following:

- To withdraw from the research project at any time without penalty.
- To discontinue with the interview if you feel any discomfort or anxiety. You will still receive the honorarium of \$50.00 in recognition of your time, inconvenience and transportation costs. If applicable, child care expenses will also be covered for that time.

If you would like to participate in this study, please reply to this letter of invitation by emailing me at akronstal@gmail.com or by leaving a message at (250) 857-4814.

I will contact you to arrange a suitable day and time to travel to your community and speak with you. Your words and your thoughts are both important and protected in this research. I thank you in advance for your time and consideration of participation in this important study.

Yours sincerely, Alana Kronstal

Appendix F: Participant Consent Form

NEGOTIATING CHANGE: COMMUNITY-BASED MENTAL HEALTH AND ADDICTIONS PRACTICE IN THE NORTHWEST TERRITORIES

You are invited to participate in a study entitled *Negotiating Change: Community-based Mental Health and Addictions Practice in the Northwest Territories*. This research is being conducted by Alana Kronstal.

Alana is a Masters student in the Department of Human and Social Development at the University of Victoria. As a graduate student, Alana must conduct research as part of the requirements for a degree in Studies in Policy and Practice. Her research is being conducted under the supervision of Dr. Marge Reitsma-Street. If you have further questions about this study, you may contact Alana at (867) 873-4813 or by email at kronstal@uvic.ca. Marge can be reached at (250) 721-6468 or by email at mreitsma@uvic.ca.

This research is being funded by International Polar Year Canada and the Northern Studies Training Program. This research is being conducted with the knowledge and support of the Department of Health and Social Services and the Arctic Health Research Network. An NWT Aurora Research Institute licence has also been obtained for this research initiative.

Research Purpose

The purpose of this research project is to document the experiences, perspectives and support needs of long-serving community-based mental health and addiction workers in the Northwest Territories.

Importance of this Research

Research of this type is important because there is a lack of information on the experiences of community-based mental health and addictions practitioners in the NWT. It is believed that front-line professionals have valuable knowledge about community health and wellness. Particularly as the Northwest Territories is undergoing a great deal of social and economic change, it is important for us to understand the work of community-based northern practitioners and how they can best be supported in their roles.

Participants Selection

You have been asked to participate in this study because you have been identified as a long-serving community-based mental health or addictions practitioner working with the GNWT Department of Health and Social Services. Veteran professionals are of particular interest for this study because of the long-term perspective they will bring to the research.

What is Involved

If you agree to participate in this research, your participation will require approximately 1-2 hours of your time for a one-on-one interview with Alana Kronstal. Alana will travel

to your community to conduct this interview on a day and time of your choosing in February or March 2008. She will ask you general questions about your mental health or addictions practice, the challenges and rewards to your work, and your views on change and support in your area of practice. None of her questions relate to confidential aspects of your work.

Within a week following the interview, Alana will provide you with a transcript of the conversation for your review. You may add or delete information at that time. Alana will only contact you again with additional questions or for clarification if she has your permission to do so. Alana will provide you with a summary of the findings from this study and upon request, with a copy of the thesis that results from this research. After reporting back to you and the other research participants about the findings from this study, Alana may also share this information with GNWT Department of Health and Social Services administrators and policy-makers so that the research results may be used to inform policy decisions. Alana may also seek opportunities to share these research findings with the general public through local media (newspapers, radio, and television) or academic publications.

Inconvenience

Participation in this study may cause some inconvenience to you, primarily the investment of time devoted to participating in the research. Depending on the time of day that the interview is held, this might mean time away from work or family.

Risks

There are no known or anticipated risks to you by participating in this research.

Benefits

The potential benefits of your participation in this research include the opportunity to have your personal viewpoints heard and the chance to raise awareness of the experiences and support needs of northern community-based mental health and addiction practice among health administrators, policy-makers and academics.

Compensation

As a way to compensate you for any inconvenience related to your participation, you will be provided an honorarium of fifty dollars (\$50.00) in addition to child care expenses for the duration of the interview. If you agree to participate in this study, this form of compensation to you must not be coercive. It is unethical to provide undue compensation or inducements to research participants. If you would not participate if the compensation was not offered, then you should decline.

Voluntary Participation

Your participation in this research must be completely voluntary. If you do decide to participate, you may withdraw at any time without any consequences or any explanation. You will still receive the honorarium of \$50.00 to cover time, inconvenience and transport costs. If applicable, child care expenses will also still be covered. If you do

withdraw from the study, Alana will ask you for your permission to use any previously recorded information you have shared. If you do not give your permission, she will immediately destroy the data and it will not be included in the research findings.

Anonymity

Due to the small population base in the NWT and the even smaller number of mental health and addiction practitioners, it is not possible to absolutely guarantee your anonymity. However, all personal information your identity will be kept confidential. See information below for a detailed description of the steps taken to ensure participant confidentiality.

Confidentiality

The following steps will be taken to ensure your participation in this research is kept confidential: Your name, the name of your community and other identifying characteristics will not be included in the research summary report and thesis resulting from this study. If you choose, you will also have the opportunity to review the transcript of your interview and add or remove information prior to data analysis. No one other than Alana Kronstal and a professional transcriber will have access to the audio files and paper transcripts that result from this research. However, if you wish to be credited for your participation in this study, you can request that your name be included in the acknowledgements section of the research reports and thesis.

Dissemination of Results

It is anticipated that the results of this study will be shared with others who have an interest in community-based mental health and addictions practice in the Northwest Territories. This may include senior administrators and policy-makers within the Department of Health and Social Services, Government of the Northwest Territories. Research findings from this study may also be shared with the general public through the publication of newspaper articles, radio interviews or academic journals.

Disposal of Data

All of the audio recordings from this study will be erased from the researcher's computer within one year of the completion of the study. Within five years of research completion, all electronic and paper transcripts (with names and other identifying information removed) will be destroyed.

Contacts

Individuals that may be contacted regarding this study include Alana Kronstal and her supervisor Dr. Marge Reitsma-Street. Their contact information is on the first page of this consent form. In addition, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Human Research Ethics Office at the University of Victoria (250-472-4545 or ethics@uvic.ca).

Your signature below indicates that you understand the above conditions of participation in this study and that you have had the opportunity to have your questions answered by the researcher.

Name of Participant: _____

Signature: _____

Date: _____

Witness Name: _____

Signature: _____

Date: _____
