Understanding community crisis response in isolated Indigenous communities; *A community portrait*

Kaila de Boer

School of Social Work
McGill University, Montreal
April, 2017

A thesis submitted to McGill University in partial fulfillment of the requirements of the degree of a Master of Social Work.

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Abstract

Though crisis response theories and models have existed for a long time in mainstream contexts, there has rarely been Indigenous-specific research, despite the disproportionate prevalence of crises in Indigenous communities. This research thesis combines results from key informant interviews with representatives of the fourteen agencies involved with community crisis response with an analysis of community notes and documents (dating back to 1991) pertinent to crisis response in the community of interest, to answer the research question: 'what are the organizational policies, procedures, and professional practices which guide crisis response in one isolated, Indigenous community?' In addition to descriptive results on the historic and current context for crises and practice of crisis response, thematic analysis provides insight to the community's culture and values, context and resources, and strengths and challenges vis a vis crisis response. The research concludes with discussion on the importance of understanding community culture, values, context, and resources when discussing and implementing crisis response in isolated, Indigenous communities.

Les théories et les modèles dominants de la réponse aux crises existent depuis longtemps pour la société en général, mais la recherche spécifique à propos des peuples Autochtones est rare, malgré la prévalence disproportionnée des crises dans leurs communautés. Cette thèse de recherche combine les résultats d'entrevues avec des représentants clé des quatorze agences impliquées dans la réponse aux crises communautaire avec une analyse de notes et de documents (remontant à 1991) qui sont pertinents à la réponse aux crises dans la communauté d'intérêt, pour répondre à la question de recherche : « quelles sont les politiques, procédures, et pratiques professionnelles qui guident la réponse aux crises dans une communauté Autochtone isolée ? » En plus des résultats descriptifs sur les contextes historiques et actuels des crises et la pratique de

la réponse aux crises, une analyse thématique amène un aperçu sur la culture et les valeurs de la communauté, son contexte et ses ressources, et ses forces et défis vis-à-vis la réponse aux crises. La recherche se termine avec une discussion sur l'importance de comprendre la culture, les valeurs, le contexte, et les ressources d'une communauté dans le cadre de la discussion et de l'implantation de la réponse aux crises dans des communautés Autochtones isolées.

Acknowledgements

The completion of this Master of Social Work research thesis would not have been possible without the support of the Indigenous research advisory committee, the Indigenous government, and the multiple organizations providing services within the community. Their recommendations and willingness to share information are what made this research process fruitful. I wish to extend a special thank-you to all key informants.

The professors and fellow students at the McGill School of Social Work and the Centre for Research with Children and Families have been wonderful in providing guidance through the research process. My thesis supervisor – Vandna Sinha – has been invaluable for all her patience, wisdom, and feedback. She has been a phenomenal at listening to my thoughts and experiences and reviewing my writings and planning. I am so grateful for all the times she's been there to push me to grow.

I have been blessed with the encouraging support of friends and family, without whom this process would have been far more overwhelming. Not only have they supported me through the research process, they have supported me through the multiple crisis response activities which I have been involved in. Without this loving support, I would be lost.

Most importantly, I wish to acknowledge the community and the trauma they have experienced and continue to experience. I wish nothing more than that there was no cause to

write this thesis, but that is not the current reality. My heart is heavy and my eyes fill with tears thinking about all the community members who live with traumatic loss(es).

Preface and Contribution of Authors

The primary researcher was the sole contributor to research within this thesis. All research components are original scholarship, contributing knew knowledge on crisis response practices within this northern Indigenous community.

Introduction

"*Attawapiskat suicide emergency: Health Canada, province send in crisis teams; Officials say 11 people attempted to take their own life on Saturday alone*" (CBC News, 2016);

"*Shamattawa still in crisis weeks after fire destroyed lone grocery store; Community struggles to deal with aftermath of grocery store blaze, ongoing housing issues*" (Hoye, CBC News, 2016);

"*'We're taking this very seriously': Nunavik leaders on suicide crisis* " (MacKinnon, CBC News, 2016);

"*Inside the deadly school shooting that shattered La Loche*" (Quan, National News, 2016)

For those who follow Canadian northern and Indigenous[1] news, this sampling of news titles may sound familiar. Indigenous Canadians are six times more likely to be victims of homicide than non-Indigenous Canadians (7.20 per 100,000 vs. 1.13), making up 23% of homicide victims, despite only being 5% of the Canadian population (Miladinovic & Mulligan, 2015). Indigenous Canadians are also more likely to die by suicide: from 2 times more likely for First Nations and Metis to 10 times for Inuit (Statistics Canada, 2016). These events – among others – can constitute a 'crisis' for individuals, families, and communities.

'Crisis' is a term used for a wide range of purposes, from common parlance to clinical terminology. Such a wide-range makes it difficult to define; in the words of Maloney (1971), "crisis is a lay term in search of a scholarly meaning" (p. 1). For the context of crisis interventions, Roberts defines crisis as "an acute disruption of psychological homeostasis in

[1] The inclusive term 'Indigenous' will be used when discussing Canada's first peoples – First Nations, Inuit, and Metis – , unless citing the material of someone else, wherein their terms will be used. Wherever possible, First Nations, Inuit, and Metis will be specifically identified as such, as it is recognized that each culture and community is distinct. In keeping with the ethical commitment to not identify the community where the research occurred, it will be identified only as 'Indigenous'; the strengths and limitations to this approach are discussed within the Research Methodology section.

which one's usual coping mechanisms fail and there exists evidence of distress and functional impairment"(2005, pp. 779). The Mizrahi and Davis go on to say

> *The main cause of a crisis is an intensely stressful, traumatic, or hazardous event, accompanied by two other conditions: (a) the individual's perception of the event as the cause of considerable upset or disruption; and (b) the individual's inability to resolve the disruption by previously used coping methods (Mizrahi & Davis, 2008, p. 485).*

As such, the experience of crisis is subjective; an event which constitutes a 'crisis' for one individual, may be considered a regular activity of living for another.

The focus of this thesis will be on events which are intensely stressful, traumatic, and/or hazardous for a community of people and additionally disrupt and/or overwhelm previously used coping strategies. Response to these events may involve multiple different agencies, such as police, fire department, health and social services, municipal/regional/federal governing bodies, and psychological and spiritual supports to name a few. Within the context of this research, suicide is – by consensus of all key informants interviewed – considered a predominant community crisis, though other events such as house fires, murders, missing people, etc may also constitute a crisis. 'Crisis response' is used to describe the multiagency services provided following such an event to ensure safety, ameliorate stressors, and ultimately regain a new normalcy.

Response to crises has been a topic of study by mainstream mental health practitioners since the 1940s (Mizrahi & Davis, 2008). However, within Indigenous communities, literature on violence and suicide has focused on understanding the disproportionate prevalence (eg. Brave Heart, 2000; Kirmayer et al., 2007; Reading & Wien, 2013; Richmond, 2009), learning from experiences of suicide, traumatic loss, and violence (eg. Aho & Liu, 2010; Chachamovich & Tomlinson, 2010; Chandler, Lalonde, Sokol, Hallett, & Marcia, 2003; Department of Justice

Canada, 2008), and developing strategies for prevention and promotion (eg. Centre for Suicide Prevention, 2013; Chandler & Lalonde, 2008; Chouinard, Moreau, Parris, & Cousins, 2010; National Aboriginal Health Organization, 2005); however, relatively little has been written on the organizational responses to crises in Indigenous communities.

Despite lack of literature on responding to crises in Indigenous communities, Indigenous communities are responding, seeking training to strengthen these responses, and writing their own manuals to guide responses (National Knowledge Exchange, 2016). Within their manuals on crisis response, communities stress the importance of recognizing their community and cultural strengths and resources (National Knowledge Exchange, 2016) and frontline workers highlight the importance of understanding the issues through a culturally appropriate lens, which acknowledges context (Hughes, 2006). The lack of knowledge on organizational responses to crises which occur within Indigenous communities is a gap this Master of Social Work thesis intends to fill by asking:

What are the organizational policies, procedures, and professional practices that guide crisis response in one isolated, Indigenous community?

The question for this thesis was born out of discussions with frontline workers in the community of interest. They expressed that they felt the differing roles and policies of agencies involved were not always clearly understood nor supported by those within the community/region and that more understanding was needed as a foundation for discussions on how crisis response within the community could be strengthened. Likewise, the question was also identified as beneficial to those outside of the community and in positions able to provide external supports (eg. governments and/or non-profit agencies) or who may be moving to work

within the community. Finally, such a question will contribute to a research base on crisis response within isolated Indigenous communities.

Literature on Crisis Response

History of Crisis Response

The notion of crisis response dates back to 1942, following psychiatrist Dr. Eric Lindemann's treatment of 101 survivors and family members after a fire which killed 493 people in a nightclub in Boston (Mizrahi & Davis, 2008). During this process, Lindemann observed the distress to be acute at onset and then follow a similar pattern to resolution, leading him to believe that early intervention could prevent long-term pathology (Mizrahi & Davis, 2008). In 1948, Dr. Eric Lindemann and Dr. Gerald Caplan implemented the first community mental health clinic for those bereaved or victimized by disaster (Hillman, 2013).

Building on this work, Klein and Lindemann (1961) made several key assertions on crisis intervention counselling:

- that crisis interventions can be accomplished quickly (eg. in 10 sessions);
- that supportive networks of friends, families, and paraprofessionals can play a key role in care;
- and that individuals in crisis can be open to major life changes wherein adaptive resolution can lead to enduring positive change.

These principles have carried into modern models of crisis intervention. According to Mizrahi and Davis (2008), the key principles of crisis intervention are that the work is typically time-limited and goal-directed with the intent of resolving immediate problems and emotional conflicts and minimizing distress.

Through the 1960s and 70s, crisis intervention became a subject of interest amongst practitioners and scholars, particularly as research showed the utility of early intervention at reducing long-term psychiatric consequences (Bordow & Porritt, 1979). By the 1980s – following the eruption of Mount St. Helenes in 1980 and the Oklahoma shooting in 1981 – the American National Organization for Victim Assistance (NOVA) recognized the need for

coordinated efforts to train professionals in crisis response and thus published the first *Community Crisis Response Training Manual* in 1987 (Young, 1998). NOVA offered extensive training in the following years as well as supporting professionals providing crisis response, and these two activities led to a second publication in 1994 and a third in 1998 to reflect lessons gained (Young, 1998). NOVA suggested five primary stages of responding to crises: physical rescue, crisis intervention, post-trauma counselling, interventions to address secondary trauma or re-experiencing, and self-development through survival and growth (Young, 1998). In the topic of crisis intervention, they focused on ensuring physical, mental, and emotional safety and security; providing opportunities for individuals to express their stories and receive validation for their experiences; and preparing individuals for moving forward, including educating them on future reactions (Young, 1998).

Since the 1990s, crisis response was increasingly considered across differing areas of subspecialty. Crises occurring within schools became one area of specialization (Adamson & Peacock, 2007; Cornell & Sheras, 1998; Ronan & Johnston, 2005), with articles such as that by Cornell and Sheras (1998) presenting means by which to improve crisis response in such settings, with recommendations around leadership, teamwork, and responsibility. Response to suicide clusters were another rising specialization (Andriessen & Krysinska, 2012; Askland, Sonnenfeld, & Crosby, 2003; Bartik, Maple, Edwards, & Kiernan, 2013), which shall be discussed in more depth subsequently. Crisis response in situations of war, mass violence, and natural disasters, were also growing areas of practice and research (Boscarino, 2015; Fox et al., 2012; Kimiksana, 2003; Rynearson, 2006), with increased recognition that in addition to the individual traumas, such mass catastrophes have devastating impacts on the political, economic,

sociocultural, and health care infrastructures which may under better circumstances be the recourse for individuals (Mollica et al., 2004).

Three models of crisis response will be discussed: Critical Incident Stress Management, Psychological First Aid, and Suicide Postvention. These models are being focused on because they were raised by key informants and some professionals within the community of interest have received training in them; to the best of my knowledge, there have not been other trainings specific to crisis response models for professionals of this community. Critical Incident Stress Management (CISM) and Psychological First Aid (PFA) both provide guidance in responding to any crisis which may occur within a community, though CISM focuses more on organizational actions, whereas PFA is framed around the psychosocial needs of children, adults, and families. Suicide postvention – though perhaps not typically considered a crisis response model – is discussed within this section due to the very high prevalence of suicide within the research context and the fact that all key informants identified suicide to be the most common crisis within the community of interest. Collectively, this will provide grounding on current approaches to crisis response. As this research occurs within an Indigenous context, this section concludes with a discussion on how mainstream approaches like these apply cross-culturally.

Critical Incident Stress Management

In 1983, Critical Incident Stress Debriefing (CISD) was coined as a proper noun to describe the specific act of group debriefing following crisis (Everly & Mitchell, 2000; Mitchell, 1983). From this arose a broader continuum of services, from pre-crisis preparation through to post-crisis follow-up/referrals, termed Critical Incident Stress Management (CISM) (Everly, Flannery, & Eyler, 2002; Everly & Mitchell, 2000). Critical Incident Stress Management (CISM) is a structured multi-component strategy to address crisis situations which was born from earlier crisis intervention and debriefing techniques. Everly and Mitchell – leaders in the

development and research on CISM (Everly et al., 2002; Everly, Flannery, & Mitchell, 2000; Everly & Mitchell, 1999; Mitchell, 1983; Mitchell & Everly, 1986) – present the model with eight stages (presented in Figure 1).

Figure 1: Critical Incident Stress Management (CISM) core components

	INTERVENTION	TIMING	ACTIVATION	GOAL	FORMAT
1.	Pre-crisis preparation.	Pre-crisis phase.	Crisis anticipation.	Set expectations, Improve coping, Stress management.	Groups/ Organizations.
2a	Demobilizations & staff consultation (rescuers).	Shift disengagement.	Event driven.	To inform and consult, allow psychological decompression. Stress management.	Large groups/ Organizations.
2b.	Crisis Management Briefing (CMB) (civilians, schools, business).	Anytime post-crisis.			
3.	Defusing.	Post-crisis (within 12 hours).	Usually symptom driven.	Symptom mitigation. Possible closure. Triage.	Small groups.
4.	Critical Incident Stress Debriefing (CISD)	Post-crisis (1 to 10 days; 3-4 weeks mass disasters)	Usually symptom driven; can be event driven.	Facilitate psychological closure. Sx mitigation. Triage.	Small groups.
5.	Individual crisis intervention (1:1).	Anytime, Anywhere.	Symptom driven	Symptom mitigation. Return to function, if possible. Referral, if needed.	Individuals.
6.	Pastoral Crisis Intervention.	Anytime, Anywhere.	Whenever needed.	Provide spiritual, faith-based support.	Individuals/ Groups.
7a.	Family CISM.	Anytime.	Either symptom driven or event driven.	Foster support & communications. Symptom mitigation. Closure, if possible. Referral, if needed.	Families/ Organizations.
7b.	Organizational consultation.				
8.	Follow-up/Referral.	Anytime.	Usually symptom driven.	Assess mental status. Access higher level of care, if needed.	Individual/ Family.

Table as presented in Everly and Mitchell, 2000, p. 214

The pre-crisis preparation phase provides the opportunity for agencies and professionals to plan and prepare in advance of any crises happening. This includes discussions on potential crises which might happen and how the agencies and professionals might respond. It also gives an opportunity to proactively discuss the impact of crises on professionals responding and strategies for managing stress. Should a crisis arise, response starts with sharing appropriate information on the situation (eg. who, what, when, where) with involved personnel and giving opportunity for agencies and professionals to discuss and plan their response. As needed during the response, individual defusings and structured, group Critical Incident Stress Debriefings are provided to professionals to minimize the psychological impact of response and promote positive growth. CISM responses may also include individual, family, or group/organizational interventions and follow-up/referrals, as needed. Trainings in this model are intended to assist professionals and agencies prepare for and implement response to a crisis situation.

Critical Incident Stress Debriefing (CISD), in particular, has been source of discussion within the literature on crisis response as it has been found that *for members of the general public* who are victims of crisis, Critical Incident Stress Debriefing was found to increase levels of trauma, by way of vicarious exposure (Litz, Gray, Bryant, & Adler, 2002). These findings raised questions about the appropriateness of the CISM model, though later studies on group debriefing concluded that *for emergency service personnel*, group debriefing is important (Blacklock, 2012; Pack, 2013; Tuckey & Scott, 2014); for example, in a randomized control trial on its impacts with firemen, Tuckey and Scott (2014) found that – compared to no-treatment and stress management education – group debriefing was associated with reduced alcohol use and increased post-intervention quality of life, though no impact on post-traumatic stress or psychological distress. Pack (2013) stresses that Critical Incident Stress Debriefing needs to be

only a component within a comprehensive Critical Incident Stress Management model for a workplace (Pack, 2013).

While CISM is very helpful in conceptualizing and structuring organizational actions before, during, and after a crisis, CISM's core teachings are not structured around the psycho-emotional needs of individuals touched by crises. The focus of Psychological First Aid on the other hand, is to address the trauma individuals are exposed to in crisis situations.

Psychological First Aid

Psychological First Aid (PFA) was developed to guide mental health and crisis response workers in providing urgent support to children, adults and families after a disaster or major incident (Vernberg et al., 2008). Whereas CISM focuses on organizational activities of response to crises, PFA focuses on the psychological needs of individuals impacted by the trauma. As a change from the structured format of CISM, PFA is intended to be flexible in delivery, adaptable to different cultures, ages, and field settings, and incorporate research findings on risk and resilience (Vernberg et al., 2008, p. 382).

PFA is designed to follow Hobfoll et al.'s (2007) five basic principles of trauma response:

1. *Promoting sense of safety,*
2. *Promoting calming,*
3. *Promoting sense of self- and community- efficacy,*
4. *Promoting connectedness, and*
5. *Instilling hope*

(Hobfoll et al., 2007, p. 285-286).

These principles, drawn from empirical research on overcoming traumatic incidents are, to a great extent, the corollary of what is known about trauma: trauma strips a person of their sense of safety and security, overwhelms their capacity to respond and control the situation, and weakens

sense of social cohesion and hope. Hobfoll et al. (2007) clearly state that while these principles are meant to inform response to crises, disasters, and other traumatic events, they are not recommending a specific intervention model, as there is too much heterogeneity in scenarios and too little supporting research. Instead, these principles are intended to promote an evidence-informed approach to responding to traumatic events (Hobfoll et al., 2007).

Ruzek, Brymer, Jacobs, Layne, & al, (2007) outline that the core actions and goals of Psychological First Aid are:

1. ***Contact and Engagement***
Goal: respond to contacts initiated by affected persons, or initiate contacts in a non-intrusive, compassionate, and helpful manner.

2. ***Safety and Comfort***
Goal: Enhance immediate and ongoing safety, and provide physical and emotional comfort

3. ***Stabilization (if necessary)***
Goal: To calm and orient emotionally-overwhelmed/distraught survivors

4. ***Information Gathering: Current Needs and Concerns***
Goal: Identify immediate needs and concerns, gather additional information, and tailor PFA interventions

5. ***Practical Assistance***
Goal: To offer practical help to the survivor in addressing immediate needs and concerns

6. ***Connection with Social Supports***
Goal: To reduce distress by helping structure opportunities for brief or ongoing contacts with primary support persons or other sources of support, including family members, friends, and community helping resources

7. ***Information on Coping Support***
Goal: To provide the individual with information (including education about stress reactions and coping) that may help them deal with the event and its aftermath

8. ***Linkage with Collaborative Services***
Goal: To link survivors with needed services and inform them about available

> *services that may be needed in the future.*
> *(Ruzek et al., 2007, p 26)*

These core actions are intended to meet the needs of individuals currently experiencing or recently exposed to a traumatic event, starting with connecting with them, ensuring their safety, and stabilizing those who are emotionally overwhelmed. The support person continues to listen to the needs and concerns of those impacted, offer them practical and social supports, including providing coping strategies and connecting them to other services. Through this framework of response, the needs of the individuals affected are forefront.

Since its conception, Psychological First Aid has been used in a variety of contexts and – though evaluation can be difficult – first responders typically have a positive experience with it (Pekevski, 2013). An analysis of peer-reviewed literature from 1990-2010 on PFA found that while it is supported by "expert opinion and rational conjecture", there have been no controlled studies and much more scientific research is required (Fox et al., 2012).

While CISM and PFA are designed with a generalized focus on responding to crises and traumatic events, the community wherein this research is based is particularly impacted by suicide. Indeed, all key informants interviewed considered suicide the predominant community crisis. Thus – though it may not typically be considered a 'crisis response' framework –, literature regarding suicide postvention is informative to this context.

Suicide Postvention

Suicide and suicide postvention are a literature base separate from that of crisis response, but is important in this research context due to the very high rates of suicide (amongst the highest in Canada) in the community of interest. Though it is not scientifically clear whether bereavement due to suicide is unique from all other forms of bereavement (Andriessen & Krysinska, 2012), there has been a strong focus on 'postvention' services to contain adverse

reactions amongst those bereaved by suicide (Andriessen, 2014; Andriessen & Krysinska, 2012; Trimble, Hannigan, & Gaffney, 2012), particularly given the 'contagion' effect of suicide, wherein a completed or attempted suicide by one individual leads another individual to attempt or complete suicide, a well-documented phenomenon amongst adolescents and young adults (Askland et al., 2003; Hansens, 2011; Niedzwiedz, Haw, Hawton, & Platt, 2014). A systematic literature review on postvention, found that postvention services can evaluate and manage the risk to suicide amongst those bereaved by suicide (Andriessen, 2014).

Suicide postvention is intended to manage individual risk for psychopathology such as depression, substance abuse, anxiety, and post-traumatic and complex grief reactions as well as broader concerns including disrupted relationships, functional impairments in activities of daily living and routines, internal spiritual conflict and distress, challenges with meaning making, and punishment resulting from self-blame for the death, express Andriessen & Krysinska (2012). Both support groups and individual psychotherapy are considered promising means of addressing these issues (Andriessen & Krysinska, 2012), with empirical evidence for Cognitive Behavioral Therapy psychoeducation being effective at mitigating negative grief reactions (Wittouck, Van Autreve, Portzky, & van Heeringen, 2014) and community-based outreach interventions as cost-effective in their efforts to contain negative reactions (Comans, Visser, & Scuffham, 2013). Beyond management of the psychological distress resulting from suicide, postvention services are proposed as preventive and intervening means of controlling suicide clusters and/or suicide contagion (Askland et al., 2003; O'Carroll, Mercy, & Steward, 1988).

A comprehensive report on the South Australian Suicide Postvention Project, which included surveys of individuals bereaved by suicide, agencies, and service providers, recommends that the ideal suicide postvention service model considers service structure

(including initial crisis response at site of suicide, home visits by volunteers who have themselves lost to suicide, 24/7 telephone support services, bereavement and support groups, and a system of accessing additional supports from experts); education for general public, volunteers, professionals, and organizations; a communication strategy and network; and appropriate staff, policy, and funding for the provision of suicide postvention (A. Wilson & Clark, 2005).

Whereas CISM focuses on organizational activities following a crisis and PFA provides guidance to psychosocial support for individuals experiencing recent traumatic events, suicide postvention focuses specifically on the outreach to and clinical support for individuals and groups grieving a death to suicide, including that which extends beyond the immediate event. Each of these frameworks lends unique ways of considering response to crises within the community context, but how do they apply in a cross-cultural context?

Crisis Response in Cross-Cultural Settings

Applicability of mainstream systems and models of practice in cross-cultural settings is increasingly questioned. An international research project led by Ungar (2007, 2012), has highlighted that resilience has deep cultural roots. Within the context of crisis response, this is particularly pertinent; indeed, Landau (2013) proposes that connection to culture aids the healing from mass traumas. Further, responses to traumatic events differ across culture groups, including variable psycho-somatic experiences of distress; differing ways and formats for communication; and different rituals, ways of making meaning, and sources of resiliency (Dyregrov, Regel, & Joseph, 2007) and therefore different cultures may benefit from different response practices.

Unfortunately, the majority of research on Critical Incident Stress Management and early interventions following a trauma have been set in Western contexts, as Dyregrov et al. (2007) found in a review of completed studies. As a result, the models of intervention may not match

with culture or context in which it is being employed. Whether crisis response models adapted to a context different from where they were developed and tested was a question wrestled with by Doyle and Hungerford (2014) in a theoretical piece, with a discussion on how the adaptation of the Mental Health First Aid for the Aboriginals of Australia was successful. On the other hand, Hughes (2006) concludes her study on group debriefing in the First Nations context, suggesting that there limits to the extent to which one can borrow on mainstream crisis management approaches when working with Canadian Indigenous communities, as the mainstream understanding of crisis and crisis responses does not fully align with the Indigenous understanding and philosophies of approach.

Literature on Crises and their Context in Northern Indigenous Communities

Indigenous peoples live throughout Canada, however wherever possible this section shall focus on Indigenous communities in northern Canada, including isolated Indigenous communities in northern portions of the provinces (excluding Nova Scotia, New Brunswick, and Prince Edward Island) and the territories. In some situations, data is not specific to northern regions, and this shall be identified. Indigenous peoples within northern regions may be First Nations, Inuit, or Metis, with each having unique culture, context, and experiences; there are further variations by region and community. Context and culture of the information shared will be differentiated wherever possible.

This section shall review the context for crises within northern Indigenous communities and conclude with a discussion regarding why Indigenous-specific information on response is required. Given recognition that crises in Indigenous communities have their roots in historic and current situations and actions, both shall be explicitly discussed prior to discussion on the prevalence of crises within northern Indigenous communities. This section shall provide a framework for understanding crises and crisis responses in northern Indigenous communities.

Context for Crises in Northern Indigenous Communities

Historical context for crises in northern Indigenous communities. To understand the current context of crises in Indigenous communities, one must understand the historical context in which they arose; Indigenous Elders, advocates, governments, and scholars all stress that the colonial legacy of racism, subjugation, and violence has an on-going effect on health and wellness of Indigenous peoples and communities (Aboriginal Healing Foundation, 2006; Brave Heart, 2000; Inuit Tapiriit Kanatami, 2016; Kirmayer & Valaskakis, 2009; Qikiqtani Inuit Association, 2014; Sotero, 2006), often calling it historical or intergenerational trauma.

The concept of historical trauma has its roots in literature on *collective trauma* amongst mass disaster survivors – for example, Erikson's (1976, 1998) recount of the flood at Buffalo Creek – and *intergenerational trauma* amongst the descendants of Holocaust survivors (Danieli, 1998). First presented by Indigenous scholars in the 1990s, *historical trauma* was described to be:

> *Cumulative emotional and psychological wounding over the lifespan and across generations emanating from massive group trauma experiences; the historical trauma response is the constellation of features in reaction to this trauma (Brave Heart, 2003, p. 7).*

Brave Heart states that depression, self-destructive behavior, suicidal thoughts and actions, anxiety, low self-esteem, anger, and difficulty recognizing and expressing emotions are all common historical trauma reactions (Brave Heart, 2003) and associates the high rates of suicide, homicide, domestic violence, child abuse, alcoholism, and other social problems with historical trauma (Brave Heart & DeBruyn, 1998), providing quantitative and qualitative research to attest to this phenomenon (Brave Heart, 2000).

Given the links between historical trauma and current psycho-social distress, understanding the historical context of Indigenous wellness is critical to understanding the contemporary crisis-situations in Indigenous communities. This section shall give a brief overview to colonization in northern Canada and explore implications for current wellbeing in northern Indigenous communities.

Colonization in the North. Across the North, Indigenous peoples had differing experiences of first contact with Europeans. For example, European traders had contact with Labrador from the early 1700s, with sustained settlement by the German Moravian missionaries starting in 1771 (Arendt, 2013); whereas in the territories, sustained European contact occurred

much later – settlers did not begin arriving in large numbers until 1950 (Qikiqtani Inuit Association, 2014). Despite the variance in timing, many aspects of the experience are similar.

Prior to contact, subsistence hunting and seasonal travel were the norm pre-contact for First Nations in the north (Scott, 2014). Likewise, most Inuit families lived off the land in tight groups ranging from five to thirty people, moving seasonally between locations by dog team or boat in pursuit of the wildlife that met their basic needs of food, clothing, and shelter (Qikiqtani Inuit Association, 2014). As Hudson's Bay Company outposts became established, Aboriginal peoples engaged in trade for rifles, ammunition, and other southern goods (RCAP, 1996). Governmental policies mandating relocation, such as that from Hebron, Labrador (Brice-Bennett & Royal Commission on Aboriginal Peoples, 1994) and Tsulquate, British Columbia (RCAP, 1996), have had on-going impacts on health and wellbeing (Brice-Bennett & Royal Commission on Aboriginal Peoples, 1994; Qikiqtani Inuit Association, 2014; RCAP, 1996). Though the exact experiences of colonialism varies by region, many themes remain similar (RCAP, 1996) and so, for the purpose of understanding the Northern historical context, the findings of the Qikiqtani Truth Commission on colonization in Nunavut from 1950-1975 will be reviewed.

In Nunavut the change in lifestyle was sudden; up to 1950, Inuit came in contact with Qaallunaat (white) settlers or traders, RCMP, and/or churches only once or twice a year, but by 1975, all but a few were permanent residents of government-created settlements (Qikiqtani Inuit Association, 2014). Resulting from Cold War-driven interest in developing presence in the north, Canadian policy changes forced relocation to permanent settlements, mandated the RCMP to shoot and kill dog teams, and removed Inuit children from their families for extended periods of time (Qikiqtani Inuit Association, 2014). They provided minimal health and social services, leaving Inuit residents with insufficient housing, food insecurity, poor employment and

education opportunities, and health services so limited they drew criticism of international agencies (Qikiqtani Inuit Association, 2014).

As a result, Inuit both lost their livelihood (seasonal subsistence hunting, fishing, and gathering, facilitated by dog teams) and were forced to live in situations of overcrowding and malnutrition which fostered ill-health, with no access to adequate health or social services (Qikiqtani Inuit Association, 2014). The loss of lifestyle, particularly the loss of dog teams, was very challenging to Inuit mental wellness. One Elder poignantly expressed:

> *"In the spring of 1965 while I was at work, all my dogs which were chained up were shot… This was very painful to me as I needed to hunt… I could no longer hunt or travel once my dogs were shot… A major part of my livelihood was taken away from me, my identity and means of providing for my family.*
>
> *At this time the role of the Inuk male as a provider was the sole purpose of nurturing and protecting our family and community and that was very quickly obliterated with single gun shots held to our dogs, our only means of transportation and hunting. We took pride in our roles as hunter-gatherers and that was all we had left in our identities. Our mobility rights were taken away from us" (Inuit Elder, as quoted in Qikiqtani Inuit Association, 2014, p. 42-43)*

Such a quote speaks not only to the significant negative impacts on livelihood and food security, but also the grave impacts on cultural identity, individual's roles in society, and personal self-efficacy, something which has had long-lasting impacts on mental health amoungst Inuit (Inuit Tapariit Kanatami, 2016).

Finally, Inuit children were mandated to attend school, with the intention of "[making] Inuit into full Canadian citizens" (Qikiqtani Inuit Association, 2014, p. 33). Government officials expected that Inuit children would live in dormitories for the school year and return to their families on the land between periods; this did not go as expected: Inuit parents refused to have their children placed in the care of others, and despite not wanting to move into settlements, would do so – often living in tents until housing became available – in order to remain connected

to their children (Qikiqtani Inuit Association, 2014). This commitment to remaining close to their children is not surprising given that family, including children, youth, and Elders, is highly valued amongst Inuit culture. To the great distress of child and parent, there were some children which were sent to residential schools in Iqaluit, Inuvik, Yellowknife, Chesterfield Inlet, and Churchill, Manitoba and others who were sent to live in southern cities with Qallunaat families (Qikiqtani Inuit Association, 2014).

While the exact occurrences of colonization differ by region, many themes remain similar, such as changes in lifestyle due to contact with non-Indigenous settlers, outbreaks of diseases such as tuberculosis and influenza, mandatory attendance of residential schools, and forced resettlements (RCAP, 1996). Returning to points made at the beginning of this section, historical trauma is linked to societal challenges of high rates of suicide, homicide, domestic violence, child abuse, alcoholism, and other social problems (Brave Heart & DeBruyn, 1998). Historical traumas, compounded by current problems, lives on within Indigenous collective memory and the collision of European and Indigenous individual and collective lifestyles continues to leave Indigenous peoples struggling to find their footing. In the words of Inuit filmmaker Zacharias Kunuk in an interview with Shelagh Rogers on CBC Radio:

> *We can't go back to the old ways. The new system is not working.*
> *We are in limbo.*
> *Our youth are killing themselves.*
> *(Kunuk, October 20, 2006).*

Contemporary context for crises in isolated Indigenous communities. Contextual factors have a strong impact on the wellbeing of individuals and families in Indigenous communities (Adelson, 2005; Marmot, 2005; Peters, 2012; Reading & Wien, 2013). The National Collaborating Centre for Aboriginal Health suggests that the social determinants of

Aboriginal wellbeing include proximal (health behaviors, physical environmental, employment and income, education, and food insecurity), intermediate (health care system, educational system, environmental stewardship, cultural continuity, and community infrastructure, resources, and capacities), and distal (colonialism, racism and social exclusion, and self-determination) factors (Reading & Wien, 2013). Within the 2016 report by the Chief Public Health Officer on the 'Health Status of Canadians', income, education, housing/food security, physical activity, tobacco use, and immunizations are all key factors they consider in understanding health. This report highlights that – though datasets are not directly comparable – Indigenous peoples (Inuit, First Nations, Metis) are more likely to be living on low income, less likely to graduate high school, more likely to be housing/food insecure, and more likely to smoke than non-Indigenous Canadians (Health Canada and the Public Health Agency of Canada, 2016). Collectively these likely contribute to lower health outcomes, culminating in lower life expectancy at birth (Health Canada and the Public health Agency of Canada, 2016).

Within northern regions, geography plays a major factor in the access to goods, services, and opportunities. An anthropological account of life in Ulukhaktok, Northwest Territories describes how the community of 400 people has five scheduled flights a week (from Yellowknife and Inuvik) supplemented by charters, that serve as the only means of entering and exiting the community, for people, groceries, equipment, mail, and all other cargo (Collings, 2014). Such flights are very expensive, often serving as a major barrier to individuals and families wishing to travel in or out of the community (Collings, 2014). Further, basic nutrition and household goods – such as groceries and supplies available in small general stores – are limited and often expensive. Finally, bad weather (fog, high winds, blizzards, etc) can result in flight delays lasting hours, days, or even weeks, with no travel in or out for medical, personal, or professional

reasons, nor any incoming groceries, mail, or equipment (Collings, 2014). As one participant in a study on healthcare in small, remote communities of Labrador observed: "You are physically isolated from service by geography… you can't change that… you have fly-in communities… you have no road access… you have weather…" (as quoted in Montevecchi, 2012, pp. 4).

Exact community constitution can vary across the north, but many consist of only several hundred people or a couple thousand people, with a town/band council, small health clinic (often staffed by a few nurses, with a doctor who travels in periodically, and tertiary care in larger centers), school, a general store or to which sells everything from apples to winter coats to crescent wrenches, some format of social service provision (eg. social assistance, child welfare, and mental health services – provided in a blend of professionals 'from outside' and local paraprofessionals), and RCMP (Collings, 2014).

Many residents, communities, and representatives are strong advocates for increasing accessibility of needed services: Inuit Tapiriit Kanatami (2016) stresses the need for tertiary mental health services within the Inuit regions; Minore, Boone, Katt, Kinch, & Birch (2004) discuss the challenges in service disruptions in mental health, diabetes, and oncology in First Nations communities of northern Ontario; and Fraser, Rousseau, Kasudluak, Burmester, & Arauz (2012) look at the experience of Inuit children placed out-of-community after apprehension for child protection reasons in northern Quebec and further, how difficult their re-integration into the community is after-the-fact. In tandem with these challenges, residents and communities exhibit great resilience and strength, wishing both to be recognized for the internal capacity for meeting their own needs and to have partners in strengthening this internal capacity and resilience (Canadian Foundation for Healthcare Improvement, 2016; National Knowledge Exchange, 2016)

Crisis Prevalence in Northern Indigenous Communities

It is within this context of historical trauma and poor social determinants of health that crises in northern Indigenous communities arise. While northern-specific data is not available, in 2011, Tjepkema, Wilkins, Pennock, and Goeduis released a study reviewing the potential years of life lost due to untimely deaths among Status Indians aged 24-75 in Canada from 1991-2001. They found that the age-standardized rate ratio of years of life lost due to injuries (including non-intentional injuries such as drownings, fires, and traffic accidents and intentional injuries such as homicide and suicide) for Status Indian men compared to non-Aboriginal men was 3.72, while for Status Indian women it was 4.54 (Tjepkema et al., 2011). For Status Indian men, the rate ratios were particular high for drownings (10.45), homicide (6.84), and house fires (6.53); whereas for women, poisonings (14.55), homicide (8.61), and drownings (6.52) were particularly high (Tjepkema et al., 2011). Indeed, death due to injuries was the largest contributor to the disparity of years of life lost between Status Indians and non-Aboriginals (Tjepkema et al., 2011). Similar breakdown cannot be found for Inuit, however the life-expectancy in Inuit regions is 10 years less than the Canadian average (70.8 years vs 80.6 years) (Gionet & Roshanafshar, 2013).

By statistics, First Nations and Metis men and First Nations women are twice as likely to die by suicide than the average Canadian during the 1991-2001 period (Tjepkema et al., 2011) and Inuit individuals ten times as likely to die by suicide during the 1999-2003 period (National Aboriginal Health Organization, 2005), further, information from the Aboriginal Peoples Survey found that one in five off-reserve First Nations, Metis, and Inuit have considered suicide in their lifetime (Kumar, 2016). Suicide amoungst Indigenous youth is a particular concern: the Centre for Suicide Prevention (2013) cites that for First Nations male youth (15-24) the rate of death to suicides is 126 per 100,000 compared to 24 per 100,000 for non-Aboriginal youth and for

females, 35 per 100,000 versus 5 per 100,000. For Inuit youth, the suicide rates are 11 times the national average (Centre for Suicide Prevention, 2013).

General research finds that exposure to suicide (eg. loss of a friend, family member, or even celebrity to suicide) increases the risk of suicidality, and as Kirmayer et al. (2007) highlight, Aboriginal communities are close knit and as a result, a death by suicide is felt by the entire community, increasing the risk of suicide contagion and suicide clusters. Clusters of suicides are devastating to the community, and while common in Indigenous communities in Canada, it is important to note that not all communities have been so-affected (Centre for Suicide Prevention, 2013; Olson, 2013). Communities with strong cultural ties and community ownership are found to have little to no suicide (Chandler & Lalonde, 1998, 2008). Equally, such elevated rates of suicide were not the norm in Indigenous communities prior to impacts of colonialism and colonization (Kirmayer et al., 2007).

Need for Indigenous-Specific Crisis Response

Not only does the historical and current context for the disproportionate prevalence of crises in Indigenous communities warrant unique consideration in academia and practice, literature and research both suggest that Indigenous ways of understanding and interacting in the world must be put at the fore-front of healing and wellness policies and practices (Fast & Collin-Vézina, 2010; Kirmayer & Valaskakis, 2009; Sotero, 2006; Waldram, 2008; Bombay, Matheson, & Anisman, 2009; Brave Heart, 2003). Many western values differ from Indigenous values. Aboriginal value systems often include being in harmony with nature; working towards collective-wellbeing; sharing amongst the tribe/community; mutual-reliance for survival; subsistence harvesting; humility, honesty, and integrity; respect for traditional knowledge; and holistic understanding of the world (Heinrich, Corbine, & Thomas, 1990). Family and

community way of life, interpersonal interactions, and group leadership were founded on these beliefs (Fast & Collin-Vézina, 2010).

The conceptualization of health and wellness also differs. Within Aboriginal culture, wellness is considered as holistic wherein spiritual, physical, emotional, and mental wellness is regarded as inseparable; in the Western approach, health is viewed in components, which can be individually analyzed (Moodley, Sutherland, & Oulanova, 2008). Further, Aboriginal belief systems posit that individual healing is unlikely to occur without support from the community and efforts of the collective to create a supportive community environment facilitates individual healing (Waldram, 2008).

In the face of trauma, cross-cultural differences impact the mechanisms of healing; for example, an international mixed-methods study on resilience amongst vulnerable youth (1500 youth; 11 countries) led by Ungar, has found that while there are seven common themes of resilience – "nurturing relationships; a positive identity; efficacy; social justice; access to material resources; a sense of cohesion and belonging in one's family, school, and community; and cultural adherence" (Ungar, 2012, p. 388) – the expression of these factors varies across research sites. In addition to impacting means of resilience, different cultures have been observed to have different psychosomatic responses in the face of trauma (Dyregrov et al., 2007).

Following traumatic incidents, first responders must be sensitive to the cultural context of service provision; this holds true within Indigenous contexts (Hughes, 2006; National Knowledge Exchange, 2016). Indeed, within their draft 'Crisis and Emergency Response Plan', the Kwanlin Dun First Nation expresses: "the cultural values, sacred knowledge, languages and

practices of First Nations are essential determinants of health and wellness before, during, and following a crisis or emergency in the community" (Kwanlin Dun First Nation, 2016, p. 8).

Literature on Crisis Response Strategies in Indigenous Communities

Crisis Response Research in Indigenous Communities

As many who live in and/or work with Indigenous communities discuss, communities are responding to crises on a regular basis (National Knowledge Exchange, 2016), however crisis response strategies for Indigenous communities have not been well-studied. This lack of knowledge is concerning given that Indigenous communities across Canada are experiencing and responding to crises, but there is little academic research providing understanding or guidance to these practices.

One study on the implementation of Western early crisis response strategies by Hughes (2000, 2006), completed a qualitative assessment on a training in psychological debriefing provided to a group of First Nations mental health supports in Vancouver, BC. Despite the training being intended specifically for its First Nations participants, the participants expressed to Hughes (2000, 2006) that they thought their culture was only nominally recognized through logo and imagery of the materials and that the deeper level of cultural understanding was lacking. For example, participants noted that the language and concepts used did not align with their own and that spiritual and cultural ways of engaging, grounding, meaning-making, and healing were not included (Hughes, 2000, 2006). Participants gave clear direction that such training and services should be based upon the medicine wheel and include appropriate rituals (Hughes, 2000, 2006).

Hughes (2000, 2006) further found that the understanding of crises did not align with those of the First Nations participants: the idea of a 'critical incident' as an isolated, current trauma clashed with the understanding of the First Nations participants. From the perspective of participants, historical traumas – such as residential schools – are critical incidents given that "the incidents arising from it continue to occur on a daily basis" (participant comment, as quoted in Hughes, 2006, p. 88). Arising from this differing understanding of trauma, participants were

concerned with the imposed differentiation between short-term crisis intervention and the long-term healing processes which they perceive their communities to need (Hughes, 2006).

A case study (based on the author's personal observations and experiences) of implementing a Critical Incident Stress Management service in Northern Alaska also highlighted the mixed aspects on implementing such a model with Indigenous peoples (Terry, 1999). As the full CISM model for support could not be provided due to geography and available resources/supports, a modified version was implemented, wherein the local Community Health Aides who provided much of the community-based crisis response services received trainings, psychological debriefings, telephone-based counselling, referrals, and treatment (Terry, 1999). On one hand, Terry (1999) noted that it increased knowledge on trauma, stress, and mental health; elicited gratitude for the debriefings; increased the depth of trusting relationships; and some Health Aides made lasting commitments to sobriety, but on the other, he claims that its impact was only superficial. Terry reflected that "its roots did not reach deep enough and were insufficiently extensive to bring about real change for the Health Aides" and further that "…some of the standard interventions used by this program, and by other programs as well, … have questionable efficacy and appropriateness in this setting or in other Native communities" (1999, pp. 157).

Terry (1999) highlights that the debriefings had mixed reviews as the psychoeducational focus on bio-behavioral causes and symptoms of stress did not align with the Alaskan Native worldview. Further, the focus on individualized models of self-care and stress-management was at odds with the cultural understanding of wellness as a communal occurrence and while efforts were made to engage family and significant others, a model for meaningful engagement of them was not found (Terry, 1999). Finally, the referrals made for addictions and mental health

counselling were not actioned, in part due to culturally incongruent treatment models, in part because the services available were insufficient to meet needs (Terry, 1999). As was discussed by Hughes (2000, 2006), Terry (1999) recommended that crisis response in Indigenous communities must be responsive to the broader context of trauma, including cultural and historical trauma and ongoing contemporary traumas such as violence, suicide, and substance abuse.

Instead of the CISM approach, the Alaskan Native communities where Terry (1999) worked devised a community-based, collaboratively-developed approach to crisis response based on "Kelengakutelleghpat … a whaling term [which] means 'watching out for each other'" (p. 167). This approach arose from and aligns with traditional values of collaboration, honoring the "connectedness of each member of the group to each other and to the environment" (p. 168), and emphasizing social supports through collective actions and collaborative knowledge sharing. Based on community-guided needs and desires for crisis management, this involved public relations and education campaign to address unattainable community expectations; self-governance and new services for more responsive and suitable services; monthly audio-conferences to promote collective learning amongst Health Aides; peer support meetings for knowledge sharing and care; and computers to link Health Aids across the region (Terry, 1999).

This account by Terry and research by Hughes highlights the inappropriateness of applying a Western crisis response model to an Indigenous context without detailed consideration to the cultural understanding and experience of trauma, resilience, and healing. It further suggests that without significant adaptation for cultural applicability, structured psychological debriefing may not be appropriate for Indigenous communities as it is not reflective of cultural understanding of trauma nor cultural strategies for resilience and healing.

There is little further research on the application of Western models of crisis response in Canadian Indigenous communities, though a recent National Knowledge Exchange on 'Community Safety and Crisis Response', revealed that many Canadian Indigenous communities are responding to the crises which occur, learning from their own experience and the experiences of others, have sought training in Critical Incident Stress Management (CISM), and have developed Crisis Response Manuals modelled on this (National Knowledge Exchange, 2016).

Pertinent to crisis response, interagency collaboration is known to be important when providing health and social services in Canadian Indigenous communities. Boone, Minore, Katt, and Kinch (1997) discuss how to strengthen the interdisciplinary collaboration necessary for effective service provision in northern Aboriginal communities in an article drawing knowledge from Nishnawbe-Aski community consultations, a national survey on preparation of professionals for Northern health practice, interviews with Aboriginal health paraprofessionals, and reviews with two different interdisciplinary teams in Northern settings. Within it, they note that these interdisciplinary teams may include paraprofessionals (such as community health representatives, mental health workers, grief counsellors, addictions workers, band family service workers, crisis team leaders, child welfare workers, traditional healers, Elders, band councilors, and band constables) whom are often from the community, in addition to professionals (such as social workers, nurses, police officers, and psychologists) who often come from outside the community (Boone et al., 1997). Such a blend of agencies and individuals requires an understanding and respect for each-others' roles, including respecting the knowledge and capabilities of all team members, recognizing one's involvement within the community as an individual as well as professional, involving the community and its leaders in the development and delivery of services, honoring client confidentiality and processes to information sharing,

maintaining channels of communication, and understanding the context within which you function (Boone et al., 1997).

Though there has been relatively little research focused on crises response in Indigenous communities, suicide in Indigenous communities has garnered a lot of attention, resulting in many suicide-specific dialogues, research, and publications. Despite the fact that response to suicide is often included within general discussions on crisis response in Indigenous communities (eg. Canadian Foundation for Healthcare Improvement, 2016; National Knowledge Exchange, 2016), the breadth of work on Indigenous suicide and prevalence of suicide in this research context demands a section focused on that. The purpose is to provide an overview to what is currently being discussed around suicide in Indigenous communities and to give some understanding of what community response may look like.

Suicide Postvention in Indigenous Communities

As was discussed earlier, suicide rates in Indigenous communities are far higher than the Canadian average. To address this, there have been numerous national and regional Indigenous-specific suicide prevention strategies and toolkits, for example: *Aboriginal, Metis, Inuit, and First Nation Suicide Prevention Resource Toolkit* (Centre for Suicide Prevention, 2013)*; Assessment and Planning Toolkit for Suicide Prevention in First Nations Communities* (National Aboriginal Health Organization, 2005)*; National Inuit Suicide Prevention Strategy* (Inuit Tapiriit Kanatami, 2016); *Nunavut Suicide Prevention Strategy* (Government of Nunavut, Nunavut Tunngavik Inc., & Embrace Life Council, 2010)*; Fraser Region Aboriginal Youth Suicide Prevention Collaborative: Suicide Prevention, Intervention and Postvention Initiative* (Kahui Tautoko Consulting Ltd, 2012)*; National Aboriginal Youth Suicide Prevention Strategy (NAYSPS)* (Health Canada, 2013)*;* and *Aboriginal Youth: A Manual of Promising Suicide Prevention Strategies* (White & Jodoin, 2003) to name a few.

While suicide prevention is typically the focus, some strategies make reference to postvention as a means of containing suicide contagion. For example, to prevent suicide clusters, the National Aboriginal Youth Suicide Prevention Strategy (Health Canada, 2013) recommends:

- engaging a network of professional, paraprofessional, and natural helpers;
- creating local crisis response protocol;
- developing crisis response teams; and
- enhancing capacity at responding to and stabilizing crisis situations, including preparation, practice, and post-incident review.

Within this process, they recommend addressing after-effects of loss due to suicide, including the increased risk of suicide and suicide clusters amongst youth (Health Canada, 2013). They stress the importance of a comprehensive and locally-developed approach which engages a multitude of resources, including local resources such as local band office/chief and council; local police; Elders; youth councils; schools; clergy; community leaders; local not-for-profit organizations; and private industry (Health Canada, 2013).

In the *Fraser Region Aboriginal Youth Suicide Prevention Collaborative* (Kahui Tautoko Consulting Ltd, 2012), provision of post-suicide response includes bereavement support for families, peers, and communities and they encourage educational workshops, support groups, group therapy, and survivor groups for those bereaved by suicide. They also recommend that protocols for community response teams include both critical incident management and referral protocols for ongoing treatment (Kahui Tautoko Consulting Ltd, 2012).

To help elucidate what responding to suicides in isolated Indigenous communities looks like, Wilkie et al., (1998) wrote a case study regarding the response to a 1995 suicide cluster which occurred in a First Nations community 600km north of Winnipeg. As some context, they

report that in 1995, the community population was roughly 1500 people primarily Cree-speaking, accessible by only by plane (except in January/February when the winter road is open), with a health clinic, school (500 students), RCMP detachment, chief and council, four churches, National Native Alcohol and Drug Abuse (NNADAP) worker and sporadic mental health worker visits. At the time of the suicide cluster, Wilkie et al. (1998) state that the clinic was staffed by 4 nurse practitioners, 3 community health representatives, and a physician 2 or 3 days per week.

There were no completed suicides in the community in 1993 or 1994, but between February 3 and May 5, 1995, there were 6 completed suicides in the community; five by hanging, one by shooting (Wilkie et al., 1998). In additions to the deaths, 19 other individuals (aged 12 to 23) were sent to the nearest hospital by medivac following suicide attempts – including hanging, overdose, and gunshot – or ideation. In their section discussing the 'Reaction of the Community', Wilkie et. al. (1998) states:

> *The initial response was to rush anyone felt to be at risk out of the community. Some believed a 'break from the community' was best. Others argued that the problem could not be exported. The Medical Services Branch arranged for a psychiatrist and 2 psychologists to debrief community members for 2 days after the fourth suicide. Some people blamed the new arena and others the Chief and Council. Not enough Christian faith was cited as the root cause by others…*
>
> *The entire community was in mourning. It was suggested that the school be closed. An attempt to reduce access to lethal means was made. The nurses compiled a list of those felt to be at high risk. This included family and friends of the suicide victims, those who had discovered their bodies, individuals with a history of serious emotional problems or substance abuse, and those who were isolated with few social supports. Additional names were added at the suggestion of teachers, police, and community leaders. At one time there were 32 names on the list. A Suicide Prevention Committee already existed. By the fifth suicide this committee was overwhelmed and no longer meeting (Wilkie et al., 1998, p. 825).*

This quotation provides a snapshot of what it can be like for a community trying to cope with a series of suicides: an influx of personnel (often short-term and, at times, unfamiliar with the context), conflicting opinions on causes and actions to take, prevailing heavy emotions, an attempt to identify who might be at risk for an attempt themselves, and a sense of being overwhelmed. Though each community is different, I have heard variations of this story repeated by friends, colleagues, media, and academics in northern Indigenous contexts. Perhaps as a way proactively address the difficulty of responding to crises, many Indigenous communities have undertaken steps to prepare for crisis response through trainings, manuals, and policies.

Practices and Policies of Crisis Response in Indigenous Communities

While research and literature may be slight, Indigenous communities across Canada are in active discussion regarding crisis response and have developed – or are developing – guidelines for crisis response within their community (Canadian Foundation for Healthcare Improvement, 2016; National Knowledge Exchange, 2016). For example, the Labrador Inuit developed a manual to guide crisis response in 2002, based upon the Mikmaw model developed in 1999 (Baikie & Beck, 2002). Currently, the Kwanlin Dun First Nation in the Yukon is in the process of completing a Crisis and Emergency Response Protocol and the Anishinabe Mekina Mino-Ayawin (AMMA) Mental Wellness Team project in northern Manitoba recently completed a 'Crisis Response Procedures Manual' to guide responding to crises in their region (Canadian Foundation for Healthcare Improvement, 2016; National Knowledge Exchange, 2016). In a pre-conference workshop on 'Community Safety and Crisis Response', Indigenous Mental Wellness Teams from across Canada shared knowledge on crisis response practices and policies, including discussing training models (such as training in the CISM model in northern Saskatchewan) and collaborating to review a case study, which highlighted how each Indigenous community would

have a unique response, varying based on community resources, culture, and context (National Knowledge Exchange, 2016).

The crisis response manual developed for the Labrador Inuit in 2002 "[provides] a suggested plan of approach and response to community crisis situations" (Baikie and Beck, 2002, p. 5). "The Crisis Response Team is a community volunteer organization… [consisting] of key community agencies and community volunteers… the Crisis Response Team may be required to respond to a sudden, unexpected, uncontrollable, and tragic event that causes a family or community crisis (e.g.: deaths by fire, fatal accident, homicide/suicide, a community disaster, drowning or missing people)" (Baikie and Beck, 2002, p. 6-7). The manual provides guidance on recruiting, training, and supporting staff and volunteers and how to organize crisis responses.

The Kwanlin Dun First Nation in the Yukon is currently in the process of finalizing their 'Crisis and Emergency Response Plan' (CERP) which considers the similarities and unique nature of responses varying from a sudden unexpected death to a significant fire (Kwanlin Dun First Nation, 2016). The information presented here is from the second draft and is used with consent from an involved representative. The plan is developed based on eight guiding principles:

- *Reflect Kwanlin Dun culture, beliefs, traditions and values*
- *Ensure open and effective communication*
- *Provide special care and attention to Elders, children and people with disabilities*
- *Be specific – tailor the CERP to specifically address the most likely events*
- *A self-sufficient community: foster community involvement through education, training/certification and preparedness*
- *Use the Incident Command System (though with less militaristic terms)*

- *Effectively link with the City of Whitehorse, Yukon Government, First Responders, other First Nations*
- *Use the First Nation Mental Wellness Continuum Framework (FNMWCF) to ensure comprehensive attention to community values, culture as foundation and working with partners (Kwanlin Dun First Nation, 2016, p. 4)*

Out of this, the Crisis and Emergency Plan "contains detailed operational information on how to effectively co-ordinate a KDFN and community response to a crisis or emergency, in a way that reflects and supports Kwanlin Dun's unique heritage, traditions and culture" (Kwanlin Dun First Nation, 2016, p. 3).

Indigenous crisis response: Key points. Across these articles arise themes of the importance to having culturally-congruent (Cousins, 2010; Harlow et al., 2014; Hughes, 2000, 2006; Kwanlin Dun First Nation, 2016; National Knowledge Exchange, 2016; Terry, 1999), community-led (Baikie & Beck, 2002; Cousins, 2010; Harlow, Bohanna, & Clough, 2014; National Knowledge Exchange, 2016; Terry, 1999), collaborative approaches (Baikie & Beck, 2002; Boone et al., 1997; Cousins, 2010; Kwanlin Dun First Nation, 2016; National Knowledge Exchange, 2016; Terry, 1999) to addressing crises in Indigenous communities. To implement such an approach, these articles highlight the importance of preparatory planning (including development of response strategies/manuals) (Canadian Foundation for Healthcare Improvement, 2016; Health Canada, 2013; National Knowledge Exchange, 2016), coordination of and training for responders (such as developing and training crisis response teams) (Baikie & Beck, 2002; Canadian Foundation for Healthcare Improvement, 2016; Health Canada, 2013; National Knowledge Exchange, 2016; Terry, 1999), and implementing immediate and on-going supports for both community members and crisis responders (Baikie & Beck, 2002; Health Canada, 2013; Kwanlin Dun First Nation, 2016; National Knowledge Exchange, 2016; Terry, 1999).

Research Method and Methodology

This research focus on community crisis response arose out of questions raised by professionals and managers within the community of interest. Thus, as the researcher, I sought input from involved agencies throughout conceptualization of the research methodology, thereby ensuring respectful engagement throughout the process and that the results would be useful to the community at conclusion.

Research Question

What are the organizational policies, procedures, and professional practices that guide crisis response in one isolated, Indigenous community?

Research sub-questions. Through initial analysis of the documents and interviews, sub-questions pertinent to the overall question arose:

1. How are organizational policies, procedures, and professional practices reflective of community culture and values?
2. How are organizational policies, procedures, and professional practices reflective of community context and resources?
3. How are organizational policies, procedures, and professional practices reflective of community strengths and struggles?
4. How can organizational policies, procedures, and professional practices be improved to better serve the community?

Study Design

For this research project, I utilized key informant interviews with representatives from agencies and community services providing crisis response following a critical incident in the identified community. To systematize provision of a deeper understanding of the history and context of crisis response within the community, after consultation with the Indigenous research advisor, I added an analysis of documents identified and provided by the Indigenous government to the research methodology.

Ethics

Ethics applications and research approvals were granted by the regional Indigenous research advisory committee, provincial health research ethics board, regional health authority research review committee, provincial school board research approval committee, and provincial social services research committee. McGill University Research Ethics Board was consulted, but declined doing an ethics review, stating that the project was exempt as the focus was key informant interviews on policies, procedures, and professional practices. I inquired whether ethics applications were required from the other agencies interviewed, but they stated they were not.

Within the ethics agreement, it was outlined that the community would not be identified within external publication of the material and that service providers would go under generic names. This was to respect the confidentiality of the community and to prevent post hoc judgement of the community or service providers therein. For internal presentation of the research, agencies would be identified.

Interview Sampling and Recruitment

Agencies involved with crisis response were identified through consultation with managers and frontline staff in the identified community who responded to crises. The manual for crisis response in the community (developed in the early 2000s) was also consulted for the agencies it recommended be involved in crisis response. Out of this process, the following fourteen agencies were identified:

- Indigenous Government – Regional Leaders
- Indigenous Government - Community Leaders
- Indigenous Government – Community Mental Health and Addictions
- Indigenous Government – Community Programs

- Provincial Health Services – Mental Health and Addictions
- Provincial Health Services – Medical Services
- Provincial Child Welfare Services
- School (K-12)
- Police
- Three (3) Local Church Groups
- Ground Search and Rescue Services (GSAR)
- Fire Department

Officials within each agency were approached with a letter of information (Appendix 1), consent form (Appendix 2), and interview guide (Appendix 3), and were requested to identify an individual from their agency able to be an agency representative in presenting their organizational policies, procedures, and professional practices in responding to critical incidents in the community.

Upon identification of an individual within the organization, the agency was given the choice of approaching the individual themselves or having me, as the researcher, do so. In the situations wherein I did so, each individual was provided a copy of the letter of information, consent form, and interview guide to aid in their decision to consent in involvement within the research.

Interview Structure

Interviews occurred in person or by phone, depending on the interviewee's location and comfort. Each interview started with a review of the consent form (Appendix 2) and opportunity to ask any questions. Once the interviewee expressed understanding of what was expected, consented to be part of the process, and signed the consent form, the interview proceeded. At the start of each interview, the interviewee was reminded that the focus was on policies, procedures, and practices and that no information would be collected on actual incidents.

For these semi-structured interviews, an interview guide (Appendix 3) was utilized. The development of the interview guide drew upon the input of managers and frontline staff, as well as my own knowledge of the community and research practices. The intent was to start with broadly asking about what each agency's terming of crisis includes and what their response (both immediate and on-going) might be, before narrowing down to inquiring about their responses to hypothetical situations, to ensure the broad responses could be understood in-action. Due to interest expressed by the community on the differing levels of agency's involvement on the community crisis response team, this question was included for subsequent community-specific discussions. The interview concluded with an opportunity for the key informant to provide any other comments they may have.

Each key informant interview was audio-recorded and hand-notes were taken. Upon completion of the interview, detailed notes of the organizational policies, procedures, and practices made. Any anecdotal or personal disclosures which had been made, were removed from the data at this time. As a strategy for rigor, the detailed notes were sent to the interviewee for their review and approval. Where appropriate, a copy of the notes was subsequently sent to the individual's supervisor for their confirmation of accurate presentation of agency policies, procedures, and practices.

Interviews varied in length from 20 minutes to 80 minutes, depending on the scope of the responding agency, the specificity of agency mandate and practices, the range of contextual/historical information the interviewee included when responding to questions, and the verbosity of individual and cultural communication patters. As was outlined in the ethics application and consent form, once the detailed notes were taken, audio-recordings of the interview were destroyed.

Document Analysis

To provide context to and deeper understanding of current crisis response practices within the community, an analysis of selected documents was completed. A key informant from the health and social development division of the regional Indigenous government provided a selection of reports, official communications, and meeting notes ranging from 1991 to 2003 which are pertinent to crisis management within the community and region. Additionally, more recent documents from 2007-2013 were reviewed to pull forth information on the current context. Qualitative analysis of these documents was used to gain a contextualized understanding of crisis response in the community and to assist in structuring a framework for understanding the themes raised in the key informant interviews. In keeping with the intent to anonymize the data, these documents have been blinded – thereby removing all identifying information, such as title, author(s), names of participants/community, and any other identifying information. An anonymized listing summarizing the documents can be found in Appendix 4.

Methodology of Analysis

The method of data analysis followed recommendations by Ritchie and Spencer (1994) for qualitative data analysis for applied policy research. This framework of qualitative analysis was developed to answer the contextual, diagnostic, evaluative, and/or strategic questions of applying social policy.

There are five key stages to this data analysis process: familiarization, identifying a thematic framework, indexing, charting, and mapping and interpretation (Ritchie & Spencer, 1994). *Familiarization* includes "immersion in the data: listening to tapes, reading transcripts, studying observational notes" so that the researcher may "become familiar with their range and diversity,… gain an overview of the body of material gathered" (Ritchie & Spencer, 1994, p. 312). A *thematic framework* is developed through "[identifying] key issues, concepts and

themes according to which the data can be examined and referenced", refined through revisions which "[involve] both logical and intuitive thinking" (Ritchie & Spencer, 1994, p. 313-314). *Indexing* is a "process whereby the thematic framework or index is systematically applied to the data in their textual form" (Ritchie & Spencer, 1994, p. 316). *Charting* is a process wherein "data are 'lifted' from their original context and rearranged according to the appropriate thematic reference" which may be structured thematically (considering themes across respondents) or by case (considering each respondent across all themes individually) (Ritchie & Spencer, 1994, p. 318). Finally, *mapping and interpretation* brings together the central characteristics of data and "[maps] and [interprets] the data as a whole" (Ritchie & Spencer, 1994, p. 320). The outcome of following Ritchie and Spencer's (1994) recommendations can assist in:

> - *Defining concepts [and] understanding internal structures;*
> - *Mapping the range, nature and dynamics of phenomena;*
> - *Creating typologies [and] categorizing different types of attitudes, behaviors, motivations, etc.;*
> - *Finding associations [for example] between experiences and attitudes, between attitudes and behaviors, between circumstances and motivations, etc.;*
> - *Seeking explanations [both] explicit or implicit; [and]*
> - *Developing new ideas, theories or strategies*
>
> *(Ritchie & Spencer, 1994, p. 309).*

To answer the research question ("*What are the organizational policies, procedures, and professional practices that guide crisis response in one isolated, Indigenous community*?"), documents and interviews were charted by theme (defining community culture, values, and context pertinent to crisis response and describing organizational approaches to crises), the spectrum of agency responses was mapped (charting range of organization responses to

phenomena), patterns of responses within the documents and interviews were considered for associations (associating organizational actions with community culture, values, and context), and thematic analysis of documents and interviews highlighted strategies for possible change.

Indigenous Epistemology

In commencing research within an Indigenous community, consideration was given to Indigenous ways of knowing and ways of sharing information. Grenier (1998) suggests that Indigenous knowledge is cumulative, dynamic, possessed by all community members (with variation for individual role and responsibility), stored in memories, stories, and activities, and communicated orally and through cultural practices.

Battiste (2002) expresses that Indigenous knowledge is relational and arises out of the particular ecological context. In a theoretical piece on Indigenous methodology, Wilson (2001) states that "rather than asking about validity and reliability, you are asking how am I fulfilling my role in this relationship?" (p. 177). She goes on to recommend that in evaluating research methodologies, researchers reflect on:

> *What is my role as a researcher, and what are my obligations?*
>
> *...Does this method allow me to fulfill my obligations in my role?*
>
> *...Does this method help to build a relationship between myself as a research and my research topic?*
>
> *Does it build respectful relationships with the other participants in the research?*
>
> *(Wilson, 2001, p. 178)*

Beyond the researcher's responsibility to respectful relationships, it is important to consider Indigenous cultural values when conducting research. For example, in theorizing on the Inuit epistemology for research, Healey and Tagak Sr (2014) consider Inuit knowledge to be

based on relationships with people, land/environment, and the Spirits and that culturally-appropriate research thus considers:

1. Inuuqatigiitiarniq – "Inuit concept of respecting others, building positive relationships, and caring for others" (p. 5)
    a. Researcher's intentions and motivations
    b. Awareness of community context
    c. Formation of the question(s)
    d. Developing and fostering relationships
    e. Engagement of community members
2. Unikkaaqaatiginniq "Inuit concept related to story-telling, the power of story and the role of stories" (p. 6)
3. Iqqaumaqatigiinniq "Inuit concept of all thoughts, or all knowing, coming into one" (p.8)
4. Pittianiq "Inuit concept of 'being good'" (p.8)
    a. Consent
    b. Protection of stories
    c. Accountability as a researcher.

    (Healey & Tagak Sr., 2014, p. 5-8)

Thus, throughout this project, recognition has been given to the fact that this Indigenous community's experience with crisis response is built upon knowledge which has accumulated over time, is rooted in the context in which it arises, is stored in community member memories and experiences, and is dynamic and changing. Particular attention has also been given to my own relationship with the community and its crisis response practices as well as my relationship with the key informants interviewed and ongoing accountability as a researcher to 'do good' with my research.

Social Location and Positionality

This section will present who I am to the Indigenous community where this information was gathered and will be presented in a way similar to how I present myself to community members. As Healey & Tagak Sr (2014) express, my experience of engaging with members of this Indigenous community and region typically start with questions about who I am, where I am from, who my family is, what am I doing here, and how long am I staying. Thus, this is how I shall start this section:

My name is Kaila Rose de Boer. I was born and raised in Victoria, BC and then went to McGill University in Montreal. Both my parents have European ancestry but were born and raised in Canada. My father's parents emigrated from the Netherlands just before he was born and I experience my Dutch ancestry as being a predominant influence. I have a younger brother and no other siblings. I spent a lot of time with my grandmother while growing up, in a small community in central BC, and am very aware of her influence in my life. I have also been blessed to have grown up reading and travelling with my family, with an open exposure to different cultures and ways of life. I moved to this isolated, Indigenous region in 2012 to work as a mental health and addictions counsellor for the regional health authority. After completing the classwork for my Master of Social Work, I accepted a position in management of mental health services with the Indigenous government. Despite being frequently asked, I cannot say how long I will stay – eventually I wish to live closer to my family – , however the culture, land, and people of this region will be in my heart wherever I go.

Healey & Tagak Sr (2014) also accurately predicted the questions I have received in commencing this research thesis: what are you looking at, who is it being conducted for, what will happen with the knowledge shared, and how will the community benefit. To answer, I am looking that the crisis response practices of different agencies within the community for my

McGill graduate thesis both because it will help answer questions raised by community staff and agencies involved with providing crisis response within the community and because it will help those outside the community (such as governments, professional agencies, and academics) understand the services offered within the community. I intend to share the knowledge in my research thesis and submission for academic publication as well as through presentations to – and discussions with – involved service agencies. The discussion with involved service agencies will give an opportunity for community stakeholders to reflect on the information gathered and discuss what next steps they would like to see, particularly given continuous efforts to improve crisis response services within the community. The information shared externally will better inform other outsiders on how to best assist crisis response within Indigenous communities, for example in terms of providing resources, being allies, and preparing incoming staff/professionals.

To proceed through the other above topics listed by Healey & Tagak Sr (2014), my understanding of the community context is grounded in roughly four years of professional mental health work within the community/region and an equal period of time living there. During this time, I have been involved in the provision of crisis response, including facilitating safe spaces for distressed youth, reaching out to vulnerable individuals, and conducting clinical assessments for at-risk clients, particularly those with suicide risk. More recently, my involvement has focused on liaising interagency collaboration and supporting staff in provision of community response. The research topic and questions were born from conversations with community staff, wherein they expressed that their actions following a crisis were not well understood/respected and that they were not always clear on the mandated roles of other agencies involved. On a personal/professional level, as an incoming mental health manager (who

supports community crisis response), I was very interested in developing both a deep knowledge of how crisis response was implemented within the community and theoretical grounding in literature and research on crisis response practices elsewhere.

My relationship with and regular engagement of community members is typically centered on my role as a professional in mental health services and resident of the community. This was advantageous when engaging community members within the project, due to my pre-existing relationships and knowledge of community members, however – from a Western understanding of roles, boundaries, and relationships – was also a complicating factor for this project. On this matter, (S. Wilson, 2001) raises some very interesting questions about roles and responsibilities.

From my perspective, my role and responsibility as a researcher is to present a culturally-informed, contextually-grounded description of the policies, procedures, and professional practices which guide agencies in the community when responding to crises. In keeping with research standards, this would also include a literature review on crisis response practices, particularly in Indigenous areas, and critical analysis of the information gathered through the project. This information would both be made available to academics and professionals as well as involved participants and community.

However, I am very cognizant that from the perspective of the community, my role and responsibility as a researcher is intricately related to my professional role and responsibility as a manager of mental health services to understand crisis response practices in the community and be aware of other models of crisis response. Additionally, the community understanding would include my personal role and responsibility as a community member invested in the collaborative

efforts for shared wellbeing. Thus, my roles and responsibilities with regards to this research include those which are academic, professional, and personal.

My multiple roles and responsibilities within this community and region are simultaneously major strengths and challenges within this research project. On the positive side, living and working within the community and region has granted me a much deeper pre-existing understanding of the context, culture, and resources. It also meant that I was already forming relationships of trust and respect with community stakeholders and was familiar with the pertinent agencies and organizations. Having an on-going connection to the community and region also increases the ways which this knowledge can be presented to and integrated into the crisis response services; this is particularly important given that many community members have expressed frustration that they rarely see change in their communities following research.

On the negative side, my dual role has complications that I have needed to be extremely aware of. As a mental health manager and community member, I possess knowledge which I do not have consent to use within this thesis. I have thus worked very closely with my thesis advisor and the Indigenous research advisor in order to differentiate pieces which are from my thesis from pieces I know as a mental health manager and community member; journaling thoughts and experiences have also been advantageous to this differentiation process. The blinded document section was also helpful in ensuring my knowledge and perspectives were removed, as it provided a set of documents from which to draw information in a structured manner.

Finally, I am in a professional position – one with authority – within the community and region and have needed to be extremely cognizant of differentiating this project from that of my work as a mental health manager and being very clear that during this period, I was approaching

things as a researcher. I had multiple conversations with my thesis supervisor, employer, and the Indigenous research advisor to ensure that this was appropriately managed; of note, I was very careful in who I approached within organizations, ensuring that it was someone with appropriate authority, so that my professional authority would not carry over, and explicitly discussed this with potential participants in introducing the project, in reviewing consent forms, at conclusion of the interviews, and when a pertinent point arose throughout the interviews. All participants verbalized comfort with this dual role and also highlighted the advantages of the information being gathered by someone with ties to the community.

Overall, it is my perception that my multiple roles within the community – given appropriate navigation of the inherent complexity – were a strength to the research process. A strong pre-existing understanding of and connection to the community and region has facilitated the research process and will aid in the implementation of the information on completion of the project. That said, I have been very cautious throughout the project to be aware of my multiple roles as an academic, professional, and community member, to ensure they do not conflict.

Strengths and Limitations

There are multiple strengths and limitations inherent within this research thesis: this project was designed with a narrow focus on one community, presenting an opportunity for depth rather than breadth; the community where the research occurred has not been identified, to protect the anonymity of the community and its agencies, which may make it more difficult to interpret results; the project targeted key informants from community organizations, missing the experiences of community members; and the methodology is designed to be descriptive rather than evaluative. Each of these aspects will be discussed in turn. My multiple roles and responsibilities are additional strength/limitation as were discussed above.

A narrow focus – in this case on a single community – is common for qualitative research: in the words of Ambert, Adler, Adler, & Detzner (1995, pp. 880) "qualitative research seeks depth rather than breadth; instead of drawing from a large, representative sample of an entire population, qualitative researchers seek to acquire in-depth and intimate information from a smaller group of persons". This allows for a focus on the "contextual and subjective" as opposed to the "generalizable and objective" (Whittemore, Chase, & Mandle, 2001, p. 524). In the case of this thesis, such depth allows for a detailed and nuanced understanding of crisis response within the isolated, Indigenous community of interest, but does not claim to be representative of the crisis responses across other isolated, Indigenous communities.

Anonymizing the community and agencies therein was a decision made in consultation with the Indigenous research coordinator as a means of not making 'the community' the focus, but instead to place the focus on the response processes. By doing so, it provided assurance to involved organizations that their identity would be kept in confidence and would not become the focus of any post-hoc judgement of their performance. Respecting the wishes of the community and agencies to remain unidentified was considered important for the project, however added a layer of complexity in ensuring that appropriate contextualized information was provided and it limits the reader's ability to seek further information about the community beyond what is provided. The inclusion of a blinded document analysis was beneficial to ensuring the reader had sufficient – de-identified – information.

The choice to focus on the voice of service providers also has elements of strength and disadvantage. Given the focus on professional practices, programs, and policies, the key informant interview structure was not designed to include the voice of community members. It is however recognized that community members – particularly youth and Elders – can play

important informal roles in supporting the community through times of crisis. A future project considering the social and informal networks of support following crises would be very advantageous to addressing this gap.

This research project provides a descriptive presentation of crisis response. Such an approach gives great depth of understanding on how services currently operate, however does not evaluate the effectiveness of current services. Such an evaluation of current services may be a future project and the findings from this research project will certainly be brought back to the community for discussions regarding strengths and areas of improvement. This internal, collaborative approach for assessing and improving services is more in-line with community values and ways of doing things and will flow naturally from the conclusion of this project.

Overall, this research project has been designed to respond to '*what are the organizational policies, procedures, and professional practices that guide crisis response in one isolated, Indigenous community?'*. While there are downsides inherent to the methodology and always more questions to be asked, in answering this question, this research project contributes new information to understanding the multi-organizational response to crises within isolated, Indigenous communities.

Results: Community Context for Crises

To commence the results analysis section is information gathered from the blinded document analysis regarding the historic and current context for crises and crisis response. This section shall lay the groundwork for understanding crisis response in this context, before moving into the section speaking about the model developed in the early 2000s for community crisis response and the key current organizational practices in responding to crises. The results section shall conclude with two sections of thematic analysis, one on the community culture, values, context, and resources and the second regarding the community's strengths and struggles in responding to crises and recommended areas for improvement.

Historic Context for Crises

Similar to what was discussed in the literature review, historical trauma is identified as impacting the wellbeing of this community and its members. As a quick summary of the key historical events identified as impacting this region:

- Contact with European traders
- Establishment of missionary settlements
- Outbreaks of infectious diseases, with very high mortality rates
- Forced relocation
- Forced attendance at residential/boarding schools

In addition to these identifiable events, the blinded documents highlight that the gradual transition from a traditional nomadic lifestyle to one settled within a community using a wage-based economy has had long-lasting impacts on wellbeing. Continuing contact with 'outsiders' has been observed to be eroding traditional values/practices and greatly contributing to language loss.

Current Context for Crises

As was discussed within the literature review, poor social determinants of health in Indigenous communities impacts wellbeing, increasing likelihood of crises and shaping crisis response. In this case, according to the most recent Statistics Canada report, the population of the community is just over 1000 people, with nearly all stating 'Aboriginal Ancestry' and just over one third speaking their 'Aboriginal Language' (Statistics Canada, 2013). Almost three out of every four people is in the bottom half of the Canadian family after-tax income distribution and there was a roughly 25% unemployment rate (Statistics Canada, 2013). The community is not accessible by road. The blinded document review highlighted that housing and food insecurity are significant concerns within the community.

Once again aligning with the literature review, the blinded documents highlight that mental health and addictions concerns within the community include a high rates of suicide (among the highest rates in Canada), intergenerational and complex trauma (including experiences of abuse/violence, traumatic loss, and systemic oppression), substance abuse, interpersonal violence, and associated psychological distress such as grief, depression, anxiety, and low self-esteem. Current service provision includes that provided by the Indigenous government alongside provincial/federal services.

Mental health and addictions services, as outlined by recent strategic documents developed by Indigenous community and regional stakeholders, are intended to meet a continuum of care from wide-reaching promotion/prevention/education activities to community-based therapeutic interventions to specialized services such as psychiatry and/or inpatient treatment. To provide these services are a variety of professional and paraprofessional staff, with foci including youth outreach, addictions and mental health interventions, and cultural and wellness programming, to name a few. Additionally, attention is paid to addressing social

determinants of health, such as advocating on housing and food insecurity, promoting education and employment, and supporting healthy parenting and early child care. All elements of this is reflected within literature.

In keeping with Indigenous engagement practices discussed in the literature review, programming is expressed by the blinded documents to draw upon Indigenous traditional/cultural knowledge as well as mainstream best practices and research. In doing so, learning from Elders on how to best engage in the world through cultural values such as respect, equality, sharing, humility, cooperation, and perseverance, is encouraged throughout programming. The value placed on land/water, family/community, and language/culture is stressed throughout the documents.

Results: Community Crises Response Practices

This section includes information from both the blinded document analysis and the key informant interviews to provide information on the model developed over a decade ago for community crisis response, the current organizational definition of and response to crises, and finally, the multiagency response to four different hypothetical crises. This section reveals the organizational policies, procedures, and professional practices as they apply to crisis response.

Model for Community Crisis Response Delivery

In the early 2000s, after a two-year process of consultations with community and regional stakeholders, document review, and research on other models, two mental health consultants (one being Indigenous and from the region) who were contracted to support response to crises in this community, presented a working manual for a community crisis response team. This document recommended a volunteer group (including interagency representation, Elder and youth involvement, and general community member volunteers), split into two teams, under the directions of a coordinator. It provided numerous pertinent definitions, outlined the role of the crisis response team, discussed the signs and symptoms of critical incident stress and coping strategies, described how the crisis response process should flow, gave guidance on how and when to provide individual, family, and group counselling/debrief sessions, and discussed how to complete team debriefing.

One year after the release of the manual, in the final work report submitted by the consultants, the consultants noted that the crisis response team was already faltering, with high rates of burnout and insufficient volunteers. They also noted that the staff involved with mental health work in the community needed a high level of on-going support to maintain their own wellbeing in the face of the crises. Indigenous key informants involved with service provision in the community/region and familiar with the history of crisis response in the community also

stressed that the model for crisis response proposed by this manual is only loosely operationalized, since community-ownership of the crisis response team did not materialize.

Current Organizational Response to Crises

Below, the fourteen organizations involved with crisis response are listed, along with the situations which they respond to as a crisis and discusses their organizational response. For some agencies, these responses are outlined by formalized policies and procedures, whereas for others the response procedures and professional practices have become standard, though un-written, or may yet remain quite flexible; for the purpose of this study, the response practices and procedures are the focus, not the level of formalization of policies. Agencies are grouped by their primary service focus: those which ensure physical safety and security, those which provide psychosocial and emotional supports, those which offer spiritual and emotional supports, and finally those which focus on advocacy, leadership, and resource coordination.

Physical Safety and Security

• ***Police***	*Foci:* Criminal and other major incidents within the community	-Assess the safety of the scene, secure and contain the scene, and investigate if a criminal offence occurred
• ***Fire Department***	*Foci:* Fires within the community limits	-Contain and extinguish fires within the community -Mitigate loss of life and property to fire to the fullest extent possible
• ***Ground Search and Rescue Services (GSAR)***	*Foci:* Situations wherein people are missing/overdue to return when out on the land and/or unable to return to the community on their own accord	-Conduct a search for and return of the individual(s) who are missing/overdue to return -In some situations, may support water-searches, which are the mandate of Coast Guard

• ***Provincial Health Services – Medical Services***	*Foci:* An unexpected, very serious and urgent medical emergency which overwhelms clinic routine	-Complete trauma nursing primary assessment, restore/resuscitate life, sustain life, and stabilize the individual -Consult with the doctor at the regional hospital and defer to doctor's judgement on treatment plan (may be care in community or transportation to regional hospital) -Provide follow-up/on-going care as per doctor recommendations
• ***Provincial Child Welfare Services***	*Foci:* Mandated to respond to events wherein there is a risk to the safety/security of a child/family	-Mandated response follows child welfare policy manual -Where staffing/resources allow, will support other community agencies in responding to events deemed a crisis by the community

Psychosocial and Emotional Supports

• ***Provincial Health Services – Mental Health and Addictions***	*Foci:* An event wherein strong emotional reactions are anticipated and the situation exceeds what is expected in normal referrals	-Provide psychosocial support to the community from a clinical mental health framework, either in individual or group formats -May respond immediately in situations of extreme distress such as following a suicide or other traumatic event
• ***Indigenous Government – Mental Health and Addictions***	*Foci:* Sudden, unexpected events which have a profound impact on the whole community	-Provide support (home visits/outreach, supported gathering areas, individual/group support sessions, referrals, etc.) to community members and groups to promote coping, resilience, and healing in the face of trauma/distress -May provide immediate response to situations deemed urgent due to emotional and social vulnerability of impacted individuals, particularly where there is a risk of suicide contagion
• ***Indigenous Government – Community Programs***	*Foci:* Unexpected, tragic events which negatively impact the community or individuals therein	-Provide follow-up supports including home visits, food, and assistance making arrangements/ meeting needs -May provide immediate support, if they are notified that the level of distress is exceeding capacity of First Responders

• ***School (K-12)***	*Foci:* Events which cause distress to students within the school	-Support students through providing security, stability, and emotional support -Monitor student distress and provide referrals to other supports as needed
	Spiritual and Emotional Supports	
• ***Long-standing Community Church***	*Foci:* Situations wherein individuals/families make contact seeking urgent support	-Provide spiritual and emotional support to community members -Is involved with all funerals/burials within the community, as the only cemetery is managed by this church
• ***Pentecostal Church***	*Foci:* As defined by the impacted individual; anything which causes trauma/stress to the individuals reaching out	-Provide immediate and on-going spiritual and emotional support through providing a place to talk and pray to community members, by telephone, home visit, or meeting at the church office -May facilitate funerals, where requested by the individual and with the consent/collaboration of the community church
• ***Mennonite Church***	*Foci:* Situations deemed critical by community members/professionals	-Will provide physical and spiritual support to individuals in need, for example through food, a place to talk, song, or prayer -Will assist the efforts of other community organizations, as requested
	Advocacy, Leadership, and Resource Coordination	
• ***Indigenous Government - Community Leaders***	*Foci:* Issues which threaten the safety and security of the community	-Ensure appropriate responses are being implemented, assist in organizing the community to come together in responding, and advocate for additional resources as needed
• ***Indigenous Government – Regional Leaders***	*Foci:* No formal definition of crisis as it depends on the full context of the situation, what is requested of them, and what needs exist in the community/region	-No standard response to situations given that there is no clear definition of 'crisis' -May play a role in supporting access to needed resources, developing a communication strategy, and hosting special events -May debrief the situation at a regional level to share information, learn, and explore options for prevention

As can be seen above, different agencies fill different roles in responding to crises. Thus, an individual agency may or may not be involved for any given crisis, and further the approach that it takes may vary slightly depending on the event.

In looking at response, there can be overlap in the roles of involved agencies, for example across the three churches, between the provincial and Indigenous mental health providers, and among the differing levels of Indigenous governments. However, within these similarities, unique strengths of different agencies were highlighted – for example, the Indigenous mental health service providers were often more familiar with the community and therefore better able to identify who may require follow-up and provide the necessary outreach, whereas the provincial mental health service providers often focused on clinical responses, such as mental health assessments and therapeutic counselling. It was noted that outreach engagement often depended on who the impacted individuals had pre-existing relationships with. Further, it was expressed that impacted individuals themselves may choose to engage one service provider over another, depending on their needs and comforts. Thus, while organizational response to crises is guided by generalizable policies, procedures, and professional practices, there exists variability in the response to events. This point was clearly highlighted by the Indigenous Regional Leaders, when stating that they had no formal definition of crisis, and subsequently re-iterated by others, in saying that crisis is subjective. Specifics of how agencies respond to a four potential crises are discussed next.

Interagency Response to Crisis Situations

This section is intended to build understanding on what community crisis response may look like across four different hypothetical crises. It reports on agency's immediate and ongoing actions across four different situations: a missing person, a death by stroke, a death by suicide, and a house fire. Key informants confirmed that these four hypothetical situations are all

relatively common within the community, though key informants expressed that a senior's death by stroke typically did not constitute a 'crisis' per say.

Crisis situation: Missing person. A young male from the community is reported missing on a Sunday evening after not returning home from going-off on ski-doo and weather conditions are getting worse.

Roles of agencies immediately involved.

Police. Gather pertinent information, contact Ground Search and Rescue (GSAR); contact other federal/provincial search resources as required by policy; maintain contact with the family; and share information with media if needed.

Ground Search and Rescue (GSAR). Attain and assess all pertinent information (eg. missing mans' plans, preparedness, and experience) and assess weather conditions; attempt to confirm the individual is not in the community/in a safe place (eg. a cabin); conduct a hasty search, by sending out a two experienced volunteers to look in the reported direction of travel; and progress to more extensive searches and seek additional resources (eg. helicopter) as needed.

Medical Clinic. Once alerted to the situation, prepare for any medical needs (eg. hypothermia) of the young man.

Roles of agencies providing on-going support.

Indigenous and Provincial Mental Health and Social Services. May provide psychosocial support to individuals impacted, particularly if the situation is prolonged.

Churches. May provide spiritual and emotional support to individuals impacted, as requested/depending on the situation.

Regional and Community Indigenous Leaders. May be involved in seeking additional resources for a prolonged search and/or sharing information with the media.

Crisis situation: Death by stroke. A senior dies in the regional (out-of-community) hospital in on Thursday morning following a serious stroke Wednesday night which required a medevac (by plane) from the community clinic.

Roles of agencies immediately involved.

Medical Clinic. Provide medical care to the individual, as medically indicated, in consultation with the doctor, until transfer to the hospital is complete.

Churches. May provide spiritual and emotional support to individuals impacted, as requested.

Roles of agencies providing on-going support.

Indigenous and Provincial Mental Health and Social Services. May provide psychosocial support to individuals impacted, particularly for vulnerable individuals/families.

Indigenous Government Factions. May assist family members making arrangements for funeral, such as navigating logistics of returning body to community and accessing funds and/or donations.

Churches. Support funeral facilitation and burial; provide ongoing spiritual and emotional support as needed.

Crisis situation: Death by suicide. A teenaged female completes suicide by hanging herself in her home in community at 1am on a Tuesday night.

Roles of agencies immediately involved.

Police. Secure and contain the scene, notify one or two family members with support of Pastor (other notifications as requested and feasible), investigate if a criminal offence occurred, collaborate with the medical examiner's office.

Medical Clinic. Nurses attend the scene if there are signs of life and follow Trauma Nursing Assessment; if the young woman is dead, the clinic nurse or police would secure her body within the morgue until it may be transported out of the community for an autopsy, if deemed necessary, or prepared for burial. Nurses would refer any individuals with suicide risk to Provincial Mental Health and Addictions services.

Indigenous and Provincial Mental Health and Social Services, School, & Churches. Convene to discuss community vulnerabilities and collaborative interagency response, with particular attention to containing suicide contagion: activities may include outreach to impacted/vulnerable individuals, providing monitored gathering places for youth, and screening individuals for suicide risk. These discussions would continue for as long as crisis persists.

Churches and Indigenous service providers. May support the police and family members in notifying family members and others personally impacted by the loss.

Roles of agencies providing on-going support.

Indigenous and Provincial Mental Health Services. Provide on-going individual/group support for emergent suicidality, traumatic reactions, and grief/loss. Both Indigenous government and provincial mental health services may supply additional mental support personnel where necessary, with a very strong preference for personnel with familiarity with the community.

School. Administrators/teachers would meet to discuss anticipated impacts on students and make a determination whether to proceed with regular school programming or to interrupt regular programming in favor of providing safe, supervised, and supported spaces for children/youth to seek comfort. Would continue to meet to assess student needs until the crisis abated. School board may send in additional personnel who specialize in student mental health to consult with teachers and support students.

Indigenous Government Factions and Provincial Social Services. May provide additional support to the family/community as needed/requested, such as conducting home visits, preparing food and organizing events, and assist family members making arrangements for funeral.

Churches. Support funeral facilitation and burial; provide ongoing spiritual and emotional support as needed.

Crisis situation: House fire. A house catches fire and, given the recent dry weather and current winds, there are concerns the fire will spread to neighboring homes.

Roles of agencies immediately involved.

Police. Secure and contain the scene, coordinate with other agencies to ensure safety/security of those impacted, collaborate with the fire investigator to determine if a criminal offence occurred.

Fire Department. Attend the scene, work to contain and douse the fire, and mitigate loss of life and property.

Medical Clinic. Would be alert to the situation to prepare for any medical needs.

Roles of agencies providing on-going support.

Indigenous and Provincial Health and Social Services. May provide support to individuals impacted, particularly if there is loss of life and/or significant emotional distress.

Indigenous Government Factions. May provide additional support in accessing resources to meet basic needs as requested/needed, particularly if the fire impacts multiple households.

Churches. May provide spiritual and emotional support to individuals impacted, as requested/depending on the situation.

Across the four scenarios, there many similarities to actions of any given agency and the response focus of the agency determines whether or not the agency is likely to respond, for example, fire department usually responds only to fires and provincial medical services focuses on medical needs. Within this however, there is room for adaptability and collaboration to best meet the needs of the community.

Results: Community Culture & Values and Context & Resources

This section integrates thematic analysis of the blinded documents and key interviews to discuss how community culture and values guides crisis response and how the context and resources shape it. Both of these dynamics are critical to understanding the previously discussed implementation of crisis response within this community.

Community Culture and Values in Crisis Response

Given Landau's (2013) assertion that recognition of culture is important in healing from mass trauma, reflection on cultural coherence of crisis response is important. This section shall provide both a historic perspective of culture and values, drawn from the blinded documents, and a thematic analysis of how these are reflected within current practices.

Historic perspective on culture and values in crisis response. Themes in the blinded documents related to community culture and values in crisis response included: interagency communication/collaboration and community consultation; importance of tradition and celebrating culture; employing Elder wisdom and valuing youth; addressing root problems though these solutions take time; and Indigenous leadership and community ownership for change. A brief synopsis of these themes follows.

Across documents, the importance of good communication and strong collaboration was highlighted. While many documents mentioned the difficulty of maintaining collaborative partnerships across the multiplicity of groups and agencies within the community, there was a theme of community leaders and agencies coming together in times of crisis to discuss, plan, and collaborate. In addition to the gatherings of community leaders and agencies, the documents present a common theme of the value placed on consulting with the community as a whole, through means such as public meetings, questionnaires, and interviews with community

members. It was also highlighted how important it is to share information back with the community about how things progress.

Throughout the documents the importance of including Elders in the discussions around concerns and listening to their wisdom, responding to their guidance, and receiving their support was highlighted. The importance of intergenerational communication was also conveyed, particularly around opportunities for youth and Elders to engage with each other. Indeed, concern for the wellbeing of the community's youth was central to many discussions. Within this, reference was made to seeking the direct input of youth regarding their concerns and needs. It is important to note, that this valuing of youth is not perceived by the youth; reports on consultations with the youth frequently revealed that many felt un-valued and unheard.

The documents often referenced to how things were historically done. Related to this, loss of traditional culture – including land-based lifestyle, language, parenting practices, and so forth – were repeatedly cited as root problems, and that knowledge could be gained from how these used to transpire. Values such as holding one's self accountable, respecting others, and sharing with others were stressed as important. Within this were repeated mentions to improve one's self to become a better person, parent, community leader, etc. and in doing so role modelling these behaviors to others. There was further recognition of the value of community celebrations and cultural events. People highlighted that having opportunities to come together for positive matters - whether that be cultural occasions, musical or sports events, or community-wide feasts and festivities – increased positive morale and strengthened community connectivity.

The documents frequently returned to themes related to 'root problems': impacts of colonization and historical trauma, loss of traditional way of life and cultural values, substance abuse and family violence, poor housing and infrastructure, limited employment and

opportunities, and insufficient supports and recreation resources. Rarely were individual crises specifically discussed, instead the problems were discussed on a broader level of community hardship. In tandem with the focus on root problems, there was a focus on how overcoming the problems faced by the community would take time. People recognized that it would take lengthy collaboration and combined efforts to overcome the issues which were at the root of the current crises. In an example highlighting this point, in community meetings, a Community Leader expressed:

> *"We do not think that the problems facing our community can be solved by us today, or that they can be solved in a short time. We know, as we hope you do, that solutions to our problems are going to take a long time to bring about. Changes can only happen if all of us work together and share the responsibility for our future." – Community Leader, Opening Remarks, 1991*

The documents reflected the conviction that Indigenous leadership and control over matters occurring within the community/region was necessary. Multiple different areas of control were discussed including: education, health, social services, land and resources, language, etc. Further, discussion was had about how the community as a whole had to lead efforts for change. It was expressed that change had to start from within the community and could not be led by external agencies or even by community leaders themselves.

These community cultural values are important to keep in mind when considering the current crisis response practices. It is these cultural values which underpin many of the policies, procedures, and professional practices, and it by these cultural values which community members understand and assess the suitability of policies, procedures, and professional practices.

Current practices coherence with community culture and values. The section shall reflect on the cultural and values considerations raised in the document analysis – communication and collaboration; Indigenous leadership; Elder, youth, and community

involvement; addressing root causes; and recognition of traditions and culture –, given the information shared by the key informants.

Reviewing the interview question on communication revealed that agencies communicate and collaborate with each other in planning and providing community crisis response services. Exact patterns of communication and collaboration vary depending on the incident, but by and large there appeared to be agreement that this was occurring. Within the response provision, the Indigenous government expressed itself to be suitably informed and briefed on the situation, in leadership role in making decisions around needs, and able to seek additional resources as needed. Key informants frequently expressed both respect for and willingness to share with each other and the community.

On the other hand, key informants expressed that Elders, youth, and the broader community do not currently have an active role in planning or providing crisis response services within the community. There is no consistent inclusion of Elder or youth representatives within discussions on crisis response and there are few community volunteers in providing response. It was repeatedly highlighted that while the desire was for the community to be self-supporting through volunteers and a strong natural support network, frequently health and social services staff – particularly those from the community – were the ones to take a lead in providing support following an incident. While it was expressed that there are families and situations wherein there is a strong natural support network and no need for additional professional support, the lack of community member consultation/involvement in crisis response was repeatedly expressed as a concern.

Though the interview questions were focused on organizational immediate and on-going actions following a community crisis, mention was made – particularly by Indigenous key

informants – of some of the broader context within which crises arise and crisis response services are provided. These references – along with the broader foci presented within the Indigenous government's service delivery models/frameworks for health and mental health – belie a continued focus on root problems and recognition that lasting solutions take time. Interviewees also made several mentions to the importance of honoring traditional ways of life and celebrating community and culture.

Impact of Community Context and Resources on Crisis Response

In addition to culture and values, the blinded document and key informant interview analyses highlighted dynamics of crises and crisis response born from the community context and resources. This section shall discuss both the historic perspectives on the impact of context and resources, as well as the current references to it. It is important to note that in time span between the blinded documents being considered (up to 2003) and the key informant interviews (2016), available services have increased.

Historic perspectives on the impact of community context and resources. Within the blinded documents, the limited infrastructure and housing within the community were repeatedly highlighted as a primary concern. The desire for new and/or improved recreation and community spaces; a longer, better positioned airstrip which would allow improved access; and a greater diversity of businesses were highlighted by the documents. The need for more and better housing to address the issues of overcrowding was particularly stressed. Further, there was extensive discussion on the lack of appropriate resources; specifically, there was an expressed desire for mental health and addictions counsellors, a crisis phone line, recreational activities, tertiary mental health care, and so forth, much of which was not initially available or else insufficient in the face of the needs.

The challenges of northern isolation – such as high costs of food, goods, and supplies – were expressed as a barrier to wellbeing. Further, it was frequently discussed how there were limited employment and other opportunities for adults and youth. While isolation from other resources was discussed as a challenge, people expressed positive sentiments about the land on which they live and its bounty of fish, animals, and plants (eg. "…we are rich…"). It was also discussed how, due to costs, many people are unable to go hunting, fishing, and gathering regularly, despite the strong pride expressed in the land.

Finally, the documents expressed concern with the poor representation of the community within the media. People expressed that the media was particularly fixated on the problems of the community, with great reluctance to present its strengths. For example, they discussed how CBC approached a youth at a sports meet with a specific interest to hear their perspective on the suicides in the community, with no interest in the youth's sports achievements.

Current commentary on the interaction with community context and resources. Within the document analysis, community context and resources were frequently a topic of discussion. This section shall review how these factors shape current crisis response.

Numerous key informants made reference to how being a small and isolated community impacts crisis response. People highlighted that connectivity within a small community is greater, increasing the likelihood of personal and working relationships between service providers and with community members. Federal/provincial agencies highlighted that their role in services was often greater than it may be elsewhere as a result of the community size and connectivity. Key informants stressed how life in a small community means that it is likely that responders/supports already know the individuals impacted by crises. It was also suggested that

being in a small community increases the level of reverberation following a crisis, with greater cumulative impacts.

Being in a small community was also connected to having a different understanding of community members' needs and expectations following an incident. Many agencies highlighted that response to a crisis was different depending on the overall context. Key informants highlighted that different individuals and families were known to be more or less able to respond to a situation on their own accord. Linking community size and resources, key informants also made reference to how loss of housing and/or goods due to fire could be a major concern within the community. Likewise, supplying food following a crisis was identified as both culturally important and practical in a region where food costs are high and many are food insecure.

Community isolation had other impacts on resource access: one aspect which was raised several times by interviewees was the complexity of funeral arrangements. If there is an autopsy or if the individual dies outside the community, the body needs to be returned to the community. There is no funeral home within the community and decisions need to be made about whether it is feasible and desired to have the body prepared at a funeral home elsewhere. Likewise, money for caskets and any needed transport needs to be procured. As the region is relationally close, yet does not have road connections, family and friends of the deceased are often faced with the struggles of making arrangements for their own travel. Several individuals discussed how they may be involved in supporting families through this process, should it be requested of them.

Whereas analysis of historic documents revealed a strong theme of needing more services and resources within the community, the current interviews did not have the same focus on this. While it was repeatedly identified by key informants that more volunteers and community ownership of crisis response supports was needed, people did not identify the need for more

frontline services within the community. The difficulty of accessing tertiary medical care (eg. doctors and psychiatrists) was referenced, as was the need for infrastructure and employment opportunities, but these did not present as strong themes or concerns in this series of interviews. This may have been due to the nature of the questions as service needs were not queried.

In the historic document analysis, media representation was a major concern; in this series of interviews it was not a key theme in discussions, however the Indigenous government did note that they take the lead as spokespeople for the region/community and have a department which works on the communication strategy.

These contextual aspects of crises and crisis response shape the policies, procedures, and professional practices which are currently employed. As we move forward into the section on community strengths and struggles in crisis response and areas for improvement, these dynamics are important to keep in mind, as they continue to shape what is possible.

Results: Strengths, Struggles, and Areas for Improvement

This section discusses the strengths and struggles this community is having in providing crisis response, as arose out of the thematic analysis of the key informant interview, and concludes with a discussion on areas of improvement which will be discussed with the community.

Themes of Community Strengths and Struggles when Responding to Crises

The strengths and struggles are grouped by theme, as they are easier to understand in this manner. Within each theme, there are often aspects which are functioning well and ones which could be improved upon. Discussion on how things might be improved upon will follow in the Areas for Improvement section.

Differential response. Indigenous government factions and health and social services providers expressed that crisis is subjective and that a holistic view of the situation was taken in deciding a response. It was stated that situations in the community are cumulative, such that when there have been multiple losses and/or tragedies in a short timeframe, people are grieving the multiple losses concurrently and the situation is recognized as more difficult for healing. It was also recognized that responses vary depending on the incident; for example cause of death, age of deceased, means of death, level of predictability, and relationship to the community can cause differing grief and loss reactions. Further, families and impacted individuals have differing needs and desires of support: some have strong natural support networks and/or are private while others have a greater need and/or desire for external supports.

There was also recognition that resources in the community fluctuate and that therefore responses may vary. Key informants said that their response will vary dependent on the resources available within their organization and within the community at the time. Regardless

of the exact resources available, key informants recognized the importance of ensuring all needs are met, including physical/basic, emotional, and spiritual needs.

Role distribution. Commentary related to role distribution was a strong theme. Key informants expressed that the Indigenous health and social service providers took a lead in providing crisis response services. Indigenous key informants emphasized that this placed great burden on their staff and that, while others collaborated with and supported them, they were still often left with the impression "we are it" when it comes to crisis response.

Key informants made reference to the multiple roles some individuals play. For example, both the fire department and ground search and rescue expressed that about half their volunteers are involved with both services. In another example, key informants expressed that their staff will often choose to volunteer on their own time in providing response services. There were both strengths and challenges expressed about this: on one hand, it belied values of pitching and supporting each other/the community, but on the other hand, it could contribute to burnout.

Within consideration of role distribution, interviewees stressed the importance of considering their role as follow-up service providers. Amongst mental health and addictions service providers in particular, it was expressed that the 'crisis' didn't end in a short period, but extended into follow up care, often including new referrals for individual counselling and possibly group services for an identified vulnerable group. This can mean that service providers continue to be involved with crisis response work long after the crisis itself has occurred; this can be a significant addition to the workload of these service providers.

A theme of exclusion was strong within some interviews. There were key informants who identified that they had previously been volunteers with the crisis response team, but had "stopped being called" and were never informed why. It was expressed that they never explored

whether this applied to other previous volunteers, but that they suspected that it might. In further discussing exclusion, key informants expressed that it was their perception that since professional organizations and staffed agencies started providing services within the community, informal and volunteer responses ceased to be as valued and/or included. Key informants expressed that community members expected and relied on organizational response and that informal, community supports ceased to be as appreciated and utilized as they were historically. In one interview, the repeated theme was of being "pushed aside" and "looked down on by the community".

Staff and volunteer care. Many key informants made reference to the importance of providing adequate training, practice/preparation opportunities, debriefing/support, and appreciation to staff and volunteers involved with crisis response. It was identified that these actions enable effective responses and prevent and contain negative staff reactions such as burn-out, compassion fatigue, or withdrawal.

The provision of staff and volunteer care varied somewhat, by agency and situation. One important reflection was that at the commencement of the crisis response team in the late 1990s/early 2000s, there was lots of support for those involved in the crisis response team and that this has since faded off. Several people linked reduction in volunteer care as a reason for the diminishing involvement of community volunteers within the crisis response team. Currently, care appears to be provided organizationally but that no organization has assumed full-responsibility for ensuring the care of community volunteers.

Deriving from the importance of staff and volunteer care was a discussion on how the frequency and intensity of crisis situations in the community can be overwhelming for many involved with the crisis response team, particularly if they have other care-giving responsibilities

or are personally impacted by the tragedies (such as knowing and/or being close to the victim(s) or having a personal history of related trauma), both aspects which are common within the community. It was discussed how the original plan for the crisis response team was to disperse the burden, but that in recent years there are insufficient numbers of people involved and that response falls on the shoulders of a few. Caring for staff and volunteers thus becomes more difficult and some key informants discussed that they are witnessing how the high level of crisis response is impacting their staff wellbeing to levels they find difficult to address.

Community expectations for care. Across interviews, comments were made regarding the community's expectations for care. Provincial/federal key informants made reference to how being in a small community means that their agency plays a larger role within the community than it would elsewhere, largely because of closer relationships with other service providers and the client-base. Further there were strong community cultural expectations that everybody would 'pitch-in' and contribute to meeting the needs.

Key informants discussed how the community preference was for support to be provided by people known to the recipients as people prefer to "see a familiar face". Born from this, several made reference to how sending in external resources may not be helpful or desired by the community. Indeed, key-informants from the community specified that the preference was often specifically for community-residents to be the ones providing support. As part of the population is unilingual in their Indigenous mother-tongue, they need bilingual support people.

Key informants discussed how community members often expect a high-level of support from organizations. In some cases, key informants expressed that expectations went beyond their role or abilities. For example, requests and/or assumptions that the organization(s) be the ones to provide notifications of death to extended family members or individuals/families asking

for resources (particularly money) which are outside the funding role of the organization. Further, it was referenced how at times there can be resentment when people perceive that they receive less support than someone else.

Related to community expectations, were the concerns raised by key informants that situations which do not meet organizational mandate for being a 'crisis' were treated as such. For example, natural deaths – such as the stroke example – have at times received a crisis-style response. Key informant discussion suggested that part of this 'mandate drift' was related to how the community has come to expect such a high-level of organizational supports and the anger which can arise when community members perceive they have been treated unfairly, such as not receiving the supports another person was given.

Capacity of community to care for itself. This section had some of the most nuanced responses. On the one hand, provincial and federal organizations made frequent reference to the strength of community staff and the Indigenous government in assessing and responding to community needs. On the other hand, there was commentary – particularly by Indigenous factions – that community members needed to do more in supporting each other in times of crisis, rather than defer to agencies and organizations.

Key informants discussed the importance of not interrupting natural grieving processes, including natural supports. Some critiqued that there are times wherein organizations jump-in to provide support too quickly, without providing time for family and community to come together without organizational supports.

Different experiences with volunteers were also evident. On one hand, the volunteer-based Ground Search and Rescue and Fire Department spoke highly of their very committed and willing volunteers. Likewise, other organizations expressed that their staff are usually willing to

pitch-in on tasks when asked. However, a very frequent comment, particularly by those with long-standing involvement in the crisis response team, was that there were insufficient community volunteers.

Overall, there appeared to be both a pride in what staff and volunteers within the community are currently doing, while also a desire for increased non-organizational community self-caring.

Implementation of community culture and values. Across several key informant interviews, there was discussion on how community traditions and values have changed and how well community culture and values are (or are not) being implemented.

One common theme was that Elders are valued as a source of wisdom and support, but that they are not consistently involved or included in community crisis response. For example, the long-standing community church noted that their Church Elders (who are themselves Indigenous) have a much smaller role than they did historically in planning response. Several expressed variations on the idea that "we are trying to keep our traditions alive, but the community is changing".

There was also commentary that the treatment of death and suicide has changed within the community over the years. One interviewee noted that all businesses used to close for all funerals, but that currently businesses will only sometimes close. There was some desire to revive old traditions, as it was an important sign of respect. Another interviewee discussed at length how treatment of suicide has changed, such that today individuals are honored in a manner similar to all other deaths, but that up to the 1970s, individuals who died by suicide were not given a funeral in the church and were buried face-down, outside the cemetery, at times under the footpath. Finally, there was reference to how changing values due to community size,

access to television and external media, and the proliferation of social media have changed the connectivity within the community/region, with particular reference to challenges that news of death is being transmitted over social media, rather than the direct communication people would prefer.

As a final comment on culture and values, several key informants raised the importance of coming together as a community, both in grief and in celebration, as a means of overcoming challenging situations. There have been crisis situations wherein one follow up activity was to host celebratory activities focused on community culture, strength, and pride.

Discussion

This discussion section shall review how the crisis response policies, procedures, and professional practices outlined in this research aligns with literature-recommended crisis response strategies, explore areas for improvement within this community's crisis response, and discuss the implications of this research for other communities in Canada and internationally as well as areas for future research.

Alignment with Mainstream and Indigenous Crisis Response Strategies

In the literature review section, three different mainstream theories on crisis response were discussed – Critical Incident Stress Management (CISM) (Everly et al., 2002, 2000; Everly & Mitchell, 1999; Mitchell, 1983; Mitchell & Everly, 1986); Psychological First Aid (PFA) (Ruzek et al., 2007; Vernberg et al., 2008); and suicide postvention (A. Wilson & Clark, 2005). The literature review also explored Indigenous approaches to crisis response. This section shall consider how the policies, procedures, and professional practices of crisis response within this community align with these recommendations.

Critical Incident Stress Management (CISM) outlines eight components of crisis management: pre-crisis preparation; demobilization, staff consultations, and crisis management briefings; defusing; Critical Incident Stress Debriefing; individual crisis debriefing; pastoral crisis intervention; family CISM; organizational consultation; and follow-ups and referrals (Everly & Mitchell, 2000). Within the key informant interviews, CISM response practices and terminology were rarely explicitly used, however some of the activities discussed did align with the CISM recommendations. For example, following a crisis, responders come together to discuss, plan response, and allow time for stress management within the responders; individuals and/or families and/or groups may receive direct support to mitigate symptoms and promote coping, from mental health service providers and/or pastoral care; and follow-up referrals and

care are given as necessary. A couple key informants made specific reference to Critical Incident Stress Debriefing and the contra-indicatory research on it meaning that it is not a format used with community members. Key informants made reference to the fact that pre-incident preparation and post-incident support for responders could both be built upon.

The key actions of Psychological First Aid (PFA) (Ruzek, Brymer, Jacobs, Layne, & al, 2007) are contact and engagement with affected persons; enhancing safety and comfort; stabilizing and calming those overwhelmed by the incident; gathering information on needs and concerns; providing practical assistance to meet immediate needs; connecting people with social supports; promoting coping strategies to support individuals; and linking people to the services they may need in the future. These core actions and goals are all evident when the key informant interviews are considered as a whole, cohesive response to a crisis situation, from conducting home visits to connect with affected individuals to providing referrals for on-going mental health support services and all steps in between.

Recommended service structure for suicide postvention includes initial response at site of suicide, home visits by volunteers who have personal experience with suicide, 24/7 telephone supports, bereavement and support groups, and means of accessing additional supports from experts (A. Wilson & Clark, 2005). Across key informant interviews, reference is made to having RCMP and/or medical staff attend the site of suicide, there being home visits to those who are impacted and/or vulnerable, and that referrals are made for those requiring on-going counselling or further services. There is a 24/7 provincial mental health helpline for those requiring it, in addition to the national First Nations and Inuit Hope for Wellness Help Line. The community does offer a variety of support groups and key informants reference the ability to offer specialized supports and programming where needed.

Literature review on Indigenous crisis response strategies highlighted the importance of culturally-congruent (Cousins, 2010; Harlow et al., 2014; Hughes, 2000, 2006; Kwanlin Dun First Nation, 2016; National Knowledge Exchange, 2016; Terry, 1999), community-led (Baikie & Beck, 2002; Cousins, 2010; Harlow et al., 2014; National Knowledge Exchange, 2016; Terry, 1999), and collaborative approaches (Baikie & Beck, 2002; Boone et al., 1997; Cousins, 2010; Kwanlin Dun First Nation, 2016; National Knowledge Exchange, 2016; Terry, 1999) to addressing crises in Indigenous communities. By and large, these recommendations are exemplified by this research, both in the document review and through key informant interviews on how crisis response is actually implemented within the community. The key informant interviews demonstrate a cross-agency approach to collaboration during response, with particular recognition of the lead role the Indigenous agencies play in determining the approach such that it is contextually and culturally appropriate.

The Indigenous literature review further brought up the importance of preparatory planning (including development of response strategies/manuals) (Canadian Foundation for Healthcare Improvement, 2016; Health Canada, 2013; National Knowledge Exchange, 2016), coordination of and training for responders (such as developing and training crisis response teams) (Baikie & Beck, 2002; Canadian Foundation for Healthcare Improvement, 2016; Health Canada, 2013; National Knowledge Exchange, 2016; Terry, 1999), and implementing immediate and on-going supports for both community members and crisis responders (Baikie & Beck, 2002; Health Canada, 2013; Kwanlin Dun First Nation, 2016; National Knowledge Exchange, 2016; Terry, 1999). Again, through the document review and the key informant interviews, these topics were touched upon, however within key informant interviews it was mentioned how preparatory trainings and immediate and on-going supports for staff could be further developed

and that attention for on-going support provided to community members may lag amidst the focus on crisis response. Several agencies highlighted that these are all areas which they are continually reviewing and improving upon in order to be in keeping with best practices and current needs and resources.

Overall, there are many similarities between the recommended practices of the literature and the practices within the community of interest, however, as shall be discussed below, there are some areas of improvement.

Areas for Improvement in Community Crisis Response

While it will be up to the agencies involved with crisis response how they wish to implement this analysis of the knowledge gained from this process, the document review and key informant interviews highlighted four areas wherein discussions on improvement may be warranted:

1. Engagement of community members, particularly Elders and youth, in provision of response;
2. Distribution of roles and responsibilities;
3. Pre-crisis preparation and training; and
4. Post-crisis support and care for responders.

As was referenced by key informants, it is likely that these areas are interconnected: pre-crisis preparation and training along with post-crisis support and care will both assist in maintaining committed volunteers, which will allow for greater distribution of roles and responsibilities and in turn, reduce the pressure and stress which discourages responders. While this section will discuss the recommendations from the literature with regards to these areas of improvement, it should be recognized that – in keeping with the literature on Indigenous crisis response (National Knowledge Exchange, 2016) – these questions are best answered through active discussions in

the community of interest to ensure that they are culturally-congruent and contextually-realistic, and to promote community-ownership and leadership.

For the areas of engaging of community members in response and distributing roles and responsibilities, literature acknowledges the importance of community-leadership and engagement in response (eg. Health Canada, 2013; National Knowledge Exchange, 2016) and the benefit to social supports such as family, friends, and community in overcoming trauma and grief (Landau, 2013; Ruzek et al., 2007; Vernberg et al., 2008) as well as the importance of distributing roles according to capacity (Mitchell & Everly, 1986; Young, 1998), however literature cannot provide guidance on specifically how to implement this within any given context, though community-based crisis response manuals can provide some guidance (eg. Baikie & Beck, 2002; Kwanlin Dun First Nation, 2016).

Pre-incident preparation and trainings are available and being availed of by Indigenous communities. For example, communities are receiving trainings in CISM, Applied Suicide Intervention Skills Training (ASIST), and Mental Health First Aid (MHFA) – all of which have been adapted to Indigenous contexts (National Knowledge Exchange, 2016). During the key informant interviews, reference was also made to trainings in CISM and PFA, as well as ASIST and MHFA, for different staff. The consistency and additional needs for trainings for the community would need to be a broader discussion with community staff and members.

Post-incident support for respondents was another important topic raised. In key informant interviews, it was noted that agencies have internal capacity for debriefing staff and making referrals for on-going mental health services where appropriate, however there was no current structure for this to occur for those not associated with an agency (eg. for community volunteers) or for all crisis responders to systematically come together following an incident.

While Critical Incident Stress Debriefing (CISD) does provide a model for systematic review of response and responder well-being (Everly et al., 2002), utilization of this model within this context may be inappropriate given differing understandings of crisis, trauma, and healing (Hughes, 2006) and that detailed review of the proceedings of each agency may breach client confidentiality and expose individuals to potential vicarious traumatization (eg. the work of RCMP necessitates a different level of knowledge and exposure to a case than – for example – a school teacher), a particular consideration given the research finding that misapplied CISD has no positive effect for post-trauma recovery (Rose, Bisson, Churchill, & Wessely, 2002). Nationally, Indigenous crisis response providers may enact different varietals of debriefing, in accordance with their cultural traditions, such as smudging and/or talking circles (National Knowledge Exchange, 2016). Once again, the best format of support for responders within the community is something to determine through consultations with the community responders.

These will be discussions held with the agencies involved in the community crisis response when conveying results and exploring how the community wishes to make use of this information.

Research Implications and Areas for More Research

In exploring the organizational policies, procedures, and professional practices which guide crisis response in one isolated, Indigenous community, this research brought forward the community culture and values which underpin crisis response, the community context and resources which shape the crisis response, the strengths and struggles the community is experiencing regarding its current response to crises, and concluding with a discussion on what the community may wish to consider as means of improving the response. But beyond this one isolated, Indigenous community, what can be learned from the crisis response practices, procedures, and policies within isolated, Indigenous communities across Canada and/or

internationally? This section shall both explore the implications of this research and discuss areas for more information.

In considering the results within this research thesis, the first consideration is how much organizational mandate shapes the policies, procedures, and professional practices of a crisis response. For example, the school has a focus on student welfare following a crisis; the RCMP has a focus on criminal acts and public safety; child welfare services has a focus on child safety and family wellbeing; and the provincial clinic responds to medical concerns. Understanding the roles and responsibilities of different agencies involved at the community level is thus a critical first step when trying to understand, develop, and/or implement crisis response within isolated Indigenous communities. However, beyond what the mandated role may be – and therefore what the guiding policies, procedures, and professional practices are – many key informants reflected that their agency attempts to be flexible and provide additional supports where needed and possible. Often, context itself demands this level of flexibility, for example because there are only limited services within the community and therefore an agency and/or its staff may provide additional supports.

Broadly, in both the blinded document analysis and key informant interviews, community context and resources arose as a strong theme in understanding crisis response within this isolated, Indigenous community. That said, between the historical documents (ending in 2003) and current interviews (conducted in 2016), there was an increase in available services, though isolation and limited infrastructure continue to be key considerations. These contextual considerations were likewise highlighted in Wilkie et al.'s (1998) case study on response to a cluster of suicides in a First Nations community of Manitoba and Terry's (1998) discussion of response to crises in Inuit communities across Alaska; understanding the context was highlighted

as critical to understanding crisis response. Without this understanding of the context and resources in an isolated, Indigenous community, it can be really difficult to understand crisis response practices; one example of this which really stood out to me is the complexity of needing plane-transport to a city-center for hospital care, an autopsy, or burial preparations of the body. Likewise, if additional personnel or supplies are needed in the community, they must fly-in, and all are subject to the frequently inclement weather, which causes flight delays and/or cancellations.

Consequently, it is important to understand the specifics of what resources are available in the community and what limitations there may be in employing them, as the availability of resources, including personnel, supplies, and funds, often shapes what is possible for any given crisis response. Indeed, key informants highlight that week-to-week fluctuations of staffing have a noteworthy impact on crisis response – having one or two staff people on vacation, out of town for work, or on medical leave, has a noticeable impact on what resources might be employed within the community. Thus, it is important to start discussions on crisis response with an understanding of who is currently available to assist in the response.

In addition to understanding the general context and resources of the community, this research highlights the importance of understanding to context of any specific crisis. Key informants frequently discussed that understanding other recent events within the community, the dynamics of the impacted family, and the nature of crisis itself, is all critical to planning the crisis response. While this is not something which is always so explicitly discussed within literature, reference is often made to gathering appropriate information when planning the response for any given crisis (eg. Baikie & Beck, 2002; Everly et al., 2000).

Much as literature and research on Indigenous crisis response strategies has highlighted the importance of culturally-congruent (Cousins, 2010; Harlow et al., 2014; Hughes, 2000, 2006; Kwanlin Dun First Nation, 2016; National Knowledge Exchange, 2016; Terry, 1999), community-led (Baikie & Beck, 2002; Cousins, 2010; Harlow et al., 2014; National Knowledge Exchange, 2016; Terry, 1999), collaborative approaches (Baikie & Beck, 2002; Boone et al., 1997; Cousins, 2010; Kwanlin Dun First Nation, 2016; National Knowledge Exchange, 2016; Terry, 1999) to addressing crises in Indigenous communities, this research found the same. The blinded document and interview analyses brought up multiple cultural values within this particular community, such as engaging youth and Elders and using cultural and traditional knowledge, approaches, and gatherings. While specific values and cultures may vary across Indigenous communities, incorporating the appropriate cultural values is very important to promoting and strengthening resiliency (Landau, 2013). As was found by Hughes (2000, 2006) and Terry (1999), failure to meaningfully reflect and employ Indigenous culture within strategies of crisis response, will weaken the utility of the approach, and may even cause it to be rejected entirely. Indeed, Terry (1998) discusses how the community in Alaska where he worked, found the mainstream approach so non-coherent, they created something new for themselves, which was based on Indigenous values and worldview. Therefore, in approaching crisis response in Indigenous communities, it is critical that one is aware of the importance of cultural values and seeks the appropriate information on their use and application.

Likewise the blinded document analysis reflected existing literature (eg. Baikie & Beck, 2002; Cousins, 2010; Harlow et al., 2014; National Knowledge Exchange, 2016; Terry, 1999) on the importance and need for Indigenous and community leadership and ownership of the response, and community-member involvement in the response activities. Through the interview

analysis, the Indigenous leadership of response and organizational collaboration were identified as strengths, though there were questions about how community-member involvement could be strengthened. The importance of recognizing and bolstering informal and formal Indigenous support networks and community capacity to care for itself was a strong theme within this research project, and one reflected elsewhere in literature on Indigenous communities (Cousins, 2010; Kirmayer, Fraser, Fauras, & Whitley, 2009; National Knowledge Exchange, 2016).

These values for Indigenous leadership and community ownership when responding to crises in communities is important to consider, particularly when, as may happen at times of urgent need, there may not be much time for detailed discussions and planning. At the start of this thesis, a CBC news article is cited "*Attawapiskat suicide emergency: Health Canada, province send in crisis teams…*" (CBC News, 2016); paradoxically, the commentary of many key informants highlighted that while the desire to 'send in' external supports may be well-intentioned, doing so can mean that Indigenous community leadership and ownership of the response is compromised. Indeed, some participants highlighted that their experience of the professionalization of response (referencing that it is now primarily police officers, nurses, clinicians, staff of health and social service agencies, which respond to crises) has meant that community Elders have been 'pushed aside' and that they have been left with no role in responding. Further, key informants stressed that the desire within the community is for a 'familiar face' to provide the support services and that much of the response activities (eg. reaching out to those impacted) requires detailed community knowledge. It was mentioned by some that 'sending in' supports can be an added burden to the community, if the supports lack adequate community, contextual, and cultural knowledge.

This is not to say there may not be times wherein external supports are needed – key informants identify that they sometimes pull-in external resources – , so long as they are adequately prepared for the community culture and context. One area where external supports may be particularly valuable is in providing support to the crisis responders themselves. In isolated, small Indigenous communities, it can be difficult for support people to receive the supports they need and external supports may assist in this gap (National Knowledge Exchange, 2016).

In considering applying mainstream models of crisis response in Indigenous communities – for example the National Organization for Victim Assistance (NOVA)'s Community Crisis Response Training Manual (Young, 1998); Critical Incident Stress Management (CISM) (Everly et al., 2002, 2000; Everly & Mitchell, 1999; Mitchell, 1983; Mitchell & Everly, 1986); Psychological First Aid (PFA) (Ruzek et al., 2007; Vernberg et al., 2008); and suicide postvention (Andriessen, 2014; A. Wilson & Clark, 2005) – it is thus really important to consider community cultural values as well as its context and resources. While the community response strategy presented this research addresses the actions of these models, it does so in a way which reflects the community's unique culture and context. While training for responders in mainstream models – such as CISM and PFA – is cited by key informants and literature (eg. Canadian Foundation for Healthcare Improvement, 2016; Health Canada, 2013; National Knowledge Exchange, 2016; Terry, 1999), it must consider the culture and context of the service providers (Hughes, 2000, 2006; Terry, 1999), as too should the preparatory planning (including development of response strategies/manuals) (Canadian Foundation for Healthcare Improvement, 2016; Health Canada, 2013; National Knowledge Exchange, 2016).

As Hughes (2000, 2006) highlighted, understanding of context extends beyond the current; historical trauma such as residential schools, relocation, and colonialism are also important considerations in responding to crises. It is a result of historical trauma that crises are so prevalent in Indigenous communities; Brave Heart claims the high rates of suicide, homicide, domestic violence, child abuse, alcoholism, and other social problems stem from historical trauma (Brave Heart & DeBruyn, 1998, Brave Heart, 2000). Thus, understanding and addressing the root causes is important to crisis response in Indigenous communities.

It is no surprise then that within this blinded document analysis, there was a strong theme that root causes of crises must be addressed, even though this work would take time. Likewise, much of the literature on suicide in Indigenous communities centers on the prevention rather than postvention strategies (eg. Health Canada, 2013; Inuit Tapiriit Kanatami, 2016; Kahui Tautoko Consulting Ltd, 2012). This focus on addressing root concerns is particularly evident within the 'National Inuit Suicide Prevention Strategy', which outlines priority several priority areas which focus on root causes such as 'healing unresolved trauma and grief', 'creating social equity', 'creating cultural continuity', and 'nurturing healthy children' (Inuit Tapiriit Kanatami, 2016, p. 28).

In sum, organizational policies, procedures, and professional practices for crisis response within this isolated Indigenous community are in part shaped by agency mandate, but also reflect the community's context and resources and cultural values. Such an approach is in line with mainstream (Landau, 2013; Ruzek et al., 2007; Vernberg et al., 2008) and Indigenous literature on crisis response practices (Hughes, 2000; Terry, 1999; Wilkie et al., 1998). While mainstream models of crisis response – such as the National Organization for Victim Assistance (NOVA)'s Community Crisis Response Training Manual (Young, 1998); Critical Incident Stress

Management (CISM) (Everly et al., 2002, 2000; Everly & Mitchell, 1999; Mitchell, 1983; Mitchell & Everly, 1986); Psychological First Aid (PFA) (Ruzek et al., 2007; Vernberg et al., 2008); and suicide postvention (Andriessen, 2014; A. Wilson & Clark, 2005) – may be applicable within Indigenous contexts, it is important that they allow Indigenous leadership and ownership of the response, including explicit space for cultural and contextual considerations. Without this grounding in context and culture, crisis response strategies may be less effective and/or poorly received by the community – as was the case in research by both Hughes (2000, 2006) and Terry (1998).

While this thesis contributes to understanding what crisis response in isolated Indigenous communities may look like, there is much yet to be learned. This research project presents only one community's response – what are responses in other isolated Indigenous communities? what are the commonalities and differences across the responses in different communities? From this project, it is not possible to answer these questions, however hopefully future research will do so. Questions regarding informal support networks would also greatly assist in understanding response to crises – how do youth, adults, and Elders provide support in the face of crises? in what ways do families care for themselves? Further, while this research discusses the response within this community, it is through the eyes of organizations and does not assess and/or evaluate this response; it would be fascinating to follow up this study with questions about the experiences of community members themselves, particularly those who are recipients of crisis response services – how well are these services meeting their needs? how do they perceive their role following a crisis? Such answers would be greatly beneficial in strengthening and improving the crisis response within this community and more broadly across isolated Indigenous communities and regions.

Conclusion

Given that Indigenous communities disproportionately experience crisis situations, how can we improve and strengthen the implementation of crisis response services in these contexts, so as to contain the negative consequences and promote resilience and wellbeing? I posit that doing so starts with understanding what currently exists – the roles of the informal and formal support networks, the influence of context and resources, and the guiding wisdom of Indigenous culture and values. If we know what is currently there, we can start considering, discussing, and evaluating what strengths exist in current practices of crisis response in isolated Indigenous communities and what are areas of weakness that may be strengthened. This was the recommendation of the community of interest and the philosophy underpinning this research project.

While each isolated Indigenous community will vary in its culture, values, context, and resources, as well as the organizational policies, procedures, and professional practices, it is hoped that through reading the research thesis there have been opportunities to reflect on what might be impacting any given community's crisis response and to learn about ways to understand and/or strengthen existing crisis response practices in isolated Indigenous communities. This research has also raised many questions for future consideration; there is certainly much more to discuss and learn about crisis response in Indigenous communities, but perhaps the most important part in doing so, is to start with discussions in the communities themselves, with the individuals most closely involved with crises. Certainly, my next steps as a researcher will be to return to the community to discuss the results and explore with them what might be means of strengthening the existing response practices.

To conclude, I wish to bring attention back to Community Leader's comments in 1991:

> *We do not think that the problems facing our community can be solved by us today, or that they can be solved in a short time. We know, as we hope you do, that solutions to our problems are going to take a long time to bring about.*
>
> *– Community Leader, Opening Remarks, 1991*

For many, the ultimate goal is reducing the prevalence of crises in isolated Indigenous communities and this goal will take time, as the root problems – such as historical trauma and ongoing social inequity – are complex to address and overcome. While this work is being done, efforts must be made to ensure that the response to crises in Indigenous communities is one which promotes resilience, healing, and wellbeing and minimizes negative outcomes, including the accumulation of unresolved trauma and grief. To do this, governments, academic research and teachings establishments, service agencies, and frontline (para) professionals of both Indigenous and non-Indigenous descent, must foster a shared understanding of how crisis response best transpires in isolated Indigenous communities, with explicit consideration for Indigenous culture, values, context, and resources. To conclude the above Community Leader's quote and my thesis:

> *"Changes can only happen if all of us work together and share the responsibility for our future."*
>
> *– Community Leader, Opening Remarks, 1991*

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Appendix 1: Letter of Information

McGill
School of Social Work

Dear _____,

I am a graduate student at McGill University with experience in mental health services in {region name}. As part of my graduate program, I am conducting my Masters of Social Work research thesis on community crisis response in isolated, Aboriginal communities. I am writing to you to request that an appropriate representative of your organization be identified for me to speak with. This should be someone who is familiar with crisis response in {community name}, organizational policies, procedures, and professional practices, and able to speak as an agency representative.

Arising from questions from service providers in {community name}, this thesis research project will explore the organizational policies, procedures, and professional practices agencies in {community name} follow when responding to critical events such as deaths by fire, fatal accident, homicide, suicide, community disaster, drowning or missing people. The intent is to produce a comprehensive picture of the processes followed by differing agencies when responding to community crises, so as to deepen understanding and hopefully, strengthen services.

To complete this project, I am looking to speak with representatives from agencies involved with crisis response in {community name} about the policies, procedures, and professional practices which guide your organization in responding to crises. Questions will center on:

- The type(s) of events your organization respond to as a crisis
- The actions, both immediate and subsequent, your organization may take following such events
- The interactions your organization may have with other agencies in providing this response.

To ensure my understanding of how these policies, procedures, and practices could apply in a real life situation, a hypothetical example of each a suicide, missing person, unexpected death, and house fire will be employed. These examples are not based on real-life occurrences

and any discussion of real life events will be redirected during the interview and any disclosures made will removed from the data.

The interview is expected to take approximately one hour, with a potential for subsequent clarifying questions, taking roughly twenty minutes. The interview will be audio recorded so I may take detailed notes on the processes of crisis response. The interviewed individual will have an opportunity to review these notes, as will your organization, if so desired. The outcome of this research will be presented as a report for pertinent agencies in {region name}, a Master of Social Work thesis, and submitted for academic publication.

I greatly appreciate your assistance in this project and am happy to answer any questions you may have,

Kaila de Boer,
Graduate Student,
School of Social Work
McGill University
kaila.deboer@mail.mcgill.ca

Appendix 2: Consent Form

McGill

Consent to Take Part in Research

TITLE: Understanding community crisis response in isolated Aboriginal communities

INVESTIGATOR(S): Kaila de Boer, *Graduate Student, McGill University*

SUPERVISOR(S): Vandna Sinha, *Assistant Professor, McGill University*

You have been invited to take part in a research study. Taking part in this study is voluntary. It is up to you to decide whether to be in the study or not. You can decide not to take part in the study. If you decide to take part, you are free to leave at any time.

Before you decide, you need to understand what the study is for, what risks you might take and what benefits you might receive. This consent form explains the study.

Please read this carefully. Take as much time as you like. If you like, take it home to think about for a while. Mark anything you do not understand, or want explained better. After you have read it, please ask questions about anything that is not clear.

The researchers will:
- discuss the study with you
- answer your questions
- keep confidential any information which could identify you personally
- be available during the study to deal with problems and answer questions

1. **Introduction/Background:**
   The community of {community name} has been responding to crises such as deaths to suicide, house fire, homicide, etc for decades and in {early 2000s}, published a manual outlining {crisis response team} guidelines for responding to crises in {community name}. Over time however, crisis response in {community name} has evolved, membership on the {crisis response team} has waned, and the guidelines of the {crisis response team} manual no longer align with this new context. Related to these changes, some members of the {crisis response team} express experiencing stress in work and home life and uncertainty of who, when, and how to respond to events within the community. To better understand the current context and to support professionals and agencies responding to crises in {community name}, the need for information about the current organizational policies, procedures, and practices of the different agencies involved with crisis response was identified.

2. Purpose of study:
The objective of this study is to speak with agency representatives familiar with their organizational policies, procedures, and practices which guide crisis response in {community name} so as to form a picture of crisis response practices across agencies serving {community name}.

3. Description of the study procedures:
Agencies and organizations providing community crisis response services in {community name} identify staff familiar with the policies, procedures, and practices of crisis response to act as key informants on these topics. These identified individuals are the ones asked to participate in this study.

As a participant, you will partake in a semi-structured interview which explores your agency's policies, procedures, and practices pertinent to crisis response. This will include detailing what events might be considered a crisis, what actions may be taken following such event, and if there are interactions with others in providing the response. Examples of a hypothetical suicide, missing person, unexpected death, and house fire will be utilized to ensure understanding of how the policies, procedures, and professional practices discussed are operationalized, but these examples will not be based on any actual responses. Any discussions of past crisis responses, personal experiences, or individual opinions will be redirected and any disclosures made will be removed from the data.

Each interview will be audio-recorded for the purpose of detailed note-taking. The audio-recording will subsequently be destroyed and the notes will be used to detail the organizational policies, procedures, and practices in cases of community crisis.

4. Length of time:
Participant interviews will last approximately one hour. Participants may be contacted by phone following their interview if further clarification on organizational policy, procedure, or practice is required; such follow up conversations should not last more than twenty minutes.

5. Possible risks and discomforts:
Involvement in this study may raise memories of previous community crisis responses, which could be distressing. However, it is important to note that previous experiences with crisis response will *not* be discussed during the course of this study. The risk of emotional distress is considered low, with supports are available should they be needed, through the {regional health services}, Employee Assistance Plans (EAP), or Non Insured Health Benefits (NIHB) for {Indigenous peoples}.

6. Benefits
It is not known whether this study will benefit you. However, it is hoped that this study will facilitate improved understanding of organizations' policies, procedures, and professional practices guiding response to crises in {community name} and thereby assisting collaboration for the benefit of both {community name}'s community members and the people who serve them.

7. Liability statement:

Signing this form gives us your consent to be in this study. It tells us that you understand the information about the research study. When you sign this form, you do not give up your legal rights. Researchers or agencies involved in this research study still have their legal and professional responsibilities.

8. What about my privacy and confidentiality?

All information gathered for this study will focus on the organizational policies, procedures, and professional practices of the agency for which you work. No personal information – such as stories about your experiences, opinions, or perspectives - will be sought and any such disclosures will be redirected during the interview and removed from the data prior to any data analysis. There will be no personal information collected by this study and the information you provide will be presented as that of the organization you are representing. As you are being interviewed as a representative of your agency, the agency will be aware of your involvement, and may choose to review the information provided prior to data analysis. This will occur after you have reviewed the detailed notes made about the policies, procedures, and practices discussed during the course of your interview; any personal information which was accidentally disclosed during the interview will be removed prior to this review.

If required by law or the research ethics board, your identity may be disclosed to the appropriate authorities.

Access to records

Only the primary researcher and the research supervisor will have access to records which identify you as the representative of your organization.

Your organization will have access to data collected regarding their policies, procedures, and professional practices prior to research publication, after your review of this data.

Use of your study information

The research team will collect and use only the information they need for this research study.

This information will include

- *The name of the organization/agency for which you work*
- *Organizational/agency policies, procedures, and professional practices guiding response to community crises in {community name}.*

Your name and contact information will be kept secure by the primary researcher. It will not be shared with others without your permission. Your name will not appear in any report or article published as a result of this study.

Information collected for this study will be kept for five years.

If you decide to withdraw from the study, the information collected up to that time will be destroyed. This information will only be used for the purposes of this study.

Information collected and used by the research team will be stored in a locked filing cabinet. Kaila de Boer, principal investigator, is the person responsible for keeping it secure.

Your access to records

You may ask the study researcher to see the information that has been collected about you. The detailed notes about your organization's policies, procedures, and practices made following the interview with you will be shared with you and you will have the opportunity to make additions, deletions, or changes.

9. **Questions or problems:**

If you have any questions about taking part in this study, you can meet with the investigator who is in charge of the study. That person is:

Kaila de Boer, Principle Investigator
kaila.deboer@mail.mcgill.ca
Office: xxx-xxx-xxxx
Cell: xxx-xxx-xxxx

You may also contact my supervisor if you have any questions about taking part in this study:

Vandna Sinha, Thesis Supervisor
vandna.sinha@mcgill.ca
Office: 514-398-5032

Or you can talk to someone who is not involved with the study at all, but can advise you on your rights as a participant in a research study. This person can be reached through:

Ethics Office
Health Research Ethics Authority
xxx-xxx-xxxx or by email at info@hrea.ca

After signing this consent you will be given a copy.

Signature Page

Study title:

Name of principal

investigator:

To be filled out and signed by the participant:

Please check as appropriate:

I have read the consent	Yes { }	No { }
I have had the opportunity to ask questions/to discuss this study.	Yes { }	No { }
I have received satisfactory answers to all of my questions.	Yes { }	No { }
I have received enough information about the study.	Yes { }	No { }
I have spoken to the researcher and he/she has answered my questions	Yes { }	No { }
I understand that I am free to withdraw from the study at any time without having to give a reason without affecting my employment	Yes { }	No { }
I understand that it is my choice to be in the study and that I may not benefit.	Yes { }	No { }
I understand how my privacy is protected and my records kept confidential	Yes { }	No { }
I agree to be audio taped	Yes { }	No { }
I agree to take part in this study.	Yes { }	No { }

_____ _____ _____

Signature of participant Name printed Year Month Day

<u>To be signed by the investigator or person obtaining consent</u>

I have explained this study to the best of my ability. I invited questions and gave answers. I believe that the participant fully understands what is involved in being in the study, any potential risks of the study and that he or she has freely chosen to be in the study.

_____ _____ _____

Signature of investigator Name printed Year Month Day

Telephone number: _____

Appendix 3: Semi-Structured Interview Guide

McGill
School of Social Work

Semi-Structured Interview Guide

Note to participants: Throughout this interview, please keep in mind that this research project is interested in better understanding organizational policy, procedures, and professional practices with regard to community crises. Please do not disclose information about specific incidences and/or events.

1) To start this interview, I would like to understand what type of events would be considered a "crisis" warranting a response in your organization. What type of events would your organization respond to as a crisis?

2) Now that I have some information about what might be considered a crisis event warranting a response from your organization, I am going to ask some questions to help understand how your organization may respond to these crises. I realize that different events may warrant different responses and encourage you to discuss these differences.

   I. Of the types of crises you identified that your organization responds to, are there events your organization would have an immediate response to?
   II. What would this immediate response(s) consist of? Please discuss if there are any differences in responses for different types of crises.
   III. For the types of crises you identified, are there events where your organization would have action(s) at a later point in time, such as the next day or week? What would this response consist of? Please discuss if there are any differences in responses for different types of crises.
   IV. For the types of crises you identified, would your organization be in contact with other service providers or individuals in providing their response? If so, who? When? For what purpose? Please discuss if there are any differences in responses for different types of crises.

   NOTE: Depending on the number of crisis-responses identified in question one, this section may be adapted to ask about each type of response in turn: eg. "you identified that you would respond to a _____crisis, what would the immediate response consist of?..."

3) To ensure I'm understanding how your organization would respond to an event affecting {community name}, I'm going to provide four hypothetical events. These examples are not based on actual events and I would like to remind you not to discuss any actual events. Please discuss if it would be considered a crisis which your organization would have a response to and, if there is a response, walk me through the response your organization may have from the moment they are notified, in as much detail as possible. These are examples of tragedies and may be distressing; if you would prefer to skip this section, that is fine.

I. A young male from {community name} is reported missing on a Sunday evening after not returning home from going-off on ski-doo and weather conditions are getting worse.
II. A senior dies in the hospital in {nearby 'city' name} on Thursday morning following a serious stroke Wednesday night which required a medevac from the {community name} clinic.
III. A teenaged female completes suicide by hanging herself in her home in {community name} at 1am on a Tuesday night.
IV. A house catches fire and, given the recent dry weather and current winds, there are concerns the fire will spread to neighbouring homes.

4) Does your organization consider itself a part of the {community name} Crisis Response Team? If so, in what capacity?

5) Any other comments about policies, procedures or professional practices which guide your organization's response to crises in {community name}?

Appendix 4: Listing of Blinded Documents

Historic Documents (1991-2003)

1. Community Ideas on Alcohol, Violence, and Crime
2. Report on Community Consultation Process
3. Community Meeting on Recent Crimes
4. Invitation to Community Consultations
5. Community Leaders Discussion on Suicide - 1
6. Press Release - Join Forces for Community
7. Community Leaders Discussion on Suicide - 2
8. Recommendations for a Crisis Line
9. Recommendations to RCAP on Suicide
10. RCAP Presentation from Community Leaders
11. Results from the Youth Questionnaire
12. Communication from Community Leader - Connection with Youth
13. Community Special Meeting on Suicide
14. 'Committee' Report
15. Youth Letter for 'Committee' Report
16. 'Committee' Meeting Notes - 1
17. 'Committee' Meeting Notes - 2
18. 'Committee' Meeting Notes - 3
19. Draft Liquor Control Act
20. 'Committee' Letter on Liquor Act - 1
21. 'Committee' Letter on Liquor Act - 2
22. 'Committee' Recommendations - Youth Space and Alcohol Free Space
23. Invitation to Community Forum on Liquor Act
24. Community Crisis Response Guidelines
25. Community Support Team Report

Recent Documents (2009-2013)

26. Strategy for Addictions/Substance Abuse
27. Strategy for Mental Health
28. Strategic Health Plan