

ATHABASCA UNIVERSITY

HOOPS AND HURDLES: EXPLORING BARRIERS TO MENTAL HEALTHCARE FOR  
INDIGENOUS PEOPLES IN THE PEACE REGION

BY

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**Approval of Thesis**

The undersigned certify that they have read the thesis entitled

**HOOPS AND HURDLES: EXPLORING BARRIERS TO MENTAL HEALTHCARE FOR INDIGENOUS PEOPLES IN  
THE PEACE REGION**

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## **Dedication**

I would like to dedicate my thesis to Indigenous Peoples in Canada and the collaborative pathway forward to reconciliation. Decolonizing institutions and systems, reclaiming land, history, knowledge, and culture is more important than ever. My research project remained central to educating the truths of colonialism and colonization and extending heartfelt efforts towards reconciliation. I would also like to dedicate my thesis to the Nawican Friendship Centre in Dawson Creek. The Nawican Friendship Centre is a vital resource in the Peace Region, whose staff have dedicated their time and traditional knowledge to making this study culturally informed and impactful.

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## **Abstract**

Securing mental healthcare services in Canada may be a challenging task for Indigenous Peoples who access publicly funded services in rural communities. Whether mental healthcare is culturally appropriate, accessible, and inclusive is determined by the healthcare institution, and the frontline workers who provide services. This research project sought to explore frontline mental healthcare practices delivered by Northern Health mental healthcare professionals, in the Peace Region, British Columbia (BC). This project clarified how institutions such as Northern Health, organize, direct, and dictate the work of frontline professionals relating to decolonizing and culturally safe work practices. The project provided insight for organizations and mental health professionals how service provision may improve for Indigenous Peoples and communities in the Peace Region. The findings of this study advocate for enhanced Indigenous community collaboration, clarifying decolonizing practice guidelines, and creating opportunities to advance ongoing cultural competency.

*Keywords:* mental healthcare, public healthcare, Indigenous Peoples, British Columbia, Canada, Northern Health Authority, health authority, rural community, decolonization, institutional ethnography, qualitative research

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## Key Terminology

This study discusses issues relating to accessing mental healthcare services, service delivery, and mental health implications. This study also uses terminology which is specific to institutional ethnography. For improved clarity, the following section defines key terms within the context of this study.

**Actualities:** The lived and observable experiences or activities which people experience in their day-to-day lives (Campbell & Gregor, 2008).

**Barrier to Healthcare:** Any factors that prevent an individual, population, or community from acquiring access to health services or achieving equitable healthcare (Nader et al., 2017).

**Cultural Safety:** Mental healthcare services which show respect for culture and identity, including consideration of individual needs, which are free from discrimination and prejudice (Dawson et al., 2022; Josewski, Morrow, et al., 2023).

**Culturally Appropriate:** In the context of this proposal, culturally appropriate refers only to mental healthcare that acknowledges the impact of culture on a person's mental health and healing (Montesanti et al., 2022).

**Colonization/Colonialism:** The explicit acts of European settlers to establish control and authority over Indigenous Peoples in Canada (Nguyen et al., 2020). Includes the use of residential schools, the Indian Act, Sixties Scoop, and attempts to assimilate Indigenous Peoples through the stripping of language, culture, and identity (Wu et al., 2023).

**Decolonization:** Explicit attempts to de-center the dominant culture, dismantle historical attempts at assimilation, and prioritize traditional ways of knowing and healing (Josewski et al., 2023).

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**Disjuncture:** A noticeable gap or tension experienced between people’s everyday experiences and the textual or institutional account of what is happening (Campbell & Gregor, 2008).

**Equity/Inequity:** The fair (or unfair) distribution of resources, opportunities, and support to meet health needs and health outcomes (Wu et al., 2023). Equity involves considering social determinants of health in a population.

**Indigenous Peoples:** A collective name grouping the Peoples who have roots to ancestral lands, often united worldwide by the shared experiences of colonization (Nelson & Wilson, 2017).

Recognized distinctly in Canada as First Nations, Inuit, and Métis, which each group has unique histories, languages, cultural practices, and spiritual beliefs (Nader et al., 2017; Nelson & Wilson, 2017). In the Peace Region, this may include individuals who are not members of a specific nation, and live off reserve within the communities of Dawson Creek, Chetwynd, and Fort St. John.

**Local:** A term in institutional ethnography to describe the position and setting where the frontline professionals’ experience takes place. The local is where the frontline work is taking place and where the standpoint is.

**Mental Healthcare Professional/Provider:** A healthcare professional or service provider who treats mental health conditions and disorders. They work in a variety of settings such as hospitals, clinics, schools, and private practice. May include counsellors, psychotherapists, social workers, nurses, mental health case managers, mental health clinicians, or therapists.

**Mental Health:** A state of mental well-being. Includes emotions, feelings of connection to others, thoughts and feelings, and condition regarding psychological and emotional well-being (Canadian Mental Health Association, 2021).

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**Mental Health Problems/Experiences:** An experience related to challenges or changes to mental well-being (Canadian Mental Health Association, 2021).

**Microaggression:** Indirect, subtle, or unintentional words, actions, and behaviours which hold negative biases toward a particular group of people (Turpel, 2020).

**Problematic:** A set of questions, tensions, or puzzles that arise from people's everyday lives (Smith & Griffith, 2022).

**Reflexivity:** Bringing awareness to one's own worldview or way of knowing, and understanding how this influences one's behaviours and way of being (Dawson et al., 2022). In the context of Indigenous healthcare research, this may include bringing awareness to power and privilege.

**Ruling Relations:** The social relations of institutions coordinate and organize everyday life. Ruling relations link and coordinate local settings with larger institutions or organizations (Rankin, 2017).

**Rural/Remote Area:** Rural and remote communities (including small towns) are defined as having a population of fewer than 10,000 people. May also be described as a community situated far outside of metropolitan communities (Vodden et al., 2021).

**Small Hero:** The small hero is a metaphor used in Dorothy Smith's work on institutional ethnography which represents an individual seeking to understand how their experiences are connected to larger, social, political, and institutional forces (Smith, 2005).

**Social Determinants of Health (SDOH):** Health outcomes, such as mental health problems, which are determined by social and economic factors such as income, education, experiences of racism, and historical trauma (Browne et al., 2016; Nelson & Wilson, 2017).

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**Standpoint:** Within the context of institutional ethnography, a standpoint refers to a researcher's position or stance located in relation to a complex system of institutions, with focus on the knowledge of people and their experiences (Smith & Griffith, 2022).

**Texts:** Within the context of institutional ethnography, texts may be defined as material objects that carry messages of various kinds to coordinate the work that people do across multiple sites and time (Smith & Griffith, 2022). Texts are the primary instrument of ruling relations.

**Translocal:** The processes and forms of organization which are coordinated beyond the *local* or everyday frontline experience. Often in the form of texts. Inquiry into translocal processes helps to better understand ruling relations (Dalmer, 2019).

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## Chapter 1. Introduction

Approximately 1 in 5 Canadians will experience a mental health problem during their lives (Canadian Mental Health Association, 2021). For many individuals, accessing mental healthcare services is a complicated and daunting process, which involves a series of complex steps to acquiring care. Despite accessibility being an important cornerstone of Canadian healthcare, many Canadians are currently experiencing barriers to accessing the mental healthcare they require (Friesen, 2019). Canada has a publicly funded healthcare system, however funding for mental healthcare services is currently lacking (Josewski, Morrow, et al., 2023). Barriers to care commonly include an inadequate number of resources, such as lack of healthcare providers, coupled with long wait times, and high staffing turnover (Cajax, 2016). For Canadians residing in rural communities, accessing mental healthcare is a complex issue involving multiple factors such as unique geographical, and sociocultural factors (Friesen, 2019).

While rural living provides increased challenges for accessing services, the experience is even more nuanced for Indigenous Canadians due to the complex history of colonization. The experience of mental health problems is generally higher for Indigenous people in Canada, when compared with non-Indigenous people (Montesanti et al., 2022). I will begin my introduction of this research project by introducing how I came to this research focus, and my positionality. I then provide preliminary information on the unique challenges facing Indigenous Peoples living in rural Canada before introducing my research question that examines the issue of mental health access and care in the context of the Peace Region in British Columbia.

### **The Peace Region**

I was born and raised in the small, rural community of Dawson Creek, British Columbia (BC), consisting of a population of 12,323 residents (Statistics Canada, 2021). Dawson Creek is

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one of the communities in the Peace Region, which includes a subset of seven rural municipalities including Chetwynd, Fort St. John, Hudson's Hope, Taylor, Tumbler Ridge, and the village of Pouce Coupe. The Peace Region is situated on Treaty 8 territory, which is the traditional home and lands of the Dene, Dane-zaa (Beaver), Cree, Métis, Sauleau, Sicannie (Sikanni), and Slavey Peoples. Statistics Canada 2021 census of population indicated that 15.1% of the population in the Peace Region were made up of Indigenous Peoples (Statistics Canada, 2021). When compared with the overall population of Indigenous Peoples in Canada, the Peace Region was nearly three times higher (Statistics Canada, 2021).

As a resident of Dawson Creek, and a self-proclaimed 'Northerner,' I will discuss my experience of living in a small community as a resource provider. The separation between Dawson Creek, and the closest metropolitan city of Prince George, BC, is approximately 405 kilometers. Dawson Creek and other Peace Region municipalities are considered rural communities rather than remote, as each community is connected through road access. Focusing on the Peace Region as the area of inquiry for my research is incredibly important, as Northern residents often feel forgotten about. Northern residents take pride in our ability to thrive and flourish, despite living in an area lacking in many resources when compared to urban communities. What the Peace Region lacks in resources is often made up for in resiliency, self-dependency, and passion for the community.

### **Background**

This project originated in 2020, while I was working for BC Public Service as an Adult Probation Officer. During the first few years of working in this profession, I worked alongside many different clients from diverse backgrounds. In this profession it was expected that we would fulfill the role of a *helper*, which entailed assuming the role as an agent of change, and

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helping individuals who needed diverse services or community resources. Living in a small community as a helper was a seemingly impossible task, as community resources, especially mental health resources, are incredibly scarce. Furthermore, the expectation that we were to ‘address’ the overrepresentation of Indigenous Peoples within the criminal justice system as frontline workers, also felt like an impossible task. Probation officers are trained to utilize specific tools designed to address the needs of clients – tools that were informed through Euro-centric research and ways of knowing.

Through my graduate studies, and learning about respecting all people, cultures, and worldviews, my thinking has shifted when reflecting on my past career. I have reflected on how my tools for helping were actually tools of oppression, which failed to acknowledge any sociocultural implications of colonization, and the context of the lived experiences of Indigenous clients. While I was unable to make any concrete changes in my past career, I hope that through my research I am able to shine light on this experience as a frontline professional. My overarching goals of this research was to advance my learning, learn how frontline mental health work is organized, and make recommendations to systems and institutions that may require guidance. My goal is to also give concrete guidance to others who may have similar experiences, but are unsure how to make changes.

### ***Standpoint and Problematic***

Through my reflection on past experiences, I have chosen to utilize a methodology that seeks to better understand how systems shape everyday lives. In the following section I will outline how Institutional Ethnography (IE) and the concept of taking up or assuming a *standpoint* aligns with my research focus. IE researchers assume that people will often see a problem, or a disconnect within a system, but are unable to identify what is occurring (Devault & McCoy,

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2006; McLiesh et al., 2024). Reflecting on my past experiences has allowed me to understand how I experienced this disconnect, but was unable to identify or explain what was happening. The experience of identifying a problem in everyday practice is a common approach to IE, and is described as the researcher taking a *standpoint* or considering a situation of investigation (Devault & McCoy, 2006). The standpoint I am taking is from the perspective and experiences of the everyday frontline mental health professional, and exploring how their everyday work is coordinated elsewhere. Chapter 4 discusses how this standpoint is used to ‘look up’ and considers how ruling relations, discourses, and contexts coordinate the work of frontline professionals.

Following taking up a *standpoint*, often a *problematic* is identified. A problematic is an issue or problem that directs research questions (Campbell & Gregor, 2008). To move beyond current practices and expand on what is already known, institutional ethnographers begin with a *problematic* (Campbell & Gregor, 2008). A feature of IE that drew me in was the emphasis on my *problematic*, as the questions I wanted to explore were unaddressed, and accepted as facts within the institution I occupied. I knew that I was governed by specific policies which contributed to the continued marginalization and oppression of Indigenous Peoples, but I did not know how to change it. Therefore, the *problematic* of my research initially came from the question of how policies and practices within government contributed to continued oppression, and how this created additional barriers for Indigenous Peoples.

As my interests and curiosity shifted towards looking at mental health institutions, I also wondered how my *problematic* affected the everyday work of mental healthcare professionals. This *problematic* led me to question how do mental healthcare workers perpetuate or contribute

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to systemic and cultural barriers for mental healthcare of Indigenous Peoples residing in rural communities?

### **Positionality and Positioning Myself in Relation to this Work**

One consideration of reflexivity is that of positioning and positionality. Positionality refers to the researchers ability to situate themselves within the study including acknowledging power, privilege, and biases (Berry, 2011). Maintaining reflexivity helps researchers consider their own personal positionality, including being open to differing views and challenging personal assumptions (Wilkinson, 2013). Creswell and Poth (2024) argued that all writing is positioned, as researchers inevitably shape their writing. This deeply personal consideration helps situate the researcher within the research process and recognize their influence on the research itself (Wilkinson, 2013). Thambinathan and Kinsella (2021) suggested that one way to do this is to reframe positionality from discoverers of community knowledge to learners.

I position myself in relation to the Indigenous community, which my study will be considering, and shift my mindset to a learner rather than a researcher. I acknowledge that I am a non-Indigenous person, of Caucasian and Chinese descent. I acknowledge my relative position of privilege and power, as an individual who is able to pursue higher education which allows for researching this project. I also position myself within a family who has experienced mental health challenges, and have had the privilege to obtain and benefit from mental health services. I acknowledge how my experiences, family history, and shared family values for helping have contributed to my positionality within my research.

I recognize that while I have conducted research concerning Indigenous Peoples and have made attempts to understand experience, that I will not be able to fully assume the position nor experiences of an Indigenous person. I have sought advice, and ongoing feedback from two local

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Elders, and individuals from the Nawican Friendship Centre in Dawson Creek, and have situated my research within their experiences, specifically acknowledging the need for culturally safe and appropriate mental healthcare in the Peace Region. I also acknowledge that as an ally to Indigenous Peoples, I am a listener and learner, but not an expert. I have worked in collaboration with the Nawican Friendship Centre in hope that my research reaches the appropriate audiences, and acknowledges the importance of Indigenous rights to research which concerns them. I acknowledge I believe in the right to Indigenous People's autonomy, right to respect, and free will, and approach this study out of curiosity, and respect as an ally. My reflexivity practices are detailed throughout this research, which document my ongoing thought processes, research decisions, acknowledgement of biases, and critical thinking related to data analysis.

### **Purpose and Relevance of Study**

The purpose of my study is to critically analyze and bring awareness to how mental health professionals are influenced by systemic forces and how everyday work is organized by the larger institution of public healthcare. Drawing on critical theory and decolonizing theory I have critiqued the current public mental healthcare system, and how it organizes the work of mental health professionals in relation to providing care for Indigenous Peoples. My study has also highlighted the importance of appropriate training, and ongoing collaboration with local Indigenous communities. Amidst initiatives for truth and reconciliation, Elders in Dawson Creek are calling for action. Multiple benefits have derived from conducting this research, including a broadened understanding of cultural barriers to mental healthcare for Indigenous populations. My study is relevant and important for considering action, and how this may look in practice. From this study, I have provided recommendations for consideration for health authorities, and

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mental healthcare professionals to expand their scope of practice to improve care for Indigenous Peoples in the community.

### **Research Questions**

Through my previous life experiences, the development of my *standpoint*, refining my problematic, and understanding the purpose and relevance of my study, I have come to three distinct research questions. My research questions were considered throughout the duration of my research process, which also formed the basis of my data collection, analysis, and discussion.

My three research questions are as follows:

1. How do institutional policies and practices contribute to barriers for Indigenous Peoples residing in rural communities in the Peace Region, BC?
2. To what extent do mental healthcare workers integrate decolonizing practices in their approaches to mental healthcare for Indigenous Peoples?
3. What opportunities exist to integrate decolonizing practices into mental health services for rural communities in the Peace Region, BC?

### **Chapter Summary**

The experience of mental health problems has become a common reality for many Canadians, however accessing mental healthcare creates a challenging landscape to navigate. Unique barriers to care such as living in a rural community, or being an Indigenous person may further compound issues of access. I have grown up in a rural community which has uniquely shaped my worldview and experiences. I have positioned myself as a non-Indigenous person, and considered the deeply personal position I will be taking to challenging my assumptions, and opening my mind to differing worldviews. My lived experiences working and living in the Peace Region have provided me with my *standpoint* and *problematic*, which create the lens that I will

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explore this study through. The Peace Region in BC offered unique research opportunity to explore issues of access to mental healthcare for Indigenous Peoples. My study is relevant and purposeful, as I have critiqued the current public mental healthcare system, with intentions of recommending changes to practice.

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## Chapter 2. Literature Review

In 2022, more than 5 million Canadians met the criteria for a mood, anxiety, or substance use disorder, which reflects a substantial increase of mental illnesses over the last decade (Statistics Canada, 2023). A recent study by Statistics Canada examines the prevalence of mental disorders and access to mental healthcare, which found that mental health disorders are increasing and only half of Canadians will receive professional help (Statistics Canada, 2023). Unfortunately, this newer study did not examine mental health incidences within the population of Indigenous Peoples in Canada. Researchers have heavily documented findings that suggest inequalities in health for Indigenous Peoples, but little research is focused specifically on mental health (Nelson & Wilson, 2017). Due to the impacts of colonialism, Indigenous Peoples' mental health experiences are often insufficiently addressed using Westernized Euro-centric services (Wu et al., 2023).

The experience of mental health problems is generally higher for Indigenous Peoples in Canada, when compared with non-Indigenous people (Montesanti et al., 2022). However, much of the existing mental health literature points to mental health policies and practices disregarding Indigenous perspectives (Barcham, 2022; Nelson & Wilson, 2017). Health policies and practices tend to conflate health inequities, when in fact they are part of the colonial history and ongoing health inequities (Josewski, 2012; Josewski et al., 2023). Newer areas of research are acknowledging and advocating for decolonization within the healthcare system, which involves systemic and systematic changes to acknowledge Indigenous ways of knowing (Barcham, 2022).

First Nations Peoples in Canada are often grouped into geographical categories of residence including on-reserve or off-reserve. However, I will focus on the health and contexts of off-reserve Indigenous Peoples as an under-researched area of inquiry, as this has been identified

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as a “dramatic gap” in literature (Nelson & Wilson, 2017, p. 28). I will first trace a brief history of colonization in Canada, followed by consideration of the effects of colonization on the health of Indigenous Peoples in Canada. I also discuss the public healthcare system, including public mental health institutions in BC, and discuss barriers to mental healthcare for individuals in rural and non-rural communities. I have also reviewed various barriers faced by Indigenous Peoples to accessing equitable mental healthcare, and conclude with discussion of decolonizing mental healthcare practices.

### **Indigenous Peoples and Colonization**

Indigenous Peoples in Canada comprise approximately 5% of Canada’s overall population, but this number is continually growing (Nader et al., 2017; Nguyen et al., 2020). In Canada, the Federal government recognizes three main groups of Indigenous Peoples including First Nations, Métis, and Inuit, all of whom are distinctively different in culture, language, and beliefs (Nader et al., 2017). Colonization is the action or process of settling, and establishing control over the local Indigenous Peoples in an area (Nguyen et al., 2020). Indigenous Peoples in Canada continue to experience the impacts of colonization efforts. The implications of colonization and colonialism have created lasting impacts on the mental health of Indigenous Peoples in Canada, and many of the inequities and health gaps between non-Indigenous and Indigenous Peoples can be attributed to the effects of colonization (Browne et al., 2016; Montesanti et al., 2022; Nguyen et al., 2020).

Colonization has previously excluded Indigenous Peoples from policy making, and controlled the use of traditional healing practices, which continues to affect their healthcare outcomes presently (Nguyen et al., 2020). An example of exclusion from policy making includes the creation of the Indian Act, which was an effort to colonize and assimilate Indigenous

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Peoples. The Indian Act is a federal legislation that was first enacted in 1876, with the intention to govern Indigenous Peoples, politics, and societies (Halees, 2022). The Indian Act has had numerous amendments including in 1951, 1985, and 2019. However, the same ideas during the inception of the Indian Act still apply, including restrictions on self-determination, rights to autonomy, identity, and membership in accordance with Indigenous cultures (Halees, 2022).

The mental health of Indigenous peoples in Canada is best understood under the lens of the current and historical colonial experiences including the loss of land, culture, traditions, systems of governance and autonomy (Montesanti et al., 2022). The Indian Residential School System, the Indian Act and other colonizing efforts have marginalized Indigenous people and created a landscape of discrimination and disparate mental health inequities for this population (Kirmayer et al., 2003; Wu et al., 2023). The Indian Act has served as a form of policy to politically govern Indigenous Peoples, women, and children, which has had an effect on healing and reconciliation. Colonization efforts, and residential schools have contributed to the mental health disadvantages faced by Indigenous Peoples (Boksa et al., 2015; Nader et al., 2017). Presently, attempts to reconcile the history of colonization are pervasive in Canada, and the Truth and Reconciliation Commission of Canada (TRC) have worked to document, publish, and make known the effects of colonization.

### ***Colonization, Truth, and Reconciliation***

The TRC was developed by Indigenous Elders, Indigenous scholars, Knowledge Keepers, and policy makers to address many of the health disparities and inequities existing for Indigenous Peoples. The TRC has acknowledged the importance of truth, including informing all Canadians of historical colonization efforts, and the accompanied severe intergenerational trauma caused by colonization. The TRC has also created the Calls to Action, which aim to

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reconcile areas which were impacted by colonization such as education, justice, health, and child welfare (Truth and Reconciliation Commission of Canada: Calls to Action, 2015). The TRC has addressed these issues throughout the 2015 Calls to Action, which urgently affirm the need for Indigenous healing practices, traditions, treatments, and medicines to be normalized and used in mainstream healthcare. The TRC created an interim report with Calls to Action, which are intended to address the “legacy of residential schools and advance the process of Canadian reconciliation” (Truth and Reconciliation Commission of Canada: Calls to Action, 2015).

The TRC emphasized the importance of addressing health disparities between Indigenous and non-Indigenous Peoples, and has called upon the government of Canada to reform mental health services for Indigenous Peoples in Canada. Call to Action #19 specifically urges the government “in consultation with Aboriginal peoples, to establish measurable goals to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities” with efforts focused on mental health (Truth and Reconciliation Commission of Canada: Calls to Action, 2015). Call to Action #24 also calls upon the government of Canada at all levels, to “provide cultural competency training for all healthcare professionals” (Truth and Reconciliation Commission of Canada: Calls to Action, 2015). While reconciliation efforts are steadfastly increasing, there are still many Calls to Action which have been unaddressed. The need for reconciliation efforts are important considerations when looking closely at the health disparities between Indigenous and non-Indigenous Peoples. In the next section I will discuss the negative health outcomes that Indigenous Peoples in Canada are experiencing, and how colonization and social determinants of health explain disparities amongst Indigenous and non-Indigenous populations.

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## **Social Determinants of Health**

Despite having a smaller overall population, Indigenous Peoples in Canada have disparate mental health incidences in comparison to non-Indigenous Peoples (Montesanti et al., 2022). Indigenous Peoples in Canada are affected by negative health outcomes resulting from the creation and continuation of systems, structures, policies, and institutional practices that were created through colonization (Browne et al., 2016). Social determinants of health (SDOH) are defined as the broader social conditions that are considered to cause mental health problems (Nelson & Wilson, 2017). An example of SDOH are experiences of racism and discrimination stemming from colonialism. Inequities in social determinants of health among Indigenous Peoples contribute to the health disparities between non-Indigenous and Indigenous Peoples (Nader et al., 2017). Health disparities include deficits in health outcomes for Indigenous Peoples including increased rates of disease, malnutrition, homicide, suicide, and interpersonal violence (Barcham, 2022). Researchers argue that health disparities amongst Indigenous Peoples are due to social determinants, and systemic and systematic inequalities (Barcham, 2022; Nader et al., 2017; Nelson & Wilson, 2018).

When compared with non-Indigenous groups, Indigenous Peoples were found to be the least likely to receive help for experiences of mental health problems. Researchers have called upon policy makers to have a better understanding of SDOH among Indigenous Peoples to understand how culture and context affect ability to access care (Goetz et al., 2023). Similarly, Nader et al. (2017) found in their study of healthcare access in Alberta, that Indigenous Peoples have much lower rates of utilizing healthcare services compared to non-Indigenous People, which affected determinants of health. Horill et al. (2018) stated that Indigenous Peoples are

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often blamed for their health status, as the present-day mental healthcare system has post-colonial perspectives embedded within it (as cited in Nguyen et al., 2020).

The colonial systems and structures still exist presently, and continue to be practiced in various institutions. The residential school systems have also perpetuated lasting intergenerational trauma that has impacted the social determinants of health for Indigenous Peoples in Canada (Mandal & Burella, 2021). Another example of current colonial structures includes the creation of isolated reservations that are often situated away from urban centres, which often lack the necessary resources and infrastructure needed to thrive (Browne et al., 2016). The sociocultural implications of colonization have contributed to inequities in health that are recognized as mental health problems.

Indigenous Peoples experience a wider range of mental health problems at higher rates, when compared with non-Indigenous Peoples (Browne et al., 2016; Kirmayer et al., 2003; Smye et al., 2023). Other intergenerational effects resulting from colonization are highly prevalent in Indigenous communities in Canada, including post-traumatic stress disorder, high rates of violence, and higher likelihood to die younger than non-Indigenous Peoples (Smye et al., 2023). Individuals residing in Canada, including Indigenous Peoples residing off reserve, may rely on public mental healthcare institutions as the primary method of treating or addressing mental health needs.

### **Public Mental Healthcare**

Public mental health resources are often designed to eliminate issues of access, and to create health services that are easily accessible, affordable, and responsive to the needs of individuals requiring them (Nader et al., 2017). In Canada, universal coverage is intended to improve mental health for Canadians and protect the wellbeing of residents, while

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acknowledging diversity and reducing health inequities (Nguyen et al., 2020). However, mental healthcare services in Canada tend to fall short by failing to address social and health inequities that are influenced by culture or other social phenomena (Nguyen et al., 2020). Furthermore, Westernized models of health generally fail to meet the needs of Indigenous Peoples by failing to address social and health inequities.

In Canada, the Federal government is responsible for setting the standards for healthcare and organizing care for Indigenous Peoples living on reserve, while the individual institutions and structures of healthcare are managed at the provincial level (Manns et al., 2024). Several provinces in Canada, including BC, separate healthcare institutions by regions, which is intended to provide benefits to healthcare delivery. The provincial health authority is responsible for managing and offering mental health services for off-reserve Indigenous Peoples. However, public mental healthcare systems have various embedded systemic issues, which create barriers to care for Indigenous Peoples in Canada (Browne et al., 2016; Josewski et al., 2023).

Josewski (2012) found in their study of cultural safety within provincial health authorities that mental health workers felt initiatives to incorporate partnership with Indigenous communities as useless for the needs of Indigenous Peoples. Josewski found that healthcare systems have proven to be unresponsive to the needs of Indigenous Peoples, including addressing historical traumas and social determinants of health. Josewski also found evidence pointing to public mental health systems continuing to be generally underfunded and lacking in culturally safe and culturally appropriate care. The researcher's findings state policy makers within the organization felt a fear of scrutiny from the provincial health authority for making decisions that went beyond the organization's strict policies (Josewski, 2012).

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Researchers have cited problems in healthcare as occurring at the service delivery level, and often where service delivery will fall short is within the institutions that direct practice and policies (McLiesh et al., 2024). To address where care is falling short, BC has created the First Nations Health Authority (FNHA) to assist public health authorities with guiding the care of Indigenous health services (Josewski et al., 2023; Manns et al., 2024). Some government mandates in Canada have incorporated Indigenous health practices to make accessing and utilizing mental health resources more culturally appropriate. An example of more culturally appropriate policies, include the acknowledgement of decolonization within healthcare, which I discuss in the following section on decolonization.

### **Barriers to Mental Health Resources**

Canada has a problem with access to mental health resources despite 1 in 5 Canadians reportedly experiencing mental health problems in any given year (Faber et al., 2023). Statistics Canada has reported that a high percentage of those who are experiencing mental health problems will have their needs unmet (Statistics Canada, 2023). Some reasons for unmet needs include lack access to mental health services due to long wait times, understaffing, and financial barriers (Statistics Canada, 2023). While the area of inquiry concerning general barriers to mental healthcare is particularly well understood, there is room for exploration and additional research concerning barriers to care for Indigenous Peoples in Canada.

There appears to be consensus among the literature, stating Indigenous people have challenges with accessing mental healthcare, thus creating a barrier to access (Nelson & Wilson, 2018). McIntyre et al. (2017) found in their study assessing service use for mental health resources for Indigenous people in Canada, that treatment dropout occurred at a much higher rate than for Indigenous Peoples than non-Indigenous people. The researchers acknowledged the

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evidence was unclear about predictors or patterns that led to this finding of treatment dropout for Indigenous Peoples (McIntyre et al., 2017). Other researchers found that a lack of Indigenous service providers, long wait lists, and other structural issues created barriers for Indigenous clients (Goetz et al., 2023; McIntyre et al., 2017). However, these findings were also consistent with the general population and non-Indigenous clients.

Existing literature has addressed common barriers to mental healthcare, however, there is limited research connecting the role of mental healthcare professionals to these barriers. Barriers to care for Indigenous Peoples are rooted in a colonial landscape, which is acknowledged, but not clearly analyzed in previous research (Nelson & Wilson, 2018). The following sections discuss commonalities found across the research suggesting barriers to mental health resources for Indigenous Peoples at the frontline level.

### ***Cultural Barriers***

Cultural barriers including lack of cultural competence with mental healthcare workers, was found to be a substantial barrier to care in other studies (Faber et al., 2023; Nader et al., 2017). Goetz et al. (2023) found in their study of help seeking behaviours among Indigenous populations that Indigenous people greatly emphasized incorporation of culture when seeking treatment. The history of colonization, which is embedded in institutions has contributed to a finding of reluctance or avoidance for Indigenous people to seek mental healthcare (Goetz et al., 2023). Other researchers also cited findings of feeling mistrust, and a lack of cultural safety with providers that were predominantly white or reliant on Westernized perspectives (Faber et al., 2023; Goetz et al., 2023; McIntyre et al., 2017).

Turpel (2020) found in their study of barriers to accessible and culturally safe mental health services, that Indigenous approaches to healing were often dismissed and underutilized.

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The underutilization of Indigenous approaches is an example of a systemic failure to account for ongoing colonial practices that continue to marginalize Indigenous Peoples in Canada. There have been no clear policy remedies to decrease barriers to care, despite calls on the Canadian government to address systemic barriers within healthcare institutions (Faber et al., 2023; Josewski et al., 2023). Presently, there is limited access to government funded resources with Indigenous-led or informed approaches to mental wellness, such as land-based or traditional healing initiatives (Josewski et al., 2023).

### ***Racism and Discrimination***

Ongoing racism, discrimination, and colonial practices in healthcare including a lack of culturally safe care have been found to contribute to health inequities within Indigenous populations. Experiences of racism have been shown to exacerbate barriers to mental healthcare (Browne et al., 2016; Smye et al., 2023). Josewski et al. (2023) found in their ethnographic study of Indigenous mental healthcare contracting, that Indigenous Peoples felt like their voices were silenced when it came to their mental healthcare. Incidences of racism and discrimination within the mental healthcare system were cited by Josewski et al. as a reason Indigenous Peoples may feel unsafe continuing care. The researchers concluded that the existence of an institutional culture of racism and discrimination was prevalent, as service providers often made subtle and suggestive racist and discriminatory statements to clients (Josewski et al., 2023).

In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Healthcare, is an independent review by Turpel (2020). This independent review explored individual experiences of Indigenous discrimination within public mental healthcare, and found that 84% of Indigenous respondents reported experiences of disrespect and discrimination including racist stereotyping. Commonly held stereotypes which were identified in the study

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included: Indigenous people were seen as less worthy of care, are drinkers or alcoholics, are drug seeking, are less capable, and that Indigenous people are unfairly advantaged. These stereotypical beliefs often showed up in staff behaviour through microaggressions, which were often subtle, indirect, or unintentional. Turpel's study included the voices of over one thousand participants, which suggested that the BC healthcare system contained widespread systemic racism against Indigenous people. The researcher concluded that the findings of racism have resulted in incredibly harmful effects including impacts on self-esteem, emotional health, mental health and feeling unsafe (Turpel, 2020).

Turpel (2020) conducted an independent review into the experiences of discrimination within public mental healthcare, and found that 84% of Indigenous respondents reported experiences of disrespect and discrimination including racist stereotyping. Turpel's study was specifically conducted in British Columbia, and included the voices of over one thousand participants, which suggested that the BC healthcare system contained widespread systemic racism against Indigenous people. The researcher concluded that the findings of racism have resulted in incredibly harmful effects including impacts on self-esteem, emotional health, mental health and feeling unsafe (Turpel, 2020). Browne et al (2016) also found in their study that experiences of discrimination or racism when accessing care for sensitive or vulnerable problems can often lead to feelings of mistrust.

### ***Healthcare Provider Barriers***

While healthcare providers are practicing with the intention to be helpful, there is research that shows providers may be perpetuating harms in practice. Wylie and McConkey (2018) found in their study that many mental healthcare providers are unaware of or do not acknowledge colonization or social determinants of health as a source of illness (as cited in

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Nguyen et al., 2020). Similarly, Kirmayer et al. (2003) found in their study of traditional healing methods that practitioners attempted to be unbiased in practice but struggled to work against the structural culture of racism and marginalization. Smye et al. (2023) found in their study that additional trauma was often recreated when social inequities, stigma and discrimination were not addressed. Smye et al. found that the presence of discrimination and stigmatization resulted in negative healthcare experiences, unmet health needs, and the recreation of trauma. For Indigenous Peoples specifically, the researchers found this harm to be amplified, as Indigenous Peoples internalized their inability to receive appropriate help (Smye et al., 2023).

Wu et al. (2023) conducted a study looking at best practices for integrated care programs, and found that often practitioners often implicitly perceived Indigenous knowledge as inferior to Western knowledge. This finding was inclusive of mission statements or mandates within the practitioner's organization in support of culturally safe practices. Inherent biases towards Western knowledge and ideologies are also still deeply ingrained within culture, society, and various healthcare institutions post-colonization (Wu et al., 2023). However, Nelson and Wilson (2018) found in their study examining barriers to healthcare resources for urban Indigenous Canadians, that health service workers were concerned with racism and discrimination in the system but struggled to know how to make concrete changes.

The various barriers discussed above highlight the unique realities Indigenous Peoples face when accessing mental healthcare or healthcare services. Considering the general barriers to healthcare that are highly researched and well understood (long wait times, understaffing, financial barriers), adding the additional barrier of rural residency may significantly increase barriers to care (Manns et al., 2024). The reality might be that culturally inappropriate services may be the only services that are readily available and accessible for rural Indigenous Canadians.

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The above barriers may be compounded further when considering Indigenous Peoples living in rural areas, because of increased accessibility issues.

### **Mental Health in Rural Communities**

For rurally residing Canadians, mental health issues and barriers to care may be more apparent. While rural communities are equally as susceptible to barriers faced by urban communities, there are also unique geographical barriers that affect rural communities (Friesen, 2019). Health resources are scarce across the Canadian landscape; however, this scarcity is particularly evident in rural, Northern areas of the country. There is a disproportionate number of mental health services available in rural areas when compared with urban areas of Canada (Mandal & Burella, 2021). For rural residents, the reality is often having to travel to larger urban centers, which results in extra costs for travel and accommodations and additional stressors on mental health (Caxaj, 2016; Goodwin et al., 2016; Nguyen et al., 2020).

Higher rates of suicide in rural communities may be attributed to the increased social isolation, and limited access to mental health resources as experienced by rural residents (Caxaj, 2016; Friesen, 2019; Mandal & Burella, 2021). However, rural communities have reportedly lower rates of mental illness, despite having increasingly high rates of suicide (Friesen, 2019). Researchers have determined that inadequate or limited access to mental health resources may partially explain the prevalence of negative mental health outcomes including suicide (Caxaj, 2016; Friesen, 2019; Mandal & Burella, 2021).

One of the most substantial factors that contribute to the poor mental health outcomes of rural residents is inadequate access to mental health services. Some researchers have suggested the heightened likelihood of isolation in rural communities, combined with the decreased availability of mental health resource providers, have contributed to the scarcity of necessary

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mental health resources (Montesanti et al., 2022; Ryan-Nicholls & Haggarty, 2007). Limited access to services is often affected by issues such as recruitment and retention of staff in Northern and rural communities. Caxaj (2016) found in their study of mental health delivery in rural communities that inadequate staffing often accounted for unavailability of services. Caxaj also cited unique barriers to mental healthcare in rural communities such as a risk of stigma, cultural and gender inequities, poor socio-economic conditions, and other occupational factors that impacted help-seeking behaviours. Policy makers are encouraged to create approaches that reflect the strengths and resiliency of rural residents, while also acknowledging the unique environment they reside in (Caxaj, 2016).

Health research on rural communities appeared to be an under researched area of inquiry, and most of the literature focused on urban centers where there are generally more resources. For example, a preliminary search of mental health research in Canada was solely focused on larger authorities, such as Interior Health in BC, whereas Northern Health in BC had much less research efforts and literature available. While previous research efforts have focused on Indigenous Peoples living on-reserve, there is a significant research gap exploring the mental health of rural, off-reserve Indigenous Peoples. The following section will examine mental health barriers specifically for rurally residing Indigenous Peoples.

### ***Mental Health for Rurally Residing Indigenous Peoples***

Rural settings were an under-researched area of inquiry, especially within an Indigenous mental health context. Considering the socio-cultural barriers faced by Indigenous Peoples, those located in rural communities may experience additional barriers related to their geographical location. Newer research projects have covered mental healthcare for urban Indigenous Peoples,

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however there is a gap in mental health research exploring health outcomes for off reserve, rurally residing Indigenous Peoples.

For Indigenous Peoples who may not have access to mental health services on reserve, or those living in rural communities, they may have no choice but to access community-based mental health services. Despite access to mental health resources typically being higher in urban areas, urban Indigenous Peoples are still experiencing limited to no access to Indigenous-led mental health solutions (Josewski et al., 2023). The BC provincial government has made efforts to streamline care by regionalizing healthcare, and attempting to contract Indigenous contractors or service organizations. However, these efforts are unsuccessful as barriers continue to persist, including issues of retention and recruitment in Northern areas.

Even when rural communities may have access to mental health services, social and cultural barriers may also exist. Indigenous people in Canada living in rural, remote, or isolated areas experience inequitable issues of access to services, and utilization of resources when compared with their urban counterparts (Nelson & Wilson, 2018). Browne et al. (2016) found that Indigenous people living in urban areas report experiences of racism and discrimination when accessing care. Montesanti et al. (2022) identified in their study of mental health priorities for Indigenous mental health, which increased funding and availability of mental health services in rural communities was a key gap in care to be addressed.

Josewski (2012) found in their research study that Western mental health terminology failed to acknowledge the socio-historical and political contexts of Indigenous Peoples. Despite the literature providing some research studies of urban Indigenous Peoples' mental health barriers, there did not appear to be any studies or literature about racism and discriminatory experiences in rural or remote settings. Josewski found in their research study of urban Indigenous mental

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healthcare organizations that service cuts and funding cuts to mental health and addictions services was a common barrier to care. Where rural communities are concerned, there appears to be a pattern of difficulties with retention, recruitment, and funding for resources within these communities (Josewski, 2012; Josewski et al., 2023; Smye et al., 2023).

### **Decolonization of Mental Healthcare**

Decolonization may be defined as a way of expanding practice to include increased acceptance of Indigenous ways of knowing and being, and is suggested as a solution to colonial approaches to healthcare that have otherwise been continuing the legacy of colonization.

Decolonization of mental healthcare is supported by de-centering the dominant culture, and prioritizing Indigenous healing practices and health knowledge (Josewski et al., 2023).

Indigenous and non-Indigenous scholars have advocated for decolonizing approaches that can reduce access barriers, negative mental healthcare incidences, and other treatment approaches that are unhelpful and unsafe (Josewski et al., 2023; Montesanti et al., 2022; Wu et al., 2023).

Some suggestions to decolonize practice and break the cycle of colonization include anti-racism efforts, promotion of cultural safety, and incorporating Indigenous knowledge into practice (Turpel, 2020; Wu et al., 2023).

Decolonizing workplaces may assist mental healthcare staff with better meeting the needs of Indigenous Peoples, including addressing health and social inequities, and social determinants of health. Change should ideally start at the institutional level in healthcare through the creation of policies, procedures, and guidelines for healthcare staff (Jacklin, 2012). The following are various suggestions across the literature for beginning to decolonize healthcare: engaging in anti-racist practices, creating cultural safety in healthcare, and incorporating Indigenous worldviews and ways of knowing.

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## ***Anti-Racism***

A commitment to anti-racist attitudes, and culturally safe work was found to create a sense of safety, mutual respect, and more successful mental health outcomes (Kirmayer et al., 2003; Nguyen et al., 2020; Wu et al., 2023). Nguyen et al. (2020) found in their study examining barriers and mitigating strategies to healthcare access, that culturally safe services can be reaffirmed by hiring Indigenous mental health providers or non-Indigenous staff who are motivated to work with Indigenous Peoples. The researchers found that the development of anti-racist policies, and providing cultural sensitivity training were also paramount to supporting Indigenous Peoples in mental healthcare (Nguyen et al., 2020).

Other researchers suggested funding cultural competency training for staff, screening for willingness to explore different models of health, and placing importance on collaborating with Indigenous communities (Josewski, 2012; Montesanti et al., 2022). However, sometimes cultural competency training is sometimes not enough. Montesanti et al. (2022) found that mental health providers must be provided with education, context, and awareness of Indigenous people's experiences and begin to challenge their own personal biases. Furthermore, learning directives must include changing how care is provided at the institutional level to provide a safe environment for Indigenous clients (Montesanti et al., 2022). Providing anti-racist care and practice is integral to creating culturally safe healthcare services.

## ***Cultural Safety***

To address mental health disparities, researchers have argued for culturally safe care, improved access, and changes to policy and practice to improve the mental health of Indigenous Peoples (Faber et al., 2023; Josewski et al., 2023). Cultural safety has been described by some researchers as a type of integrative care, which allows for Indigenous perspectives and

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Westernized perspectives to integrate together (Wu et al., 2023). Cultural safety training also takes cultural competency further, by emphasizing a change in personal biases, and challenging one's own cultural systems (Curtis et al., 2019). Cultural safety may also be considered a requirement for equitable care, rather than cultural competency. Curtis et al. (2019) have suggested that cultural competency training is not enough, rather creating cultural safety through acknowledging biases is necessary to address institutionalized racism. Dawson et al. (2022) has suggested that cultural safety starts with healthcare professionals engaging in reflexivity and challenges their own biases and privileges.

Nguyen et al. (2020) found in their study that healthcare staff often had inadequate cultural safety training, which led to negative bias and stereotypes in the workplace. The Interior Health Authority in British Columbia has made reference to policy and programming which was intended to foster "the development of holistic health and wellness system[s] that are responsive to the mental health needs of [Indigenous] communities" (as cited in Josewski, 2012). A mitigating strategy that may remedy this challenge, is incorporating cultural safety training so that mental healthcare providers can foster relationships with Indigenous clients based upon mutual respect and communication (Nguyen et al., 2020).

There appears to be an increased need for culturally appropriate and safe mental health services that are government funded, and driven by appropriate policy. Browne et al. (2016) found in their study of health service research that cultural safety has the potential to reform practices, policies, and entire organizations by prioritizing social justice goals as central to mental healthcare. Researchers have advocated for cultural competency training for staff, screening for willingness to explore different models of health, and placing importance on collaborating with Indigenous communities (Browne et al., 2016; Josewski, 2012; Montesanti et

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al., 2022). There have also been calls for critical policy and practice reforms to dismantle the discriminatory systems and structures that remain in place presently (Josewski, 2012). Ensuring culturally appropriate care where Indigenous people's safety is prioritized is explicitly stated within the literature as a top priority for mental healthcare providers (Nelson & Wilson, 2018). Furthermore, prioritizing safety includes acknowledging Indigenous ways of knowing and worldview.

### *Incorporation of Indigenous Knowledge and Ways of Knowing*

Westernized healthcare often views mental illness as an individual pathology which stems from individual dysfunction and personal choices (Josewski, 2012). Mental well-being can be viewed as a holistic concept, whereby most Indigenous communities view mental health problems as a response to the historic intergenerational trauma resulting from colonization and forced assimilation (Josewski, 2012; Nguyen et al., 2020). Access to healthcare using traditional medicine is limited within the Western medical system due to strict organizational policies and practices (Nguyen et al., 2020). Browne et al. (2016) also recommended acting by focusing on staff values, beliefs, assumptions, and reflexivity at all levels of care. Additionally, developing an understanding of diverse cultures, including Indigenous systems of healthcare may contribute to cultural safety efforts (Jacklin, 2012).

Researchers have specifically stated that efforts must be made by staff, managers, and community leaders to affect change at the wider level by showing support and willingness for structures, policies and processes that will create equity for Indigenous Peoples (Browne et al., 2016; Montesanti et al., 2022). Researchers have concluded from their studies on the mental health of Indigenous Peoples, that institutions need to financially prioritize changes for real change to occur, and consult Indigenous communities through policy and decision making

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(Browne et al., 2016; Montesanti et al., 2022; Wu et al., 2023). Prior research highlights the reality that for decolonization of mental health practice to occur, it must occur at multiple levels starting with acknowledging and appreciating Indigenous knowledge and Indigenous partnerships. Researcher findings have suggested that collaborative approaches with Elders and traditional Knowledge Keepers would hopefully mediate limitations and problems within healthcare (Kirmayer et al., 2003; Wu et al., 2023).

### **Existing Literature and Rationale for Study**

Various gaps have been noted throughout this literature review including a lack of research on rural communities, including BC's provincial health authority Northern Health. There was also little research on specific policy for cultural safety training that is mandated for mental health staff. Nguyen et al. (2020) proposed that cultural safety training ought to be a part of healthcare institutions' policy, ideally in collaboration with Indigenous partners, which I have explored further in my research project. Additionally, previous research has cited the importance of willingness amongst staff, management, and policy makers to incorporate Indigenous knowledge and acceptance of other ways of knowing. This study examined the extent that mental health professionals are acknowledging Indigenous worldviews, and incorporating decolonizing practices into their profession, which is discussed in later chapters.

My study expands and builds upon previous literature by supporting existing recommendations for reconciliation, and acknowledging how decolonizing practice starts with creating cultural safety. Existing research and literature have provided thorough details of individual accounts of barriers to care, including narrative studies detailing Indigenous Peoples' first-hand experiences. However, there was little literature which examined and explored the accounts of mental health professionals.

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## **Chapter Summary**

In Chapter 2, I highlighted the most relevant research discussing current mental healthcare practices and barriers in BC relating to Indigenous Peoples, rural communities, and mental health service provision. I reviewed the current context of Canadian healthcare institutions, including the history of colonization and the social determinants of health for Indigenous Peoples. I reviewed how colonization shows up in mental healthcare practice, and how decolonization of mental healthcare practice including anti-racism, cultural safety, and acknowledging Indigenous ways of knowing creates a system of health which is more accessible for Indigenous Peoples.

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## Chapter 3. Methodology

In this chapter I will discuss the theoretical and methodological framework for my study. I have drawn from Institutional Ethnography (IE) concepts to explore how institutional forces govern public mental healthcare policies and practices for mental health professionals, with the focus of the study being Indigenous Peoples' experiences within the public mental healthcare system (Northern Health Authority) in the Peace Region, British Columbia (BC). I have also drawn from critical theory and decolonizing theory to gain deeper understanding of influences on practice and experience. Through writing, inquiry, and data analysis, I have considered my research questions: How do institutional policies and practices contribute to barriers for Indigenous Peoples residing in rural communities in the Peace Region, BC? To what extent do mental healthcare workers integrate decolonizing practices in their approaches to mental healthcare for Indigenous Peoples? What opportunities exist to integrate decolonizing practices into mental health services for rural communities in the Peace Region, BC?

I begin this chapter with an introduction to institutional ethnography as the methodology chosen for this study. I will then discuss my chosen research methods, including informant information, recruitment, ethical considerations, and data collection, management, and analysis. I conclude the methodology chapter with a discussion of rigour, reflexivity and reliability, limitations, and the plan for knowledge dissemination.

### Introduction

I came to my research question about two years before applying for graduate school. In Chapter 1, I discussed how my experiences working as an adult probation officer in Dawson Creek, I suspected healthcare barriers for many of my clients including issues of transportation, long wait times, and a lack of mental health service providers. I noticed barriers were different

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for Indigenous Peoples, as they shared uniquely negative experiences when accessing mental health or counselling services. By referring Indigenous peoples to services that were inappropriate or inadequate, I later came to recognize that I myself, as a white and Chinese settler, also contributed to neglecting the cultural context of Indigenous Peoples' lived experiences. I felt powerless in my role, and felt an inability to create any changes within a role that was guided by stringent policies and practice guidelines. The professional disconnect I was experiencing is what drew me to the counselling profession, critical theories of inquiry, and the desire to start my research journey.

### **Institutional Ethnography**

IE researchers explore people's everyday activities as they take form within institutions (Smith, 2006). IE, founded by Dorothy Smith, is an approach to inquiry where the research process begins by exploring the daily lives of workers within an institution of interest, with the intention to begin to understand the activities, concerns or involvement related to the institution (Foo et al., 2021; Sinding, 2010; Smith, 2006). IE researchers share a common goal with traditional ethnographers, which is to obtain a detail-rich description of practices and experiences (Foo et al., 2021).

The main goal of the IE is to uncover and understand how policies or practices affect the everyday work of people, and investigate how people are coordinated and organized in a particular place by work happening elsewhere (Devault & McCoy, 2006; Foo et al., 2021; Rankin, 2017a). At the conclusion of this study I uncovered how people talk about this work happening elsewhere, often referring to this work as the "higher ups". IE is often described as an approach for people, rather than about them, as it offers information about processes that people cannot normally see (Melino et al., 2025). Once workers are able to see how processes are

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coordinated, this provides opportunity for them to act and make changes. I will outline the methodological assumptions in the following section, and provide additional rationale of how I chose IE as my methodology for this study.

### **Epistemological and Ontological Assumptions**

Epistemological assumptions create a framework for the way one views the world, and how people organize themselves within it (Thambinathan & Kinsella, 2021). IE is aligned with other critical analytical frameworks, but differs with a set of core epistemological assumptions (Campbell & Gregor, 2008). IE is a methodology that relies on the epistemological assumption that “all knowledge is socially organized and socially constructed” (Rankin, 2017a, p. 2).

Smith (2005) described the ontology at the core of IE, is the assumption that people’s social relations are determined by the institutions that they are situated within (as cited in Rankin, 2017b; Devault & McCoy, 2006). IE researchers adopt an explicitly critical assumption, and requires a distinct “ontological shift” before conducting an institutional ethnography (Rankin, 2017b). Institutional ethnographers hold the belief that people may not be fully aware of how the institutions influence their work (Foo et al., 2021). Smith (2006) emphasized that in IE, researchers are more concerned with how things happen versus why things happen. Institutional ethnographers assume that there is something happening to connect social relations, chains of action, and social experiences (Devault & McCoy, 2006). Therefore, part of the ontological shift that is happening for IE researchers is looking at a world of people’s actual practices or activities (McLiesh et al., 2024).

My focus of inquiry has required a personal, distinct, epistemic, and ontological shift in understanding. I shifted my perspective towards the epistemic assumptions of IE by recognizing that barriers to healthcare might be created within the institution, and coordinated at levels higher

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than the mental health worker and clients. I also shifted my understanding from wanting to know why things happen, to wanting to understand how things happen. Campbell and Gregor (2008) explained how IE offers the capacity to look at the everyday world and figure out how things happen the way they do. After learning about IE and challenging my ways of knowing, I moved further beyond wanting to know “how”, and became interested in understanding and seeing the social organization of mental healthcare settings. Therefore, my research goal of linking, describing, and exploring the organization of practice, rather than theorizing them, aligns with the core ontological and epistemological assumptions of IE.

### **Theoretical Underpinnings**

Throughout this research I drew from critical theory and decolonizing theory to inform my process of data collection and data analysis. My writing and research process was also informed by framing and situating IE as a decolonizing method of inquiry. Below discusses how these theories informed my study, writing style, and thought process I have undertaken as a researcher.

### ***Critical Theory***

This research project draws from the central tenants of critical theory, while also discussing IE as an inherently critical methodology. In this research project, I understood critical theory as a roadmap to forming questions during data analysis, and making sense of the data and information gathered from informants. Critical theory is often concerned with issues of power, justice, matters of race or class, social institutions, and cultural dynamics, and how these interact within various social systems (Kincheloe & McLaren, 2011). Critical theorists may analyze competing powers between groups or individuals within a society, and attempt to make sense of this and critique it. Critical theorists also argue that privileged groups in society seek to maintain

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the status quo, and make various attempts to protect their privileges. The dynamics between the protection of privilege, and the inherent byproduct of social inequalities are what critical theorists seek to understand and critique (Kincheloe & McLaren, 2011). I will attempt to narrow my focus using a critical lens by focusing on social injustices within this research project, including uncovering social injustices within public mental healthcare institutions, and inspiring transformative change through critical suggestions and recommendations for health authorities.

Institutional ethnography is a critical methodology, which focuses on people's everyday experiences and how their lives are organized or coordinated by institutional forces (Kearney et al., 2019). Thus, the incorporation of ideas drawn from critical theory, and the goals and central tenants of critical theorists align with my research. IE is distinctly different from other critical theories or methodologies, as it explicitly explains what is happening within institutions, and how this may relate to outside organizational forces (Kearney et al., 2019). IE allows discovery of what may not initially be known, questioned or visible, and offers opportunity to critique institutions by making recommendations for positive change.

### *Decolonizing Theory*

Decolonizing theory may be applied to many different institutions and systems, however for my research I have focused on decolonizing theory as it relates to public health institutions. Decolonization in healthcare is defined broadly as efforts to address a disconnect between healthcare and poor Indigenous health outcomes, whilst drawing on knowledge and practices of pre-colonial times (Eni et al., 2021). Public health systems continue to fail meeting the needs of Indigenous Peoples, which is linked to colonialism (Barcham, 2022). Colonization efforts have disenfranchised Indigenous Peoples in Canada by stripping away traditional practices and ways of being, and replacing traditional practices with Western, assimilationist policies and practices

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(Barcham, 2022). Colonization is also the primary consideration for Indigenous Peoples' social determinants of health (Jacklin, 2012).

To address the ongoing practices of colonization, particularly in public healthcare, acknowledging and practicing decolonization is necessary for reconciliation. Research discussing decolonizing practice argues for decolonization efforts to be focused on active involvement with Indigenous and non-Indigenous peoples. Decolonization also involves the active and intentional dismantling of dominant models of health in Canadian society (Eni et al., 2021). I have considered how my research contributes to decolonization, and considered how my research methodology may honour decolonization efforts.

### *IE as a Decolonizing Methodology*

Historically, most research concerning Indigenous Peoples has been conducted by white settler populations using colonial, non-Indigenous ideas and perspectives (Nelson & Wilson, 2017). Excluding Indigenous Peoples from research concerning their communities continues the legacy of colonization, and perpetuates harms by failing to respect Indigenous knowledge and worldview (Panel on Research Ethics, 2022). I have acknowledged my identity and positionality in relation to this research as a non-Indigenous researcher, acknowledged how my research efforts align with TRC Calls to Action, and have made explicit efforts to include a discussion of decolonization. Like decolonizing healthcare practices, decolonizing methodology consists of transforming colonized ideas or views, and creating space for alternative, traditional ways of knowing (Morton Ninomiya et al., 2020; Thambinathan & Kinsella, 2021).

Morton Ninomiya et al. (2020) suggested that IE is positioned to explore how institutions continue to colonize the lives of Indigenous Peoples and communities. Decolonizing research recognizes and builds on traditional Indigenous worldviews, considers contextual relevance of

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research, and critiques dominant power structures or institutions that are responsible for social inequities (Morton Ninomiya et al., 2020). Similarly, IE can be situated to embrace other ways of knowing when the researcher meaningfully includes the community being researched (Thambinathan & Kinsella, 2021). Cultural safety starts with research that is grounded in the same ideologies.

IE is therefore well suited to identify and begin to dismantle the dominant power structures that are perpetuating social inequities. IE has helped me understand how mental health professionals continue colonization efforts through the activation of texts (i.e., institutional policies) and practices, which will be discussed further in Chapter 4 and 5. My final suggestions and recommendations for health authorities highlight the need for change, including the creation of clear decolonization practice guidelines. I have engaged with the Dawson Creek Nawican Friendship Centre, and two Elders in the community to ensure that decolonization remains at the heart of this study, which is discussed below in the community engagement section. I acknowledge that the feedback, critique and collaboration from Indigenous Peoples in my study was critically important to ensuring Indigenous interests and rights were considered.

### **Research Methods**

#### **Recruitment and Interviews**

Throughout this study, I refer to the interviewed frontline mental health professionals as *informants*. Frontline professionals often become informants in institutional ethnography, as these professionals often create the link between clients and ruling discourses (Smith, 2006). Recruiting informants for this study was a straightforward process, whereby the distribution and posting of recruitment posters was the initial mode of recruitment (see Appendix E). The

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recruitment posters were posted at four separate sites: Dawson Creek Mental Health Unit, Dawson Creek Hospital, Chetwynd Primary Care, and the North Peace Primary Care Clinic. The first round of recruitment secured two informants, who then later assisted with snowball sampling by informing their colleagues of the study. My reasoning for utilizing snowball sampling is due to the difficulty in gaining access to this population, slow recruitment success, and trusting the initial informants with guiding recruitment in the right direction. The second round of recruitment secured three informants who heard of the study from their colleagues or managers.

Interviews are a valuable form of learning information directly from people about their individual experience. Institutional ethnographers will often use whatever method is the most practicable or appropriate for the institutions they are researching (Devault & McCoy, 2006). IE researchers may interview people about their experiences within the institution of study, to determine how their work is coordinated or organized at higher levels, often by policies, protocols, standards, and social norms (Foo et al., 2021; Rankin, 2017b). In IE, interviews may investigate the organizational and institutional processes that shape individual experiences (Devault & McCoy, 2006; Smith, 2006). Interviews will allow researchers to uncover the *ruling relations* or linkages central to actual everyday experiences (Devault & McCoy, 2006).

This study gathered information from five separate informants, who are all current employees of Northern Health in a mental health service delivery role. Within the context of this study, the designation of mental health professional included five distinct roles within Northern Health: Social Worker (in hospital setting), Registered Nurse (RN) emergency, Registered Nurse (RN) Med Surg, Mental Health and Substance Use Clinician primary care, and Social Worker primary care in community (see Appendix I). Each informant participated in a 60–90-minute

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interview, which consisted of semi-structured interview questions. Interviewing five informants has kept this project manageable, yet has provided rich, thick descriptions of experience directly from frontline professionals.

Institutional ethnography provides the opportunity for a context-rich, thick description of a particular context that might otherwise be unknown (Draper, 2015). The questions within the study were tailored to help me understand what is actually happening on the frontlines, and how various professionals do their work. The interviews were specifically centered on understanding the everyday work practices and experiences of the informants who provide mental healthcare services. I utilized exploratory style questioning, which was aligned with the style IE researchers will typically assume. The semi-structured nature of the interview allowed for dialogue and conversation to unfold naturally. Following each interview, I began to gain confidence with interviewing informants, and how to unravel or better understand their experiences as a Northern Health mental health professional. The interviews were conducted, transcribed, and audio recorded over Microsoft Teams (MS Teams), and verified verbally by each informant for release to the data analysis process.

### **Data Analysis**

Data analysis in IE may draw from both interview and textual analysis. In the following section, I will explain the planned process to analyze both interview and text data. IE researchers are discouraged from informing their research with prior theoretical frameworks, as it may derail the researcher from describing accurately what people are actually doing (Rankin, 2017a). However, an IE researcher is encouraged to develop at *standpoint* before beginning their research (Smith, 2005). There is not an exact way which IE researchers plan their projects; therefore I did not initially have a concrete plan for analysis, however this plan began to unfold

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as I made sense of the data I was working with. This research study is not a true IE, rather it is informed by the concepts and processes of IE. My goal during the analysis process was to use interview notes, recordings and transcriptions, texts, and reflexive journal entries to make connections between the work of mental health professionals and the barriers to care for Indigenous Peoples. Specifically, examining the data collected allowed me to see emerging accounts of social relations and the disjuncture between texts such as the Northern Health Strategic Plan, and informant job descriptions.

The goal of data analysis in IE is to explicate the ruling relations, and fully explore how something is happening. Working with data in IE often calls for researchers to find logical or conceptual links between the findings (Campbell & Gregor, 2008). Specifically, how something at the local setting (frontlines) is organized elsewhere (Smith, 2005). My study began at the local level, with frontline mental health professionals, and moved to the *translocal* level, which looked to larger ruling relations governing the practices and work of mental health professionals.

The coding process in IE often occurs through what is known by Dorothy Smith as *indexing* (Devault & McCoy, 2006). Indexing aids in finding themes or commonalities within the data that may be connected with texts and other collected information. To organize the large dataset I utilized highlighting, and placed themes into loosely defined categories based upon the meaning behind informants' answers. Another suggested way of conducting analysis, is to ask oneself the question of "what does this tell me and how does this setting or event happen the way it does?" (Campbell & Gregor, 2008). This question was used as a way to prompt deeper thinking into the dataset, and allow for the ontological shift in thinking that institutional ethnographers must utilize.

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I had initially proposed data analysis through NVivo, to organize and identify patterns and themes, however I decided against using a software for theming data. Campbell and Gregor (2008) cautioned against using ways of categorizing data which may “distort or obscure” the relations and meaning behind the data (p. 85). I decided against using NVivo as to not obscure, or overly simplify the richness that the raw data obtained. My process included reviewing each interview transcript, making comments and questions to myself throughout, and using the highlighting tool in Microsoft Word to assign emerging themes, which then led to the creation of a thematic colour coded legend.

### **Texts & Text Data Collection**

IE differs from a traditional ethnography, as texts, books, or other artifacts are the primary data gathered for analysis (Rankin, 2017b). Institutional ethnographers may better understand how social relations are organized and enabled through texts (Walby, 2007). Texts also play a key role in understanding everyday experiences, and offering additional contexts of social relations (Kearney et al., 2019). Social institutions and the individuals working within that institution are managed and governed through the use of texts (Campbell & Gregor, 2008). The ontological underpinnings of using texts in IE stems from the belief that texts often rule or direct organizations and institutions (Devault & McCoy, 2006; Rankin, 2017b). The work of healthcare professionals is often ruled, and guided by texts, which will direct practice and communication as they engage in work (McLiesh et al., 2024).

During the ethics approval and organizational approval process with Northern Health, I was informed by the Northern Health Research Ethics Committee that workplace texts which employees use everyday, are not accessible to the public. Therefore, I was limited to analyzing publicly facing documents which were accessed online. My pursuit of texts for this project

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started with simple web-based searches on Northern Health webpages. Northern Health's various websites produced several relevant texts for this project. I sought to look at public policy, commitments, reports, institutional promises, and mandates available online. During interviews I also asked questions during the to determine the nature, role, and purpose of texts within informants' professional practice, and listened for any mention of texts, policies, or specific documents. However, I was not successful in gaining access to explicit texts or paperwork that guided practice from informants directly.

The texts collected and analyzed in this study included the Northern Health Strategic Plan, the identified job descriptions of informants as advertised by Northern Health (see Appendix I), and Northern Health Committed to Cultural Safety for Indigenous Peoples in the Healthcare System posters (Northern Health, 2023; Northern Health Indigenous Health, 2025). The roles were copied and pasted into a text document for clarity and ease of access, whereas I referenced and cited the Northern Health Strategic Plan and posters as they are lengthy documents. Analyzing texts helped me draw connections between the work people are doing, where it might be coordinated, and how their practices are organized or conceptualized. Additionally, texts helped in aiding the mapping of my analysis which is discussed in Chapter 4.

### **Rigour, Reflexivity and Reliability**

Rigour in IE is often determined by the researcher's ability to describe accurately what is actually happening for frontline workers (Melino et al., 2025). Specifically, IE researchers are able to strengthen their rigour in a study when they explicate how something has happened and where it is organized. To strengthen the rigour in my study, I have explicated the everyday work practices of mental health professionals and made connections between ruling relations in

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Chapter 4. I have also engaged with reflexive practices to enhance congruence between my personal thoughts, biases, the problematic, data collection process, and data analysis.

Reflexivity can be defined as the process of reflecting on lived experiences, so that the researcher or writer is able to understand and reveal deeper connections to the subject or data (Berry, 2011). Furthermore, reflexivity is often based on the principle that a researcher can never fully remove themselves, or distance themselves from their values, beliefs, and biases (Draper, 2015; Ryan, 2017). Reflecting on ones values will also contribute to understanding how the researcher arrived at their conclusions or findings in the research and helps to create a thick description (Ryan, 2017; Wilkinson, 2013).

Throughout this study I kept a research journal, and wrote reflective memos after each day of work. I acknowledged the connections which I made between the data, and made comments and notes throughout my writing. I tracked my emerging thoughts, biases, assumptions, and rationale for decision making throughout the research project during each stage of writing. I also kept notes of emerging thoughts during each interview with informants. My research journal shows the progression of my emerging understanding of IE, and how I came to organize and make sense of the dataset.

### **Ethical Considerations**

This study underwent ethical approval through the Athabasca University Ethics Review Board (REB), which was granted March 25, 2025 (see Appendix F). Further external ethical approval was obtained from Northern Health, specifically a full ethical approval review (see Appendix G) and an institutional operational approval review (see Appendix H), which were granted in June and July of 2025. I have completed the Tri-Council Policy Statement course

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(TCPS 2): Ethical conduct for research involving humans in preparation for this study in 2022 (see Appendix A).

My research included human participants, as their personal information and experiences were collected for data analysis. Each informant was provided with an invitation to participate (see Appendix B) and informed consent package (see Appendix C) which detailed information about the study, potential risks and benefits, nature of the study, and procedures related to participation. Opportunities for clarification and questions were solicited before interviews were scheduled to ensure informants fully understood the study. This study was conducted in the Peace Region where I personally work, study, and reside. I took extra precautions not to interview anyone who was a conflict of interest, or in a dual relationship with me personally. To protect the identity of each informant and mitigate risks of identification, their individual role titles will not be connected to them, and any identifying information was removed in their quotations.

Ethical concerns were further mitigated by checking in with informants before the interview, acknowledging any questions or concerns, and fully acknowledging the goals and objectives of the study. Consent was obtained in writing through signed documentation scanned and sent to my secure email, and verbal consent at the outset of interview. Informed consent was discussed as an ongoing process, and informants were informed that withdrawal from the study would be unavailable after the transcript is verified by them and entered into data analysis. Following the interview and transcription, each informant verbally verified their transcripts for accuracy, and invitation to comment on or remove certain information was solicited.

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### *Community Engagement*

My research project, although not involving Indigenous Peoples as direct informants, has the welfare and consideration of Indigenous Peoples at the forefront. Community engagement is an integral consideration for researchers, and a necessary condition for research with Indigenous communities in Canada (Panel on Research Ethics, 2022). Community engagement may include, but is not limited to meeting with local Elders or Knowledge Keepers, members of the Indigenous community, negotiating research agreements with formal leadership, or working with an advisory group (Panel on Research Ethics, 2022).

To ensure utmost respect and acknowledgement of Indigenous Peoples who are considered in this study, I have informally met with the Nawican Friendship Centre, and consulted with two Elders in the community of Dawson Creek. Ethical considerations involving Indigenous Peoples in Canada was ongoing throughout the project, including the following cultural protocol and considering reciprocity when exchanging traditional knowledge and information. Throughout the entirety of my project I have collaborated and communicated with the Nawican Centre, and discussed plans for knowledge translation and distribution which respects Indigenous right to research information and autonomy. At the outset of the project I solicited input on research design, methodology, and research direction from local Elders and Indigenous Peoples.

To expand my knowledge of allyship, Indigenous health, Indigenous advocacy, and anti-racism, during the data collection and analysis part of this project I completed the Anti-Indigenous Racism and Discrimination, and Navigating Advocacy courses to complete a certificate in Indigenous Health and Wellness, Advocacy and Allyship (see Appendix K). I have

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reflected on my learning from this course that advocacy is ongoing, and true allyship involves building relationships, collaboration, and active participation in truth and reconciliation efforts.

### **Knowledge Dissemination and Transfer**

To decolonize qualitative research, researchers are encouraged to collaborate with Indigenous communities throughout the entire research process, including at dissemination (Thambinathan & Kinsella, 2021). Thambinathan and Kinsella acknowledged that conflicts around publication or dissemination of findings have been a source of divide between researchers and study participants. The researchers argued in their study that reciprocity involves a relationship of trust, mutual respect, and accountability on behalf of the researcher to establish “collective ownership” over the entire research process (Thambinathan & Kinsella, 2021). This is important, as my study is meant to advance practice, acknowledge the importance of decolonization, and the address the associated suggestions put forward by Indigenous communities directly.

I have included Elders and the Nawican Friendship Centre with opportunity to provide input, direction, and recommendations regarding research dissemination. We have collaboratively left the research dissemination process open-ended, but an opportunity may exist August 22, 2026, for a public conference at the Nawican Friendship Center during their cultural grounds grand opening. I may also disseminate this research through social media, academic journals, conferences, or through building additional partnerships with Indigenous organizations in Canada. My goal for this study is for it to become public, as my findings may be helpful for practitioners to make necessary changes to practice. Therefore collaboration for knowledge dissemination and transfer will also happen through collaboration with Northern Health and their available channels or outlets of research sharing.

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## Chapter Summary

My research study was influenced by the theory and ideologies of institutional ethnography (IE). As a white and Chinese settler, I have been complicit in neglecting the cultural context of Indigenous Peoples' lived experiences. I have situated the research framework within my personal experiences, critical theory, and decolonizing theory as I came to my *problematic*. I have also discussed the ontological and epistemological shift that occurs when researchers adopt IE as a methodology, and explained how IE may be an appropriate methodology for conducting decolonizing, critical research with the focus on healthcare systems. In this chapter I have also detailed how data analysis and textual analysis was conducted, while also acknowledging study rigour and ethical considerations. Through collaboration with local Elders and the Nawican Friendship Centre, my knowledge dissemination plan is left open to available opportunities, but will be centered on making my findings publicly available.

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## **Chapter 4. Explicating the Everyday Realities of Mental Health Professionals**

Institutional ethnographers are attempting through their research to explicate the experiences of workers, by uncovering or attaching meaning to the social relations and ruling relations that coordinate their work (Campbell & Gregor, 2008). I have explicated how the everyday experiences of frontline workers (local) are coordinated elsewhere (translocal), and how this coordination creates a disconnect between cultural safety theory and practice.

My analysis is centered around tensions, confusion, and disjuncture in the collected Northern Health job descriptions, Northern Health Strategic Plan, and Northern Health Commitment to Cultural Safety, and the contexts, discourses, connections between internal Northern Health governance, and larger legislation which they work in. In this chapter, my initials have been abbreviated to *MM*, whereas each informant was abbreviated to I1, I2, I3, I4 and I5 for clarity and conciseness. I have developed three main themes which will form the basis of my analysis: frontline actualities, invisible work practices, and training in theory versus practice.

### **Northern Health**

Smith (2005) described that IE views institutions as complex governance practices rather than a singular building or organization. Northern Health and the provision of mental health services within public health, is the institution of interest in this research study. My understanding of studying Northern Health as an institution extends beyond the local (frontline) setting, and into other higher coordinating processes. Northern Health is one of BC's health authorities, which provides healthcare services for Dawson Creek, Fort St. John, Chetwynd, and more Northern communities in BC. Northern Health is publicly funded and serves a population of nearly 300,000 people across Northern BC. Northern Health offers a wide range of services

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from primary care, long-term care, mental health and substance use services, home and community care services, and other public health services. Northern Health employees individuals within various healthcare positions, including social work, nurses, doctors, counsellors, and psychiatrists.

I have interviewed five informants from four distinct Northern Health roles: mental health and substance use clinician, community social worker, in-hospital social worker, and registered nurse. I have remained focused on the frontline work of these professionals, how their work is coordinated, and how they come to perform invisible work duties which may be coordinated elsewhere. For context, I have not worked within Northern Health, therefore everything learned about this institution and information used for analysis was directly from informants. Additional information about Northern Health was found online on Northern Health public documents and websites.

### **Standpoint: Connecting the Small Hero to Higher Processes**

Before discussing the main themes of this research, I will explain how conceptual mapping aided my analysis of the dataset. Smith (2005) developed a diagram depicting the *small hero* who is connected by higher translocal processes (processes located elsewhere through people, legislation, and texts) through ruling relations. In this research study my *small hero* is the mental health professional, whose practices and everyday actualities are happening on the frontlines. In mental healthcare, mapping translocal ruling processes helps to understand how governing processes often work against the interests of frontline workers on the ground (Melino et al., 2025). I used Smith's (2005) *small hero* diagram to understand the standpoint of the informants of this study, and to conceptually map the translocal happenings (context, discourse, legislation, and Northern Health governance). The *local* (frontline worker) became the focus of

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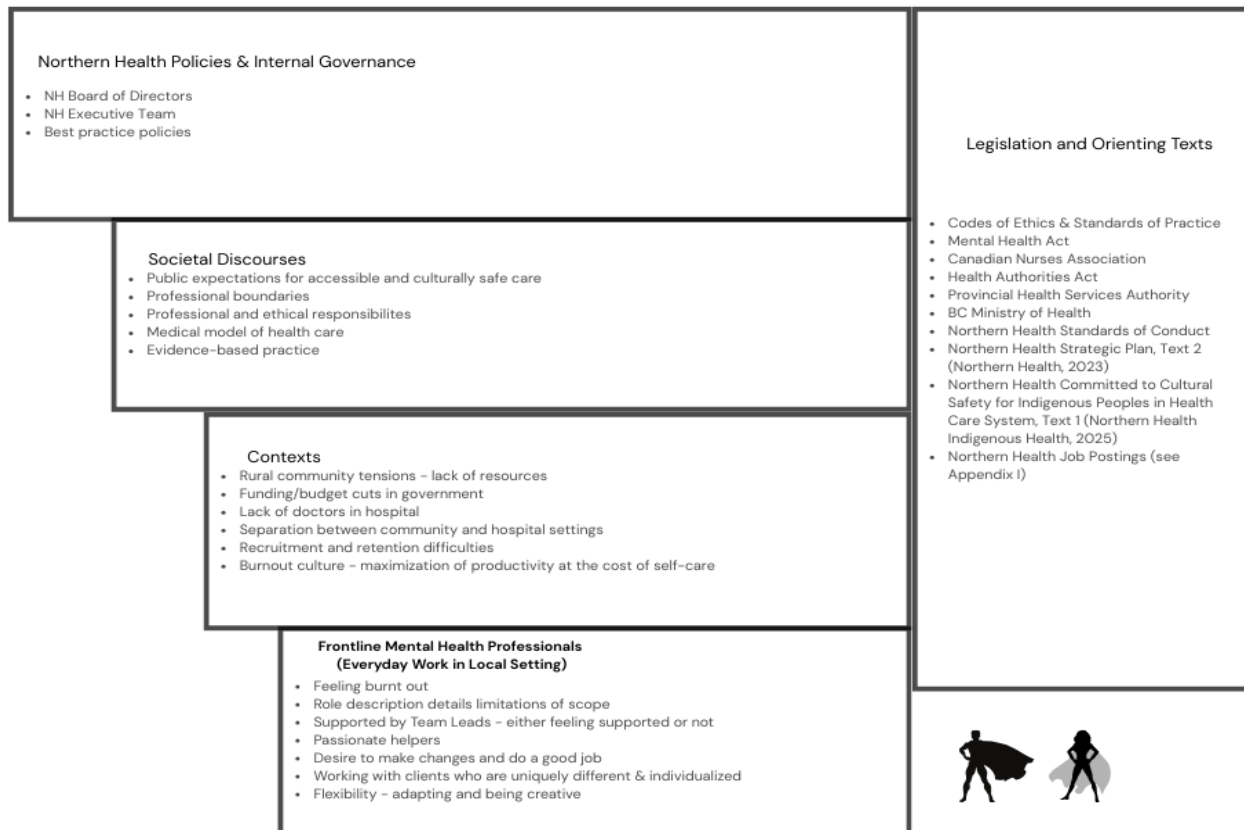
my investigation, as I sought to understand mental health professionals and how their work is coordinated.

I have adapted the small hero diagram to better understand my studied social phenomena, and visualize the higher coordinating processes which the small hero is ruled by. The relations of the small hero (frontline mental health professional) will be explained further, by understanding how texts coordinate their work, and how their work is coordinated from multiple different levels. This diagram allows us to theoretically look up from where the small hero stands, to better understand the experience of the clients they serve, and what barriers look like from the frontlines. As I discussed mental health professionals generally throughout this study, each informant was mapped from the *small hero's* standpoint in Figure 1. The *small hero* can be seen in Figure 1 working within the broader discourse, contexts, and higher institutional processes happening within Northern Health. The *small hero* is also ruled by legislation and orienting texts which guide their practice.

### **Figure 1**

*Small Hero Diagram*

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## Connecting Texts & Textual Analysis

There are several texts that I explored in this research project. In Chapter 3 I detailed my pursuit of texts, what texts were collected, and my rationale for which texts I analyzed in this project. Institutional processes are usually based within texts, as texts direct how people coordinate and conduct their work (Smith, 2006). Texts helped to guide my focus of where I might see evidence of invisible work, or tensions and constraints between texts and how they are activated in practice. When analyzing texts, I considered how the texts may coordinate work performed by the informants of this study, kept in mind my hope of understanding invisible work practices and the contributions to barriers in mental healthcare. For reclarification, I analyzed the Northern Health job descriptions which corresponded to the informants interviewed (see

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Appendix I), the Northern Health Strategic Plan, and Northern Health Committed to Cultural Safety posters (Northern Health, 2023; Northern Health Indigenous Health, 2025).

I analyzed and interpreted the Northern Health commitments and promises, as these detailed the expectations for Northern Health employees and how they ought to practice culturally safe work as permitted by the institution. These texts are activated by mental health professionals through their everyday work, specifically mentioning in the text quality care, services free of racism and discrimination, challenging one's own biases, and the responsibility for culturally safe practices (Northern Health, 2023; Northern Health Indigenous Health, 2025). The Northern Health strategic plan was of particular interest to me, as it contained detailed commitments, missions, and strategies which stated promises from the institution to the public, which implicitly suggested staff or employees uphold these promises (Northern Health, 2023).

I analyzed the Committed to Cultural Safety posters as guiding, implicit reminders for how employees are to practice culturally safe care. While most informants acknowledged never seeing the posters, they reported understanding the knowing the information contained within them. I understood this finding as a statement supporting that Northern Health is consistently supporting reminders of culturally safe work practices. I also analyzed the job descriptions to understand how Northern Health conceptualizes and describes the roles of their frontline staff, and how this may coordinate their work practices. Examination of the job descriptions attached to the roles of informants helped me to determine what work is explicitly stated by the organization, and what work is done invisibly. Through interviews I was introduced to Learning Hub, the online resource which Northern Health employees receive training and education courses. The Respectful Relationships course which is available to Northern Health staff through their Learning Hub was discussed by informants as their main source of cultural safety training

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(see Appendix J). It became clear to me through analysis and interviews how courses such as Respectful Relationships served as a translocal text which coordinated work related to cultural safety practices.

### **Frontline Actualities (Everyday Work Practices)**

When I wanted to better understand how the frontline actualities are experienced by mental health professionals, I sought to understand how their work is organized and directed through their individual job descriptions. Upon further exploration, I noticed how each job description I collected resembled each other, specifically, I noticed vague and indirect wording which detailed informants' work practices (see Appendix I). The vague and indirect nature of the job descriptions appeared to translate in practice through the everyday actualities of mental health professionals.

There were consistencies between each informant of their actualities on the frontlines, specifically noting the burden of overwork, burnout, and the pressures they experience from lack of staffing, funding, and resources. Each informant described passion for the roles they hold, and a strong desire to do their jobs well, which will be expanded later in this chapter. Informants described tensions of working within the larger discourse of community care. Specifically, the pressures to offer excellent healthcare services while they are burdened by contexts of underfunding, understaffing, overwork, and a lack of community resources to provide continuity of care. The following section notes some of the thematic constraints of the everyday actualities which mental health professionals are experiencing.

### ***Continuity of Care***

Informants in this study discussed how their roles, as described by the health authority, expect them to provide high quality care to patients, with expectations that continuity of care

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happen across various settings to result in better long-term health outcomes. However, when staff are attempting to provide consistent, quality care, which meet their own personal expectations, they are overwhelmed by competing translocal texts of confidentiality and privacy, and safety policies which prevent outreach work. Informants described outreach work as work which extends beyond their typical work setting (in the office and hospital). Informants expanded on this by stating they would like to be able to see clients in their home, or the community, but barriers existed to do so. Additionally, meeting institutional mandates and policies of efficiency, appeared to undermine the expectation of providing consistent, quality care. Informant 1 noted this difficulty when talking about how their services are offered to clients:

*MM:* I heard you also say that in some cases you're not supposed to see clients for a long time ... can you tell me more about that?

*I1:* So in our role ... the higher ups in management have decided we only see [clients] for 6 to 8 sessions. But you cannot put people in a box like that. As we get exploring [their problems] they start talking about something much deeper.

Informant 1 acknowledged how the decision to see clients for 6 to 8 sessions was coordinated at levels about them. Informant 1 then broadened their discussion of continuity of care, by acknowledging what they are noticing happen in practice:

*MM:* When you describe continuity of care as being a barrier, what is it about this that you find concerning or would otherwise expect?

*I1:* Continuity of care is a huge limitation for me ... and I am huge on continuity of care, including care teams talking to each other and that is one really big concern because they (Northern Health) don't seem to embrace it ... I have suggested let's have a round table

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... Northern Health's policy on privacy has really affected that ... like if you do that you are breaching confidentiality.

Informant 5 echoed the experience of being encouraged to keep services moving, and how this often felt like a pressure for quantity of clients served versus quality of services offered:

**MM:** Tell me a bit about the expectations of your role, as in your job description or maybe that are dictated to you by your supervision? What do they tell you should be doing?

**I5:** With our program, how it looks now with four to six sessions, there is a pressure because we are a free service ... There is a notion to keeping things rolling. So making sure that clients are progressing and obviously progress is going to look different for everybody.

Informant 5 expanded on this idea of tensions between efficiency in policy, and providing a client centered care:

**I5:** So 4 to 6 sessions is kind of just a guideline. We definitely can go [beyond that] because if someone struggles with personality disorders or things like that they're definitely going to be more than four to six sessions. We can definitely go past that.

Informant 5 also expressed a desire to perform outreach services to minimize barriers for clients who are unable to make appointments for various reasons:

**MM:** If you were to change anything to eliminate some barriers, what do you think you would change?

**I5:** Obviously having more supports, or more people to fill positions where gaps are but that's not always possible. I think changing if I was allowed to go out to the community, and have appointments out there so that they don't have to come into town ...

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remembering appointments can be so difficult, so being able to be accommodating to what they need ... it would be helpful if the roles that are already there are changed to give us a little bit more freedom to meet clients where they're at.

Other informants noted similar barriers, specifically that a lack of consistencies within practice may lead to difficulties with continuity of care. Some roles rely quite heavily on outside, community resources for services that cannot be provided in hospitals long term. While quality of care remained central to their role, Informant 2 noted difficulties relying on professional resources in the context of a rural community to ensure continuity of care:

**I2:** One of our biggest barriers is the lack of professional resources in community. It is really difficult to set somebody up and get them better ... We can't [always] provide care when they're in the hospital ... it's hard to follow through because we have such a lack of resources that can help sustain some of the wellness. So I find that a barrier for continued health maintenance, especially mental health.

Informants noted experiencing opportunities for outreach and believed clients would benefit from outreach work, but described being unable to extend their role outside of their formal office due to policies prioritizing safety. Informant 5 described their experience working with clients within their scope as limiting, and alluded to how their role inherently creates barriers for clients:

**I5:** So the interprofessional team, we don't do outreach work. So I'm kind of limited to working within the office so our clientele is generally people who are able to make appointments, so they have to have transportation and the means to remember, or have reminders for appointments things like that.

Informant 1 echoed this sentiment, and how prioritizing staff safety limits their ability to perform outreach practices, and meet clients where they are at:

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**MM:** You had described some polices that prioritize staff safety and privacy over client care. If you were to change anything what would that be?

**I1:** Well there would be lots of round tables. So not only do we not really talk in the building, we don't really talk with anyone outside the building. It's like we're almost isolated ... I would be involving every single person that I should. I would be a benefit to this person and anyone they want to be involved. A family member, friend, advocate, bring them in and let's figure this out together as a team ... I think too that when we're working with our Indigenous population it is challenging when you have no Indigenous representation at the table. It has to be a safe space. It has to be an identifiable space ... They're not really receptive to us going out and going into different parts of the community. If I had my way I would go into people's homes. It's so much more comfortable, they're in their own space and people are so much more willing to talk.

Informant 1 alluded briefly above to the challenges with bringing in Indigenous representation, and questions how this ought to happen in practice. This will be discussed in the next section on cultural safety.

### ***Culturally Safe Practices and Care***

Cultural safety is defined broadly as services which show respect for culture and identity including consideration of individual needs, which are free from discrimination and prejudice (Dawson et al., 2022; Josewski et al., 2023). Within healthcare, this often looks like services which honour differing cultural views of health, and offering services which are inclusive and equitable. Each informant acknowledged the importance of cultural safety in the workplace, and with patient and client care. Informants had slightly differing ideas of how this ought to happen in practice, but described how their ability to provide culturally safe care was often constrained

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or coordinated by texts describing Northern Health's relationship and partnership with Indigenous communities. Specifically, informants communicated confusion about how cultural safety was supposed to be happening, and how to build relationships with Indigenous communities and partners. Informant 1 described this confusion, and how they have experienced it on the frontlines:

**MM:** You mentioned there being nothing to accommodate other Indigenous language, and nothing really welcoming in the waiting rooms. Can you tell me a little bit more about that?

**I1:** So it's never actually been discussed. I've never heard anyone talk about it or anyone raise that kind of flag. Growing up my [family] had Indigenous things on the walls ... I don't think [the office] is a very comfortable place for a lot of Indigenous People ... I've tried in the waiting room, just something to cheer it up and it got back to me ... in case somebody throws it (an object) they're concerned. I feel Northern Health's primary concern is employee safety more than anything else I'll say.

Other informants acknowledged that their work environments are standardized, colonial feeling, and may also feel unwelcoming for Indigenous Peoples. Specifically, Informant 1 acknowledged how creating culturally safe physical environments fell completely to staff, but felt unable or constrained to make changes:

**I1:** I don't know of many Indigenous People specifically seeking out our services because I don't think we are as welcoming. There is someone at the front [to greet them], but it's extremely colonial. It's very government. Can we maybe say welcome in the Dene language [to acknowledge] their worldview. There's nothing welcoming for Indigenous People and letting Indigenous People know that this is a place for you too.

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Informant 4 also described a desire to transform physical office spaces to accommodate diverse cultures, especially Indigenous cultures:

**I4:** I think it would be fair to see some of the Indigenous prints within Northern Health. Like when you come into the health units you see something that is about Indigenous [Peoples].

**MM:** What kind of things are Northern Health doing to make these spaces *feel* culturally safe?

**I4:** From my own point of view I feel like there should be something that is specifically for Indigenous Peoples, I mean even the prints to show we acknowledge them. It doesn't have to be something big, but let it be visible to everyone when people come in so they can see it.

Informant 4 expanded their belief about how activating texts of cultural safety should be an ongoing, and collaborative process between Indigenous communities and Northern Health:

**I4:** I feel [the Commitment to Cultural Safety] is sugar coated. Like not saying the actual things about cultural safety. I feel like they should just go to Indigenous Elders and just ask them, ok, what do you want us to write? What should we write on our declaration.

Informant 1 expanded on their confusion with how cultural safety practices and texts on collaboration with Indigenous communities should be happening in practice:

**I1:** Say a client who is Indigenous has come in with a psychiatric condition ... there's never talk about elders, or cultural practices. Do you want to smudge before our meeting? Do you want any [cultural accommodations]? There's nothing because they don't have that knowledge.

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Informants acknowledged the importance of the Indigenous Patient Experience Advisor, formally known as the Aboriginal Liaison, as a key and integral role in the hospital for meeting cultural safety expectations for Indigenous patients. Informant 3 specifically shared their experience when this role was vacant, and how hard it was to ensure culturally safe care:

**MM:** What might you do differently if you are working with an Indigenous patient for example?

**I3:** I don't think it really varies at this moment in time, but one amazing resource we have at the hospital is an Indigenous worker ... we definitely involve her. [The previous Indigenous Patient Experience Advisor] was amazing, they cover so many roles. They might come and go to [patients] houses and get them clothes. Or we've had them come in and facilitate a smudging process of a palliating family member. We went a long time not having them.

Informant 3 further shared the importance of this role, and how activating texts of culturally safety, culturally sensitive, and patient-centred care was more easily met when they have staff who can speak traditional language:

**I3:** [The Indigenous Patient Experience Advisor] does so many things. The last person actually spoke a little bit of Cree so she was so good at communicating with some of the elders that we had in care ... there was a little bit of language barriers so she could communicate with their families a little bit more. They felt more comfortable and would be more open with her, and some of the Indigenous patients too. She was an awesome resource, and you need a special type of person to fill their role. I can't say how many good things she did at work. She was great.

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While Informant 3 clearly highlighted the importance of this position, Informant 2 noted how this specific role is hard to fill, and how the efficiency of this role is dependent on who the institution hires:

**MM:** How do you build cultural connections at work?

**I2:** We have supports now ... The Indigenous Care Coordinator, we had one and then the position was left open for a bit, now we have somebody again. But it all depends on the person who is in the role and if they can accommodate that. We have somebody now who is Indigenous, who is in the role and very eager to learn, but does not have a lot of cultural experience.

Informant 2 added how when this role is left vacant, the hired individual is new, or they are non-Indigenous, the expectation to fill gaps to offer culturally safe care falls on staff. Informant 2 acknowledged how the expectation for flexibility is highlighted, but also undermined simultaneously with activating texts of providing quality care and working with a multidisciplinary team – a team which may sometimes not exist due to understaffing:

**I2:** We don't have the opportunity to offer them a full meal deal kind of thing yet. We're doing what we can with what we have, which is a start.

**MM:** What kind of things do you specifically do to support cultural safety?

**I2:** When a patient is resistant to something, we try to have multiple attempts to kind of see what it is the patient needs and what culturally we can do.

Informant 5 acknowledged that specific culturally safe or inclusive mental healthcare tools is something which they would have to learn on their own time, but having someone such as an Indigenous patient liaison in the community could better bridge this gap in care:

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**MM:** Is there anything in your job that if you think you did have it, that it would help you with working with Indigenous patients?

**I5:** I think something that would be helpful is someone who bridges communities like a mediator or liaison. Somebody who because I think that, yeah, there is a lot of hesitation to trust somebody who works in the medical field because of all the trauma ... having somebody they trust and bridging that gap between us ... there is someone like that in the hospital, but within the community, in outpatient we don't have that ... If somebody came in and said they wanted to learn coping skills which align with cultural beliefs and background, a more holistic perspective, we could do our own research into that and provide it to them.

This section broadly spoke to the tensions and constraints which informants are experiencing in their attempts to enact culturally safe practices. To fill these gaps in their vague and indirect roles, mental health professionals described often practicing flexibility, but also experiencing tensions between blurred boundaries of where their roles start and end.

### ***Blurred Boundaries: Black, White and Grey Roles and Responsibilities***

When discussing discrepancies between their roles in practice versus what they might entail in the job description, the informants of this study acknowledged there is a lot they do which is not specifically covered in their formal job descriptions. Specifically, their everyday actualities involved the blurry boundaries between where their roles start and end. I analyzed each job description which matched the job titles of each informant. My initial analysis showed how informants' job descriptions use terms and descriptors which are vague, indirect, and open to interpretation. I argue that that the vagueness is intentional to capture the various responsibilities of mental health providers. However, vagueness in job descriptions appeared to

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undermine and fail to account the vast amount of invisible work which mental health professionals do.

In some interviews informants noted work that is being done (is invisible), which is otherwise unaccounted for, which will be discussed in depth in a later section of this chapter. Informant 2 noted that supporting students, staff, and providing on the job training is not necessarily part of their role but vaguely falls into the work they are doing. Informant 2 described their invisible work as “soft parts of their role” which is otherwise unwritten and unaccounted for:

**I2:** Supporting staff, that’s kind of within my scope, but not a written thing. Its not in the job description, but seems to be a soft part of my role ... So I guess as we work with a team it’s usually the team working to support the patient, but also as the team supporting each other.

Informants described how demands or tasks which fall outside their roles will often be referred out to community agencies, or community resources. Multiple informants described how this overreliance on resources created a gap in care, which they were expected to navigate according to vague and indirect job descriptions. Informant 1 described how tensions in their job description to provide client-focused care and advocacy, are met with tensions and restrictions on training opportunities:

**MM:** What is it about [certain client problems] such as trauma that leads you to refer them out?

**I1:** Policy tells us we’re not allowed. So for example we have several clients who will come in and they have been diagnosed with borderline personality disorder ... they (Northern Health) will not pay to train us ... so we deal with the other issues. I look at the

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whole person, but it puts us in a very difficult position not being allowed to deal with BPD. I'm not allowed because I'm not trained so ethically, how could I, if I don't have the training to provide them that kind of support?

Informant 5 explained what this has looked like for them in practice, and how it can be frustrating for both the mental health professional and the client:

**MM:** How have you found the resources in your community? Another layer to my study is what your experience has been like in a rural community, and I'm curious what does this look like for you?

**I5:** Resources are limited. Its hard because sometimes you struggle to even get a hold of the resources, like phone numbers are constantly changing. Staff turnover seems to be high everywhere, so sometimes there's a role and no one who's in that position. Lots of waitlists as well, when you're referring somebody out and there is a waitlist, nobody wants to hear that. So it's frustrating for both parties as well.

Informant 2 acknowledged how overreliance on community resources has created a tension between texts of client advocacy, client-centered care, and continuity of care:

**I2:** I think one of our biggest barriers is the lack of professional resources in community. So it's really difficult to set somebody up and get them better. I've sometimes liken it to if you come to the hospital and you get dressing for a cut, and then I send you home to living in a box with no nutrition, a dirty environment and no supplies, and I expect you to get better ... we can't provide care when they're in hospital and it's hard to follow through because we have such a lack of resources to sustain that wellness.

Lack of community resources, and inability to fill gaps in care appeared to result in the need for increased flexibility in the roles of informants. Informant 5 shared how filling gaps to account for

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lack of resources meant that staff had to “wear multiple hats”, and assume duties which may fall outside of their job description:

**I5:** Because there are limited resources, we sometimes have to wear different hats. So we have a great social worker now, but for a while though she was the only one. So we were trying to take on some of the tasks that would normally have gone to social work ... we were often alleviating some of the stress that our social worker and our social worker assistants were doing ... sometimes we have to help in other areas of people’s lives that wouldn’t normally fall within our scope, because sometimes there [isn’t] somebody else there who can help them do that.

Informant 3 also noted how their allocated area of the hospital should be for acute illnesses only, but due to growing demand and lack of community resources, they are starting to see more patients with mental health and addictions concerns:

**MM:** You mentioned how sometimes people will come into med surg just cause of the nature of their condition, but [will also] have mental health concerns. How is that happening?

**I3:** The medical wing is supposed to be for acute illnesses, but in my experience with our large and growing geriatric population, you’ll see it anywhere from 75-100% full of people awaiting long term care ... we see people there that also have mental health and addictions ... all walks of life come through my floor.

**MM:** I also heard you say that sometimes they come in on a social admit. Can you explain to me what that is?

**I3:** It can be an array of things. Sometimes it could be a homeless person, and we don’t have a safe place to send them back home ... a social admit could be someone who no

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longer has [a home] or it's not safe to go back. There's been times where we haven't had a social worker, and then us nurses kind of take that on and do the best we can.

Informant 3 noted above how their role as a nurse often extends beyond typical nursing practices, and as boundaries become blurry and patient needs become complex, they are sometimes assuming the role of a social worker. Informant 5 described feelings of "struggle" when sharing a patient experience with many healthcare providers involved. They specifically acknowledged tensions between what they thought they were supposed to be doing, and what was actually happening:

**I5:** A more recent case [I worked with] upon discharge they were certified, and I was following up with them ... it was a struggle as it seemed like there was a big gap in service. In terms of case management he had myself, and another clinician who was [part of another team]. In that sense it was almost like there was too many cooks in the kitchen ... they were living on reserve ... they required more follow up, more communication and more interaction with us. It is really hard to sometimes get a hold of them, track them down, and because we're limited to go out into the community ... we can't go to them ourselves ... so it's very difficult to be able to provide the care that those clients are needing.

**MM:** You're limited by your ability to go to communities even when you're providing crucial medication for certified individuals. Why can't you do that?

**I5:** I think because it's our mandate, but generally the clientele that our services are designed to accommodate are those who are able to transport themselves to appointments ... or having supports who can remind them of appointments ... I think this is another time where maybe we're wearing a hat that doesn't fit what our role is ... trying to stretch

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ourselves so that we can [provide a service] because I don't think that another service [offers this] ... my team we're trying to make ourselves available to this demographic, but we're just not designed for it.

Informant 5 briefly alluded above to competing demands between worldviews or roles, which they acknowledged feeling amidst their work between healthcare providers. These unseen forces or demands are described in depth in the next section.

### *Balancing the Demands of the Role, and Competing Worldviews or Roles*

Informants acknowledged how their job descriptions detailed offering care sensitive to diverse cultures and Indigenous patients, but that this was often undermined by adherence to Northern Health's medical model of care. Informants mentioned in their interviews how they are consistently balancing the demands of competing worldviews, conflicting role requirements, or confusing role boundaries. Informants described feeling the weight of balancing demands between roles and knowing where their role started or stopped. Informant 5 described this feeling of tension in the previous section, but expanded on their thoughts further:

**MM:** You said this is a case of too many cooks in the kitchen, yet at the same time gaps aren't being filled [with care]?

**I5:** So I'm trying to delegate with this other person on their team. So what's my role?

What's your role? But then the areas that the clients needing support neither one of us can really provide that.

Informants described challenging workplace environments when they are working with conflicting worldviews or health models, specifically Indigenous health models and the traditional medical model. Texts which coordinated this tension are activated through Northern Health's Strategic Plan 2025, which promises a commitment to centering Indigenous ways of

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being and knowing in the health services they provide. Informant 2 noted that depending on the role in healthcare, mental health providers often experience competing models or demands, but are trying to reach the same goals:

**MM:** How are you supported by your organization amidst the chaotic nature of the job?

**I2:** I worry sometimes ... bumping up against the nursing model versus the social work model ... but knowing I have this full like 100% support from my team leads and psychiatrists who have a view of the whole picture [helps].

Informant 2 alluded to this experience earlier on in their interview when asked how they may explore patient preferences for treatment and care:

**MM:** So when you're working with people, you're asking them questions to see what their preferences might be for treatment? How do you know what questions to ask?

**I2:** I guess it comes from a strong sense of giving each person a voice and understanding more of who they are ... I've always been more of a meet the person where they're at and let them have a voice. We're not to control people, we're there to support them.

**MM:** Is that something you are supported with or is this more of a personal goal for you?

**I2:** It's how I work and something the organization likes to say they do. In their statements they talk about wanting to be person centred and we're encouraged to do that, but sometimes there is a bit of pushback. With treatment plans a doctor or psychiatrist has an idea medically that this approach works. Then [I'll] come to them in a discussion and say well this is not what the patient wants and sometimes there is resistance.

Informant 1 expressed similar experiences, stating that working within a medical model creates tensions in the expectations of their role as a mental health professional in the community setting:

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**I1:** Coming from a background in [a non-medical setting] we want to talk, and we want all kinds of people to come together. The clinical approach where a doctor sees a patient, then a nurse sees a patient but they don't do it together ... it [disrupts] continuity of care, to be honest it's a bit puzzling trying to make sense of [the clinical approach].

Informants implicitly described how attempts to carry out their role amidst navigating different worldviews often created awkward or difficult situations for them. Informant 5 acknowledged how meeting the expectations of their role are difficult without the support of an Indigenous liaison or cultural support:

**I5:** When I'm explaining to a family member what's this medication, and what it is going to be doing to their son who is certified and they're mandated to take it ... it's hard, because that's not within their culture and values and things like that ... we need a middleman, I think that could be helpful.

Informant 3 described similar tensions between texts of promoting culturally safe care, and wanting to acknowledge historical implications of colonialism, but feel their role or job description in healthcare sometimes perpetuates harms:

**I3:** I think they should mandate a course [on cultural safety] ... because there is a terrible rap sheet in history of Indigenous patients not being treated well, like you hear about these stories in the news and stuff not being treated appropriately or fairly ... you just want to be more mindful and have a clue with what you're doing and what you see when patients come in. You don't have their full story and everybody has a story. Everybody has a history.

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Informant 3 also suggested tensions between patients meeting explicit criteria to access care, and abilities within their role description to help them, suggesting that their role may not allow them to provide care to patients if they do not meet certain criteria:

**I3:** We definitely lack resources, especially around mental health, and addictions. We could use so many more detox centres and more rehabilitation centres. People will come into emergency and they're like, I'm ready to get help, I'm ready to get clean, and we can't medically keep them unless there's something medically wrong with them ... We will try to hook them up with resources within the hospital but we can't hold them while they find placement, and you are so lucky to score a bed in detox.

### **Invisible Work of Northern Health Mental Health Professionals**

Invisible work is labour or work that often goes unnoticed, unacknowledged or is undervalued and unregulated (Ming et al., 2022). Invisible work within the study is conceptualized as work that is happening by mental health professionals, but is otherwise unseen, unaccounted for or unacknowledged on behalf of Northern Health. Invisible work appeared to show up for mental health professionals as attempts to fill gaps and acknowledge tensions between their job descriptions, and the larger contexts, discourses, and institutional policies. The following section will describe how informants fill gaps using their personal resources outside of their role in creative ways, and carry an invisible mental and emotional workload.

### ***Creativity, Adaptability, and Personal Resourcing***

Of particular interest to me was the inclusion of creativity and adaptability which informants brought to their specific roles. Specifically, I noticed patterns between informants interviews of them sharing how they fill gaps or bridge barriers in their roles using creative means, personal

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resources, or unique forms of adaptability. When discussing how staff further manage the demands of their role and the presence of blurred boundaries they discussed pulling from their personal resources (previous job history, personal experiences, or other roles outside of Northern Health), and using creativity to adapt in their roles. Informant 1 noted how they have lots of resources, specifically referring to their internal knowledge rather than outside agencies or resources:

**MM:** You said you have a lot of resources to use. What were you referring to when you said this?

**I1:** I have those inner resources. I love exploring our own personal resources, like resiliency and giving yourself some grace. And you know all of that is a very important component to the work that I do.

Informant 1 also expanded on this notion explicitly, by stating that they “use inner resources”, “love exploring our own personal resources like resiliency and giving yourself some grace”, and acknowledged how their role is “a small box [they’re] put in” but that they “go outside that box a lot”. Informant 1 also shared a personal piece of themselves which they bring to their role, which provides them a unique lens to view their clients through:

**MM:** I appreciate this humanness you bring to your role and the care you put in – some things you’ve described are not captured in policy or your job description. Can you expand on this?

**I1:** I thoroughly enjoy [clients] ... I do a lot of work on myself and I came from a lot of trauma ... sometimes I connect on a level and I know that there’s hope. No one is hopeless. I don’t disclose my history, I have good boundaries, but I think that if somebody treated me with humanness I might have had a different outcome.

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Informant 2 noted similarities of using creativity or personal resources to fill gaps that naturally exist because of the rapidly changing environment in a hospital setting, including staffing changes:

**MM:** What is your understanding of how [continuity of care] isn't happening?

**I2:** People move and change and have different things in their life ... it gets to be difficult. With that I've also kind of incorporated that with my time with patients on the unit and getting them more comfortable with change and how to manage those pieces, because they're gonna happen.

Informant 2 further expanded their discussion about their inclusion of personal resources which they bring into their mental health profession at Northern Health:

**I2:** Group work is where I'm able to ... give people an experience or an opportunity to learn a new skill and have fun learning it. It doesn't have to be all ticky boxes ... sometimes it's more memorable if I put in a more creative lens. I've been given permission to continue [art therapy], which is not really part of my role, but I just go for it. Another thing that I am doing that is not part of the role is building resources for patients to be able to take home for families. I guess I'm kind of doing my own side of the desk research.

Informant 1 described how they connected with Indigenous clients if they were feeling unsafe and how they personally created safe environments:

**MM:** You mentioned really trying to be sensitive of their (Indigenous Peoples) situations additionally, and culturally sensitive as well. Can you tell me more about what that might look like?

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**I1:** You know, I'm a big believer in, like, just breaking bread with people. So while I can't do that in my office, I'm not allowed to offer food. I would if I could because I find it to be such a beautifully intimate experience. Like when we break bread together, there's a whole new level. So without that, what I really try to do is share a little bit of me as well with them eye contact, laughter, some humility, you know, and there's always tissue, kind of whatever they need.

### *Mental and Emotional Workload*

Informants in this study often described how they cope with parts of their role that might be out of their control. Specifically, if they are unable to help a patient and how they deal with this. Multiple informants described that the mental weight of constraints, difficulties, or failures in their job weighed heavily on their minds after work. Informants also described making decisions which they did not agree with, but had to follow through with due to policy and practice coordinated from higher levels. Through analysis I found informants are competing with the demands of quality of care, but are experiencing difficulties on the frontline offering quality care amidst role guidelines and boundaries as laid out in their job descriptions. This competing experience shows up as mental or emotional stress which they bring home after work has ended.

Informant 4 discussed their experiences of mental and emotional invisible work. Informant 4 explained how they often wonder what happens to their patients when they cannot extend help past the boundaries of their role, and resources are stretched thin:

**MM:** What do you do when you are trying to bridge gaps, and we are so limited resource wise?

**I4:** We try and find resources in other communities ... but we know that there's not enough and it's a struggle. Even myself, when I'm dealing with such a client, it doesn't

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end day after the appointment. No, I carry that thing at home and I'm thinking about it, like oh my God, my client will they be okay?

Informant 3 noted similar difficulties with accepting that their quality of care is all they can offer, despite the pressures and tensions from Northern Health to offer quality care. Specifically, Informant 3 felt invisible pressures to do the job without additional help or support, in an otherwise understaffed working environment. Some informants described that this meant they had to “accept” a lower quality of care, which created a mental burden that they brought home with them. Informant 3 described pressures from Northern Health to move people through the emergency department by quickly through “patching them up and sending them on their way”. Informant 3 was questioned about how this experience shows up for them mentally in practice:

**I3:** Often when people go home I wonder what happened to them, because you know in the emergency department we deal with traumas and emergencies.

Informant 3 added how the lack of resources, funding and staffing contributed to mental and emotional strain. Specifically, they shared how a lack of resources created increased pressures for maintaining quality of care:

**I3:** We constantly see people come in and they need outside help that we don't or cannot offer in our little rural hospital. I'm talking about detox, rehabs, group home like assisted living – we lack so many things like pediatric stuff. I have seen a kid in mental health crisis waiting to get a bed, waiting in emergency which is not a place for a child especially in an extremely vulnerable situation. It's an everyday problem and we are so understaffed some days are better than others ... When we are short staffed you have to take on that patient load and the amount of the quality of your care falls because you can

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only spread yourself so thin ... We don't have the resources that people have in cities. So I do feel like you see a little more suffering here.

Informant 1 described similar experiences of taking a mental and emotional load home with them after client interactions. They described how inexperience in the beginning of their career led to a troubling client interaction, which they still recall years later:

**I1:** She was so angry and I felt so bad ... we have to go through this as workers. I got spat on and everything. Looking back it would have been such a different response had I seen her today ... I was not supported, and I just started there ... it was a really sad outcome and I've never seen her again. I think of her, and I really wish she would come back someday. I really would love to make amends with her.

Informant 5 described the challenges with navigating their role in a community with limited resources, specifically how it can be frustrating communicating to clients that they are unable to fulfill their role requirements due to minimal community resources:

**MM:** I'm curious what it looks like referring to other resources [in your community]?

**I5:** Resources are limited. It's hard because sometimes you struggle to even get a hold of the resources, like phone numbers are constantly changing. Staff turnover seems to be high everyone, so sometimes there is a role and no one who's in that position. Lots of wait lists as well, when you're referring somebody out and then they're on a waitlist, nobody wants to hear that. So it can be frustrating for both parties as well.

Other unseen work practices may include supporting colleagues mentally and emotionally.

Informant 2 noted how supporting staff was an important part of their job, despite not necessarily being covered by their job descriptions clearly:

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**I2:** Supporting staff is kind of within my scope, but not a written thing. It's not in [my] job description, but seems to be a soft part of my role ... we work within a team right, its usually the team working to support the patient, but also as a team supporting each other. Connecting this to the broader context where mental health professionals work, these pressures to provide quality care may be an isolating experience, and one that can create a significant mental load. This unseen labour of providing emotional support to colleagues and the families of patients is noted by Informant 2 further:

**I2:** I'll have different staff members kind of stop in and just kind of debrief something that was difficult and then they go ... I also work with a lot of families as well. Just in helping explain what's going on for their loved one, how to support them, and maybe to get collateral from families.

### **Training Protocol: Theory versus Practice**

Informants provided me with information on their training experiences when they started their positions with Northern Health. Informants discussed what training looked like for them, what they took away from their training experiences, and how cultural safety or education involving caring for the mental health of Indigenous Peoples was woven into their training. Through data analysis I have organized the interviews into themes centering how training is discussed theoretically by Northern Health, and what is happening in practice. Below, I have sorted these tensions between theory and practice into two subthemes: cultural safety training, and Learning Hub.

#### ***Learning Hub***

Each informant in this study naturally brought up Learning Hub, which is Northern Health's online platform for training and educational material. Informants described Learning

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Hub as an online resource, where staff have access to a variety of courses, some of which are mandated upon being hired, and others which are optional and encouraged. Multiple informants described Learning Hub as a source of tension between what they are mandated to do, what they should do, and what they are not doing. Specifically, informants acknowledged that they know Learning Hub is there for them as a resource, but finding time to expand their learning was incredibly difficult due to competing demands of efficiency:

**I5:** Filling your free time with Learning Hub ... it's hit or miss because it depends on how busy the other clinicians are or nurses are ... for a while we didn't have any staff ... it's tricky because sometimes everyone in the office is busy, people are seeing three to four clients a day ... I've talked about it with coworkers in the past that there's all these opportunities within Northern Health to continue our education, like courses we can take that we can apply for to be covered by Northern Health, but we're too busy. We don't have the time to put toward those kinds of things. So unless it's something that we're getting forced to do, or Northern Health is creating that time for us to do the education, it's something that I think is kind of getting neglected.

To ease the tensions of Learning Hub and training expectations, staff acknowledged that training and education is often happening by their colleagues. Multiple informants described that their training comes from learning from their colleagues and peers. Informant 1 acknowledged that community health sometimes hires people without "adequately training them", and as a senior employee the responsibility fell to them for training newly hired employees:

**MM:** You mentioned training. I'm curious what does your training look like?

**I1:** Mostly online for 2 weeks solid on Learning Hub, then you'll get some face to face for a couple of things ... [a new hire] got to sit with me for a couple of days and then

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[they] were cut loose. Then [they] walked down and grabbed probably 30 referrals ...somebody should have been sitting in there with her for a very long time. There's Learning Hub and then they shadow. I think that is not enough.

Informants expanded on this idea of training by their peers as necessary and helpful, but most informants felt their training was lacking especially regarding cultural competency, safety, and knowledge:

**I3:** I think always having someone like [the former Aboriginal Liaison] around, that was such an amazing resource because they could educate us too. We could use a few more of them, like one per unit.

Informant 5 also shared how the terms “mentoring”, “peer-consultation” or “shadowing” was used to capture this invisible work, specifically the expectation of employees teaching and training others. Informant 5 discussed how staff in rural communities sometimes lack educational requirements when compared with urban centres:

**MM:** How might your role differ being in [a rural community] versus like an urban community for example in the lower mainland Interior Health?

**I5:** Well in this role like myself, and I can think of a couple colleagues as well, we're definitely working in a position that normally elsewhere would require a masters. It can be hard because we do lack some of that experience and education. We've got great mentors. Our resource nurse, she's fantastic. She does a really great job of helping us out when we need it, but also allowing us to kind of learn on our own as well.

When further discussing the purpose of Learning Hub for newly hired employees, Informant 5 also discussed how hands-on training is an inevitable, and sometimes necessary requirement for senior employees to train new employees:

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**I5:** [Learning Hub] serves a purpose. I think that in terms of a lot of the courses you have to take when you're working for the health authority that are basic without hand-on work required, it does a good job of meeting those requirements ... I feel for me personally, I'm a very visual learner and so I feel it's not the most effective or efficient way to do that. Then we do a lot of shadowing. Generally for your first month you'll be paired up with somebody ... and you kind of follow them throughout their day ... That's where I did the most learning, in practice watching people interact with clients, watching sessions.

Informant 5 expanded on what is happening with peer-to-peer training and consultation in practice, and how this work blurs the boundary between invisible work and peer to peer training requirements:

**I5:** If someone isn't able to sit in on a session, generally what we'll do is debrief with them ... kind of like that peer consultation almost ... it teaches you how to redirect somebody and navigate conversations that would have been triggering for them ... This stuff that can be talked about afterwards [is helpful].

**MM:** I get the sense there is camaraderie between staff, and I hear there is a responsibility of staff to like train the new people and provide support where they can?

**I5:** Yeah, our department we're all very close. We get along really well. It doesn't even feel like work relationships sometimes ... when somebody new comes in we are all pretty eager to help out, especially since there are a couple of people who've come in basically straight out of school, that's a big step to take.

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### *Cultural Safety Training*

Each informant acknowledged during their interview that they either took a cultural safety course themselves, it was suggested to them to take it, or they have heard of it. As I looked deeper into what this course was, I found information through an online search suggesting the course described is Respectful Relationships: Culturally Safe Indigenous Healthcare (see Appendix J). While informants acknowledged the importance of this singular course, they expressed the desire for ongoing learning which is prioritized and encouraged by their organization. Informants described tensions with activating texts which promise commitments to Truth and Reconciliation by ensuring that Indigenous peoples have access to high quality, culturally safe and respectful services, while also expressing confusion that ongoing training is not happening. Informant 4 described the importance of continuing education, but suggested that the responsibility lies within employees to complete this on their own time:

**MM:** What do you remember about [the cultural safety] course?

**I4:** I remember Indigenous Elders speaking about what happened in the past and how it impacted them ... I think the cultural safety course is the main one, the mandatory one. But as a person you have to make sure that you keep up with your own learning ... just go online and try to find some courses to do.

Informant 4 expanded on their experience of this mandated course, and expressed concerns about what is actually being learned from it, and how solidified this learning is in practice. Informant 4 shared how learning is best done experientially, rather than through online platforms:

**I4:** I would reach out to the Elders within the community and invite them to come and do in-house training about Indigenous Peoples, because what we learn on Learning Hub, it's a mandatory course right, people who do it, we don't even know who takes the time ... it

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takes time to understand the course, so are they just doing it because it they know it's mandatory?

Of consideration are the constraints and contexts which staff work within, specifically the broader promises, commitments and mandates posed by Northern Health to the public through their Strategic Plan and Commitment to Cultural Safety. The expectation for additional cultural competency and safety training was described by informants as staff-led and done on independent time. Informants described constraints between the texts of Northern Health's commitment to cultural safety, but are met with competing translocal texts of quality of care and efficiency.

Cultural safety was described by some informants as an "afterthought". Informants described cultural safety as something which is encouraged, but that their training has been limited to a single mandated course. Some employees mentioned being hired many years ago and never taking this mandated course. There appeared to be inconsistent messaging about mandated requirements of cultural safety training, and informants acknowledged this inconsistency and confusion. Informant 3 reported that they were hired over a decade ago, and to their knowledge they were not mandated to take a course on cultural safety:

**MM:** Did Northern Health make you take any cultural competency training or anything like that?

**I3:** Within Northern Health we have like an online portal for nurses and doctors and healthcare staff called Learning Hub. We can sign up and take any of the courses offered online. There are quite a few Indigenous cultural courses ... but we have to just take those on our own [time].

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**MM:** So it's not something that is mandated for staff? It sounds like its more so initiated by people just wanting to do them themselves?

**I3:** Yeah exactly, I think if I were to take another position for example, I wonder if it is part of the orientation now. I think they'd want you to take a couple courses like that, but in my role I know we don't.

Informant 5 described the mandatory cultural safety course as “surface-level”, and as information that felt more informative rather than prescriptive:

**I5:** It (the Indigenous cultural safety course) was pretty surface level, but it was a while ago that I did it. It wasn't anything I hadn't already learned ... I was a bit familiar with it already, and it was very much common narratives that are common [knowledge] right now ... It touched on residential schools and generational trauma.

Informant 4 acknowledged a similar experience of taking this course, and feeling it was informative but not prescriptive, nor new to their existing knowledge base:

**I4:** [The Indigenous cultural safety course] wasn't new for me as a social worker, because during my studies it's something we studied a lot.

When discussing how they should be practicing with Indigenous patients, Informant 5 noted that prescriptive practices are not outlined clearly for them. This statement is suggestive that staff are experiencing tensions with translocal texts of cultural safety and best practices, with competing texts of leadership, teamwork, and training:

**I5:** In my experience, I've never received anything from Northern Health outlining what the best practices are. A lot of it is kind of passed along informally, like through the resource nurse for example. Or a lot of it was when I was doing that shadowing and the

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other clinicians address what the best practices are, like things to be considered of and conscious of.

Data collected through interviews evidenced how informants often felt that the mandated cultural competency training course was not enough. Although Northern Health poses suggestions and encourages staff in the pursuit of ongoing cultural competency training, this was undermined by more powerful competing extra-local happenings of productivity and efficiency. They described trying to find time for additional training on Learning Hub, but that this felt impossible given the vast amount of other work that takes priority. The following examples below highlight how informants desire more time for learning, but feel conflicted due to everyday work requirements. Informant 3 further acknowledged their desire to do more training, and how important this is to their role and other healthcare professionals:

**I3:** I think they should mandate courses [in Indigenous cultural safety], especially with people who are new into healthcare. Because there is a really terrible history of Indigenous patients not being treated well, like you hear about these stories in the news and stuff about not being treated appropriately or fairly.

When discussing the importance of continuing education regarding cultural safety, sensitivity, and inclusivity, Informant 5 acknowledged that cultural safety is treated as an afterthought due to an initial mandatory course, but no follow-up mandatory education time:

**I5:** I think with cultural safety you do it in the orientation and then you build a caseload and then there's just not a lot of time for that. So I think because it's not prioritized, in my opinion as much as it should be, that's why its not continuing.

Informant 2 acknowledged that they have taken additional cultural safety training, but as a requirement for work outside of their Northern Health role. They stated it has been "helpful," but

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not “required” for their Northern Health employment specifically. Informant 4 expanded on the importance of the organization setting a standard for prioritizing cultural safety training and creating the time, space, and opportunity for it to happen:

**I4:** I feel like having someone in person, coming in, and talking to people about what they face is crucial. Have an Indigenous person come in to speak for themselves, speak for their community ... have someone come in while everyone is at work, and then have an hour, just one hour, it doesn't hurt to have that education. People need that education because someone people they're still not culturally competent.

### Chapter Summary

In Chapter 4, I discussed my data analysis of the informant interviews, and the tensions between text data. In this chapter I organized interview data into themes, and explained *what* work is happening directly on the frontlines. Chapter 4 explored themes of frontline actualities, including culturally safe practices, experiences with continuity of care, competing roles and worldviews, and blurred boundaries between their job description and informants are experiencing in practice. Informants have also explained how their work is coordinated at higher levels, which shows up in practice as invisible work. Informants also shared their experiences of training on Learning Hub, and cultural safety training. I have briefly commented throughout this chapter how there are competing texts which coordinate work and create confusion or tensions in practice. Chapter 5 will explain and discuss *how* this work is organized to happen the way it does, and further explain how it is organized by translocal texts and higher processes.

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## Chapter 5. Discussion

The following discussion expands on the identified themes and analysis in Chapter 4, and situates them within larger themes of institutional ethnography (IE). I will discuss my findings in this chapter, and incorporate the findings of my research into further existing literature. In this chapter I will also address my question of how institutional policies and practices contribute to barriers for Indigenous Peoples residing in rural communities in the Peace Region, BC. While policy exists to address decolonizing practice, such as in the text Strategic Plan: Looking to 2025, I argue that clear guidelines are missing in this plan, which requires revision to acknowledge how Indigenous partnership will be needed to inform future practice.

My findings detailed informants' experiences of minimal decolonizing practice guidelines and meaningful cultural safety training upon hire. Informants' accounts of experience helped answer my research question of what extent mental healthcare workers integrate decolonizing practices in their approaches to mental healthcare for Indigenous Peoples. I have discussed how frontline professionals shared their experiences of being well intentioned, but struggled to incorporate decolonizing practices due to invisible work requirements, unclear role guidelines, and lack of resources in rural communities.

Lastly, my final question of what opportunities exist to integrate decolonizing practices into mental health services for rural communities in the Peace Region, BC, is discussed within the context of further Indigenous consultation and partnership. Reform for health institutions in the Peace Region is contingent upon many factors, however, drawing from decolonizing theory and critical theory the following section discusses how decolonizing practice should draw from existing research, and happen in consultation with Indigenous communities. I have situated this

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idea within the literature on Indigenous partnership, and argue that partnership should happen at all levels of health with policy makers and frontline professionals.

### **Hoops: Institutional Mandates and Promises**

In this study, I understand healthcare hoops to be conceptualized as policies and promises created by Northern Health, which frontline workers ought to fulfill when conducting their work practices. My findings in Chapter 4 suggested that texts such as Northern Health's Strategic Plan (Northern Health, 2023), and employee role descriptions (see Appendix I) are activated when mental health professionals are attempting to fulfill such policies and promises. In Chapter 4, I presented the *small hero* diagram and mapped the standpoint of the frontline mental health professional in Northern Health. When looking up from the small hero's standpoint, I considered the contexts and societal discourse which frontline mental health professionals are experiencing their work within. I will first describe the context and societal discourse that the *small hero* is ruled by through *ruling relations*, whilst also answering my research question of how institutional policies and practices contribute to barriers for Indigenous Peoples in rural communities.

### ***Contexts***

Mental health and healthcare professionals in Canada are burdened by many pressures, including competing demands, lack of control over work process, leadership demands, and conflicting role requirements (Bridgeman et al., 2018). Additionally, mental healthcare providers including my informants, described experiencing lack of control over available resources, and little authority to make decisions. Some other considerations included rural community service provision. Health services in rural communities often have poorer service provision when compared with urban communities, specifically due to inadequate staffing and lack of resources

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(Caxaj, 2016). Mental health professionals in rural communities are subjected to increased public scrutiny and external stigma due to perceived poorer services (Caxaj, 2016).

My findings suggest that mental health professionals in the Peace Region are subjected to similar expectations, specifically demands and pressures to offer a high quality of service. Informants described how their work practices were coordinated from higher levels, by describing pressures to keep services “moving”. Additionally, informants described how their work was coordinated by what resources were available in the community and current staffing levels in their workplace. Informants described service provision in rural communities, such as Dawson Creek and Fort St. John, as communities which experience pressures at exacerbated levels. Specifically, rural communities have higher levels of staffing deficits, increased perceived pressures, and limited community resources.

Informants described the expectation to fill gaps in care by assuming invisible duties outside their scope of practice when staffing levels are low or community resources are scarce. The impacts of these invisible duties are discussed below. While informants did not explicitly describe fear of public scrutiny, they did describe experiencing mental burden following the provision of care they deemed unsatisfactory. The findings of my research pointed me toward the question of how mental healthcare professionals may incorporate decolonizing practices into their practice if they are feeling overburdened and underequipped to do so?

### ***Decolonizing Practices & Guidelines***

This research study is informed by decolonizing theory and critical theory, and is centered on support of dismantling colonialism and colonization in mental healthcare. In particular, the TRC’s recommendations of decolonizing health practices and Call’s to Action related to health (Truth and Reconciliation Commission of Canada: Calls to Action, 2015).

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Researchers have described how decolonization and creating cultural safety refers to both the process and outcome, which involves adopting a critical lens to shift attention from the culture of the Other, to a culture of mental healthcare (Josewski, 2012; Smye et al., 2023). Shifting attention away from othering, and onto addressing power relations in mental health services, helps to acknowledge postcolonial practices, education, policy, and research (Josewski, 2012).

Informants have described how cultural safety practices are acknowledged in theory through workplace policy, but are not happening in practice to a satisfactory extent. Informants acknowledged being well-intentioned and wanting to actively contribute toward decolonizing practice in mental healthcare, but described decolonizing practice guidelines as ambiguous and confusing. Informants also shared that they felt unequipped by Northern Health to decolonize their work practices, specifically due to lack of time to further their education of cultural safety.

Eni et al. (2021) found in their study of decolonizing health from a First Nations perspective that decolonizing practice starts with decolonizing one's mindset, including understanding and respecting the thoughts, values, and perspectives of an Indigenous person. The researchers found in their study that this often started with decolonizing spaces and work patterns, including engagement in the community, and embracing health as a community endeavor (Eni et al., 2021). Informants suggested their inability to engage in meaningful community participation, such as learning from Indigenous Peoples about traditional ways of being and health at work, inability to do home visits and to leave the office, were barriers to making meaningful decolonizing practice changes.

The Truth and Reconciliation Commission of Canada (TRC) has acknowledged the importance of understanding the historical, social, cultural, and political landscape that shapes health institutions (Cohen-Fournier et al., 2021; Truth and Reconciliation Commission of

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Canada: Calls to Action, 2015). Similarly, researchers argue that decolonizing healthcare starts with decolonizing health systems and institutions (Barcham, 2022). Informants acknowledged in Chapter 4 feeling disempowered to make changes, rather, they felt pressured and compelled to maintain the status quo, and keep up with the demands of their everyday work. While frontline workers are being supported to understand history through the Respectful Relationships Course (see Appendix J), they described being unable to pursue additional education to understand, appreciate, and practice decolonizing their mindsets and ways of being.

### *The Promise of Indigenous Partnership*

Western perspectives are deeply engrained within healthcare institutions, which often starts with initial training and education programs. Incorporating historical implications into equitable health policy is challenging, and recognizing when practices mandated by policy contravene with Indigenous ways of knowing is often misunderstood (Cohen-Fournier et al., 2021). Northern Health acknowledges efforts to consult with Indigenous communities and the mission of partnership between healthcare staff, communities, organization, and Indigenous peoples in their Strategic Plan (Northern Health, 2023). Health authorities appear to operate within a top-down model of decision making, which takes frontline workers and Indigenous communities out of the decision-making process (Josewski, 2012). A top-down approach to healthcare is still true in many aspects, as Josewski (2023) noted in a more recent research study that higher decisions often reflected funding priorities rather than local frontline needs. Informants in Chapter 4 described how community engagement is not happening at the local level, rather they are disconnected from their local Indigenous community, Indigenous traditional health practices, and Indigenous ways of knowing.

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Researchers advocated for the creation of processes and practices centered on Indigenous ways of knowing, including creation of structures where Indigenous communities collaborate and participate with decision-making concerning healthcare (Barcham, 2022; Eni et al., 2021; Goetz et al., 2023). Josewski (2012) found in their study of cultural safety and policy reform, that participants felt an obligation for adherence to institutional health policies, especially when advocating to change them on behalf of Indigenous Peoples. Specifically, participants in the study felt their advocacy for change might be perceived negatively or have negative consequences. Findings in this study have found comparable results, that adherence to policy on efficiency and pressures to do everyday work, undermined efforts to advocate for Indigenous communities and their care. In a more recent study, Josewski (2023) found that health institutions placed more focus on efficiency and cost-effectiveness rather than on relationships grounded in mutual respect, responsibility, reciprocity, and local needs.

Informants described how the expectation for incorporating decolonizing practices into their everyday work practices is communicated when they are first hired. Specifically, informants acknowledged how cultural safety training felt like an afterthought, or a checkbox ticked after hire, despite texts describing the mission of Indigenous partnership through efforts of staff. Research suggested that cultural competency training is often not enough to adopt a decolonizing mindset, rather to truly have culturally appropriate mental health program and policy, Indigenous communities must be involved in research and consulted throughout policy making (Montesanti et al., 2022).

Researchers also acknowledged how allocation of funding for training should go towards hiring Indigenous mental health workers or Indigenous mental health navigators to provide training for communities who provide health support. (Montesanti et al., 2022). Informants

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advocated for changes to how cultural safety training is offered, and advocated for training with Indigenous communities rather than about them. Informants also described a desire to learn directly from Indigenous communities, and hearing directly about ways to decolonize their practices. Researchers support learning directly from Elders or Knowledge Holders through cultural mentorship and training (Montesanti et al., 2022).

This finding is consistent with the literature on decolonizing public health systems. Barcham (2022) argued that colonial structures and processes, and the actions of colonial powers, including healthcare institutions, bring about the continuing process of colonialism. Examples of continuing colonialism includes the smaller, more nuanced policies surrounding how mental health services are delivered. Barcham acknowledged how hospitals restrict visitation to individuals and smaller groups. Goetz et al. (2023) also support mental healthcare programs which target informal supports such as friends, family, Elders, and healers where possible. In this section I have considered my research question of what opportunities exist to incorporate decolonizing practices into care in the Peace Region. The lack of meaningful dialogue between Indigenous nations and communities with mental health professionals on the frontline appears to perpetuate confusion in healthcare settings.

My findings support the development of collaboration and engagement between frontline mental health professionals and Indigenous community, starting with restructuring how training is offered and communicated to mental health professionals. Informants described a desire for collaboration, but expressed confusion on where to start. Without clear direction and meaningful ongoing dialogue with Indigenous Peoples, mental health professionals are jumping through hoops to decolonize practice. My research question centered on what opportunities existed to integrate decolonizing practices into mental health services for rural communities in the Peace

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Region, BC. I understand that minimal room exists to incorporate decolonizing practices if ongoing dialogue between Indigenous partners, communities and Peoples is not happening. By offering cultural safety training online, without community engagement and collaboration with Indigenous Peoples, it communicates to mental health professionals that colonization efforts will continue through higher coordinating processes outside their control.

### **Hurdles: Barriers to Providing Care & Ruling Relations**

I have conceptualized hurdles in my study as the barriers which informants have identified to providing quality care, how they are working to hypothetically jump over them, and how they are organized at the translocal level. In this section I discuss my research questions of what extent mental healthcare workers integrate decolonizing practices in their approaches to mental healthcare for Indigenous Peoples, and what opportunities exist to integrate decolonizing practices into mental health services for rural communities in the Peace Region, BC.

Informants described role confusion and ambiguity as hurdles to incorporating decolonizing practices into their care. I have understood role ambiguity to result in invisible work practices, which informants described as duties fulfilled in the absence of community resources and staffing. Researchers have previously suggested there is a link between role ambiguity, invisible work, extra-role behaviours, and burnout syndrome (Acker, 2003; Bridgeman et al., 2018; Petitta & Vecchione, 2011; Taranu et al., 2022). I will discuss below how my findings connect with the literature on these topics.

### ***Role Confusion & Ambiguity***

Role ambiguity may be defined as the confusion or lack of clarity with the employees' role, responsibilities, or the practices to achieve their role expectations (Tycholiz, 2021). In Chapter 4, informants described confusion where their roles started and ended, and when, where,

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or how they are expected to fill gaps when their workplace is understaffed. Informants suggested that they performed behaviours which went above and beyond their role requirements when experiencing role ambiguity. These findings posed the question of how role ambiguity effects mental health professionals' ability to adopt decolonizing and culturally safe work practices. The broader body of literature on role ambiguity and role confusion relating to mental healthcare service provision in Canada is minimal, but a larger body of international literature suggested that the connection between role ambiguity, burnout, workplace stress, and invisible labour is a well-researched topic. I have included below the smaller body of literature which pertains to Canadian healthcare.

Researchers found that role ambiguity and confusion contribute to interprofessional tension and conflict, which interferes with practice and care quality (MacLeod et al., 2019). Some research shows that role ambiguity may lead to underutilization of current employees leading to employers hiring more staff (Tycholiz, 2021). Texts analyzed in Chapter 4 appeared to support ambiguous job descriptions especially between social workers and mental health and substance use clinicians (see Appendix I). This finding supported previous literature suggesting that role ambiguity may lead to power struggles among and between groups of healthcare professionals (Tycholiz, 2021). While this research project is not intended to suggest an exhaustive list of suggestions for addressing role confusion and ambiguity, there is a body of literature which calls upon health and educational institutions, and policy makers to work collaboratively to address these discrepancies (Taranu et al., 2022; Tycholiz, 2021).

My findings and analysis suggested that role tensions and ambiguity have created confusion for the informants included in this study, which may lead to effects of burnout on their ability to perform and work with decolonizing healthcare practices. The role which informants

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are supposed to take in practicing culturally safe care is vague and confusing. Decolonizing practices are encouraged, but specificity surrounding who does what and when is missing from leadership and practice guidelines. My findings also suggest that role ambiguity may lead to fear or paralysis to step beyond the boundaries of what is allowed and acceptable. Informants described wanting to make changes, but being unsure how to do so without fear of reprimand. Previous researchers suggested that supervisory support, and support from co-workers mediate effects of role ambiguity (Acker, 2003; Panari et al., 2019; Tycholiz, 2021). However, informants have described that invisible work practices including supporting their colleagues and extra-role behaviours are what follow from their experience of role ambiguity.

### *Invisible Work Practices*

The concept of invisible work and invisible labour has been researched and explored using the concepts of IE. IE has helped me to understand how public healthcare systems operate and coordinate the work of frontline professionals including invisible work practices. Through adopting an IE lens, I have come to view informants' invisible work practices as those which are coordinated and organized from higher levels of public health. Invisible labour and extra-role behaviours are often essential and unavoidable parts of service provision, which often go unnoticed and unappreciated (Hansen, 2025; Ming et al., 2022). Smith (2005) noted that ruling relations govern local practices in ways which allow for invisible labour to go unnoticed even by those doing the work. Research shows that "going above and beyond" is common for public service workers, in particular, frontline workers are known to use their personal resources to help their clients (Hansen, 2025, p. 982). Hansen (2025) discussed extra-role behaviours, as behaviours which are additional to ones role, and stemming from inadequate resources. The

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researchers determined that these tasks often go unnoticed by organizations, and contributes to the smooth and successful operations of day-to-day practices.

Ming et al. (2022) acknowledged that learning about invisible work is integral to understanding the true contributions of mental health professionals. In their study they looked at invisible work in two contexts (home care aides and community health workers), and determined that three main types of invisible work were performed: work done outside of their boundaries, work done to share knowledge to other patients or medical professionals, and the emotional burden placed on them by challenging patients. The findings of this study suggested that employers overlooked extra work, yet frontline workers often felt motivated to do more and justified their extra work.

Like Ming et al. (2022), I also found in Chapter 4 that informants often justified their extra-role behaviours and invisible work practices out of desire to be helpful. Informants described making efforts to fill gaps in care and fulfill the duties in their job descriptions, even if it meant doing more than they had to. Informants shared how they initially pursued a career in healthcare out of a desire to help others. Informants described the lack of staff leading to increased invisible labour tasks, such as assuming the roles and practices of other positions. Informants added how the mental stress of an overburdened healthcare system often took a toll on their mental state. While some informants described a desire to go above and beyond, others expressed exhaustion and feelings of discontent. My findings suggest that invisible work practices and role ambiguity may lead to experiences of defeat and mental strain. When experiencing exhaustion, defeat, and mental strain, this may inhibit mental health professionals to incorporate practices which are new and unknown to them.

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Smith (2005) acknowledged how practice is often invisibly shaped, and how individuals working at the local level have experiences which are coordinated elsewhere. For frontline workers, these experiences coordinated elsewhere often take the form of invisible labour which is shaped by ruling relations beyond the understanding of the frontline worker. Ming et al. (2022) highlighted the importance of acknowledging invisible work practices, as invisibility can lead to employers exploiting their workers and policy makers overlooking the importance of protecting their workers. My research study had similar themes noted in Chapter 4, as informants acknowledged their invisible work practices and doing things which were often “grey” areas, or tasks otherwise undefined in their workplace roles. I considered how these reported experiences may answer my research question of what extent decolonizing practice is being utilized. I argue that the continuation of invisible work practices is contributing to a culture of confusion, uncertainty, and defeat, specifically when it comes to imparting decolonizing practices.

### ***Rural Community Considerations***

Informants discussed how working in a rural community often felt isolating and frustrating due to lack of resources. I have understood working in a rural community to be another hurdle which mental health professionals are experiencing. When I consider other hoops and hurdles previously discussed, I acknowledge how rural community considerations exacerbate these barriers. Previous research has found that Northern mental health professionals are more vulnerable to working conditions which impact mental and emotional well-being (Bodor, 2009). Burnout is more present in Northern and rural community mental health professionals where workers are isolated (Bodor, 2009; MacLeod et al., 2022). Mental health professionals in rural communities reportedly struggle more with resource availability, and report personal and professional challenges with providing care (MacLeod et al., 2022). My findings have suggested

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that mental health professionals are encouraged to refer clients to community resources to ensure continuity of care, but according to informants the opposite is reported to be happening.

Disconnection to community, varying effects of burnout, and an apparent lack of resources effects professionals' ability to incorporate decolonizing practices in the Peace Region.

Informants have suggested that building stronger working relationships with professionals in the community, clients in their homes, and with the community in general would allow them to provide a higher quality of care. Research suggested similarly, that communities will have optimal health outcomes when working relationships are created with professionals, mental health clients, families, and the community (Goodwin et al., 2016). Goodwin et al. (2016) introduced the above consideration as interprofessional mental health collaborative practice, which is associated with increased job satisfaction and retention, improved patient care, enhanced professional development, and less professional isolation.

Despite some of the challenges with working in rural communities, informants have shared their experiences of resiliency and incorporating creativity into their practices. My finding is consistent with the literature, which has suggested mental health workers bring unique strengths to promote mental health and wellness in rural communities (Caxaj, 2016). Like my findings in Chapter 4, research shows mental health professionals in rural communities have higher degrees of personal engagement with their clients, and have strong multidisciplinary and collaborative approaches to their practice (Caxaj, 2016). Informants in this study suggested that they are focused on building strong relationships with clients, and exercising creativity to fill gaps in care. Strengthening relationships and heightening personal engagement may offer opportunities for future collaboration. To address my research question, opportunities for decolonizing practice

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may come from ongoing community collaboration with healthcare providers at all levels, and appropriate consultation with local Indigenous Peoples and Indigenous communities.

### **Implications of Jumping Through Hoops & Hurdles**

#### ***Occupational Burnout & Moral Distress***

Informants in Chapter 4 alluded to the phenomenon of moral distress preceding experiences of burnout. Freedman (2012) described how during interviewing we may sometimes hear implications of preferred, more valued experiences which contrast the less preferred and problematic experiences. Freedman coined these implications as material for understanding the absent but implicit, which provide descriptions of the problem, and an understanding that it does not exist in isolation. My understanding of the absent but implicit is that my informants are expressing frustration, which is made possible by work experiences in an environment conducive to ongoing moral distress (Freedman, 2012). I have interpreted my interview data to suggest informants are experiencing moral distress, which precedes burnout due to unacknowledged invisible work experiences, role confusion, and tension with navigating rural community considerations. Specifically, I am acknowledging that burnout is a consideration for frontline mental health professionals amidst jumping through hoops and hurdles to do their jobs.

Moral distress is described as any situation where a person must go against their moral beliefs due to constraints, conflicts or factors outside their control (Chai et al., 2026; Perez et al., 2025; Salari et al., 2022). Moral practice is a vital part of providing mental healthcare services, and encompasses moral decision making. Experiences of moral distress are connected to situations of staffing shortages, lack of resources, insufficient funding, lack of training, unclear or inconsistent policies or direction, and ineffective communication (Perez et al., 2025).

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Informants in Chapter 4 implied experiences of moral distress when discussing engagement in practices which went against their moral preferences, or performing invisible duties which added to their mental and emotional workload. Informants also acknowledged how their decision making came from higher decision-making levels which were out of their direct control. The experience of moral distress appears connected with occupational burnout. Salari et al. (2022) conducted a meta-analysis on moral distress which found direct correlations between moral distress and burnout. Chai et al. (2026) also found that moral distress was positively correlated with occupational burnout, and reducing moral distress directly mitigated experiences of burnout.

Occupational burnout is a common concern for health professionals, which may be defined as long-standing job stress which impacts one's mental and emotional health (Bridgeman et al., 2018; Petitta & Vecchione, 2011; Salari et al., 2022). Burnout amongst healthcare professionals may look like exhaustion, cynicism, reduced efficiency, and depletion of emotional resources (Petitta & Vecchione, 2011; Taranu et al., 2022). Researchers have determined the cause of burnout to be from individual and organizational factors, which contribute to absenteeism at work and extra-role behaviours (Petitta & Vecchione, 2011). Burnout amongst health providers is also correlated with poorer patient safety outcomes and increased medical errors (Bridgeman et al., 2018; Panari et al., 2019). Burnout may initially start as anxiety and irritability during shifts, but quickly progresses to indifference towards work and patient needs (Chai et al., 2026). Mental health professions are at risk of burnout when constantly balancing demands of their roles, and is especially common amongst professionals who are dedicated and committed to their jobs (Bridgeman et al., 2018). Through understanding the experiences of my

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informants, I question how their invisible labour tasks and extra-role behaviours might contribute to moral distress and burnout?

Understanding how burnout poses a connection between role descriptions, invisible work practices, extra-role behaviours, and role ambiguity suggests burnout may be organized at higher translocal levels. Some researchers have suggested that professional commitment and passion for one's role is a mediator for job burnout (Chai et al., 2026; Panari et al., 2019). This suggestion aligns with my findings, as informants discussed their passion, commitment, and desire to go above and beyond for their clients despite experiencing exhaustion, confusion and frustration. Chai et al. (2026) also found in their study that nurses' sense of professional mission created psychological resilience, which was a mediating effect against burnout. The researchers concluded that healthcare managers and institutions should prioritize addressing moral distress, and creating systems which enhance social support to reduce burnout (Chai et al., 2026). Panari et al (2019) also suggested clarification of professional roles through institutional and policy reform as a mediator to burnout effects.

My findings in connection with previous research suggested that burnout is prevalent amongst health professionals, and may show up in numerous ways. While the term burnout and moral distress was absent from interviews, it was heavily implied through informants' descriptions of exhaustion, confusion and frustration within their professional roles and the feeling of mental stress they take home with them after work has ended. In this section I have discussed the implications of jumping through hoops and hurdles, and answered my research question of what extent decolonizing practices are being utilized. I have interpreted my findings to suggest there is minimal availability for mental health professionals within Northern Health to incorporate decolonizing practices whilst experiencing ongoing moral distress and burnout.

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## Chapter Summary

Chapter 5 included a discussion which expanded the analysis and findings introduced in Chapter 4. Specifically, Chapter 5 included a larger discussion of the context which mental health professionals work within, and the higher levels which mental health professionals work is coordinated by from an IE perspective. I have answered my research questions in this chapter, starting with what extent do mental healthcare workers integrate decolonizing practices in their approaches to mental healthcare for Indigenous Peoples? I discussed that concrete decolonizing practice guidelines are unclear and confusing to mental health professionals. Lack of clarity regarding practice guidelines may be contributing to role ambiguity, which I conceptualized as a working hurdle for mental health professionals.

Informants described a lack of meaningful cultural safety training, without direct consultation and collaboration with Indigenous communities, which creates confusion for how to practice clear decolonizing practices and create cultural safety. My findings align with previous research and suggestions that Indigenous partnership and collaboration should be prioritized. Invisible work practices, role confusion, and role ambiguity have been identified as barriers to integrate decolonizing practices into mental health services for rural communities in the Peace Region. Rural community considerations have also been considered in the context of informants' descriptions of being overworked and underequipped to practice and deeply understand decolonizing practice guidelines.

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## Chapter 6. Conclusion

The focus of my thesis research was to explore how mental healthcare professionals experience their everyday work on the frontlines, and the relation to barriers to mental healthcare services for Indigenous Peoples in the Peace Region, British Columbia (BC), Canada. I specifically wanted to understand how institutional policies and practices contribute to barriers for Indigenous Peoples residing in rural communities in the Peace Region, BC, what extent mental healthcare workers integrate decolonizing practices in their approaches to mental healthcare for Indigenous Peoples, and what opportunities may exist to integrate decolonizing practices into mental health services for rural communities in the Peace Region, BC.

I began to understand how colonization and colonialism play a vital role in understanding how health systems operate following my review of previous literature. In my literature review I framed public mental health institutions as continuing colonizing practices despite TRC Calls to decolonize practice, and TRC Calls for collaborative work with Indigenous communities and Peoples. Recent researchers have advocated for future researchers, health providers, policy makers, and healthcare providers to decolonize practices in consultation with Indigenous Peoples, Elders, Knowledge Keepers, and communities.

My findings suggest that public health institutions still have work to do minimizing barriers to care, in particular, specifying the roles which frontline workers have in decolonizing their practices. Additionally, public health institutions may consider creating spaces that are more culturally inclusive, sensitive, and safe, and provide staff with the resources, clear direction, and time to make this happen. In this concluding chapter I reflected on my process and role in my research, the limitations of my study, summarize findings, and provided

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recommendations to the health authority which I researched, and other institutions who may be facing similar organizational pressures or challenges.

### **Personal Reflections**

In Chapter 1 I discussed how my previous experiences informed this project and led to my initial research questions. Through my previous work in social services, I was able to see first-hand how frontline public service professionals' work is often coordinated by unseen forces. I recalled feeling constrained and unsure of how to make changes while I experienced the tensions of higher forces coordinating my work. Beginning this research allowed for a significant shift in my understanding of how much frontline everyday work is coordinated elsewhere. Something I did not expect, was how much you can learn from someone by positioning yourself purely as a learner, and from their unique standpoint. Approaching the interviews with my eyes and ears completely open allowed for my analysis informed by IE to unfold. Undertaking a research-based thesis as a novice researcher with no experience has been an arduous task. Additionally, learning the language, intentions, and meanings of IE as a research methodology has also been challenging. In hindsight, I did not expect the vast amount of information I would be learning from the informants in this study.

I was pleasantly surprised to hear how passionate, motivated, driven, and client-centered informants were, despite experiencing emotional exhaustion and confusion about their roles. Informants expressed the desire to do the best they could with the circumstances they were provided. My hope is that amidst any changes to policy, practice, or role guidelines that professionals will continue to do what they can with what they have. Additionally, I acknowledge the difficulty with decolonizing practice if you do not know how to do it. My initial impression was that we are not doing enough to decolonize mental health practices. I now

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understand that most professionals are well-intentioned and wanting to do more, but posed with significant barriers and tensions from work coordinated outside their control.

### **Limitations of the Study**

This study is an initial inquiry into exploring the experiences of frontline mental health professionals and how their work may provide context for barriers to mental healthcare for Indigenous Peoples. This study has several limitations of importance to address. I was able to gain thick, in-depth descriptions of firsthand experiences and opinions of Northern Health mental health professionals through interviewing five individuals. Rankin (2017a) acknowledged how workers in similar work environments are often subject to the same ideological practices, thus experiencing similar tensions and contradictions in their work. While my study may not be generalizable to a larger population of mental health professionals due to sample size and sample location, my study is not attempting to obtain generalizability. Rather, making the *ruling relations* visible and otherwise invisible actions of workers was the primary goal of my study. Smith (2005) has coined this analytic goal as “generalizing relations” which grounds experiences as recognizable across similar contexts.

There is also a possibility of researcher bias, including the insertion of my individual ideologies into the data. However, through consistent use of reflexivity, acknowledging positionality, and challenging my biases I was able to acknowledge shortcomings or areas of bias. Another limitation was gaining access to informants, as it can be challenging accessing public institutions due to privacy and confidentiality. I have addressed this limitation by accessing the population through the appropriate channels, including ethics approval from Northern Health and REB ethics approval through Athabasca University.

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### **Recommendations for Future Research**

My research project was borne out of passion for social justice and a desire for offering culturally competent, safe, and accessible mental healthcare services. Institutional ethnography work offers knowledge which is meant for those who are wanting a more equitable society (Campbell & Gregor, 2008). My study has highlighted the frontline experiences of disjuncture between theory and practice concerning achieving equity in public health for Indigenous Peoples. Further diving into this disjuncture may offer opportunities for research, including exploration of change to specific policy and practice from the perspective of a Northern Health employee.

My understanding of Northern Health is that they are a well-intentioned organization which holds a duty to dismantle previous systems enacted by colonization. Such a task is bold, but through appropriate channels is possible. Northern Health is making active efforts towards hiring Indigenous staff or employees who are focused on ensuring Indigenous patients have culturally safe experiences. Interviewing an informant who holds the role of an Indigenous Care Coordinator may have added an interesting perspective to the study, and further informed how barriers are being bridged for Indigenous patients. Recommendations for future research may include the exploring how this role mediates cultural safety deficits, serves to minimize barriers for Indigenous patients, incorporate decolonizing practices, and how they support other frontline mental health professionals with adopting decolonizing practices.

My study also highlighted a few gaps in research concerning exacerbated effects of burnout, invisible labour, and extra-role behaviours for mental health professionals in Northern communities. Much of the literature concerning these topics were from different countries around the world, which have dramatically different histories and systems of healthcare.

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Analysis of these specific topics would help to better understand the experiences of mental health professionals and their ability to adopt decolonizing practices. A more in-depth IE research project would also help to understand how burnout, invisible labour, and extra-role behaviours are coordinated or activated using texts.

### **Summary of Findings and Recommendations**

Smith (2005) has identified that institutional ethnography (IE) offers an opportunity to identify extra-local occurrences which are creating negative experiences on the frontline, thus creating opportunities for valuable and positive changes. My findings indicated that mental health professionals on the frontline are doing honest, demanding work to address barriers to mental healthcare for Indigenous Peoples. My findings also indicated that barriers (hoops and hurdles) existed for mental health professionals to incorporate decolonizing practices into their daily work such as role ambiguity, invisible labour tasks, lack of clear decolonizing practice guidelines and institutional support. I also understood informants' experiences as exacerbated when considering rural community implications.

My research and findings are important because I have acknowledged how barriers persist, and what is needed to address the TRC's Calls to Action for mental healthcare reform, including true ongoing collaboration with Indigenous Peoples and communities (Truth and Reconciliation Commission of Canada: Calls to Action, 2015). Additionally, my findings also acknowledged the importance of mental health professionals and the services they provide specifically to rural communities. While my research is not an exhaustive study, it has allowed me to understand the complexity of health authorities and how decolonizing practice, collaborating, and dismantling colonial systems is challenging but necessary work.

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Through consultation with the Nawican Friendship Centre in Dawson Creek, and Elders local to the Peace Region, I recommend that health authorities, including the health authority researched in this project, consider increased attention to fostering environments allowing curiosity and exploration of diverse cultures and cultural practices. Prioritizing action over promises and commitments was also recommended by an Elder. The following suggestions are outlined as recommendations for changes or considerations for health authorities or organizations facing similar challenges:

1. Dedicate allocated, paid time for frontline professionals to advance ongoing cultural competency learning and training opportunities. Informants expressed a desire for meaningful training opportunities which collaborate with local Indigenous communities.
2. Collaborate and engage in meaningful community outreach and collaboration with Indigenous Peoples and communities at all levels of care extending from frontline professionals to management and policy makers.
3. Create training guidelines which collaborate with local Indigenous Peoples, communities, or partners. Invite guests including local Elders and Knowledge Keepers where possible to help with training, and allow for training through cultural experiential learning.
4. Consider the role of traditional medicines including the use of traditional medicines and healthcare, training in traditional medicines, and offering optional traditional healing opportunities in mental health care.
5. Consider hiring Indigenous Elders to assist with hiring into position which directly support Indigenous Peoples, and for ongoing cultural oversight, practice consulting and training.

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6. Consider the creation of a community outreach collaborator or community Indigenous Care Coordinator. Informants acknowledged the value and importance of the Indigenous Care Coordinator in the hospital setting. However, employees located in the community outside of the hospital setting did not appear sure of their access to consult with the Indigenous Care Coordinator.
7. Consider the accessibility of any positions which directly support Indigenous Peoples. Support needs to be completely accessible and approachable. Community engagement with local Elders and Indigenous Peoples in the Peace Region have suggested health authorities **must** hire an Indigenous person into these roles.
8. Give mental health professionals the opportunity to do outreach within limits, and in adherence with safety standards. Informants desired the ability to perform outreach practices, such as meeting clients where they are at, or going out into the community to perform duties. Informants acknowledged that their roles may require revision, but having more freedom would allow them to better meet the expectations and needs of Northern Health and the community.
9. Emphasize the importance of ongoing community collaboration meetings with local community resources to ensure continuing, proactive communication. This will allow for ongoing dialogue and reciprocity between Indigenous Peoples and health authorities.
10. Establish clear practice guidelines for how to decolonize practices, and foster an environment conducive to acknowledging truth and reconciliation.
11. Rewrite role descriptions to clarify practices, account for extra-role demands, and eliminate confusion or ambiguity regarding decolonizing practices.

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## **Concluding Remarks**

My research study provided a valuable opportunity to hear about individual experiences in public mental healthcare in the Peace Region in Northern BC. The Peace Region appeared to be under researched and underrepresented in qualitative research projects. It has been a pleasure and honour to hear the voices, stories, and experiences from Northern Health mental health professionals. Sharing moments of vulnerability, and making sense of the incredibly difficult jobs you hold has been eye-opening. The way informants spoke about their experiences showed how compassionate, dedicated, and hard-working they are. The work you are all doing is difficult, sacred, and important work. Without the work of you all, we would not have as accessible, approachable, and compassionate mental healthcare services.

Additionally, improving mental healthcare services to any extent is an important endeavor in a culture where mental health is rapidly changing and evolving. Improving mental healthcare is aligned with Northern Health's commitments to offering equitable, safe, and accessible services. Public, accessible healthcare remains an important service and a central part of Canadian infrastructure. Expanding mental health services to be culturally appropriate, especially for populations of Indigenous Peoples are integral to equitable care. My research allowed for an understanding of how barriers, and healthcare hoops and hurdles are experienced on the frontlines. Although it may take some time to see a shift in practice, clear direction and collaboration with Indigenous Peoples may help to guide this necessary shift.

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Appendix A: Tri-Council Policy Statement Certificate

PANEL ON  
RESEARCH ETHICS

*Navigating the ethics of human research*

TCPS 2: CORE 2022

## *Certificate of Completion*

*This document certifies that*

**Mikayla Mah**

*successfully completed the Course on Research Ethics based on  
the Tri-Council Policy Statement: Ethical Conduct for Research  
Involving Humans (TCPS 2: CORE 2022)*

Certificate # 0000953165

16 November, 2023

HOOPS AND HURDLES: EXPLORING BARRIERS TO MENTAL HEALTHCARE FOR  
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**Appendix B: Invitation to Participate Letter**

**INVITATION TO PARTICIPATE  
HEALTHCARE HOOPS AND HURDLES: EXPLORING BARRIERS TO MENTAL  
HEALTHCARE FOR INDIGENOUS PEOPLES IN THE PEACE REGION, BRITISH  
COLUMBIA**

date

**Principal Investigator (Researcher):**

Mikayla Mah, Athabasca University Master of Counselling Student  
Phone: 250-219-7002, Email: [mmah3@learn.athabascau.ca](mailto:mmah3@learn.athabascau.ca)

**Supervisors:**

Dr. Emily Doyle

Phone: 1-855-359-2090, Email: [edoyle@athabascau.ca](mailto:edoyle@athabascau.ca)

Dr. Kristin Petrovic

Phone: 1-844-845-7150, Email: [kpetrovic@athabascau.ca](mailto:kpetrovic@athabascau.ca)

My name is Mikayla Mah, and I am a Master of Counselling student at Athabasca University. I have chosen to complete a thesis research process as a requirement for my degree, and will be researching barriers to mental healthcare for rurally residing Indigenous Peoples in the Peace Region, British Columbia. I am particularly curious as to how mental health professionals are practicing their work with Indigenous clients and their experiences as working mental health professionals employed with Northern Health. I am conducting this research under the supervision of Dr. Emily Doyle and Dr. Kristin Petrovic with Athabasca University.

You are being invited to participate in a research study as you may be a mental health professional currently offering services to Indigenous Peoples. This form will detail the informed consent process. If you choose not to participate, this will not negatively impact you in any way. The following form will inform you of what to expect from the research project, what will be asked of you, and any potential risks or benefits associated with the project. Please read this information carefully and ask any questions you may have. Please be advised that consent is an ongoing process, and your participation is entirely voluntary.

Research findings have shown that Indigenous peoples in Canada experience significant barriers to seeking and maintaining mental health care. Barriers to care have been found to be linked with Canada's complex history of colonization, and the social determinants of health experienced by Indigenous peoples. Rurally residing individuals experience additional barriers due to their unique geographical positioning. Indigenous peoples residing in rural areas experience significant barriers to care when compared with non-Indigenous peoples. Research has shown that offering culturally safe mental healthcare may eliminate or lessen barriers to care. The current research study would look to explore some of the institutional barriers to mental healthcare. The goal of the research study is to determine what practices or policies within mental health institutions are contributing to culturally safe care, and whether there may be a

## HOOPS AND HURDLES: EXPLORING BARRIERS TO MENTAL HEALTHCARE FOR INDIGENOUS PEOPLES IN THE PEACE REGION

need for institutional reform for mental health professionals working in public health. The study will also highlight the invisible work that professionals engage in, to better understand work around the possible barriers to ensure appropriate care is provided.

To be involved in this study you must be currently employed in a mental health professional role within Northern Health. I am looking to recruit approximately 5-7 participants in total for this project. If you decide to take part in the research study you will be asked to participate in one (1) semi-structured virtual interview on Microsoft Teams. The interview will take approximately 60-90 minutes, consisting of various questions that are designed to prompt open dialogue and conversation. You may choose to skip any questions you feel uncomfortable answering, or take any breaks from the interview. The interview will also be audio and video recorded for research purposes, and later transcribed by me for clarity and consistency. If you choose not to be video recorded, I can make alternate arrangements including audio only recording and note-taking. However, at minimum audio recording will be necessary to ensure accuracy of your answers in the interview and for the final transcription. I will also be taking digital notes throughout the interview. You will be contacted for follow-up regarding the transcriptions of the interview, and will have the opportunity to provide feedback clarifying your answers or confirming accuracy of your statements.

During the session you will be asked questions about your typical practices at work, including assessment and intake procedures, practices surrounding cultural safety, working with Indigenous peoples, and your institution's policies about working with Indigenous peoples. Two weeks following the interview, and once the interview has been transcribed, de-identified, and the transcripts are verified by you, it will not be possible to withdraw at this stage, however withdrawal from the study is possible up until this point.

All information you provide during the study will be de-identified in the final report and kept private. Please see the information consent form for more information on how your data is de-identified.

All hard copies of documents including your informed consent form, will be scanned to create a digital copy, which will then be kept in my Athabasca University Microsoft server in an encrypted file folder. The hard copy of your consent form will then be shredded for confidentiality and to minimize security risks. Hard copies of the interview notes and transcripts will be stored securely in a similar manner. Digital copies will all be saved to the Athabasca University Microsoft server – all of which are password protected, encrypted and secure. All transcriptions will be de-identified, and the use of pseudonyms will be applied to protect your identity. Participants will not be identified by name in any reports of the completed study, and there will be no personal identifiers such as personal descriptions or demographic information included in the study. Your workplace role will also be generalized in the final study, and all participants will be simply labeled as a “mental health professional.” The only individuals who have access to the data will be the principal investigator and the supervisors of this project.

Direct quotations will only be used in the study with your explicit permission, and all quotations will be generalized to further de-identify your information. Your permission to obtain direct quotations will be confirmed during the consent process and confirmed with your signature on

## HOOPS AND HURDLES: EXPLORING BARRIERS TO MENTAL HEALTHCARE FOR INDIGENOUS PEOPLES IN THE PEACE REGION

the consent form. As per Athabasca University's policy, the digital data that is collected will be stored for 5 years in my AU secure account before it is digitally deleted and permanently destroyed. The data will be destroyed through the manual deletion and removal from my AU Microsoft account, by deleting the files with your information then permanently deleting them from my account's recycle bin.

There is no guarantee that you will benefit directly from participating in this study. However, the proposed research study provides you with the opportunity to voice your opinion on your experiences, workplace, practices, and institutional policies, which may hopefully raise awareness of how mental healthcare can be improved and barriers can be decreased for Indigenous peoples in rural communities. There are minimal risks anticipated from this study; however some risk of mental and emotional distress always exists when discussing your personal experiences. Discussing your experiences in healthcare settings, challenges with the institution you work for, and challenges with policies in your workplace may provoke issues or feelings you may require support to deal with. I will be providing each participant with a document that contains resources you may wish to access following the interview. If you require a counsellor to speak to about your experiences, I can refer you to a counsellor or other resources to assist you. I will also be monitoring any signs of distress throughout the interview by periodically checking in to ensure that you are okay to continue the interview.

If at any time you need to end your participation in the study, you may do so free of consequence.

Once the final report is completed you may receive a final copy of the study, or a findings summary should you wish. Please indicate to me on your consent form should you wish to receive a final copy or findings summary of the study.

If you have any questions or would like more information, please contact me, Mikayla Mah, by e-mail [mmah3@learn.athabascau.ca](mailto:mmah3@learn.athabascau.ca) or phone at 250-219-7002 or my supervisors Dr. Emily Doyle at Toll Free: 1-855-359-2090, or e-mail at [edoyle@athabascau.ca](mailto:edoyle@athabascau.ca), Dr. Kristin Petrovic at Toll Free: 1-844-845-7150, Email: [kpetrovic@athabascau.ca](mailto:kpetrovic@athabascau.ca).

Thank you for your time and consideration,  
Mikayla Mah  
Principal Investigator

**This project has been reviewed by the Athabasca University Research Ethics Board #25930. Should you have any comments or concerns about your treatment as a participant, the research, or ethical review processes, please contact the Research Ethics Officer by e-mail at [rebsec@athabascau.ca](mailto:rebsec@athabascau.ca) or by telephone at 780.213.2033. If you have additional questions or concerns about this research project, please contact [research@northernhealth.ca](mailto:research@northernhealth.ca) regarding Northern Health REB File#2025-020**

HOOPS AND HURDLES: EXPLORING BARRIERS TO MENTAL HEALTHCARE FOR  
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**Appendix C: Information Consent Form**

**INFORMED CONSENT FORM**

**HEALTHCARE HOOPS AND HURDLES: EXPLORING BARRIERS TO MENTAL  
HEALTHCARE FOR INDIGENOUS PEOPLES IN THE PEACE REGION, BRITISH  
COLUMBIA**

date

**Researcher:**

Mikayla Mah, Athabasca University Master of Counselling Student  
Phone: 250-219-7002, Email: [mmah3@learn.athabascau.ca](mailto:mmah3@learn.athabascau.ca)

**Supervisors:**

Dr. Emily Doyle  
Toll Free: 1-855-359-2090, Email: [edoyle@athabascau.ca](mailto:edoyle@athabascau.ca)  
Dr. Kristin Petrovic  
Phone: 1-844-845-7150, Email: [kpetrovic@athabascau.ca](mailto:kpetrovic@athabascau.ca)

You are invited to take part in a research project entitled: ***HEALTHCARE HOOPS AND HURDLES: EXPLORING BARRIERS TO MENTAL HEALTHCARE FOR INDIGENOUS PEOPLES IN THE PEACE REGION, BRITISH COLUMBIA.***

This form is part of the process of informed consent. The information presented should give you the basic idea of what this research is about and what your participation will involve, should you choose to participate. It also describes your right to withdraw from the project. To decide whether you wish to participate in this research project, you should understand enough about its risks, benefits and what it requires of you to be able to make an informed decision. This is the informed consent process. Take time to read this carefully as it is important that you understand the information given to you. Please contact the principal investigator, Mikayla Mah, if you have any questions about the project or would like more information before you consent to participate.

It is entirely up to you whether you take part in this research. If you choose not to take part, or if you decide to withdraw from the research there will be no negative consequences for you now, or in the future.

**Please see the “Invitation to Participate” letter for more information on the purpose of this research project.**

**Do you have to take part in this project?**

As stated in the associated consent and project information letter, involvement in this project is entirely voluntary. Should you decide before, or during the interview that you no longer wish to be a part of this project you may withdraw your participation at any time without consequence. The researcher may be contacted via email or telephone to do so. If you choose to withdraw

## HOOPS AND HURDLES: EXPLORING BARRIERS TO MENTAL HEALTHCARE FOR INDIGENOUS PEOPLES IN THE PEACE REGION

participation after the interview has been completed, you will have the possibility to withdraw up to two weeks following the interview before it is transcribed, anonymized, and data analysis has begun. If you decide to withdraw before this period, your information will be securely destroyed. Paper information such as the consent forms will be shredded securely, and any electronic information will be deleted permanently and not used at any point in data analysis.

### **Privacy, Anonymity, Confidentiality and Data Collection/Storage**

The ethical duty of confidentiality includes safeguarding participants' identities, personal information, and data from unauthorized access, use, or disclosure.

All information you provide during the study will be de-identified in the final report. De-identified information involves the removing and altering of direct identifiers from the data, making it less likely that you will be identified. With de-identified data there is some risk that re-identification is possible if someone were to access additional information.

De-identification is distinctly different from anonymization where data is altered to such a degree it is impossible to identify the individual. Due to the small sample size of this study it is not possible to achieve true anonymization. However, all efforts will be made to secure your information through the use of pseudonyms, and all identifiers will be replaced with codes and kept confidential through the use of this agreement.

Participants will not be identified by name in any reports of the completed study, and there will be no personal identifiers such as personal descriptions or demographic information, or workplace role titles included in the study. All hard copies of documents including your informed consent form, will be scanned to create a digital copy, which will then be kept in my Athabasca University Microsoft server in an encrypted file folder. The hard copy of your consent form will then be shredded for confidentiality and minimization of security risks. All transcriptions will be de-identified, and the use of pseudonyms will be applied to protect your identity. Participants will not be identified by name in any reports of the completed study, and there will be no personal identifiers such as personal descriptions or demographic information included in the study. Your workplace role will also be generalized in the final study, and all participants will be simply labeled as a "mental health professional." The only individuals who have access to the data will be the principal investigator and the supervisors of this project.

Direct quotations will only be used in the study with your explicit permission, and you may be contacted following the interview to request permission for the use of your direct quotations. All of your information will be de-identified in the final report, however due to the demographic there is moderate risk of re-identification by someone familiar with the situation. Precautions will be taken to de-identify information to minimize this risk.

There are several instances where confidentiality may be breached as required by law: if the researchers believes that child abuse or harm to a child is ongoing, or is suspected of being ongoing, if there is a case of imminent risk to physical harm of oneself or another, or cases of sexual abuse, sexual assault, or sexual harassment by a health professional.

## HOOPS AND HURDLES: EXPLORING BARRIERS TO MENTAL HEALTHCARE FOR INDIGENOUS PEOPLES IN THE PEACE REGION

This study will use Microsoft Teams (MS Teams) to collect audio and video recordings of the interview, which is an externally hosted cloud-based service. When information is transmitted over the internet privacy cannot be guaranteed. There is always a risk your responses may be intercepted by a third party (e.g., government agencies, hackers). Further, while the researcher(s) will not collect or use IP address or other information which could link your participation to your computer or electronic devices without informing you, there is a small risk with any platform such as this of data that is collected on external servers falling outside the control of the research team. This risk will be minimized by hosting the virtual interview on a secure Wi-Fi network, in a private environment. I also suggest not sharing the secure link to the meeting with anyone. If you are concerned about this, we would be happy to make alternative arrangements (where possible) for you to participate, for an in-person interview. Please contact Mikayla at 250-219-7002 if you wish to do so.

### **Who will receive the results of the research project?**

- The existence of the research will be listed in an abstract posted online at the Athabasca University Library's Digital Thesis and Project Room and the final research paper will be publicly available.
- As this project is concerning the health and welfare of Indigenous Peoples, local Elders or Indigenous community members who have an invested interest in this project will be consulted during multiple stages of this project. Your information will be de-identified, and precautions will be taken to ensure your information is de-identified in the final report.
- The research project may also be disseminated or published in an academic research journal.
- Once the final report is completed you may receive a final copy of the study, or a findings summary should you wish. Please indicate in the checkbox below should you wish to receive a final copy or findings summary of the study.

**This project has been reviewed by the Athabasca University Research Ethics Board REB Ref File #25930. Should you have any comments or concerns about your treatment as a participant, the research, or ethical review processes, please contact the Research Ethics Officer by e-mail at [rebsec@athabascau.ca](mailto:rebsec@athabascau.ca) or by telephone at 780.213.2033. If you have additional questions or concerns about this research project, please contact [research@northernhealth.ca](mailto:research@northernhealth.ca) regarding Northern Health REB File#2025-020**

### **Informed Consent**

#### **Your signature on this form means that:**

- You have read what this research project is about and understood the risks and benefits.
- You have had time to think about participating in the project and had the opportunity to ask questions and have those questions answered to your satisfaction.
- You understand what the research project is about and what you will be asked to do.

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- You understand that documents utilized as part of your role may be requested as part of this research project, but that the only documents provided will be those that are documents in the public domain.
- You understand that you are free to withdraw your participation in the research project without having to give a reason, and that doing so will not affect you now, or in the future.
- You understand that if you choose to end your participation **during** data collection, any digital data collected from you up to that point will be deleted and destroyed as per the process in the invitation to participate letter.
- You understand that if you choose to withdraw **after** data collection (the interview) has ended, your data can be removed from the project up until the meeting is transcribed, anonymized and data collection has begun.
- You understand that participating in the project is entirely voluntary and that you may end your participation at any time without any penalty or negative consequences before the interview, but will only have two weeks following the interview to withdraw your consent before the interview is transcribed and entered into data analysis.
- You have been given a copy of this Informed Consent form for your records; and
- You agree to participate in this research project.

	YES	NO
I agree to be audio-recorded	<input type="checkbox"/>	<input type="checkbox"/>
I agree to be video-recorded	<input type="checkbox"/>	<input type="checkbox"/>
I am willing to be contacted following the interview to verify that my comments are accurately reflected in the transcript.	<input type="checkbox"/>	<input type="checkbox"/>
I would like to receive a final copy of the report, or a summary of the findings.	<input type="checkbox"/>	<input type="checkbox"/>

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Date

Principal Investigator's Signature:

I have explained this project to the best of my ability. I invited questions and responded to any that were asked. I believe that the participant fully understands what is involved in participating in the research project, any potential risks and that they have freely chosen to participate.

\_\_\_\_\_  
Signature of Principal Investigator

\_\_\_\_\_  
Date

Please retain a copy of this consent information for your records.

# HOOPS AND HURDLES: EXPLORING BARRIERS TO MENTAL HEALTHCARE FOR INDIGENOUS PEOPLES IN THE PEACE REGION

## Appendix D: Semi-Structured Interview Guide

The following interview questions are a guide for helping me to semi-structure the interview, however, follow-up questions will be guided by the individual answers provided by the interviewee.

### Questions about role:

1. Please describe your role within your organization.
2. What are the expectations of your role, as described in either your job description, or directly from your supervisor?
3. Is there anything important I need to know about your role that you'd like to add?

### Questions about client work:

4. Please tell me about your experience providing care to clients?
5. Please tell me about your experience providing care to Indigenous clients?
6. If you were to change anything about your practices what would they be? What barriers might exist to making those changes?
7. How would you change the interview/intake process? The forms you fill out? The way you document sessions?
8. How does your workplace educate and/or train employees?
9. What does standard workplace training look like for the position you currently occupy?
10. What is the intention behind receiving this training?
11. How is the required training intended to support your job and the work you do?
12. Is there something you don't have in your job, that if you did have it, it would help you with working with Indigenous peoples?
13. What is your understanding best practices to work with Indigenous peoples?
14. What do you need to know about culturally safe care?
15. Is there anything about the work you do with clients that you'd like to add?

### Questions about Institution/Organization:

16. What, if anything might you change about your institution?
17. What if anything might you change about the way you do your work?
18. How might workers voice their concerns about the institution?
19. Is there anything about your organization you'd like to add?

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Appendix E: Recruitment Poster



# PARTICIPANTS NEEDED

## What is It?

- A research study titled HEALTH CARE HOOPS & HURDLES: EXPLORING BARRIERS TO MENTAL HEALTH CARE FOR INDIGENOUS PEOPLES IN THE PEACE REGION, BC
- A study examining institutional barriers to mental health care, including the experiences of invisible work practices, and work policies.

## What is Required of Me?

- If eligible, you will participate in a 60-90 minute virtual interview on MS Teams discussing your experiences as a Mental Health Professional, Mental Health Nurse, or Mental Health Counsellor.
- Participants will all receive a \$20 Amazon gift card.

## WHO IS ELIGIBLE?

- Currently employed with Northern Health in Dawson Creek, Chetwynd, or Fort St. John in a role of Mental Health Professional, Mental Health Nurse, or Mental Health Counsellor.
- Has experience working with Indigenous Peoples.

## CONTACT

**Mikayla Mah, Master of  
Counselling Student,  
Principal Investigator,  
Athabasca University**

250-219-7002

[mmah3@learn.athabascau.ca](mailto:mmah3@learn.athabascau.ca)

**Emily Doyle, Supervisor**

[edoyle@athabascau.ca](mailto:edoyle@athabascau.ca)

**Kristin Petrovic, Supervisor**

[kpetrovic@athabascau.ca](mailto:kpetrovic@athabascau.ca)

AU REB File #25930  
NH REB File #2025-020

Your participation is voluntary, and all  
information you share will be de-identified  
for your privacy.

This study has been reviewed by the Athabasca University Research Ethics Board File #25930. Should you have any comments or concerns about your treatment as a participant, the research, or ethical review processes, contact the Research Ethics Officer at 1.780.213.2033 or by e-mail to [rebsec@athabascau.ca](mailto:rebsec@athabascau.ca). If you have additional questions or concerns about the research you may also contact [research@northernhealth.ca](mailto:research@northernhealth.ca)

# HOOPS AND HURDLES: EXPLORING BARRIERS TO MENTAL HEALTHCARE FOR INDIGENOUS PEOPLES IN THE PEACE REGION

## Appendix F: Athabasca University Certification of Ethical Approval



### CERTIFICATION OF ETHICAL APPROVAL

The Athabasca University Research Ethics Board (REB) has reviewed and approved the research project noted below. The REB is constituted and operates in accordance with the current version of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2) and Athabasca University Policy and Procedures.

**Ethics File No.:** 25930

**Principal Investigator:**

Ms. Mikayla Mah, Graduate Student  
Faculty of Health Disciplines\Master of Counselling

**Supervisor/Project Team:**

Dr. Emily Doyle (Supervisor)  
Mrs. Kristin Petrovic (Co-Supervisor)

**Project Title:**

HEALTHCARE HOOPS AND HURDLES: EXPLORING BARRIERS TO MENTAL HEALTHCARE FOR INDIGENOUS PEOPLES IN THE PEACE REGION, BRITISH COLUMBIA

**Effective Date:** March 25, 2025

**Expiry Date:** March 24, 2026

**Restrictions:**

Any modification/amendment to the approved research must be submitted to the AUREB for approval prior to proceeding. Any adverse event or incidental findings must be reported to the AUREB as soon as possible, for review.

Ethical approval is valid **for a period of one year**. A request for renewal must be submitted and approved by the above expiry date if a project is ongoing beyond one year.

An Ethics Final Report must be submitted when the research is complete (*i.e. all participant contact and data collection is concluded, no follow-up with participants is anticipated and findings have been made available/provided to participants (if applicable)*) or the research is terminated.

**Approved by:**

**Date: March 25, 2025**

Venise Bryan, Chair  
Faculty of Health Disciplines, Departmental Ethics Review Committee

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Athabasca University Research Ethics Board  
1 University Drive, Athabasca AB Canada T9S 3A3  
E-mail: rebsec@athabascau.ca Telephone: 780.213.2033

HOOPS AND HURDLES: EXPLORING BARRIERS TO MENTAL HEALTHCARE FOR  
INDIGENOUS PEOPLES IN THE PEACE REGION

**Appendix G: Northern Health Certificate of Ethical Approval**



Northern Health Regional Office  
600-299 Victoria Street, Prince George, BC V2L 5B8  
Telephone: (250) 565-2649, Fax: (250) 565-2640  
[www.northernhealth.ca](http://www.northernhealth.ca)

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**Certificate of Ethical Approval for Research Studies**

Jun 20, 2025

NH REB #: REB 2025-020

*Via email to: [mmah3@learn.athabascau.ca](mailto:mmah3@learn.athabascau.ca)*

Dear Mikayla:

**Re: Healthcare Hoops and Hurdles: Exploring Barriers to Mental Healthcare for Indigenous Peoples in the Peace Region, British Columbia**

**Approval Date:** Jun 20, 2025

**Expiry Date:** Jun 19, 2026

On behalf of the Northern Health (NHA) Research Ethics Board (REB), I would like to thank you for submitting your application for ethics review.

The study has received ethics approval through NH REB. This approval letter applies to research ethics issues only and does not include provision for any administrative and/or operational approvals required from NHA before research activities can commence.

NH REB has reviewed and approved this study in accordance with the requirements of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2).

Please note, as per NH Research Review and Approvals Policy (2-2-2-010) investigators must notify NH REB of any changes in status of the project (e.g. amendments to the protocol, changes in ethics requirements, completion or termination of the study). Those changes may require additional approval.

We look forward to hearing about your findings. Please share your results with us at [Research@northernhealth.ca](mailto:Research@northernhealth.ca) at the completion of your project.

**NORTHERN HEALTH**

*Esther Alonso-Prieto*

Dr. Esther Alonso-Prieto,  
Chair, NH Research Ethics Board  
Regional Lead, Ethics Service

EAP/dt

HOOPS AND HURDLES: EXPLORING BARRIERS TO MENTAL HEALTHCARE FOR  
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**Appendix H: Northern Health Institutional Authorization Letter**



Northern Health Regional Office  
600-299 Victoria Street, Prince George, BC V2L 5B8  
Telephone: (250) 565-2649, Fax: (250) 565-2640  
[www.northernhealth.ca](http://www.northernhealth.ca)

---

**Institutional Authorization Letter for Research Studies**

July 11, 2025

NH REB #: 2025-020

*Via email to: [mmah3@learn.athabascau.ca](mailto:mmah3@learn.athabascau.ca)*

Dear Mikayla Mah,

**Re: Healthcare Hoops and Hurdles: Exploring Barriers to Mental Healthcare for Indigenous Peoples in the Peace Region, British Columbia**

On behalf of the Northern Health (NH) Research Innovation & Evaluation Office, I would like to thank you for submitting your application for research approval.

This Institutional Authorization Letter indicates that your proposal has been operationally reviewed, approved, and that the study can commence.

However, as per NH Research Review and Approvals Policy (2-2-2-010) investigators must notify NH Research Innovation & Evaluation Office and NH Research Ethics Board of any changes in status of the project (e.g. amendments to the protocol, changes in operational requirements, completion, or termination of the study). Those changes may require additional approval.

We look forward to hearing about your findings. Please share your results with us at [Research@northernhealth.ca](mailto:Research@northernhealth.ca) at the completion of your project.

**NORTHERN HEALTH**

Julia Bickford  
Executive Director, Research Innovation & Evaluation  
Northern Health Authority

# HOOPS AND HURDLES: EXPLORING BARRIERS TO MENTAL HEALTHCARE FOR INDIGENOUS PEOPLES IN THE PEACE REGION

## **Appendix I: Northern Health Job Postings**

### **ROLE #1: SOCIAL WORKER (in hospital)**

#### **Position Summary**

Are you a registered Social Worker looking to highlight your knowledge, skills, and abilities in a new and dynamic environment? We currently have an opportunity for you to bring your excellent work ethic to our Social Work department.

In accordance with established vision and values of the organization, the Social Worker provides comprehensive assessment, care planning and treatment coordination for designated clients and their families. Working collaboratively with other healthcare providers and the multidisciplinary team, the Social Worker provides direct psychosocial care, counselling and group work, system navigation and advocacy, education and linkage to relevant specialized complex care resources while facilitating client self-management. The Social Worker is responsible for providing and developing social work services to maintain or improve the health and social well-being and functioning of the identified population.

**Shift Rotation/Hours of work:** Monday to Friday, 08:00 to 16:00

#### **Ksyen Regional Hospital**

The new Ksyen Regional Hospital welcomed its first patients on November 24, 2024. More than double the size of the previous hospital, the facility features 82 beds, private rooms, and is a centre for trauma services, orthopedic surgeries, pathology, radiology, clinical support, and pharmacy services. The hospital is also a training site for medical students in the Northern Medical Program.

**Terrace** The thriving community of Terrace is northern living at its best. Snow-capped mountains, pristine glacier-fed rivers, lakes and streams all add to the beauty of this community.

## HOOPS AND HURDLES: EXPLORING BARRIERS TO MENTAL HEALTHCARE FOR INDIGENOUS PEOPLES IN THE PEACE REGION

The main industries in Terrace are communications, transportation and natural resources. The population is approximately 12,700. There are nine elementary schools, four secondary schools, and Northwest Community College and a UNBC campus. Check out [Terrace](#) where there is always something new to experience.

### **What Northern Health has to offer you!**

- Comprehensive benefit packages including, extended health/dental and a municipal pension plan for part-time and full-time employees. Casuals have the option of paying for benefits.
- Four weeks vacation with one year of continuous service
- Financial Support for Moving Expenses is available for eligible positions
- Employee referral program
- Employer-paid training and leadership development opportunities
- Spectacular outdoor activities and the shortest commutes in BC
- “Loan Forgiveness Programs” are offered through the Federal and BC Government for eligible professions.

### **IMPORTANT NOTE:**

As part of your application process, you will need to upload the following documentation:

- Registration number (if you are part of a regulated profession)
- Any supporting documents regarding education/qualifications for this position.

### **Examples may include:**

- Program certificates or diplomas
- High school/college/university transcripts etc.
- It is also recommended to provide a cover letter and resume

## HOOPS AND HURDLES: EXPLORING BARRIERS TO MENTAL HEALTHCARE FOR INDIGENOUS PEOPLES IN THE PEACE REGION

**Are you an International Applicant?** Before applying for a job with Northern Health, please follow these steps on our [Northern Health careers page](#)

### **Qualifications**

- Bachelor's Degree in Social Work from an accredited university.
- Two years recent related experience in a healthcare setting working with medically complex clients with concurrent disorders, or a combination of education, training and experience.
- Current registration with the British Columbia College of Social Workers.

### **Skills and Abilities:**

- **Assessment and Treatment:** Demonstrated ability to complete initial and ongoing client assessments (clinical and diagnostic reasoning) through appropriate/prescribed technical, therapeutic, safety type interventions.
- **Teaching:** Ability to teach clients and others both one-on-one and in groups.
- **Knowledge Integration:** Integrates best practice and current research evidence to support professional practice decisions and actions.
- **Communication:** Demonstrated ability to communicate effectively with clients, families, the public, medical staff and members of the interdisciplinary team using verbal, written, computer communication means. Ability to effectively apply conflict resolution skills.
- **Critical Thinking:** Demonstrated ability to integrate and evaluate pertinent data (from multiple sources) to problem-solve and make decisions effectively. Applies the problem-solving process demonstrating critical thinking and decision making skills using a systems approach.
- **Human Caring and Relationship Centered Practice:** Ability to promote client-focused care that demonstrates care for and with clients and significant others, sensitivity to diverse cultures and preferences, client advocacy and social justice concerns.

## HOOPS AND HURDLES: EXPLORING BARRIERS TO MENTAL HEALTHCARE FOR INDIGENOUS PEOPLES IN THE PEACE REGION

- **Management:** Demonstrated ability to organize work, set objectives and establish priorities. Manages time and resources, implements activities to promote cooperation among the interdisciplinary team and collaborates across disciplines.
- **Leadership:** Promotes staff morale, engagement and empowerment. Demonstrates creative planning for change and innovation, implementation of NH policies or other protocols, and ongoing professional development of self and others.
- **Teamwork:** Demonstrated ability to foster teamwork and a commitment to excellence in the provision of client care.
- **Equipment:** Demonstrated computer skills including the use of Meditech and Windows based programs. Demonstrated data analysis skills including appropriate data analysis and reporting tools. Demonstrated ability in the use of e-mail and word processing. Ability to operate other related equipment as required in the specific practice area.
- **Physical ability** to perform the duties of the position.

### **Who we are**

Northern Health covers an area of nearly 600,000 square kilometers and offers health services in over two dozen communities and 55 First Nation's communities. We deliver hospital and community-based healthcare for a population of 300,000.

Employing more than 7,000 staff throughout the region, Northern Health provides exceptional health services for Northerners, through the efforts of dedicated staff and physicians, in partnership with communities and organizations in Northern BC.

There is a wide variety of career opportunities available in our two dozen hospitals, 25 long-term care facilities, public health units and many other offices providing specialized services.

### **ROLE #2:**

## HOOPS AND HURDLES: EXPLORING BARRIERS TO MENTAL HEALTHCARE FOR INDIGENOUS PEOPLES IN THE PEACE REGION

### **REGISTERED NURSE (RN), EMERGENCY**

#### **Position Summary**

Do you have a passion for nursing? We have the position for you! We are seeking a motivated Registered Nurse with a dedication for delivering compassionate patient care to join our team at the Fort St. John Hospital.

Reporting to the Unit Manager Emergency/ Ambulatory Care, the staff nurse is responsible for assessing, planning, implementing and evaluating patient care and nursing practice activities of patients presenting in the Emergency Department. Also provides nursing care, assistance and relief to all nursing areas including ICU; Maternity; Med/Surg and Ambulatory Care within the frame work of quality management and in accordance with the Fort St. John Hospital & Health Centre mission statement. The role is defined by the needs of the Hospital, a select patient/family population, agency expectations and the goals for professional nursing practice.

**Shift Rotation/Hours of work:** Days, Nights, 07:00 to 19:00, 19:00 to 07:00 (rotating)

**Fort St. John Hospital and Health Centre** has 44 Acute Care beds and 124 residential beds and is equipped to handle 22,000 ER visits per year. Some more highlights about the hospital:

- Endoscopy suite, 2 state-of-the-art operating rooms, plus a procedure room
- Ambulatory clinics including Cancer and Hemodialysis
- Medical and Surgical inpatient rooms (40 beds)
- 3 Intensive care units
- Minor surgeries
- 7 single Maternity rooms for Labour, Delivery, and Post-Partum Fort St. John also has the Health Unit and Primary Care Clinic which serve the community.

**Fort St. John** is known as “The Energetic City,” which reflects the large resource base of oil,

## HOOPS AND HURDLES: EXPLORING BARRIERS TO MENTAL HEALTHCARE FOR INDIGENOUS PEOPLES IN THE PEACE REGION

natural gas, forestry and agriculture. Overlooking the Peace River, the town of Fort St John is located above the Peace River Valley and serves as the capital of the Peace River district. The population of Fort St. John is over 21,400 but it services an area of approximately 70,000. The community is the hub of the Northeast with a cultural centre and library, theatre, and art space. There are seven elementary schools, two middle schools, and one secondary school. There is also a Northern Lights College campus. Check out [Fort St. John](#) for more information on what this energetic community has to offer.

### **What Northern Health has to offer you!**

- Comprehensive benefit packages including extended health/dental and a municipal pension plan for part-time and full-time employees. Casuals have the option of paying for benefits.
- Four weeks vacation with one year of continuous service
- Financial Support for Moving Expenses is available for eligible positions
- Employee referral program
- Employer-paid training and leadership development opportunities
- Spectacular outdoor activities and the shortest commutes in BC
- “Loan Forgiveness Programs” are offered through the Federal and BC Government for eligible professions.

### **IMPORTANT NOTE:**

As part of your application process, you will need to upload the following documentation:

- Registration number (if you are part of a regulated profession)
- Any supporting documents regarding education/qualifications for this position.

### **Examples may include:**

- Program certificates or diplomas

## HOOPS AND HURDLES: EXPLORING BARRIERS TO MENTAL HEALTHCARE FOR INDIGENOUS PEOPLES IN THE PEACE REGION

- High school/college/university transcripts etc.
- It is also recommended to provide a cover letter and resume

**Are you an International Applicant? Before** applying for a job with Northern Health, please follow these steps on our [Northern Health careers page](#)

### **Qualifications**

- Registration with BC College of Nurses and Midwives as a practicing RN registrant.
- Acquires and maintains skill certification in the following: A.C.L.S., CPR, Neonatal Resuscitation, IV therapy, Blood Glucose Monitoring, Ventilator and basic Cardiac Monitoring.
- Three (3) years' full-time recent acute care experience involving intensive care, obstetrics and emergency or an equivalent combination of training and experience.

### **Skills and Abilities:**

- Ability to communicate effectively both verbally and in writing.
- Ability to deal with others effectively.
- Physical ability to carry out the duties of the position/
- Ability to operate related equipment.
- Ability to plan and organize.
- Ability to teach.
- Ability to initiate and work independently.
- Ability to apply critical problem solving.
- Ability to react/respond under pressure.
- Demonstrated knowledge of special procedures and techniques such as I.V. infusions of medications.

### **Who we are**

## HOOPS AND HURDLES: EXPLORING BARRIERS TO MENTAL HEALTHCARE FOR INDIGENOUS PEOPLES IN THE PEACE REGION

Northern Health covers an area of nearly 600,000 square kilometers and offers health services in over two dozen communities and 55 First Nation's communities. We deliver hospital and community-based health care for a population of 300,000.

Employing more than 7,000 staff throughout the region, Northern Health provides exceptional health services for Northerners, through the efforts of dedicated staff and physicians, in partnership with communities and organizations in Northern BC.

There is a wide variety of career opportunities available in our two dozen hospitals, 25 long-term care facilities, public health units and many other offices providing specialized services.

### **Role #3: REGISTERED NURSE (RN), MED SURG**

#### **Position Summary**

Do you have a passion for nursing? We have the position for you! We are seeking a motivated Registered Nurse with a dedication for delivering compassionate patient care to join our team at the Dawson Creek & District Hospital.

Reporting to the Site Manager, guided by the Vision and Values of the Northern health Authority, BCCNM Standards of Nursing Practice and Code of Ethics, identifies, plans, implements, and evaluates nursing care required to assist patients in meeting their physical, social, and psychological needs. The Registered Nurse will use Northeast Health Services Area approved Policies, Procedures, and Protocols.

Dawson Creek & District Hospital Dawson Creek and District Hospital is a full service community hospital that provides service to Dawson Creek and surrounding communities. It has 31 Acute Care beds and 15 regional adult psychiatric beds. Dawson Creek is the Orthopaedic Trauma and Surgical centre for the Northeast Region of BC. Services include:

## HOOPS AND HURDLES: EXPLORING BARRIERS TO MENTAL HEALTHCARE FOR INDIGENOUS PEOPLES IN THE PEACE REGION

- Emergency
- ICU
- Day Surgery
- Respiratory Therapy
- Primary Care
- Acute Care
- Diagnostic Imaging
- Laboratory

Visiting specialists including:

- Urology
- Dermatology
- Pediatrics
- Obstetrics and Gynecology

\*\*Construction is underway on the new Dawson Creek & District Hospital, anticipated to open in Spring 2027. This state-of-the-art facility will be over 50% bigger than the current hospital and will feature 70 beds, modern patient care spaces, and expanded and enhanced services to meet the growing needs of the community. Designed with innovation and comfort in mind, the new hospital represents a transformative step forward in health care for the region. Join us now and be part of this exciting transition to the new facility! To learn more, visit [Let's Talk DCDH](#).

Dawson Creek Wide blue skies and the rolling foothills of the Northern Rockies surround Dawson Creek. The city is also known as the Mile Zero City, as it marks the start of the Alaska Highway, a 2,400 km long highway connecting Alaska and the Yukon to Western Canada and

## HOOPS AND HURDLES: EXPLORING BARRIERS TO MENTAL HEALTHCARE FOR INDIGENOUS PEOPLES IN THE PEACE REGION

the United States. Dawson Creek has a population of approximately 12,500. It provides primary service to a population of approximately 20,000 and helps serve the larger population of the Peace River Region of 60,000. There are eleven elementary schools, one middle school and one secondary school. The Northern Lights College provides adult education. Check out [Dawson Creek](#) for more information about this community where the northern lights shine.

What Northern Health has to offer you!

- Comprehensive benefit packages including extended health/dental and a municipal pension plan for part-time and full-time employees. Casuals have the option of paying for benefits.
- Four weeks vacation with one year of continuous service
- Financial Support for Moving Expenses is available for eligible positions
- Employee referral program
- Employer-paid training and leadership development opportunities
- Spectacular outdoor activities and the shortest commutes in BC
- “Loan Forgiveness Programs” are offered through the Federal and BC Government for eligible professions.

### IMPORTANT NOTE:

As part of your application process, you will need to upload the following documentation:

- Registration number (if you are part of a regulated profession)
- Any supporting documents regarding education/qualifications for this position.

Examples may include:

- Program certificates or diplomas
- High school/college/university transcripts etc.
- It is also recommended to provide a cover letter and resume

## HOOPS AND HURDLES: EXPLORING BARRIERS TO MENTAL HEALTHCARE FOR INDIGENOUS PEOPLES IN THE PEACE REGION

Are you an International Applicant? Before applying for a job with Northern Health, please follow these steps on our [Northern Health careers page](#)

### Qualifications

- Registration with BC College of Nurses and Midwives as a practicing RN registrant.
- Current Level C CPR certification required.
- Ambulatory Care / Endoscopy / Cancer Care: Two years recent medical/surgical experience. Successful completion of Chemotherapy training within one month of appointment. Two years recent ER experience including experience with chronic venapuncture patients.
- Emergency: Two years recent related experience working in emergency department and / or two years recent related medical/surgical experience. Initiates crisis codes as per hospital policy. Responds to Code Blue calls. Assumes First Aid Attendant role as per policy.
- Intensive Care Unit: Completion of a post-graduate Critical Care Course or two years recent experience in an equivalent setting.
- Labour and Delivery / Recovery / Post Partum: Two (2) years recent related experience with a significant labour and delivery component, working in an acute care setting and / or recent completion of an Advanced Obstetrical Certificate and / or recent Midwifery Certificate. Current Neonatal Resuscitation Certification.

### Skills and Abilities:

- Work as a member of an interdisciplinary team.
- Make and apply nursing judgment using analytical skills.
- Communicate effectively both verbally and in writing.
- Interact with others effectively.
- Maintain the physical ability to carry out the duties of the position.

## HOOPS AND HURDLES: EXPLORING BARRIERS TO MENTAL HEALTHCARE FOR INDIGENOUS PEOPLES IN THE PEACE REGION

- Maintain own physical, mental and emotional well being.
- Using Critical Thinking skills, prioritize and organize patient care.
- Operate related equipment.
- Teach and provide clinical supervision.

Who we are

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### **Role #4: MENTAL HEALTH & SUBSTANCE USE CLINICIAN, PRIMARY CARE**

#### **Position Summary**

Are you a Mental Health & Substance Use Clinician looking to highlight your knowledge, skills, and abilities in a new and dynamic environment? We currently have an opportunity for you to bring your excellent work ethic to our Primary Care department.

In accordance with Northern Health's vision of an idealized system of services where people and their families receive primary care services in Primary Care Homes supported by interprofessional teams, the Primary Care Mental Health and Substance Use (MHSU) Clinician functions as a member of the interprofessional team and applies best practices to provide

## HOOPS AND HURDLES: EXPLORING BARRIERS TO MENTAL HEALTHCARE FOR INDIGENOUS PEOPLES IN THE PEACE REGION

competent, safe and ethical care for people and their families in settings such as physician practices, homes, schools and communities. Through assessment and involvement of each person and their family, the Primary Care MHSU Clinician develops and implements a plan of care and intervention to assist the person in managing their mental health or addiction challenges. The Primary Care MHSU Clinician will provide care according to the person's care plan and the person's personal goals.

**May be redeployed to satellite community clinics within the same community Week 1:**

**Tuesday, Wednesday**

**Week 2: Tuesday, Wednesday, Thursday**

Primary Care Networks are partnerships between the Divisions of Family Practice representing BC's family physicians, the regional health authorities, the First Nations Health Authority (FNHA) and local community partners, along with other community providers such as nurse practitioners. All partners are working together in their local communities and collectively to redesign B.C.'s primary and community care system so that it works better for patients and health-care providers.

**Shift Rotation/Hours of work:** Days - 08:30 to 16:30, Rotating

### **Primary and Community Care**

Northern Health's approach to person and family-centered care involves creating health care teams, which include your doctor or nurse practitioner and other health care professionals, to provide a range of health care services. The quality of care increases by providing continuity of care over time and across settings and will result in better long-term health outcomes.

**Dawson Creek** Wide blue skies and the rolling foothills of the Northern Rockies surround Dawson Creek. The city is also known as the Mile Zero City, as it marks the start of the Alaska

## HOOPS AND HURDLES: EXPLORING BARRIERS TO MENTAL HEALTHCARE FOR INDIGENOUS PEOPLES IN THE PEACE REGION

Highway, a 2,400 km long highway connecting Alaska and the Yukon to Western Canada and the United States. Dawson Creek has a population of approximately 12,500. It provides primary service to a population of approximately 20,000 and helps serve the larger population of the Peace River Region of 60,000. There are eleven elementary schools, one middle school and one secondary school. The Northern Lights College provides adult education. Check out [Dawson Creek](#) for more information about this community where the northern lights shine.

### **What Northern Health has to offer you!**

- Comprehensive benefit packages including extended health/dental and a municipal pension plan for part-time and full-time employees. Casuals have the option of paying for benefits.
- Four weeks vacation with one year of continuous service
- Financial Support for Moving Expenses is available for eligible positions
- Employee referral program
- Employer-paid training and leadership development opportunities
- Spectacular outdoor activities and the shortest commutes in BC
- “Loan Forgiveness Programs” are offered through the Federal and BC Government for eligible professions.

### **IMPORTANT NOTE:**

As part of your application process, you will need to upload the following documentation:

- Registration number (if you are part of a regulated profession)
- Any supporting documents regarding education/qualifications for this position.

### **Examples may include:**

- Program certificates or diplomas

## HOOPS AND HURDLES: EXPLORING BARRIERS TO MENTAL HEALTHCARE FOR INDIGENOUS PEOPLES IN THE PEACE REGION

- High school/college/university transcripts etc.
- It is also recommended to provide a cover letter and resume

### **Qualifications**

- Bachelor's degree (from an accredited educational institution) in an Allied Health, Behavioral or Social Science field relevant to the position plus two (2) years recent, experience in a health setting working with complex care clients with a combination of mental health and/or addiction issues. Or equivalent related knowledge, skills, and experience.
- Current valid BC driver's license.

### **Skills and Abilities:**

- Assessment and Treatment: Demonstrated ability to complete initial and ongoing assessments and utilize appropriate therapeutic interventions.
- Teaching: Ability to teach persons both one-on-one and in groups.
- Knowledge Integration: Integrates best practice and current research evidence to support professional practice decisions and actions.
- Communication: Demonstrated ability to communicate effectively with persons, families, the public, physicians and members of the interprofessional team. Ability to effectively solve interpersonal differences and resolve conflict.
- Critical Thinking: Problem solve demonstrating critical thinking and decision making skills. .
- Human Caring and Relationship Centered Practice: Ability to promote person centered care, sensitivity to diverse cultures and preferences, client advocacy and social justice concerns.
- Management: Demonstrated ability to organize work, set objectives and priorities and achieve results.
- Leadership: promotes cooperation among the interprofessional team and collaborates across

## HOOPS AND HURDLES: EXPLORING BARRIERS TO MENTAL HEALTHCARE FOR INDIGENOUS PEOPLES IN THE PEACE REGION

disciplines. Demonstrates creative planning for change and innovation and participates in professional development of self and others.

- Teamwork: Demonstrated ability to foster teamwork and a commitment to excellence in the provision of person-centered care.

- Equipment: Demonstrated computer skills including the use of Windows based programs.

Ability to operate other related equipment as required in the specific practice area.

- Ability: Physical ability to perform the duties of the position.

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### **Role #5:**

#### **SOCIAL WORKER, PRIMARY CARE**

##### **Position Summary**

Are you a registered Social Worker looking to highlight your knowledge, skills, and abilities in a new and dynamic environment? We currently have an opportunity for you to bring your excellent work ethic to our Primary Care department.

## HOOPS AND HURDLES: EXPLORING BARRIERS TO MENTAL HEALTHCARE FOR INDIGENOUS PEOPLES IN THE PEACE REGION

In accordance with Northern Health's vision of an idealized system of services built on a foundation of Primary Care where people and their families receive primary care services in Primary Care Homes supported by interprofessional teams; the Primary Care Social Worker functions as a member of the interprofessional team and applies best practice to provide comprehensive assessment, care planning and intervention for people and their families.

Working collaboratively with other health care providers and the interprofessional team, the Social Worker provides direct psychosocial care, counselling and group work, system navigation and advocacy, education and linkage to relevant specialized or community resources while facilitating client self-management. The Social Worker is responsible for providing social work services to maintain or improve the health and functioning of persons, families and communities.

**May be redeployed to satellite community clinics within the same community.**

Primary Care Networks are partnerships between the Divisions of Family Practice representing BC's family physicians, the regional health authorities, the First Nations Health Authority (FNHA) and local community partners, along with other community providers such as nurse practitioners. All partners are working together in their local communities and collectively to redesign B.C.'s primary and community care system so that it works better for patients and health-care providers.

**Shift Rotation/Hours of work:** Days - 08:30 to 16:30, Rotating

### **Primary and Community Care**

Northern Health's approach to person and family-centered care involves creating health care teams, which include your doctor or nurse practitioner and other health care professionals, to provide a range of health care services. The quality of care increases by providing continuity of care over time and across settings and will result in better long-term health outcomes.

## HOOPS AND HURDLES: EXPLORING BARRIERS TO MENTAL HEALTHCARE FOR INDIGENOUS PEOPLES IN THE PEACE REGION

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### **What Northern Health has to offer you!**

- Comprehensive benefit packages including extended health/dental and a municipal pension plan for part-time and full-time employees. Casuals have the option of paying for benefits.
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- Employee referral program
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- Spectacular outdoor activities and the shortest commutes in BC
- “Loan Forgiveness Programs” are offered through the Federal and BC Government for eligible professions.

### **IMPORTANT NOTE:**

As part of your application process, you will need to upload the following documentation:

- Registration number (if you are part of a regulated profession)
- Any supporting documents regarding education/qualifications for this position.

## HOOPS AND HURDLES: EXPLORING BARRIERS TO MENTAL HEALTHCARE FOR INDIGENOUS PEOPLES IN THE PEACE REGION

### **Examples may include:**

- Program certificates or diplomas
- High school/college/university transcripts etc.
- It is also recommended to provide a cover letter and resume

**Are you an International Applicant? Before** applying for a job with Northern Health, please follow these steps on our [Northern Health careers page](#)

### **Qualifications**

- Bachelor's Degree in Social Work from an accredited university.
- Two years recent related experience in a healthcare, or a combination of related education, training and experience.
- Current registration with the British Columbia College of Social Workers.
- Current valid BC driver's license

### **Skills and Abilities:**

- **Assessment and Treatment:** Demonstrated ability to complete initial and ongoing assessments and utilize appropriate social work interventions.
- **Teaching:** Ability to teach and coach both one-on-one and in groups.
- **Knowledge Integration:** Integrates best practice and current research evidence to support professional practice decisions and actions.
- **Communication:** Demonstrated ability to communicate effectively with people and their families as well as the public, physicians and members of the interdisciplinary team. Ability to effectively resolve interpersonal differences and resolve conflict.
- **Critical Thinking:** Problem solves demonstrating critical thinking and decision making skills.
- **Human Caring and Relationship Centered Practice:** Ability to promote person centered care

## HOOPS AND HURDLES: EXPLORING BARRIERS TO MENTAL HEALTHCARE FOR INDIGENOUS PEOPLES IN THE PEACE REGION

which includes maintaining sensitivity to diverse cultures and preferences, social justice concerns and the need for advocacy.

- **Management:** Demonstrated ability to organize work, set objectives and priorities and achieve results.
- **Leadership:** Demonstrates creative planning for change and innovation, and participates in professional development of self and others.
- **Teamwork:** Demonstrated ability to foster teamwork and a commitment to excellence in the provision of person centered care. Promotes cooperation among the interprofessional team and collaborates across disciplines
- **Equipment:** Demonstrated computer skills including the use of Windows based programs. Ability to operate other related equipment as required in the specific practice area.
- **Ability:** Physical ability to perform the duties of the position.

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### **Skills and Abilities:**

- **Assessment and Treatment:** Demonstrated ability to complete initial and ongoing assessments

## HOOPS AND HURDLES: EXPLORING BARRIERS TO MENTAL HEALTHCARE FOR INDIGENOUS PEOPLES IN THE PEACE REGION

and utilize appropriate social work interventions.

- Teaching: Ability to teach and coach both one-on-one and in groups.
- Knowledge Integration: Integrates best practice and current research evidence to support professional practice decisions and actions.
- Communication: Demonstrated ability to communicate effectively with people and their families as well as the public, physicians and members of the interdisciplinary team. Ability to effectively resolve interpersonal differences and resolve conflict.
- Critical Thinking: Problem solves demonstrating critical thinking and decision making skills.
- Human Caring and Relationship Centered Practice: Ability to promote person centered care which includes maintaining sensitivity to diverse cultures and preferences, social justice concerns and the need for advocacy.
- Management: Demonstrated ability to organize work, set objectives and priorities and achieve results.
- Leadership: Demonstrates creative planning for change and innovation, and participates in professional development of self and others.
- Teamwork: Demonstrated ability to foster teamwork and a commitment to excellence in the provision of person centered care. Promotes cooperation among the interprofessional team and collaborates across disciplines
- Equipment: Demonstrated computer skills including the use of Windows based programs. Ability to operate other related equipment as required in the specific practice area.
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## HOOPS AND HURDLES: EXPLORING BARRIERS TO MENTAL HEALTHCARE FOR INDIGENOUS PEOPLES IN THE PEACE REGION

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**Appendix J: Learning Hub Respectful Relationships Course**

11/14/25, 2:08 PM

Respectful Relationships: Culturally Safe Indigenous Health Care - LearningHub

LearningHub

# Respectful Relationships: Culturally Safe Indigenous Health Care



eLearning Course



20 hours



General

Reminder: LearningHub is only to be used by those working and studying in British Columbia.

Learning Objectives:

- Examine cultural safety in the context of respectful relationships
- Gain understanding of the role of past events in contemporary realities for indigenous peoples
- Acquire and enhance critical self-reflection in practice
- Develop, enhance, and deepen your understanding through the practical application of the skills and knowledge gained in this learning series to case studies and scenarios

This course contains four learning modules. Each module is between four and six lessons. The modules are intended to be completed sequentially with knowledge and skills in one lesson building upon knowledge and skills from the previous lesson.

Modules

- Introducing Cultural Safety
- Setting the Context: History and Contemporary Realities
- Critically Reflecting on Self and Systems
- Getting to Change: Addressing Cultural Safety and Anti-Indigenous Racism

<b>Target Audience</b>	Anyone in BC with an interest in cultural safety .
<b>Course Length</b>	20 hours
<b>Course Code</b>	28658
<b>Open To</b>	All BC Health Authorities BC Volunteers

HOOPS AND HURDLES: EXPLORING BARRIERS TO MENTAL HEALTHCARE FOR  
INDIGENOUS PEOPLES IN THE PEACE REGION

**Appendix K: Athabasca University Indigenous Health and Wellness Certificate**



# Certificate of Completion

Mikayla Watson

has completed all courses required to  
earn a certificate of completion in

**Indigenous Health and Wellness, Advocacy, and Allyship**

A handwritten signature in black ink, appearing to read "Ian Stephenson".

Ian Stephenson  
Director of PowerED  
Athabasca University

Date Friday, August 22, 2025

# HOOPS AND HURDLES: EXPLORING BARRIERS TO MENTAL HEALTHCARE FOR INDIGENOUS PEOPLES IN THE PEACE REGION

## Appendix L: Certificate of Ethical Approval Renewal



Certification of Ethical Approval

### CERTIFICATION OF ETHICAL APPROVAL - RENEWAL

The Athabasca University Research Ethics Board (REB) has reviewed and approved the research project noted below. The REB is constituted and operates in accordance with the current version of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2) and Athabasca University Policy and Procedures.

**Ethics PURE ID:** 15365261

**Principal Investigator/Faculty:** Mikayla Mah, Faculty of Health Disciplines

**Supervisor(s):** Emily Doyle & Kristin Petrovic, Faculty of Health Disciplines

**Project Title:** Healthcare Hoops and Hurdles: Exploring Barriers to Mental Healthcare for Indigenous Peoples in the Peace Region, British Columbia

**Effective Date:** 2/23/2026

**Expiry Date:** 2/23/2027

#### Restrictions:

Any modification/amendment to the approved research must be submitted to the AUREB for approval prior to proceeding. Any adverse event or incidental findings must be reported to the AUREB as soon as possible, for review.

Ethical approval is valid **for a period of one year**. A request for renewal must be submitted and approved by the above expiry date if a project is ongoing beyond one year.

An Ethics Final Report must be submitted when the research is complete (*i.e. all participant contact and data collection is concluded, no follow-up with participants is anticipated and findings have been made available/provided to participants (if applicable)*) or the research is terminated.

**Approved by:**

**Date:** 2/23/2026

Katie MacDonald, Chair  
Athabasca University Research Ethics Board