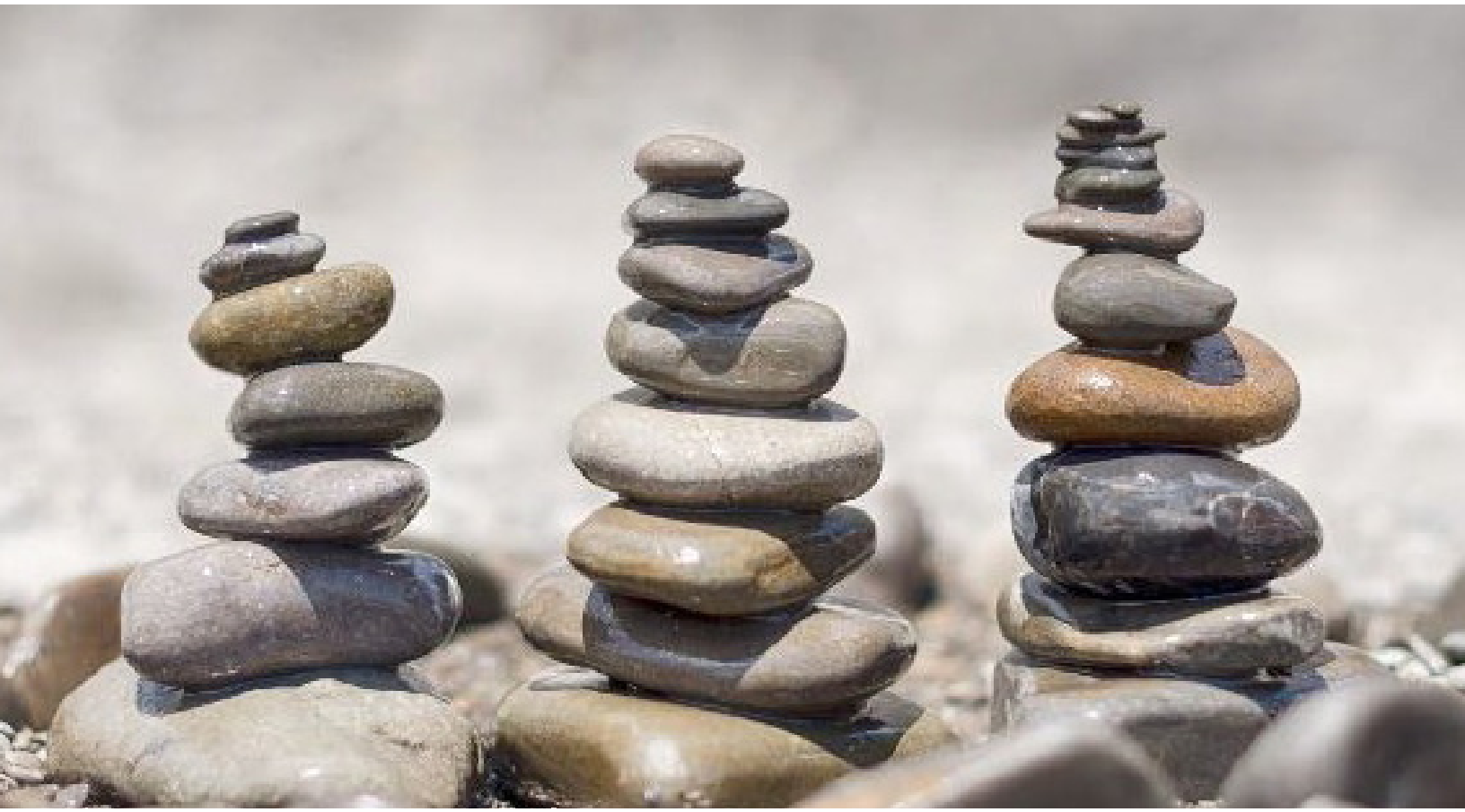
An evaluation of Mental Health First Aid First Nations

Comprehensive Report



For more information, please contact Claire Crooks at ccrooks@uwo.ca

RECIPROCAL CONSULTING

Western
Centre for School Mental Health

Acknowledgements

We would like extend our gratitude and appreciation to the host organizations and communities that allowed us to visit during MHFAFN course implementation and the individuals who shared their voices.

This research was funded by a grant from the Canadian Institutes of Health Research (#297664) to C. Crooks (Principal Investigator).

This evaluation was undertaken by an independent research team evaluating the outcomes, adaptation and implementation, and cultural safety of the MHFA-FN course. Although the Mental Health Commission of Canada provided some of the data and contacts necessary for this research to be conducted, the views contained in this report are not those of the Mental Health Commission of Canada.

A Summary Report can be found here:
http://www.csmh.uwo.ca/docs/mhfa_fn/mhfafn-summary.pdf

About the Research Team

The evaluation of the Mental Health First Aid First Nations program was undertaken by Claire Crooks and her team at the Centre for School Mental Health in partnership with Kim van der Woerd and her team at Reciprocal Consulting.

Centre for School Mental Health (CSMH) at Western University addresses the need for improved school-based promotion, prevention and intervention services for children who may be at risk for, or who present with, mental health challenges. The CSMH team of researchers, educators, students and administrators is focused on the mental health, well-being and relationship development of children from Kindergarten to grade 12. We use outcomes and lessons from nationally funded research projects to deliver evidence-based programs and training for educators in schools and communities.

Claire V. Crooks, PhD, C.Psych. is an Associate Professor at the Faculty of Education, and Director of the Centre for School Mental Health at Western University. She is particularly interested in strengths-based approached that meet the unique needs of Indigenous youth. Claire is the principal investigator on the CIHR grant to evaluate the feasibility, implementation, and impact of the Mental Health First Aid for First Nations program.

Andrea Lapp, BMSc, is Ojibwe of Aamjiwnaang First Nation and worked for 7 years with First Nations, Métis, and Inuit youth through healthy program implementation in schools. Andrea is a researcher and project manager at the Centre for School Mental Health.

Reciprocal Consulting (RC) is an award winning and leading Aboriginal run consulting firm specializing in program evaluation and research. RC takes a strengths-based participatory approach to provide evidence based and culturally responsive evaluation and research. The aim is to support organizations to build highly effective and relevant programs. Since 2003, RC has conducted program evaluations with communities and organizations at local, provincial, and national levels.

Kim Van Der Woerd, PhD, is a member of the 'Namgis First Nation from Alert Bay, BC. Kim completed her PhD in Psychology at Simon Fraser University and her dissertation research focused on a comprehensive participatory evaluation of a Federally funded First Nations substance abuse treatment centre. Kim has over 20 years of experience conducting local, provincial and national program evaluations, and conducting research.

Billie Joe Rogers, PhD, is an Ojibwe member of Aamjiwnaang First Nations and completed her PhD at Simon Fraser University in the Law and Psychology program. Her PhD research focused on the needs and strengths of Aboriginal young offenders living with FASD.

Samantha Tsuruda, MPH, has Indigenous roots in the Spuzzum First Nation in the Fraser Canyon and was born and raised on unceded Coast Salish territory. She holds a Bachelor of Arts in Psychology from UVic, and a Master in Public Health degree from UBC, with a focus on Aboriginal health research.

Monique Auger, MA, is Métis, a citizen of the Métis Nation Greater Victoria and Métis Nation British Columbia. She is a Master of Science candidate in the Faculty of Health Sciences, Simon Fraser University. For her thesis, she is working with her community to explore the meaning of cultural continuity and mental health for Métis people in BC.

Cassidy Caron, BA, is Métis is a proud member of Métis Nation British Columbia. Cassidy graduated from Vancouver Island University in 2014 with her Bachelor of Arts Degree in First Nations Studies and History. After obtaining her BA, Cassidy was accepted to the Aboriginal Youth Internship Program where she gained experience in policy and research with the BC Public Service.

Table of Contents

List of Figures

List of Tables

Executive Summary

This evaluation of the Mental Health First Aid First Nations (MHFAFN) program (2013 – 2017), assessed the process of implementation, impacts for individuals and communities, and degree of cultural safety for the course. MHFAFN, an extension of the Mental Health First Aid program, was developed in partnership with the Mental Health Commission of Canada (MHCC) and six First Nations communities to advance and implement culturally relevant programming that promoted community capacity to prevent and respond to mental health emergencies. A central part of MHFAFN is to teach skills using the acronym EAGLE. EAGLE stands for **E**ngage and Evaluate the risk of suicide or harm, **A**ssist the person to seek professional help, **G**ive reassurance and information, **L**isten without judgment, and **E**ncourage self-help strategies and gather community supports. MHFAFN aims to increase participants' skills and knowledge to help individuals and communities prevent mental health problems from arising, and to de-escalate any current mental health problems in development.

Methods

This evaluation gathered both quantitative and qualitative information about the MHFAFN. A mixed methods approach was utilized to provide many opportunities for participants to share their voices and experiences. Research questions were co-constructed with the three initial sites. The research team prioritized ethical engagement with individuals and communities by focusing on relationship building, respecting ownership of data, and providing research benefits to communities. Data were gathered from course participants and co-facilitators through the use of interviews, surveys, field notes, and MHCC archival data. Data collection methods also evolved over an iterative process, based on participant and community buy-in and reflections from the research team. Site visits were conducted during MHFAFN course trainings in 4 provinces in order to collect data. Seven of the ten MHFAFN training groups were comprised solely of Indigenous participants. Training groups' composition differed in terms of numbers of participants (5 to 24) and composition (Indigenous identity, professional role, background training in mental health, etc.). Some of the site trainings were offered within organizations (e.g., a health authority or friendship centre), while other groups used open registration and resulted in highly diverse groups with respect to age, motivation to attend, previous mental health training, and community role. Altogether, 91 participants completed surveys at the end of the course, and 89 completed interviews (and about 40% of each group completed both). Surveys included a combination of retrospective pre-post questions about knowledge, self-efficacy and stigma beliefs, a number of open-ended questions, and a scenario where participants were asked to identify their response to a colleague exhibiting signs of distress. In addition, 10 site visits and course observations were conducted, and 36 participants completed follow-up surveys 3-6 months after the course. Finally, 19 facilitators participated in surveys and interviews.

Findings

Implementation

Co-facilitators and participants largely expressed satisfaction with the course design and delivery. Participant feedback was positive with respect to the balance between learning aides, and the value of EAGLE and the Circle of Support. Participants also explained a primary strength of MHFAFN is the inclusion of Indigenous specific content (i.e., historical content, the integrated indigenous knowledge and culture). Despite this, it was noted that there were challenges due to the diversity across communities (i.e., literacy and cultural connectedness differed across Canada).

Evaluation participants expressed several implementation challenges, including: triggering content within the curriculum, geographic limitations and infrastructure challenges that interfered with course delivery (i.e., weather and travel complications, technological challenges), and external priorities of those taking the training (e.g., job related and community priorities). Timeframes to delivery MHFAFN were also a notable challenge; for example, time restrictions were often associated with issues around cultural safety. That is, it was a challenge to find enough time for respecting sharing and storytelling while maintaining the course timetable. Barriers to delivering the training to community include the associated costs when training not covered by employment and raising awareness of MHFAFN course among community members. Training for non-Indigenous individuals was noted to be of equal importance as MHFAFN training provides an alternative worldview with which to view mental health and wellness.

Impact

As a result of their participation in MHFAFN, participants identified a number of personal gains in knowledge and awareness, as well as shifts in skills, attitudes, and self-efficacy. Participants reported increased knowledge and awareness about signs and symptoms of mental health concerns, colonization and historical trauma, and supports available in communities. Outcomes related to skills, attitudes, and self-efficacy included increased confidence in MHFA skills and the ability to apply EAGLE skills (e.g., listening without judgment). Participant responses to the mental health crisis scenario further demonstrated a strong grasp of the EAGLE skills. Additionally, stigma beliefs among participants also decreased significantly between pre-training and post-training results, based on participants' self-reported ratings. Beyond the expected gains in knowledge and self-efficacy, participant outcomes commonly included opportunities for reflection, learning about traditional teachings, and contributions toward personal healing. The majority of participants who completed the follow-up survey indicated that they used things they learned in MHFAFN in everyday life (85%). The majority of respondents were able to give a specific example of how they had used their skills in the face of a potential mental health crisis and many of them explicitly noted that they were able to intervene effectively because of the knowledge and skills they gained in the course.

Cultural relevance and safety

MHFAFN was largely experienced as culturally relevant and safe by both participants and co-facilitators. Nearly all participants and co-facilitators reported that the course is culturally relevant. Aspects of the course content and delivery that help to enhance the cultural relevance of MHFAFN included: the two-eyed seeing approach, EAGLE, content on colonization and historical trauma, and traditional teachings. Co-facilitator also highlighted the ways in which they incorporate culture into the delivery of MHFAFN. Those who reported that MHFAFN is not culturally relevant most commonly noted that there is insufficient cultural content in the course. They spoke about the need for more teachings from Elders and First Nations-specific content on mental health

Recommendations

The evaluation findings illustrate a number of key recommendations to further enhance the reach and implementation of MHFAFN. The reach of MHFAFN could be improved through enhancing course promotion, adjusting the co-facilitator application process, and determining appropriate audiences for MHFAFN and tailoring the course accordingly. Course content could be enhanced by including additional First Nations teachings and languages in the curriculum to mirror the diversity of communities across Canada, and tackling specific revisions to course content to reflect feedback around terminology and

content additions. Finally, course delivery could be improved through extending the flexibility in timing delivery of MHFAFN to allow facilitators to be responsive and accommodating toward various participants' learning and emotional support needs.

Conclusion

The evaluation findings indicate that MHFAFN is an effective and feasible public health approach as it offers benefits to a wide range of participants across different community settings. Further, the importance of cultural safety within the design, implementation, and evaluation of MHFAFN cannot be overstated.

1.0 Introduction

This report presents the evaluation for the Mental Health First Aid First Nations (MHFAFN) program, from 2013 to 2017. This evaluation report will review the impacts of MHFAFN on the sites and course participants that participated in this evaluation, the effectiveness of the implementation of the course, and the extent to which the course was culturally safe for First Nations peoples in Canada.

1.1 Program Background

Mental Health First Aid First Nations (MHFAFN) is a program aimed at increasing mental health literacy within First Nations populations. The program was developed in partnership with the Mental Health Commission of Canada (MHCC) and six First Nation communities to advance and implement culturally relevant programming that decreases the risk of mental health emergencies. Since its inception in 2012, the program has sought to increase skills and knowledge that help prevent mental health problems from arising and to de-escalate any current mental health problems in development.

Mental Health First Aid (MHFA) began in Australia in 2001 with the initial focus on providing early support for mental health emergencies. Subsequent versions of the program have been adapted across various international settings. Cultural adaptation of the program began in Australia for implementation among the Aboriginal and Torres Strait Islander people; this process, and its subsequent evaluations, emphasized the importance of culturally relevant programming in first aid mental health (Hart et al., 2010). MHFAFN is similar to the adaptated version of the Australian model whereby First Nations people in Canada have access to relevant and culturally appropriate mental health first aid care.

1.2 About Mental Health First Aid First Nations

Mental Health First Aid First Nations (MHFAFN) is a program that takes a population health approach to education and intervention surrounding mental health challenges for First Nations people. The course aims to prepare responders to affirm and mediate any mental health challenges that may arise for First Nations people. MHFAFN is an extension of the Mental Health First Aid program developed to provide responsive support to individuals who may be experiencing a mental health crisis or are in the development stages of a mental health problem. MHFAFN aims to equip responders with adequate and relevant mental health first aid skills for early intervention. In addition, MHFAFN aims to build capacity at the community level through the population health approach and further a culture of prevention for First Nation communities. MHFAFN also seeks to reduce stigma beliefs through education and reframing negative language.

A central focus of the MHFA program is the first aid action plan (ALGEE) that provides guidance on intervention through action-based steps. **A**ssess the risk of suicide/or harm, **L**isten non-judgmentally, **G**ive reassurance and information, **E**ncourage the person to obtain appropriate professional help, and **E**ncourage the person to obtain other supports. The cultural adaption of ALGEE is EAGLE for MHFAFN. EAGLE stands for **E**ngage and Evaluate the risk of suicide or harm, **A**ssist the person to seek professional help, **G**ive reassurance and information, **L**isten without judgment, and **E**ncourage self-help strategies and gather community supports. Derived from Indigenous ways of thinking and doing, the EAGLE framework (Figure 1) facilitates meaningful conversations around mental wellbeing.

Figure 1: EAGLE framework with steps

In addition to the creation of the EAGLE framework, MHFAFN includes several extensions to the MHFA Basic curriculum. MHFAFN is grounded in historical context, illustrating the harm perpetrated by colonization towards First Nations peoples, while also recognizing the strengths and resiliency of First Nations peoples. Rather than taking a deficit-based approach to understanding mental health, MHFAFN is premised on the idea that culture is the foundation of holistic health and wellness. MHFAFN has space for community-based adaptations to ensure that the local context, customs, and protocols are respected during the course delivery. One activity that exemplifies this localization is the Circle of Support, which is incorporated into several modules of the curriculum. The Circle of Support involves community mapping whereby participants identify available local supports and resources (Figure 2). The MHFAFN curriculum also weaves in the notion of *walking in two worlds*, which involves bringing together Indigenous and Western knowledge about mental health and wellness.

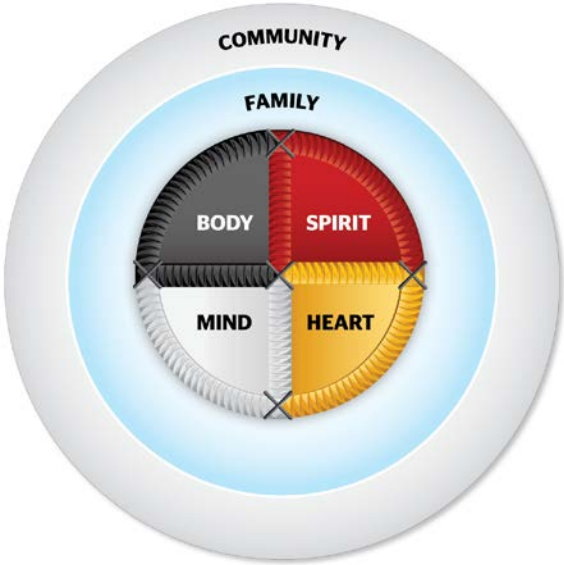


Figure 2: Circle of Support Framework

1.3 Purpose of this Evaluation

The research team undertook a series of discussion with the three communities that were initially part of the development process as well as with the MHCC to identify areas of inquiry. Based on these initial consultations, the evaluation was scoped to look at three overlapping areas: implementation, impact, and cultural safety.

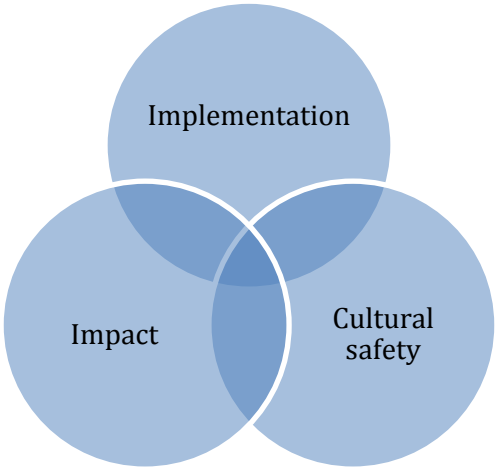


Figure 3: Overlapping domains of research in the MHFAFN evaluation

Within these domains, this evaluation aimed to address a number of questions, as listed below.

Implementation:

1. What are the successes and challenges in implementing the MHFAFN course?
2. What are the considerations for implementing the MHFAFN course in diverse contexts?
3. What are the suggested improvements for implementing the MHFAFN course?

Impacts:

4. What is the impact of the MHFA-FN course on participants' knowledge, attitudes, and skills related to promoting mental health and responding to mental health challenges?
5. How has MHFAFN contributed to a community-wide prevention approach to mental health (if at all)?
6. What are the intended and unintended impacts of the MHFA-FN course?
7. Can participants apply their mental health promotion skills in scenarios and daily life?

Cultural Safety:

8. To what extent did participants feel safe participating in the Mental Health First Aid First Nations course, and what aspects of the course content and delivery contributed to this?
9. Which contextual factors contributed to experiences of cultural safety (or lack thereof)?
10. How can the cultural relevancy of the course be improved to enhance cultural safety for participants?

2.0 Literature Review

2.1 Mental Health in First Nations Communities

First Nations people experience a number of significant and persistent health inequities (Canadian Council on Social Determinants of Health [CCSDH], 2013). While data from the 2012 Aboriginal Peoples Survey on mental health are limited to self-perceived mental health status (Statistics Canada, 2015), the data allows for comparison to the Canadian Community Health Survey, which reports aggregate mental health statistics for the general Canadian population (Statistics Canada, 2014). The data on self-perceived mental health status for the British Columbia (BC) population illustrate that First Nations people with Status less commonly report their health as excellent when compared to the non-Indigenous population in Canada (52.0% vs. 63.2%), and are more likely to report their mental health as fair or poor (16.6% vs. 10.0%; Figure 4).

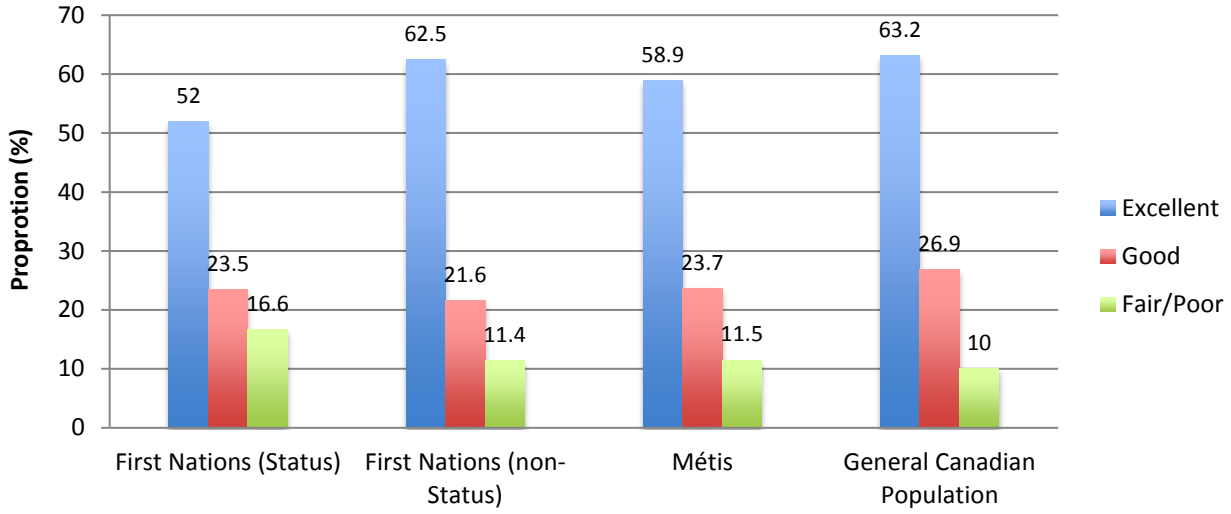


Figure 4: Self-perceived mental health status for First Nations people, Métis people, and the general Canadian population

In the second, and most recent, phase of the First Nations Regional Health Survey—a national health survey conducted across First Nations communities in Canada—the First Nations Information Governance Centre (FNIGC, 2012) reported that depression and holistic mental wellness for adults (aged 18 years and older), as well as mental health supports for youth, were identified by communities as priority areas.

Analyses within the *First Nations Regional Health Survey* demonstrated proportionately high rates of suicidal ideation (22.0%) and suicide attempts (13.1%) for First Nations adults over their lifetimes. Research has also shown that First Nations youth are among those at the highest risk for suicidal behaviours, as the national rate for First Nations youth is five to six times higher than that for non-Indigenous youth in Canada (Kirmayer, 2007). However, while aggregated rates of suicide among the First Nations population are extremely high, they mask the diversity across First Nations, Metis, and Inuit communities. While some communities have experienced suicide rates that are exponentially greater than the national average, other communities have very few cases (Kirmayer, 2007). Much of this pan-Indigenous epidemiological research has also led to an overriding focus on deficiency-based models, inadvertently concealing the roots of these disparities.

2.2.1 Determinants of mental health and wellness

Mental health is influenced by a number of factors known as the social determinants of health (SDOH). In looking at health through an Indigenous perspective, balance is an integral component of health and well-being (Loppie Reading & Wien, 2009). Families can serve as protective factors through acting as strong social support networks (FNIGC, 2012), and work to maintain balance as a whole. Research has illustrated that community-level resilience may be fostered through increasing community-control by moving to forms of self-government (Kirmayer, Sehdev, Whitley, Dandeneau, & Isaac, 2009), promoting the use of traditional languages and the transmission of knowledge between generations (Hallet, Chandler, & Lalonde, 2007), revitalizing cultural traditions (Kelly, 2007), and improving access and control over local services, including health care and education systems (FNIGC, 2012).

It is also important to note the great diversity that exists both within and between First Nations communities with respect to language, culture, and traditions; thus, there are multiple definitions and frameworks for health and healing, which are rooted in the specific contexts that Indigenous communities are situated within (Hirch, 2011). One common framework, however, lies in the holistic interpretation of wellness, where spiritual, mental, emotional, and physical wellbeing are intertwined (Lavallee & Poole, 2010; Stewart, 2008). Quantitative research findings have also mirrored the importance of holistic wellness, as the *First National Regional Health Survey* illustrates that First Nations adults who feel balanced with respect to their physical, emotional, mental, and spiritual wellness were less likely to report moderate or high levels of distress (FNIGC, 2012). This report also described a connection between mental balance and traditional wellness, as "a higher proportion of First Nations adults who reported that traditional spiritual was 'very important' in their life reported feeling mental [balance] (79.8% vs 72.7%, $p < 0.05$)" (FNIGC, 2012, p. 219). Spirituality, like other aspects of traditional wellness, has been undermined throughout historical and current colonial policies of assimilation.

Colonization has continually challenged many aspects of First Nations cultures through the imposition of Eurocentric practices and policies. Colonization has effectively challenged the maintenance and transmission of Indigenous epistemologies by essentially forcing them underground, and replacing them with different sets of values and principles, as well as perspectives and perceptions (MacDonald & Steenbeek, 2015). This was largely accomplished through the imposition of the residential school system that prohibited the use of Indigenous languages, and traditions, while replacing these aspects of culture with Western ways of thinking (Kelm, 1998). Indigenous communities were also forced to practice much of their traditional ceremonies in secret under federal bans (MacDonald & Steenbeek, 2015). Further, the imposition of external forms of government (i.e., Band Councils), controlled through the federal government, were placed on First Nations communities, forcing them to conform to Eurocentric practices that were not compatible with their traditional forms of government (MacDonald & Steenbeek, 2015). Euro-Canadian ways of doing and being, and associated knowledge systems, have become hegemonic in Canadian society, posing continuous threats to 'Indigeneity,' and have acted as "a form of disempowerment and oppression, that impacts the self-identity, well-being, self-esteem and empowerment [of Indigenous communities]" (National Collaborating Centre for Aboriginal Health, 2009, p. 1).

It is integral, as Lavalle and Poole (2010) state, to contextualize mental health inequities among First Nations communities within the context of colonialism, as "the mental health and recovery of Indigenous people in Canada have always been tied to history, identity, politics, language and dislocation" (p. 271). Colonization has become a widely-accepted factor in many of the multigenerational mental health effects that many Indigenous people are currently experiencing. This

pattern is exasperated through the high proportions of Indigenous children who are removed from their families and communities, and largely placed in non-Indigenous homes. Indigenous children account for 48% of all foster children in Canada, while only representing 7% of all children under 14 (Turner, 2016).

2.1.2. Traditional views around mental wellness

Indigenous worldview is made up of the beliefs, values, spiritual practices, and knowledge of Indigenous peoples. Having evolved over time, these views have been tested, developed, collectively gathered, and transmitted over generations. Intertwined with the land and all beings that interact with the land, Indigenous epistemologies are critical to the cultures to which they belong and must be understood in order to enhance the wellbeing of communities. In a similar way, health is commonly understood as a holistic notion that includes the mental, emotional, spiritual, and physical aspects of wellness spanning across individual, family, and community levels (Loppie Reading & Wien, 2009; Stewart, 2008). Stewart (2008) also highlights the interdependence of these components and the subsequent need for holistic approaches to mental health programming and services. Additionally, research has consistently highlighted the connection between culture and land, and the dynamic role that these components play in relationship to health within Indigenous populations (Greenwood & de Leeuw, 2012; Loppie Reading & Wien, 2009). Specifically, traditional medicines are often viewed as a bond between land and tradition, and as a way of healing; in fact, the very act of traditional harvesting has been analytically linked to an enhanced relationship with the land, leading to improvements in general well-being (Loppie Reading & Wien, 2009).

2.2 Previous Research and Evaluation of Mental Health First Aid

Mental Health First Aid has been previously evaluated in a number of different contexts. For example, in a quantitative study of MHFA outcomes among a diverse sample (n = 458) in Australia, Morawska and colleagues (2013) identified short term individual-level outcomes with respect to increased mental health knowledge, confidence in first aider skills, and utilization of skills to help others. They also found a reduction in stigmatizing attitudes among course participants. During their follow-up at six months post-course, the research team found positive results in terms of participants offering help and referrals to people with mental health concerns (Morawska et al., 2013). Further, in a recent mixed methods study of MHFA in rural communities in the United States, Talbot, Ziller, and Szlosek (2017) found that the MHFA program helped to promote treatment-seeking behaviours; however, geographical barriers to accessing care limited the impact of that particular training. Lastly, in 2014, Hadlaczky and colleagues (2014) conducted a meta-analysis of published studies on MHFA (n = 15) and found that the MHFA Basic course was effective in terms of increasing participants' knowledge of mental health, reducing stigma, and increasing behaviours that support for individuals with mental health issues.

2.3 Stigma around Mental Health and Other Barriers to Help-Seeking

While health disparities within First Nations populations, including those related to mental health and wellness, are widely recognized as being intricately connected to economic, environmental, political, and social inequities (Adelson, 2005), these factors are heightened through a number of barriers to care, rooted within colonial processes of assimilation, discrimination, and intergenerational trauma (Loppie Reading & Wien, 2009). Many First Nations communities—particularly those in rural and remote locations—lack geographical access to mental health services (Boska, Joober, & Kirmayer, 2015). Additionally, First Nations people who are able to physically access mental health services may not feel

comfortable doing so, due to issues around stigma, discrimination, and a lack of culturally safe services (Boska et al., 2015; Vukic, Rudderham, & Misener, 2009).

More broadly, stigma occurs through the perpetuation and endorsement of stereotypes, which leads to discrimination against people with mental illness; this occurs on multiple levels, spanning self, public, and structural components (Corrigan, Druss, & Perlick, 2014). In this way, it is negative beliefs and attitudes—often rooted in ignorance and misinformation—that manifest through stereotyping. Stigma related to mental health can be particularly problematic for First Nations peoples, who also commonly experience stigma related to race and culture, colonial violence, poverty, and systemic discrimination (First Nations Health Authority, Province of British Columbia, & Government of Canada, 2013).

The need for addressing and reducing stigma in First Nations communities has been identified throughout research and policy documents (First Nations Health Authority, Province of British Columbia, & Government of Canada, 2013; Health Canada, 2015; Vukic et al., 2009). Specifically, in a study based in in First Nations communities in Ontario, survey results highlighted that stigma is a concern in the general community, as well as stigma directly associated with accessing counselling services (Flynn, Wells, Graham, & Tremblay, 2013). Similarly, in a study conducted in Mi'kmaq communities in Nova Scotia, participants noted that reducing stigma-related barriers would enable community members to seek help as freely as they would seek help for minor injuries (Vukic et al, 2009).

Researchers have demonstrated the need for increased awareness and understanding, and shifting attitudes about mental illness. For example, Vukic and colleagues (2009) identified the effectiveness of culturally appropriate workshops, pamphlets and newsletters, and education programs to alleviate barriers and fears around mental health services, and increase understanding of mental health. Corrigan et al. (2014) also advocated for increased research on stigma, as well as culturally relevant programs to enhance mental health literacy and family-friend engagement. The concept of cultural safety is important in any discussion of reducing stigma and other barriers to help-seeking.

2.4 Cultural Safety

The concept of cultural safety originated in New Zealand, where health care providers were seeking to recognize, respect, and nurture the unique cultural identities of Māori people and safely meet their needs, expectations, and rights (Browne, Smye, & Varcoe, 2005). Understandings of cultural safety have since evolved as Indigenous peoples and organizations have adopted and adapted the term within their specific contexts (Brascoupé & Waters, 2009). Building on the knowledge, attitudes, and skills—as often encompassed in descriptions of cultural competency—cultural safety requires acknowledgement of the negative role that power differentials between patients and health care providers can play in health care settings (Isaacson, 2014). Thus, building on the importance of self-location, culturally safe practice requires reflection on how our culture and attitudes impact our individual and organizational relationships (Tsuruda & Shepherd, 2016). It also includes recognizing individual and institutional power differentials, including colonial relationships, and addressing inequalities (Brascoupé & Waters, 2009; Browne et al., 2005; Tsuruda & Shepherd, 2016).

Fontaine (2012) defines cultural safety as both an outcome, as it is defined and assessed by those that receive the service, and a process based on respectful engagement. Similarly, Ball (2008) indicates five core principles to cultural safety:

1. **Protocols:** Understanding and respecting cultural forms of engagement

2. **Personal knowledge:** Being mindful of one's self-location, culture, and history and how this location relates to patients or participants
3. **Partnerships:** Engaging in collaborative practice and problem-solving approaches
4. **Process:** Using an ongoing process of mutual learning and adjusting practices to align with others' cultures
5. **Positive purposes:** Ensuring that the process used leads to the outcomes that are most beneficial to the patients or participants

Many underlying factors negatively affect the health of Indigenous people in Canada, including poverty and the intergenerational effects of colonization and residential schools. But one barrier to good health lies squarely within the health care system itself. Many Indigenous people do not trust—and therefore do not use—mainstream health care services because they do not feel safe from stereotyping and racism, and because the Western approach to health care can feel alienating and intimidating (Fontaine, 2012). Thus, the need for culturally relevant and culturally safe health care is a necessity as it increases the likelihood of positive health outcomes. Further, the negative consequences of past mental health courses—which have been used in First Nations contexts without culturally safe adaptation—underscore the need for ensuring culturally relevant curricula and culturally safe implementation within MHFAFN.

2.5 Pedagogical Approaches to Mental Health

There is a strong need to integrate Indigenous pedagogies and culturally responsive curricula into mental health promotion programming for Indigenous communities. This need stems from discordance in wordviews and subsequent healing approaches. For example, a study on mental health and healing in Carrier First Nation found that Carrier people have had ways of maintaining mental health and treating mental illness for their entire existence of the traditional Carrier society (Dobson-Brazzoni, 2013). Stewart (2008) notes that the differences between Western and Indigenous worldviews can be a barrier to effective mental health promotion programming: counselling or treating Indigenous people with foreign, western methodologies in regards to health "is a form of continued oppression and colonization, as it does not legitimize the Indigenous cultural view of mental health and healing" (Duran, 2006, as cited in Stewart, 2008). In order to improve the wellbeing of Indigenous peoples, it is critical to "disrupt dominant discourses" and honour Indigenous ways of knowing in pedagogical approaches and curricula (Iseke-Barnes, 2008, p. 144).

There are many scholars who have articulated components of Indigenous pedagogy. Biermann and Townsend-Cross (2008) noted that Indigenous pedagogy is based upon the principles of identity and relatedness, within the values of reciprocity, inclusivity, nurturance and respect. Indigenous pedagogy is also characterized by reflective practice, such as unlearning racism, decolonizing the teaching process, and reclaiming Indigenous knowledge (Biermann & Townsend-Cross, 2008). Pedagogical models identified in the literature often include learning circles, which is an Indigenous practice that can help create community in a classroom (Hatcher, Bartlett, Marshall, & Marshall, 2009). In addition to learning circles, Iseke-Barnes (2008) describes several concrete activities that she uses to decolonize her teaching, including incorporating ceremony, prayer, and song. Furthermore, Yunkaporta (2009) describes Indigenous pedagogy and its powerful role:

> There is deep knowledge in our languages. There is a spirit of learning in our words. There is more than just knowledge of what to learn, but knowledge of how we learn it. This is our

> pedagogy, our way of learning. We find it in language structure, in the way things are repeated and come around in a circle, showing us how we think and use information. (p. 1)

In terms of Indigenous pedagogy for healing purposes, the concepts of wholism and interconnectedness are prominent. Generally, in a First Nations context, understanding and treating mental illness involves the interconnection of the whole person, the healer, the environment, and the spirit world (Dobson-Brazzoni, 2013). Community is central to the process of what individuals need to establish and maintain mental health and healing (Stewart, 2008); Dobson-Brazzoni (2013) further states that community has the obligation and responsibility to bind together, and to see one another through difficult times. Nadeau and Young (2006) also posit the importance of the physical body's role in addressing mental or emotional stress (as cited in Iseke-Barnes, 2008). Additionally, cultural identity gives First Nations peoples the strength to consider healing possibilities through personal self-growth, connections with family, community, and Indigenous cultures (Stewart, 2008).

Stewart (2008) also emphasizes that health promotion within Indigenous communities, in the current context of decolonization, must be based in and value an Indigenous conceptualization of health. At the same time, it is important to acknowledge that while there are commonalities between defining mental health across communities, there are also differences for how to promote mental health that are grounded in local Indigenous epistemologies. There is a demonstrated need to respect differences between and among communities in delivering mental health services, as these differences have impacted how clients have practiced mental health and healing within their cultural context (Stewart, 2008).

There is evidence in the literature that including both Indigenous and Western epistemologies is an emergent strategy in mental health promotion. This includes the notion of Two-Eyed Seeing, which refers to "learning to see from one eye with the strengths of Indigenous ways of knowing and from the other eye with the strengths of Western ways of knowing and to using both of these eyes together," (Hatcher, Bartlett, Marshall, & Marshall, 2009, p. 146). The concept stems from the acknowledgment that many different ways of knowing exist in the world, and the value of building bridges between them in a postcolonial framework (Bartlett, Marshall, & Marshall, 2009; Stewart, 2008). To begin this process, it is important to engage in a "critical analysis of history" and the "revaluing of Aboriginal healing knowledge" (Sinclair, 2004, p. 55). This includes education about history, before and after contact, and "our histories, both before and after contact, and to recognize ongoing survival, healing practices, wholeness, and ways back to Indigenous knowledges" (Iseke-Barnes, 2008, p. 144). Thus, the MHFAFN was designed to promote skills within a culturally responsive framework and to decrease stigma.

3.0 Methodology

This section of the report describes the evaluation approach and outlines the data collection methods used.

3.1 Research Approach

Through utilizing the strengths of Western and Indigenous worldviews and methodologies, a two-eyed seeing approach was a central component to this evaluation. Developed by Mi'kmaw Elder Albert Marshall, the two-eyed seeing approach equally honours dual ways of knowing, blending aspects of Indigenous and Western knowledge (Iwama, Marshall, Marshall, & Bartlett, 2009). The Institute for Aboriginal Health at the Canadian Institutes of Health Research (IAPH-CIHR) have also adopted this approach as a framework for (Institute of Health Economics & IAPH-CIHR, 2011). This approach mirrors the MHFAFN course pedagogy, as well as the composition of many of the participant groups and the research team, where both Indigenous and non-Indigenous people work together to understand and promote health equity in First Nations communities. This research also utilized a mixed methods approach, with a stronger weight placed on the importance of stories through qualitative data.

3.2 Participants

Based on responses from participants who completed evaluation surveys (n = 89), the majority of people self-identified as female (n = 80) and most were Indigenous (n = 74). In fact, while groups differed in terms of their size and composition, seven of the ten course sites that the evaluation team visited were comprised of all Indigenous participants (Table 1). All of the participants who did not identify as Indigenous were either living in Indigenous communities and/or working in Indigenous communities/organizations. The average age of participants was 42.1 years.

Some of the courses were offered with an 'open registration' process, and included diverse groups in terms of age, education, and employment roles; other courses were provided within specific organizations to their employees. A brief description of the composition of the ten groups is included in this evaluation is provided in Table 1.

Table 1: Summary table of group characteristics across the different sites

No. Participants	All Indigenous?	Description
16	No	This course brought together healthcare providers who primarily work with Indigenous communities
15	No	This course brought together staff at an urban Indigenous organization
23	No	This course brought together community members from a local First Nations community, as well as both First Nations and non-First Nations participants from the surrounding areas
14	Yes	This course brought together a diverse group of participants, and was hosted in an urban centre
9	Yes	This course brought together First Nations leaders from one community
9	Yes	This course included First Nations health directors from different communities in surrounding areas
16	Yes	This course was hosted by a tribal council and brought together participants from the local First Nations community and the surrounding areas
15	Yes	This course, hosted at an urban Indigenous organization, brought together participants who were mainly frontline workers in mental health and substance misuse
21	Yes	This course took place in a city and brought together participants from across the region
17	Yes	This course brought together a group of participants, and was hosted in an urban centre

3.3 Data Collection Procedures

This evaluation gathered both quantitative and qualitative information about the MHFAFN. Data were gathered from course participants and facilitators through the use of interviews, surveys, field notes, and MHCC archival data (Table 2). Data collection methods also evolved over an iterative process, based on participant and community buy-in and reflections from the research team. The specific data collection tools, which are described in the sections below, are also included in Appendix A.

The evaluation questions and data collection methods were formed based on input from community pilot sites. For example, while we had proposed photovoice as a culturally-relevant approach for data collection, community partners expressed that this approach would add an additional burden on participants as they felt that the time required for photovoice was more substantial than the benefits warranted. As a result, the evaluation team was directed towards a strengths-based survey instead.

At the beginning of the data collection phase, two of the research team members attended each site to introduce the research and passively observe the MHFAFN course. They stayed on site for the entire two and a half days and provided a link to the online survey for participants to complete at home. After the third site visit of using this process, the research team chose to adjust the procedure with the goal of increasing engagement, buy-in, and participation rates.

To provide additional options for participants to share their experiences with MHFAFN and tell their stories, the evaluation team began to offer an option for one-on-one interviews with participants during the course delivery. The interviews generally led to more in-depth answers than the paper survey was originally bringing forth. In addition to the interview option, the research team also brought paper copies of the survey for participants to fill out near the end of the course. During these site visits, the research team also actively participated in the course, which allowed for the building of relationships with participants and facilitators; this process may have also contributed to increased buy-in for the interviews and surveys. Following the MHFAFN course delivery, facilitators were also asked to share their perspectives and experiences through an online survey and/or a telephone interview conversation.

Table 2: Data collection methodology

Data collection method	Target group	n	Description/evaluation topics
Participant survey	MHFAFN course participants	91	⇒ Participant demographic information ⇒ Program strengths, limitations, and recommendations ⇒ Satisfaction and participant safety ⇒ Individual-level outcomes ⇒ Stigma in communities
Participant process interview	MHFAFN course participants	89	⇒ Program strengths, limitations, and recommendations ⇒ Unintended, individual-level outcomes ⇒ Cultural relevance and safety
Participant follow up survey	MHFAFN course participants	36	⇒ Participant demographic information ⇒ Utilization of MHFA skills ⇒ Program strengths, limitations, and recommendations ⇒ Stigma in communities
Facilitator Interview	MHFA FN facilitators	9	⇒ Facilitator demographic information ⇒ Reach and reception of MHFAFN ⇒ Community supports and challenges for MHFAFN ⇒ Strengths and barriers to delivering the course ⇒ Cultural relevance and safety ⇒ Community or organizational impacts ⇒ Unintended outcomes
Facilitator Survey	MHFA FN facilitators	19[1]	⇒ Facilitator demographic information ⇒ Satisfaction ⇒ Observed participant benefits and outcomes ⇒ Fidelity: Changes to the course delivery ⇒ Challenges and recommendations ⇒ Facilitator training feedback ⇒ Community infrastructure and support
Researcher Field Notes	Observations at MHFAFN courses	10	⇒ Cultural safety ⇒ Implementation ⇒ Impacts
MHCC Archival data	MHFAFN course participants	385	⇒ Feedback on the course content and facilitators ⇒ Participant safety ⇒ Confidence in skills

[1] This number includes number of responses, where one respondent filled out the survey on three different occasions and a second respondent filled out the survey on two different occasions.

3.3.1 Participant Survey

The MHFAFN participant survey (90 items) was initially administered at the end of the group. After the first several groups where we experienced low participation rates, we changed the procedure so that the survey was provided to course participants at the end of the first day of the course to record their reflections throughout the remainder of the course. The survey was collected upon completion of the course on the third day, by the evaluation team. Participants were asked to answer retrospective pre-post, Likert style questions to assess their perspectives around changes in knowledge, stigma, and self-efficacy. Additionally, the survey included a scenario that participants were asked to respond to. Participants received a $10 electronic gift card for their participation in the survey. MHFAFN participants were also given the option to complete the survey online following their participation in the course. Overall, the participation rate for the participant survey was 61%, which includes a low response rate for the first three site visits (32%), and a higher rate after the procedural changes were made (76%).

3.3.2 Process Interview (Participant Interview)

Recognizing the importance of providing an opportunity to participants to share their stories about their experiences taking MHFAFN, the evaluation team conducted in person interviews with MHFAFN course participants in seven sites (i.e., from the fourth site visit onwards). The interviews, which consisted of five questions, were guided by a member of the evaluation team throughout the duration of the course. Interview length varied from 5 to 45 minutes, reflecting diverse levels of engagement in the research from participants. Interview participants received a $10 electronic gift card for their participation in the interview.

3.3.3 Participant Follow-up Survey

Approximately 1-14 months after participating in the MHFAFN course (mean 8.5 months), participants from the sites were invited to participate in an online survey. The goal of this follow-up survey was to understand the ways in which participants have used their MHFAFN skills, longer-term outcomes, and reflections of the course after some time passed. The survey also included questions related to changes in stigma in communities. Participants received a $10 gift card for their participation in this survey.

3.3.4 Facilitator Survey

This survey was distributed to facilitators after they delivered at least one MHFAFN course. This survey covered topics of: courses delivered and other MHFA training taken, the strengths and challenges of delivering the course, satisfaction with course components, and perceived outcomes and satisfaction for course participants. Questions also touch on changes made to the course content and delivery (i.e., fidelity) and facilitators' lessons learned.

3.3.5 Facilitator Interview

The evaluation team contacted MHFAFN facilitators to schedule interviews, with the goal of hearing stories about their experiences delivering the course in their community, as well as their perspectives on the challenges, successes and recommendations for the course. Nine of the twelve facilitators also participated in interviews. Each facilitator received a $20 gift card for their participation. These

interviews lasted between 25 and 105 minutes and consisted of 16 open-ended questions related to the course reach, design, implementation, and outcomes.

3.3.6 Researcher Field Notes

Throughout the duration of the site visits, the evaluation team recorded field notes and reflections on the course delivery and reception. Field notes were organized by the data collection matrix and sorted into the themes of implementation, cultural safety, and impact. These field notes are presented in the findings as an additional line of evidence.

3.3.7 MHCC Archival Data

Prior to receiving their completion certificate for the MHFA FN course, participants are required to complete a survey facilitated through MHCC. The survey, which is standard across all of the MHFA courses, including 12 items related to overall satisfaction, relevance, perceived safety, and strengths and weaknesses of the course. This survey does not include demographic information (such as age and gender of participants). This evaluation includes responses from 385 individuals across 26 different courses.

3.4 Data Validation

After each interview, the transcripts were returned to participants. This is first to follow the OCAP™ principles of Ownership, Control, Access and Possession, and to facilitate reciprocity in the research. Interview participants were then able to verify the data, and provide their input or changes to ensure valid documentation by the researcher. Interview participants were given a deadline to return their edited transcripts, and if the evaluation team did not hear back within that timeline it was assumed that the interview participant approved the transcripts.

3.5 Data Analysis Methods

Qualitative comments from the surveys were coded with the use of a codebook developed by two members of the research team. Participant and facilitator interviews were coded using an inductive approach to content analysis. Interview data were analyzed with a process of systematic coding by hand; this involved several rounds of open coding, grouping, and thematic categorization (Creswell, 2013). A group coding procedure was used for these data, whereby the initial questions were coded by a small team of researchers, allowing for discussion around the essence of each data point and group consensus around the generation of emergent codes. Following this initial procedure, team members coded individual portions of the data, with ongoing discussion around complex data. Quantitative ratings from participant surveys and MHCC archival data were analyzed in SPSS using descriptive statistics.

3.6 Ethical Considerations

This research was approved by the Research Ethics Board at Western University and was also guided by the OCAP™ principles: Ownership, Control, Access and Possession, which were developed and trademarked by the First Nations Information Governance Centre (2014) to increase self-determination for First Nations individuals and communities over research. Within this evaluation, these principles

were operationalized through sharing interview transcripts back with each participant with the goal of increasing participant-level ownership over data and validating the data collected. As part of sharing knowledge back with the participating communities and organizations, community-level summaries were created and shared within three weeks of our site visits.

3.7 Limitations

Limitations within the evaluation methods included relatively small sample sizes for the participant surveys. The smaller number of survey respondents led to few participants who reported certain outcomes, and thus it limited the evaluation's ability to present patterns in the data. Particularly in terms of determining gender differences, given the low numbers of male participants who completed the surveys. In addition, because only three participants reported a lack of safety in their experience of the course, were not able to identify patterns underlying those experiences.

Additionally, the survey included various dichotomous measures, which masked nuances in the data. The retrospective pre-post measures also come with well-recognized limitations, including social desirability bias and imperfect memory when recalling information. Furthermore, the changes to our methods made mid-point in data collection would have been better implemented (with higher response and participation rates), if they had been implemented at the outset.

3.8 About the Evaluation Participants

3.8.1 Participant survey

As part of the participant survey, participants were asked to share some basic demographic information, including an opportunity to self-identify Indigenous ancestry, age, gender, and previous training.

Indigenous identity
Survey participants were asked to identify what cultural communities they identify with. The responses were categorized into indigenous (n=74) or non-indigenous (n=14). There was a small number of respondents (n=3) who did not indicate cultural identity.

Age and gender
Survey participants were asked to indicate their year of birth and to self-identify their gender. A total of 70 respondents identified as female and 19 as male, while two did not answer the question. Participants' ages (at the time of taking the survey) are also presented in Figure 5 (four participants did not indicate their age).

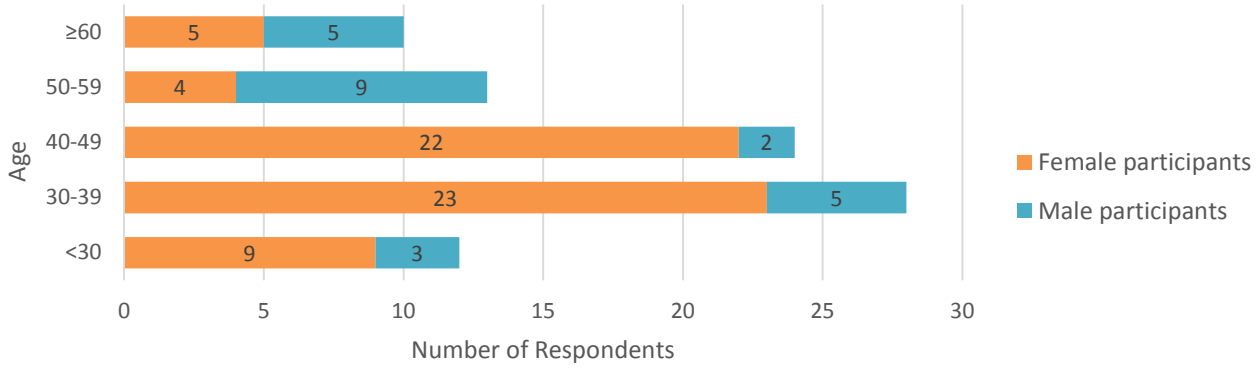


Figure 5: Age and gender of survey participants

Previous training attended and participant comprehension of MHFAFN

Participants indicated their previous training in the area of mental health. Initially the qualitative responses were coded into four categories: relevant post-secondary education (e.g., counsellor), Mental Health course (e.g., MHFA Basic, ASIST), and no previous mental health training. The frequencies of previous training for all survey participants, males, and females, are described in Table 3.

Within the MHCC feedback forms, participants were asked to rate the extent to which the MHFAFN material was new to them, as well as the level of easiness of the curriculum. On a scale from 1 (not at all new) to 10 (very new), participants rated the material as being moderately new to them (mean = 6.68; SD = 2.60). In terms of comprehensibility, the average rating was 8.94 (SD = 1.12), where 1 was very hard and 10 was very easy to understand, indicating a generally high level of satisfactions regarding the comprehensibility of the curriculum.

Table 3: Previous training in mental health by gender

Course Type	Total (n)	Female (n)	Male (n)
Post-Secondary	25	21	4
Mental Health Course	36	29	7
None	25	19	6
No response indicated	5	1	2
Total	91	70	19

3.8.2 Facilitator survey

Most of the surveyed facilitators noted that they were trained in MHFAFN less than one year ago (n = 13), while others were either trained between one and two years ago (n = 3) or between three and four years ago (n = 4). At the time of the survey, facilitators varied in terms of the number of courses they had delivered (Figure 6).

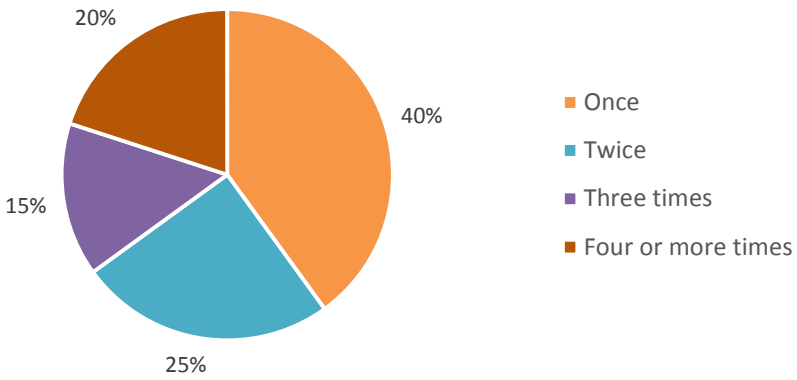


Figure 6: Number of times facilitators have delivered MHFAFN

In addition to being trained in MHFAFN, some of the facilitators indicated that they have also been trained in MHFA Basic (n = 5) or MHFA for Adults who Interact with Youth (n = 3). Three quarters of the surveyed facilitators also reported that their community or organization has delivered other MHFA courses in the past (n = 15).

4.0 Findings

In this section of the report we present our findings in four areas: course participants, implementation, impact, and cultural relevance and safety.

4.1 MHFAFN Course Participants

Findings regarding study participants are presented below, including feedback on the methods in which course participants heard about the MHFAFN course, reasons for attending a MHFAFN course, and who the MHFAFN course is providing training to (within the sites that were visited as part of this evaluation).

For this research study, participants':

Reasons for Attending MHFAFN was attributed to one of five reasons:

- Personal interest in the content
- To develop skills to help others
- For the First Nations cultural perspective
- To become certified to train others
- Job related reasons

4.1.1 How participants heard about MHFAFN

The majority of MHFAFN participants heard about the course through their place of work; either their employer, health director, executive director, or mental health coordinator. Others heard of the course through word of mouth from friends, family or co-workers who had either taken the course or heard of it themselves. Information about the MHFAFN course was also shared through community health centres, tribal councils, or community band offices.

Participants also shared that they heard about the course through various health organizations including Tribal health services, community mental health departments, health authorities, or through First Nations and Inuit Health Branch. Some participants explained that they learned of the course though online advertisements on Facebook or other social media, or on the MHFA website. Finally, participants learned about the course through their MHFAFN facilitators or though taking previous MHFA courses.

4.1.2 Reasons for attending MHFAFN

Of the 91 participants who were surveyed, their reasons for attending were coded into five categories (Figure 7): Personal interest (includes acquiring knowledge), skill development to help others, First Nations cultural aspects or perspective, to become certified and/or offer the course, and job/career (i.e., directed to by manager, boss, or because course is part of mandatory training for job, or perceived as beneficial to job). Some indicated multiple reasons for attending the course (n = 16), in which case each reason was coded separately.

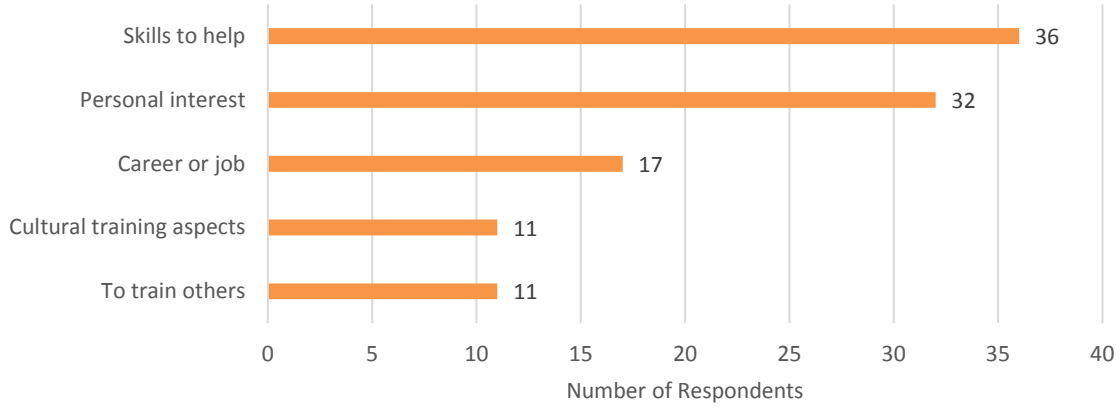


Figure 7: Participants main reasons for taking the MHFAFN course

Most participants surveyed were not becoming trained facilitators (83.5%), compared to those who were taking the course with the intention to become a trained facilitator of MHFAFN (16.5%).

4.1.3 Facilitators Thoughts on Target Audience[2]

Many of the current target audiences receiving the course, according to the facilitators interviewed, included front line workers such as nurses, social workers and counsellors. They explained that this course needs to be delivered to frontline workers as they are the ones working with community members on a daily basis. Other facilitators shared that the course is currently being delivered to Health Directors because the front-line staff who have been trained in MHFAFN requested that their Health directors take the course to bridge a communication and understanding gap. Finally, one facilitator shared that the course is currently being delivered to a mixed group of health professionals, addictions workers, sports and recreation staff, and community members. With regard to the mixed group, one facilitator shared that if possible frontline workers should be trained separately from the mixed group. For example, counsellors, nurses, and support workers should be trained separately from community members who do not work in the frontlines.

One facilitator shared that they want to deliver the course to more staff that work in hospitals. Facilitators also shared that they want to deliver the course to more community members and anyone who is working in the communities; however, they identified barriers such as the cost of the course if it is not covered through employment. With financial barriers in mind, one facilitator suggested there should be avenues created to develop sponsorships for community members to attend the course if the cost is a barrier. Another barrier identified to training more community members was around sharing the information about the course and getting it out to community members. Finally, one facilitator shared that geography can be a barrier to training certain audiences.

[2] In this section we share facilitators' thoughts on reach and audience; however, it is important to note that this is based on the subset of facilitators that were part of our study, and there were many, many more groups run across Canada during the same period. Thus, the perceptions of this group (and who the program is or is not reaching) may not represent the larger implementation.

Facilitators spoke about the demand for the course, "*it went like wild fire, we will not say no to people, we will go out as many times as possible*." They shared that they will need more facilitators to keep up with the demand for the course.

4.1.4 Expanding to other populations

Participants spoke about the importance of reaching various populations with this course. This included the need to offer this course in local communities, given that it is culturally relevant, and that it can include anyone from the community regardless of experience. Some participants felt that the course should be mandatory in communities and offered to youth in high schools as well as to band employees. They also noted that this course should be offered to different agencies to promote cultural safety among non-Indigenous workers and that it should be mandatory for health care practitioners and frontline workers: *"I think it should be made mandatory for health caregivers so they can be more culturally sensitive to the Aboriginal population."* Participants also generally noted that the course is relevant and that other community members should take it. Specific communities that may benefit from this course, included remote communities and Northern communities, as one participant noted:

- *The north is lagging in so many ways as it's been isolated for so long. The [Catholic and Christian] religion is really strong up here and they [don't accept native teachings], which comes from the fear from the residential schools. This is so strong. It angers me and makes me sad. It disappointed me. I've come back after many years and things are slowly changing. A lot of people are against the culture and they're still teaching my son bible studies in the school, so this course is good at being cultural. The one girl said she learned so much about our culture. It's hard to grow here spiritually when people around you aren't and it's hard to connect with people.*

Interestingly, the facilitators who reported that the course was not relevant to First Nations communities noted that they would be comfortable in delivering this course to non-Indigenous participants:

- *Even though we've gone through the process adapting the basic course to meet the realities of First Nation communities, in my mind personally it's not meeting the needs. I would feel comfortable delivering this course to white people and people who are well experienced in the mental health language and terminology of what's taught in the academic realities. When it comes to community, there's so many things I'd rather do. I'm feeling bounded by my training, not to change it that much. What I've been mulling over – you know what, we can do our own teachings of how to be a good helper for people who are struggling with life period. The other part is information; it may not be relevant to the people living in the communities, they may not attach any meaning to it (the labels). That's my concern regarding delivering it.*

Participants shared comments on who the course should be delivered to, most commonly noting that it would be beneficial to deliver the course to more community members. Participants shared that they want more people in the communities to take the course so that they can make a difference at the community level. For example, one participant explained that training community volunteers should be prioritized over training those who already have received intense training or education in mental health and addictions. One participant further explained that this course is designed for community members to be able to develop their listening skills and empathy.

- *I like the program. It's something I needed a long time ago. I wish it could have been brought to my attention a long time ago before my brother died. It should be offered to the public, not just service providers.*

Participants shared that the course should be offered to anyone who may be considered a first responder to a mental health crisis in community, such as volunteer critical response teams or community members who work on the frontlines such as community police services.

Furthermore, participants shared that the course should be delivered to youth in the community. With that, participants suggested that the course be altered to be more youth focused to empower young people in the communities. It was noted that adding a component for youth and children would be important for them to gain awareness of mental health issues and for them to understand that it is okay to ask for help regarding mental health issues. Participants also shared that it would be valuable to offer the facilitator training to youth: *"This would be great for the youth to bring back to other youth – they have a whole different way of presenting things."*

Participants suggested that the course should be delivered to non-Indigenous individuals (in addition to Indigenous individuals). They shared that it would be beneficial for non-Indigenous individuals who work with First Nations communities; participants spoke about the importance of non-Indigenous peoples participating in the course to gain a better understanding of Mental Health from a different worldview. Similarly, as part of the facilitator survey, one person noted, *"I am getting other agencies out there that are asking about training we should note that this course is open to all not just First Nations cause I still get people asking me this."*

Participants shared that there is a need for this course to be delivered to all health employees including health care professionals; however, there is need to tailor the course to be specific for this target group. They explained that if the course were to be specific to health care professionals some information would need to be eliminated so that it is not repetitive as they have already been trained or educated in much of the material. One participant noted that they wished the course went into more in-depth technical training. Regarding other health employees, participants shared that everyone in this setting should take the course including health directors, and even the receptionists and janitors. However, some participants also stated that this course should be delivered to people who are not professionals in the health field, one participant shared, "*I know it is important to bring in people that do have the knowledge, but it would be beneficial to have other people, because they can gain that knowledge as well*."

Additionally, participants shared comments about the audience of the course noting that MHFAFN certification should be mandatory for some groups. For example, participants suggested it be mandatory in certain professions, just like regular first aid, others recommended it be mandatory for youth and band staff, and another participant noted it should be mandatory for everyone, especially those who work with First Nations peoples (e.g., hospital staff, primary health workers, government, RCMP). Finally, participants shared that it is important to identify and clarify the most appropriate audience to deliver the course to and be intentional about spending the community resources in an efficient manner.

4.1.5 Community reception and readiness

Facilitators widely noted that the MHFAFN course has been well received within First Nation communities. They noted that there has been a high demand for course sessions and that people are sharing positive feedback about their experience. They attributed this positive reception to the cultural content within MHFAFN, which is attracting both Indigenous and non-Indigenous community members, as well as the skills that are taught throughout the course. One facilitator noted:

- *As soon as they see the poster with the First Nations component they want to take it, they don't even know it was made by us for us, we let them know that when they came. But they see the title of the course and it excites them, they are interested to see how it is cultural… Helping not just our community members but the non-Native workers – we had a co-worker who didn't know anything about residential school, she told us that it sparked an urge to find out more when she took the course.*

As part of the facilitator survey, facilitators were asked to rate indicators of community support for MHFAFN, on a scale from 1 (not at all) to 5 (very much). As shown in Table 4, the ratings generally endorsed the idea that community supports existed and that there was alignment between the community or organization priorities and the MHFAFN course (average = 4.55).

Table 4: Ratings related to community support for MHFAFN

Measure of Community Support for MHFAFN	Average Rating
Are there additional supports in your community or organization for you to deliver MHFAFN?	4.20
How much does MHFAFN match your community or organization's priorities and objectives?	4.55
Is there an identified person at the community or organization level to support delivery of MHFAFN?	4.00
Have you established new community partnerships as a result of MHFA-FN?	3.55

4.1.6 Garnering community support for MHFAFN

When asked about factors that have been helpful in lifting the MHFAFN course off in their communities, facilitators primarily spoke about the methods that they have used for promoting MHFAFN in communities. They commonly noted that word of mouth has been very effective in sharing the benefits of the course. Facilitators also spoke about the importance of buy-in from decision-makers?, which can be garnered through understanding the need for MHFAFN training. They noted that leaders and staff could be very influential in promoting the course to community members. Facilitators spoke about the importance of offering the MHFAFN course, or an orientation presentation around the course, to leaders in the community to demonstrate the importance of MHFAFN. Other facilitators noted the helpfulness in having a contact in the community to facilitate connections, logistics, and participant sign-up was also identified as beneficial in supporting the uptake of MHFAFN in communities. Infrastructure

support was additionally noted as an important enabler to community uptake for the course; this included having organizational support, including facilities available, as well as mental health support.

4.1.7 Recommendations for additional supports

When asked about additional supports to help to make the course successful in their communities, facilitators most commonly spoke about the value in forming a **community of practice** to provide increased opportunities for facilitators to network with each other and share wise practices. For example, one person noted, "*Making sure we are getting together, to get on the same page, get all the facilitators together to talk about what we are doing, get new ideas from each other."* A community of practice could also assist facilitators in debriefing, as a form of self-care, as one person said, "*going over the course content you do hear a lot of stories, and a lot of things are shared with you, giving a chance to debrief for the facilitators as well."* They noted that the community of practice could be convened over social media or on the intranet. However, one facilitator also spoke about the need to ensure that the intranet performs consistently, without technical glitches.

Facilitators also noted the need for increased **financial supports**; these could be provided through the provision of manuals at no cost, or opportunities to provide subsidized course in communities. As one facilitator noted, the cost of MHFAFN and travel can add up, *"We feed people in ours, when we go to different communities, asking them to pay for our hotel and our mileage, the course material, and food for the participants, it is asking for a lot."* They also spoke about the need for increased funding to reach additional communities, as well as sustainable funding to offer MHFAFN long-term.

In order to support facilitators in their delivery of MHFAFN, they require **supportive and flexible workplace environments**. One facilitator reflected on their own organization, noting the importance of their support for MHFAFN: *"our staff is supportive, if we have to be out of the office to deliver they are there and they have our back. It is a lot of time for us to be out of the office, it takes participants' time but also ours."* Another noted that more master trainers in MHFAFN are needed, given the busy schedules of the four existing master trainers:

- *They need to make sure you have enough master trainers, there are four in Canada, but we also have other jobs, and I've told the coordinator give me enough notice because I have to take time off to deliver the MHFAFN training, and have to fit it into own job.*

4.2 Implementation

This section presents data related to the implementation of the MHFAFN course, including strengths, challenges, and recommendations related to the course design, content, and delivery. This section also presents findings around the utility, relevance, and satisfaction of MHFAFN.

4.2.1 Strengths of the course design

Participants identified many positive aspects about the **overall design** of the MHFAFN course. For example, they shared that the course is well formatted and well rounded, and that they appreciated the balance of reading, breakout groups and activities. Facilitators often spoke about the activities as a strength of the course, including the role-playing exercises and the application of EAGLE:

- *The exercises, some are engaging and break up the energy of sitting and listening, and the little clips and vignettes of examples of how MHFA-FN course can be delivered was very helpful. There's one with assisting suicide ideation in the band, those were really helpful.*
- *Now that we are reading back on the feedback they are saying keep up with the role playing, that is what they are saying, it helps them connect and understand where our people are coming from – it helps with their understanding – when they understand what the person is going through, that helps them.*

Participants also gave positive feedback about the **materials** in the course, such as the hand-outs and manuals. Some participants had already taken other versions MHFA (e.g., MHFA Basic), but noted that they preferred this version because it "has more heart to it."

For the most part, co-facilitators and participants expressed satisfaction with the course design and delivery

- Participant feedback was positive with respect to the balance between learning aides, including: reading materials, interactive role play, manuals, handouts, videos, slides, and circles
- Participants noted that EAGLE and the Circle of Support were useful in their learning

Participants explained a primary strength of MHFAFN is the inclusion of Indigenous specific content (i.e., historical content, the integrated Indigenous knowledge and culture)

- Despite this, it was noted that there were challenges due to the diversity across communities (i.e., literacy and cultural connectedness differed across Canada)

Timeframes to delivery MHFAFN were a notable challenge. Co-facilitators explained that when changes were made to the course delivery, it was related to time. For example they extended the time spent on specific topics

- There was mixed feedback on the time to implement MHFAFN training, with some saying it was a good pace, and others saying they needed more time for debriefing sensitive topics, and time for discussion/sharing

Evaluation participants expressed several implementation challenges, including:

- Participants being triggered by course content and discussions
- Geographic limitations and infrastructure challenges that interfered with course delivery (i.e., weather/travel complications, water advisories, and technological challenges)
- External priorities of those taking the training (job related and community priorities)

Facilitators also spoke about the diverse learning aides that are used in delivering the course, including the slides, videos and circle work. Some of the facilitators have also been creative in providing additional learning activities for tactile or kinesthetic learners: "*I find we have incorporated idle hands, what that means is we have playdoh and adult colouring books, over half of them say that it has helped them focus in the training."*

Participants further reflected that the MHFAFN course **addresses the needs of First Nations**. Another participant mentioned that they hope to see this course offered more frequently as it is a missing component. One participant shared, "*I get a sense of relief that finally there is a program like this for First Nations – it helps me think that it is addressing what we need to do in our communities."*

Many facilitators spoke about the **value of including Indigenous specific components**, including the historical content and cultural teachings, as well as incorporating fun and humour within the course. One facilitator shared, *"I love that we train a course that has Anishinaabe content in it. It brings a different meaning and we can bring in our own experiences and perspectives to the course when we facilitate."*

Another facilitator spoke about the **flexibility** of the course implementation as a strength:

- *I feel like overall it has been good – we are not being micromanaged, we are able to be flexible and personalize it which is awesome, so that we aren't just reciting from a book. I like that there are options for activities*.

While most of the facilitators noted that they have not made any changes to the course, six of the respondents noted that they have. These changes most commonly related to implementation time, and included extending the course time to discuss particular topics in the course, increasing the course length to discuss individual or community issues, and/or shortening the course by excluding activities. Others noted that they included new activities and energizers; for example, one facilitator included "*team builder activity to get the group moving and learning about how challenging facing change can be*." One facilitator also noted that they added additional resources to the course. Additional modifications included making time for telling community stories related to historical trauma and resistance, and being mindful of language when delivering the course in Métis communities.

4.2.2 Strengths of the course content

Participants shared many aspects of the content of the MHFAFN course that worked well. Overall, it was shared that it was effective to walk in both worlds through **integrating Indigenous knowledge and culture** into the MHFA Basic course. Specifically, they mentioned that incorporating information about Canada's colonial history enhanced the cultural relevance and safety of the course. One participant shared:

> *They laid the foundation at the beginning and talked about the things that affect our communities like residential school. Although I learned I have learned about it here and there, they don't teach that in school... But it has affected us and we see the impacts.*

Ceremony, circles and prayer were also noted as important to include. They further described that including Indigenous-specific content increases participants' interest in the course. Additional aspects of Indigenous knowledge and worldviews that worked well included:

- ✓ A focus on holistic health and looking at the whole person
- ✓ Learning about the medicine wheel
- ✓ Having freedom to talk about culture and traditional teachings

Participants also identified **mental health topics** that worked well to include in the MHFAFN course content. These included the terminology for mental health issues (e.g., the signs and symptoms), how to deal with someone at risk of suicide, and bi-polar disorder. Substance use, mood disorders and self-harm in particular were noted as important issues to address in their communities, and thus were important to learn about. Furthermore, participants shared that they have personal experience with alcoholism and depression, which made the topics relatable and helpful. Facilitators similarly noted that it was valuable to ensure participants have an understanding of various mental health disorders.

In terms of the **activities**, participants shared that the videos and case studies are relatable, meaningful, and helpful to apply their skills. They also shared that the role-playing was an effective experiential learning opportunity. One participant shared,

> *The parts that I really liked were the interactive activities with lots of discussion or role modeling in the activities. I think that's because of who I am as a First Nations person—the more I am engaged with others, it seems to resonate most with me.*

Participants additionally highlighted that the four cards activity helped understand the intergenerational impacts of colonization. Both participants and facilitators reflected on the value of integrating community-level context into the course, such as through the Circle of Support activity, as it illuminated the availability and accessibility of mental health resources in communities. The PowerPoint and shadow games were further noted as positive learning tools. In addition, facilitators noted that it was valuable to have visual content integrated throughout the course.

In particular, many participants mentioned that the **EAGLE model** worked well in the MHFAFN course content. For example, they shared that it establishes a format to deal with situations quickly, and that it gives them boundaries to work within. Many participants, as well as facilitators, also noted that the repetition of applying EAGLE in different situations was valuable, as it helped them to learn how to use the model. It was also mentioned that the EAGLE acronym helps them feel calm and close to the Creator.

4.2.3 Challenges of the course content

Participants also discussed being emotionally triggered by the **course content and discussions**. The discussion topics that participants were triggered by included residential school content and suicide. One participant shared that they were triggered by the some of the art included in the manual, as it raised feelings of grief. They also noted activities that were triggering to them, including when participants call out labels that people use for those who are mentally unwell. Another

I almost left the group that day. But I stayed. I'm glad I prayed for the strength to keep on with the course.

participant was triggered by the index card activity[3] and subsequent stories shared about residential school: one participant shared, "*I got tears in my eyes and thought of my own family and how much they mean to me; my health and family; made me think of how important they are."* In addition, a participant discussed that they felt uncomfortable when participants were laughing during the activity around schizophrenia.

4.2.4 Strengths of the course delivery

Participants also shared many aspects of the delivery of the MHFAFN course that went well, largely around the facilitation. The most frequent positive feedback was about the **spaces for engagement** and being hands-on with the material. For example, they noted that group work (e.g., role playing, case studies) allows for opportunities to engage, interact and learn from each other – it further breaks up the day in terms of activities and more didactic teaching. Participants further mentioned that they appreciated spaces for brainstorming and giving feedback throughout the course. One participant additionally shared that they learned to work as a team through the activities.

The **facilitators' delivery style** was also noted as effective, such as that they were clear and worked well as a team. It was also noted that sharing **personal stories** was effective, as it helped participants learn from each other and interpret the information being discussed. They further discussed that sharing was valuable from both participants and facilitators, as they could identify common experiences and bring more "weight" to the content. Facilitators also noted that sharing was helpful for meeting new people and learning about their communities. One facilitator reflected that it was valuable guidance provided by the Master Trainers to use personal experiences to bring the material to life.

> ***People are better to relate if they are hearing our stories, by us being open and willing to share a little something they are able to better connect with us and get a better understanding of a topic.***

Related to this, humour was identified as an important component to weave through the course to balance heavy topics. Participants also mentioned that the **discussions and check-ins** worked well, where sharing circles for debriefing provided the opportunity to heal and release feelings that they were experiencing. Checking in and out each day was also noted as an important aspect of the course delivery. Similarly, participants shared that facilitators created a **safe space** for sharing and discussions around sensitive subject matter. One participant mentioned:

- *I find that everybody is sharing their stories and obviously we're comfortable to share our personal stories and I think that we're growing more that way. The manuals are there but as you said our personal stories add the meat to it, and I feel like everybody feels safe and no one's worried about what they're saying and feeling judged – I feel it's a safe environment.*

Participants also shared that the **organization** of the course was positive, in that it was effectively put together and the content flowed well. One participant noted that the material was broken down into

[3] During this activity, co-facilitators hand out four index cards to each participant and ask the, to write the most important things in their lives, such as their children and other family members, their culture, and their education. Following this, the co-facilitators walk around the room and take two or three cards away from each person. They then ask how participants feel about the activity to garner reflections. At the end, the cards are all returned to participants.

parts that were easy to understand, and that the smaller groups made it easier to share stories and information. It was also emphasized that determining group expectations and protocols on the first day was an important organizational component, as it allowed for participants to come to a shared understanding of everyone's expectations.

There was mixed feedback given about the **timing** of the course: some course participants responded that there was a good pace of delivery, but others felt it was too fast for the topics. However, they appreciated the need to stay on time, and that the facilitators adapted the pace of the course for the group. Other aspects of the course delivery that worked well are described in the Table 5.

Table 5: MHFAFN course aspects that worked well

Aspect of delivery	*n*	Description
Group size and make-up	4	✓ Small group setting was beneficial for the course ✓ Knowing participants in the room meant that trust was pre-established ✓ Enjoyed having First Nations community members together
Elder present	3	✓ Having an Elder present (for the opening and throughout the course) made participants feel more at ease
Location/setting	3	✓ Grateful that the location was in a beautiful space, as it helped for taking in heavy content ✓ Liked that the course was in a First Nations setting
Logistics	3	✓ Appreciated that meals were served (e.g., they didn't have to leave, which is important particularly if people are triggered)
Networking	2	✓ Enjoyed opportunities for networking amongst participants
Gender	1	✓ Worked well to have one male and one female facilitator
Evaluation	1	✓ Happy that the course is being evaluated

4.2.5 Challenges in delivering the course

When asked about the challenges that they have experienced in delivering the course, facilitators most commonly identified **time constraints** (see Figure 8 below). They noted that the timeframes were difficult to work within for many communities: facilitators described that extra time is required to debrief sensitive topics, as well as to have adequate space for discussion and sharing. Another facilitator noted that it would take an additional 1 to 1.5 days to deliver the course in communities. They also indicated that some of the activities had triggered participants and that some of the activity instructions were unclear. Additional challenges included lacking time to prepare with their facilitator, and challenges in cross-referencing between the facilitator and participant manuals.

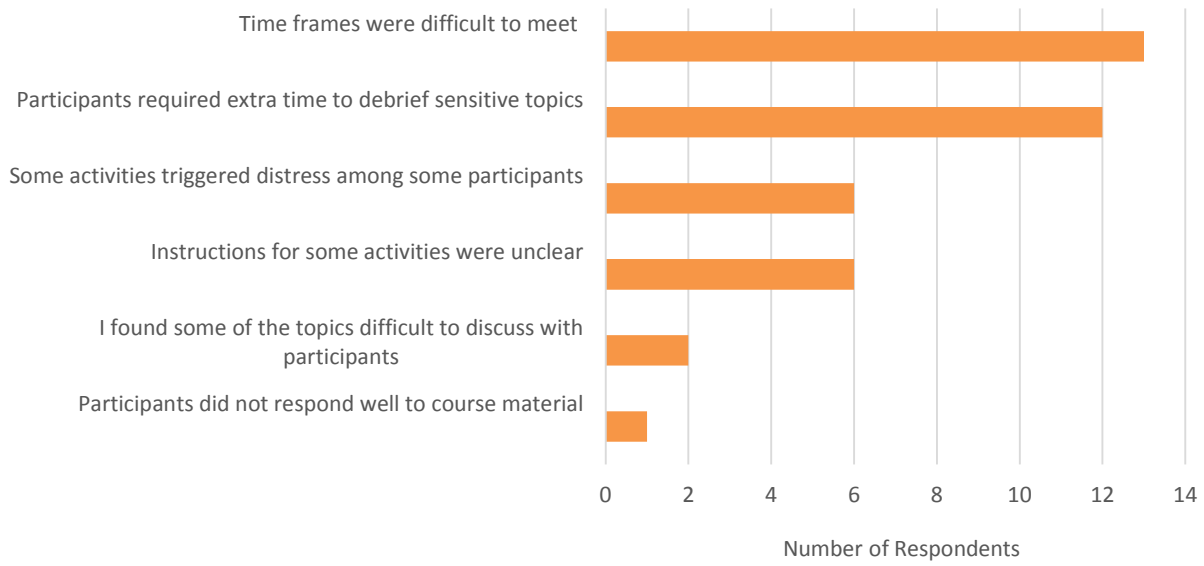


Figure 8: Most common challenges for facilitators in delivering the MHFAFN course

The facilitators described some of the challenges that they have experienced when delivering the MHFAFN course in communities. Most commonly, they spoke about the **diversity across communities** in terms of course atmospheres (i.e., urban vs. rural, northern vs. southern), different beliefs and values across communities, different literacy and education levels, and different types of lived experiences with mental health and emotional understanding. In speaking to these differences, one facilitator said, *"In different communities they have different beliefs and values, they are so little but they are there and it can be a sensitive topic for some, we feel it more in different communities."* Facilitators spoke about the importance of honouring diverse community values and being appreciative of all feedback received. Another person noted how facilitators can grow from delivering the course in different community contexts through ongoing learning.

They also spoke to **geographic limitations** in delivering MHFAFN, including weather and travel complications, as well as limited infrastructure in some communities (e.g., water advisories, limited lodging). In reflecting on these challenges, they spoke about potentially training more facilitators within northern areas, or considering hosting the course in city centres to avoid infrastructure challenges. Two facilitators spoke specifically about technological challenges in delivering the course, and noted the importance of setting up at the location the night before to ensure that all equipment and materials are in place.

Facilitators also spoke about **external priorities in their communities**, which are competing for time and resources against MHFAFN. They specifically spoke about crises and other concerns in communities, which can disrupt the delivery of planned course implementations. In speaking to this, one facilitator noted, ***"****sometimes things happen, a death in the community, things happen, life happens, when it happens in community, the priorities shift, it's not about achieving the completion of the course."* Conflicting organizational priorities, which include mandatory training sessions on topics other than mental health, also impede the uptake of MHFAFN. Additionally, community members have had job obligations arise while they are participating in the course, impeding their ability to complete the MHFAFN course, as one facilitator noted:

- *In community, when delivering the program, there was an energy of other obligations, it interfered with the delivery of the program. [Less than half of the original participants] received the certificate. Their time is very precious in that they had other responsibilities to respond to. That's the energy we face.*

Another facilitator highlighted the importance of cultural contexts when delivering the course and encouraged adapting the course as appropriate:

- *Another concern is the agenda states that lunch would be covered, to ensure people stay at the site. Unfortunately this would most likely not work in the FN communities where family is a priority. Parents would want to be home for lunch for their children and/or spouses, and would want that full hour for lunch.*

Some of the MHFAFN **course requirements** were also identified as barriers to delivering the course in communities. Challenges to delivery include financial barriers related to purchasing MHFAFN resources and supplies, and the amount of time required to prepare and practice for delivering the course. Other course requirements and structural components that serve as barriers are described in Table 6.

Table 6: Structural challenges and associated comments from facilitators

Structural challenge	Quote
Requiring participants to attend and complete all modules in the course	*One of the biggest challenge we have, is sometimes life happens and you could have someone there for the first two days and something major happens and they can't legitimately make it to the last day; family members get sick. We feel bad because it is hard to find days to make it up. Even if they step out for a few minutes for a legit reason, for them to come back, we can't say they completed the course because they stepped out for a half hour, so we can't give them certificates.*
Fluctuating demand for the course can impede the MHCC requirement for facilitators to delivering two course sessions each year, with a minimum of 12 participants in each course	*[The trainer] didn't get her two in last year, so she got a letter from [MHCC] who told her she needed to do another one or she loses her provincial standing. In my first year, I couldn't line up the training/course opportunities to meet the provincial designation for instructors. In December, when she got that letter, we were thinking, "when can we deliver," we tried, we did lots of outreach, but the minimum number of requiring 12 participants was a hindrance, we could get 6 or 8, but not 12, we started thinking who could we collaborate with.*
Having a restriction on the maximum size of the class	*Physically there's a barrier to providing it to community membership outside of professional staff due to the restrictive size of class, like our max class is 25. In order to get the training out to a few of the areas we would have to hold multiple classes.*

4.2.6 Suggestions to improve the content

Participants provided a number of suggestions regarding what they would change about the course. Many of their suggestions were around the content, and specifically **adding topics** to the MHFAFN curriculum—these were largely centred on cultural components. Participants suggested broadening content around cultural diversity, and including different languages and cultures that are more nationally representative. They also suggested including cultural teachings around:

- ⇒ Psychotic disorders (e.g., people with schizophrenia are viewed as having gifts)
- ⇒ Importance of dreams in First Nations cultures
- ⇒ Elder teachings

One participant noted concerns with how mental health diagnoses fit culturally: they gave the example of being diagnosed at a clinic with bipolar disorder, but from a cultural perspective, "*When a person spirals spiritually it is them trying to bring in cultural reclamation."* While one participant thought there was too much spent time on the historical context, others suggested adding more information around historical trauma, and earlier colonial events than the residential school system and the Sixties Scoop. Facilitators also suggested having a full day dedicated to the historical context. They also recommended having more information around present day systemic racism, such as in the child welfare, health and justice systems. Participants suggested defining trauma and how it impacts the spirit (e.g., witnessing an event can be equally as harmful as experiencing it). They also suggested adding content around lateral violence to help participants understand its colonial roots: "*There is a loss of control in people's lives, so they hurt others to get the control back."* Another participant shared that information about grief and loss should be prominent in the course, as *"we are grieving as communities,"* and content around this could help people understand themselves better.

To balance this information, participants shared that more information on solutions or ideas for communities to deal with intergenerational trauma and the legacy of colonization (e.g., suicide, mental health disorders) would be helpful. Participants also suggested adding more strength-based content to the course and honouring communities' knowledge:

- *We don't give our communities enough credit, they are very educated on events even if they aren't formally educated, people have information and take part in education sessions and seminars, or traditional teachings were good and relevant and current information is shared.*

At the same time, it was noted to be careful about **making assumptions** that Indigenous people know about ceremony and are connected to their culture. They shared the importance of respecting "non-traditional" people in the room, and defining "spirituality and heart activities" to ground people in a shared understanding.

In addition to the current information about substance use, participants suggested additional areas of content, including:

- ⇒ Discussions about communities that lack supports and first responders
- ⇒ Risk factors that LGBTQ2S+ youth experience
- ⇒ Trigger words for participants (e.g., what not to say to someone in distress)

They also shared that more time could be spent on the impacts of our own attitudes on our ability to give care. This related to the suggestion of including self-care advice for those who witness trauma and those in leadership roles in the community –emphasizing the importance of counselling, debriefing, and personal safety. One participant shared:

- *To prevent [PTSD] there needs to be debrief with a circle of people (chief and council) to say I'm here for support, to check-in how that effected you; so I can say I couldn't sleep, I cried, my nerves are shot, I'm deterred. We need that self-care too. It can't be one direction, only giving to people, it has to come to us too… especially if you want to see strong leadership at the community level.*

In addition to topics that could be added, participants suggested **strategies** that could be helpful to include in the MHFAFN course. For example, one participant noted that content around how to deal with people in different life stages is important, as there would be differences in approaches when working with children or adults. They also were interested in a strategy to identify drug-seeking behaviour around prescription pill use. Another participant suggested adding content around how to handle situations when people do not want support or help. An additional gap was around culturally relevant strategies to support people, as participants were hoping to gain knowledge on Indigenous practices for healing:

- *I don't feel like I took away something concrete and wouldn't be any better or worse at dealing with situations that require cultural sensitivity than I was before I completed the training.*

Participants also identified some **content that could be removed or changed**. This included the measurement of drinks, noting that this is common knowledge in community, and that the substance use disorder information is too in-depth. Additionally, one participant shared that the DSM-V information is too clinical and may not be appropriate for teachers and community members: they alternatively suggested providing a small background on it instead, without prioritizing it in the course. Participants also noted inconsistencies in terminology in the manuals (e.g., Aboriginal vs. Indigenous vs. First Nations). Another participant discussed that a process for updating the manual would be helpful to keep the content and sources current.

4.2.7 Suggestions to improve the design and delivery

Course participants also shared aspects of the **design** that they would add or modify. In terms of additions, they suggested adding contextual information about the course at the beginning of the course, as well as a "teamwork agreement" that includes protocols around confidentiality and respect. Participants also had mixed feedback in terms of the role-playing; some enjoyed those exercises and others found them to be anxiety provoking and less helpful. They suggested to alternatively have videos that participants could critique and discuss, or have focused case studies in small groups. In addition, participants suggested various resources that could be incorporated into the course to enhance the application of knowledge when they return to communities: these included a quick reference card with the steps of EAGLE, and pamphlets containing information on community supports and cultural resources.

Regarding modifications to the design, **time was often raised as being too tight**. To address this, course participants suggested either increasing the length of the course to be 3 or 4 full days, or to shorten the number of modules to be able to deepen discussion about the material. They further discussed flipping the course development strategy, where it would begin with First Nations content and knowledge, and then Western ways of knowing would be integrated to complement that information. Participants felt that this would enhance the bicultural approach taken in the MHFAFN course. Other suggestions to change the design included using more Indigenous terms (e.g., "mino pimatisiwin" which translates to "the good life" and can be used for mental wellness). They also clarified that the **"history" section is the present day reality for Indigenous peoples**, where colonization and racism continue to perpetuate the health and social inequities experienced by Indigenous communities. One participant stated, *"If we only mention it as a historical happening, people think it is over, its not – we still experience it today in different ways."*

Facilitators provided suggestions to **modify the application process**, including the facilitator application. They shared that it is too in-depth for what the course includes, and took a great deal of time to complete: participants alternatively suggested that it focus more on connection to history and culture. One participant commented that the application process provides a good indication of where participants are at, and that facilitators could study that information to be able to tailor the course to the audience. The components that participants identified as important to include in the application process were:

- ⇒ Knowledge of history and culture
- ⇒ Resume and cover letter outlining their interest, experience, and why they would make a good trainer
- ⇒ Potentially include ASIST training[4] as a prerequisite (to provide background information about suicide)

Course participants shared various ways that they would **modify the delivery** of the course. Their suggestions largely revolved around enhancing time to spend on activities in the course, and to be able to debrief modules and scenarios. Given that there are sensitive discussions that take place during the course, participants noted the importance of having an additional facilitator, support worker or Elder in the room. In terms of the slide delivery, participants recommending ensuring the information in the manuals mirrors the slides, and that they are in the same order to increase flow of the course. They also noted that more stories with lived experience would bring heart to the material.

In addition, facilitators provided recommendations around the **preferred characteristics of people who would be facilitating** the course, based on the successes from their personal experiences. One person noted that it is beneficial to work with facilitators with different types of expertise where one is knowledgeable about clinical mental health, another can provide stories and teachings to supplement the course. Others noted the importance of having Indigenous facilitators, working with three facilitators rather than two and having an Elder as a facilitator.

Facilitators also provided **advice that they would give to new facilitators for MHFAFN**. These lessons learned are described in Table 7.

[4] Those considering adding ASIST as a prerequisite may wish to read Sareen et al., 2013 for a discussion of fit with First Nations participants and communities

Table 7: Advice that facilitators would give others delivering MHFAFN for the first time

Meta-Theme	Theme	n
Preparation	Be familiar with both facilitator and participant manuals and practice the delivery beforehand	4
	Prepare print-outs and activities and know the community resources	1
	Understand what is going on in the community (e.g., events, crises)	1
	Need to spend at least a full day together with facilitators to practice	1
Flexibility	Go with the flow of group, take breaks when needed	3
	Allow for time and a culturally safe space for discussion	2
Facilitation	Give direction to the group during discussion to ensure that they stay on track	2
Elders	Have an Elder attend for the duration of the course	2
Self-care	Practice self-care, such as by using the evenings to relax	2
Timing	Going to offer a three-day course with shorter days and more time to debrief	1

4.2.8 Utility and relevance

In speaking to overall strengths of the MHFAFN course, both participants and facilitators often spoke to the utility of the course in their families, workplaces, and communities. They described the contexts of their communities as a way of describing the need for MHFAFN. Course participants spoke about the value of MHFAFN within their communities, where the non-judgmental approach can be easily applied across community contexts, as well as at the workplace, to support co-workers and staff. They spoke about the ways that they can use the skills from MHFAFN with their families, while some participants expressed that they wished they had the MHFAFN training in the past to assist family members who were struggling. Some participants also noted the ways that they would use the MHFAFN training for personal healing and self-care purposes, noting the importance of taking care of themselves before they can help others.

Facilitators spoke to the utility of the course, noting that MHFAFN is valuable, relevant, and useful in everyday and workplace settings, with both Indigenous and non-Indigenous people. They also spoke about the importance of this course within the context of mental health crises in communities, specifically speaking about high rates of suicide within some communities. One participant reflected about a personal experience that happened while they were in the MHFAFN course:

- *Today, when [another participant] was talking about the suicide call this morning, it hit home again, this is real. I thought this [the course] won't impact me in a month, or 2 months later, but I saw it this morning. It hit me, "oh geez, this is reality". At this very moment, someone is thinking about suicide, and it hit me that I can help this person; it made it important for me to complete the course (and for everyone to complete this course).*

Findings from the MHCC feedback forms corroborate the facilitator feedback on the relevance of MHFAFN. On a scale from 1 (not at all relevant) to 10 (very relevant), the average rating of relevance of

the course content by course participants was 8.94 (*SD* = 1.12), illustrating an overall perception of the MHFAFN material as very relevant.

4.2.9 Satisfaction

Participant Satisfaction

Participants shared their satisfaction with varying aspects of the course. Overall, 60% of participants were extremely satisfied with the **course overall**, and 33% were somewhat satisfied. They shared that the course was highly informative in dealing with mental health issues among First Nations people, and that it provided them with tools to use in their work. One participant shared, "*I believe that everyone should be exposed to this training because it paints a beautiful picture of who we are as individuals."* Another participant shared that the course touched them in "healing ways." At the same time, other participants shared that the course was tiring, particularly with the added homework – yet they recognized the necessity of it.

I truly walked away with so much through this training because not only did it help my position in my work place but also as a person – I grew roots through my soul and all my beings.

They also gave positive ratings for the **facilitators** that led the training, where 63% were extremely satisfied and 35% were somewhat satisfied. Participants contextualized their responses by stating that the facilitators were skilled and engaging, and liked that they were Frist Nations themselves. One participant commented, *"The trainers have and do create and provide an excellent First Nations perspective, reality, and experience."*

In terms of the quality of the **program manual**, 56% of participants were extremely satisfied and 35% were somewhat satisfied. While they noted that the manuals are very informative and contain a lot of information, errors in the manual (e.g., mistakes with spelling, grammar, and information) and mismatched information from the PowerPoint detracted from participants' satisfaction.

Facilitators also shared the limitations of their satisfaction regarding the manuals. In terms of gaps in content, facilitators noted that they would like to see more information on FASD, as well as discussion points related to medical marijuana:

- *One challenge right now is when we get to marijuana use, for medical reasons there… the last couple that we have done they ask about medical marijuana, we only can list on what is on our notes. People have a big discussions about this. For us not knowing what medical marijuana is doing for mental health.*

Facilitators also noted that the participant manual content should be parallel to both the presentation slides and the facilitator manual. In terms of overcoming the challenges, one facilitator spoke about framing the manual and materials as living documents and suggested that the materials be regularly updated (i.e., every two years). Another facilitator noted that they prefer the layout of the MHFA Basic manuals, in terms of colour coding, icons, and referencing.

Additionally, facilitators requested that the Circle of Support and EAGLE posters be enlarged, and that some of videos be updated (e.g., the psychosis video to be First Nations specific). While some of the facilitators noted that they were satisfied with the **MHFAFN resources** overall, others noted that they prefer to use them for guidance while primarily speaking from their own experiences:

- *It's there, I look at it, I read it, but it's natural for me. I just do it. It comes from my heart, history, how I live. I read it and see where we're at, but then I go on visions of my own, I know it's hard, I probably have a harder time because I have to put it in my Cree way of being taught, then put it in the Western way. That's how I've been taught, so that's how I do. I can bring in the story of what they're talking about. It's there for guidance.*

Just over half of participants (52%) were extremely satisfied with the **topics covered** and 40% were somewhat satisfied. They reflected that the topics and subsequent discussions were interesting, and specifically liked that they were reminded about previous modules before starting new ones. However, some participants were dissatisfied with the First Nations component, noting that they had higher expectations for learning this material.

The **length of the course** received slightly less favourable ratings, where 48% were somewhat satisfied and 33% were extremely satisfied. There was very mixed feedback about this, where some participants felt that it was too long and others wanted it to be longer to go more in-depth with the material – specifically they wanted more time to discuss the medicine wheel and self-reflection techniques to explore personal triggers.

Facilitator Perspectives

Facilitators were asked to rate three aspects related to their satisfaction in delivering the MHFAFN course. Using a scale from 1 (not at all) to 5 (very much), Table 8 displays the average ratings based on 21 facilitator ratings.

When asked how prepared they felt to deliver MHFAFN after the course, on a scale from 1 (not at all prepared) to 5 (very prepared), facilitators reported an average of 4.05. Using the same scale, facilitators also rated the level of participant satisfaction with, and participation in, the course (Table 9).

Table 8: Overall feedback on facilitator experiences with MHFAFN

Measure	Average Rating
Delivering MHFAFN was a positive experience	4.48
I would recommend MHFAFN to my co-workers	4.95
MHFAFN is beneficial to my community	5.00
Overall satisfaction with the training	3.90
Satisfaction with the topics covered	4.10
Satisfaction with the length of course	3.60
Satisfaction with your course instructor	4.05

Table 9: Perspectives on participant satisfaction with, and participation in the MHFAFN course

Measure	Average Rating (1-5)
The extent to which participants enjoyed the course	4.70
The extent to which participants participated in the course activities	4.65

4.3 Impact

This section identifies the impacts of the MHFAFN course, with a focus on participant-level outcomes. Participants identified a number of personal gains in knowledge and awareness, as well as shifts in skills, attitudes, and self-efficacy. This section also discusses issues and outcomes related to stigma at both the individual and community levels.

As a result of their participation in MHFAFN, participants identified a number of personal gains in knowledge and awareness, as well as shifts in skills, attitudes, and self-efficacy

Participants demonstrated increased knowledge and awareness about:

- Mental health, including recognizing signs and symptoms
- Social determinants of health
- Colonization and historical trauma
- Supports available in communities

Outcomes related to skills, attitudes, and self-efficacy included:

- Increased confidence in MHFA skills
- Ability to apply EAGLE skills, including the ability to listen without judgment

Stigma was described as a community concern by nearly all of the MHFAFN participants

- Stigma beliefs decreased significantly from pre-training to post-training results, based on participants' self-reported ratings
- Participants also described increases in self-awareness and skills for alleviating stigmatizing behaviours

Unanticipated outcomes commonly included opportunities for reflection, learning about traditional teachings, and contributions toward personal healing

4.3.1 Knowledge and awareness

Quantitative results

Findings from the retrospective pre-post survey measured differences in self-reported knowledge for participants before and after the course. There was a significant increase in self-reported knowledge about mental health from pre-test (*M*=2.90*, SD* = 0.70) to post-test (*M*=3.60*, SD*=0.43), where t(87) = -11.50 (p = .000). When pre-post differences were examined for each training background group separately (i.e., those with post-secondary, those with other training, and those with no training), each showed a significant increase in self-reported knowledge. These groups also started at different places on the different measures. Collectively, the analyses showed that participants started in different places based on their training, but regardless of their background and starting point, they increase in self-reported knowledge about mental health.

For knowledge about social determinants of health, there was also a significant increase in self-reported knowledge for the whole sample, where t(88)=-9.26, p =.000. However, on this scale, those with post-secondary training did not rate a significant increase, while participants in the other two training groups did. Pre-post findings are shown in Appendix C (Table 16).

Qualitative results

When speaking to the most valuable aspects of the MHFAFN course, many participants identified personal impacts that the course has had for them in terms of increased knowledge and understanding. Similarly, when facilitators were asked about the impacts of the course for participants, they most commonly identified areas of increased knowledge and awareness. Participants spoke about learning new mental health information and having increased knowledge on mental health, including the ability to recognize signs and symptoms and conceptualizing mental health as a continuum. Participants also

noted that they have learned new information with respect to history, culture and traditions. One participant noted the importance of this for non-Indigenous peoples:

- *There's a lot of people that don't know our traditions. From a perspective of not living in community, this would be effective as a teaching component for non-Indigenous people and how that historical experiences that we have had can impact our trauma and the mental health issues that we experience.*

Similarly, facilitators spoke about outcomes related to an increase in understanding of Indigenous content in the course. This was particularly poignant, they noted, for non-Indigenous staff: *"It's like fireworks, they get a better understanding of who we are as First Nations people and who we come from. [It is] culturally sensitive. They get to realize what it is like to be the two-eyed seeing."* Facilitators also identified that some participants experience increased awareness of white privilege and unconscious racism:

- *It opens their minds, there is that thing called unconscious racism that we are kind of reaching, as nurses they don't realize it or other people. When you see someone come in and they look intoxicated, they could be having a psychotic event, but that unconscious racism kicks in and the think he is drunk or high and they don't mean to, but unconsciously what they were taught when they were growing up. Making them realize it and making them aware of it, it is always going to be there, but you are always not aware of it.*

Additionally, facilitators identified that participants experience increased **awareness of community supports** via the circle of support activity. As part of the online survey, facilitators also noted that participants have increased knowledge of mental challenges, as well as understanding of community contexts, including challenges and opportunities for integrating mental health services. This was also true for participants who responded to the follow up survey; they spoke about looking to the community for help, and creating their own social support circles. One respondent noted, "*I've taken a mental note of what facilities are available around me and my families that we can access help, information or guidance in certain situations*."

Areas of new knowledge were also identified by participants when asked about unanticipated outcomes they received from the course. This included specific areas described, with quotes, in Table 10.

Table 10: Outcomes related to new knowledge for participants

Outcome	Comment
Increased knowledge about risk factors, signs, and symptoms for substance misuse and mental illness	*Giving away of things, before I never thought it was a sign, I would've accepted it as a gift. That surprised me in terms of what I learned so far.*
Increased knowledge on colonization; increased knowledge on the importance of knowing the history	*It's still an issue – we can see it and feel it, the addictions problem, youth suicide—it all comes from a long historical sad story.*
Increased understanding of the supports available in communities from the Circle of Support activities	*Seeing it up on the wall like that, there is so much help out there for people, we just need the guidance to find that support, this course will help us share that this knowledge is out there.*
Increased knowledge about tools to be a first aider	*They are telling us about EAGLE… that will be helpful because it guides us what to say, how to react, to keep calm and keep the person calm and not be judgmental.*

4.3.2 Skills, attitudes, and self-efficacy

Quantitative results

As part of the retrospective pre-post survey, participants responded to two measures related to self-efficacy: confidence in their skills as a Mental Health First Aider and ability to listen without judgment. A mean was calculated for each of these measures and analyses were run to examine the overall pre-post change. A general linear model was also run to look at gender as a moderator.

Overall there was a significant increase from pre-test ratings of self-efficacy (*M*=2.94, *SD*=0.76) to post-test (M=3.67, SD=0.43), t (88) = -11.08, p = .000. All three groups reported a significant increase in self-efficacy from pre-to-post. There was a significant gender by self-efficacy interaction. It is apparent that female participants reported higher self-efficacy than males at both pre- and post-intervention ratings, but males reported larger gains from pre- to post. Similarly, the archival data, analyzed for 385 respondents, demonstrates a high level of confidence in their MHFA skills post-training with an average rating of 8.42 (*SD*=1.21) on a scale from 1 (not at all confident) to 10 (very confident).

To understand ways that participants might apply MHFA skills and strategies, participants were also asked to respond to a scenario about a hypothetical friend—John—who is described as suffering from a possible mental health crises. In their responses, all respondents reported that they were concerned about John and successfully identified that he might be dealing with an issue that required assistance. While the question did not directly ask for participants to use EAGLE strategies, they described on average three (of five) EAGLE actions in their written responses (*M* = 2.96, *SD* = 1.31). Overall, all participants who responded to the scenario were able to identify at least one of the EAGLE actions in their written responses. The most commonly reported EAGLE strategy used to address the scenario was to "Engage and evaluate the risk of suicide or harm" (79.1% of participants identified this action). Sample responses, frequencies, and gender differences are provided in Appendix C (Table 17).

Qualitative results

Participants spoke about having an understanding of the importance of **active and non-judgmental listening**; of being mindful of body language, eye contact, tone when talking to someone in crisis; and of the importance of ensuring their own safety. Similarly, during our participation throughout the site visits, we heard from participants that they felt more equipped to support people in distress, to apply EAGLE, to have non-judgmental conversations, to listen with the heart, and to share MHFAFN knowledge with their colleagues. They also spoke about having increased confidence in their knowledge and skills:

- *Because I don't have any counselling background. I never thought I was capable at helping people. I knew I could, but I didn't feel confident. But with this I think I would be able to help more in my job. I mostly work with youth programming.*

Additionally, facilitators commonly identified participant outcomes related to **confidence and new skills**, noting that participants are gaining self-confidence in their employment, are better able to recognize people in need of support. One facilitator said:

- *I think it has given a lot more self-confidence to the workers to the various degrees in being more flexible in dealing with the clients… they have conveyed that they feel better at being able to do their jobs more effectively and their sense of validation for being a care giver has been raised has been validated, it improves confidence levels.*

Facilitators also noted that they have seen participants' experience **increased empathy** for what people are going through with respect to mental health journeys. Similarly, facilitators who responded to the online survey identified that participants have increased their understanding and confidence in helping people in a crisis as a result of participating in MHFAFN.

During the follow-up survey, participants were asked if they had applied any skills from the MHFAFN in their everyday life. Nearly all of the respondents (82.8%) noted that they have applied the knowledge and skills from MHFAFN to their everyday lives. They spoke about having increased skills and an overall ability to help others, increased awareness of causes of mental health issues, and increased confidence. Respondents also reported that they now have enhanced communication skills. Another respondent spoke about having increased patience, which has transferred over into their parenting skills: "*It assisted me with being more patient with my children and listen a lot better to keep situations from getting out of hand*."

Some participants offered very compelling accounts of utilizing their EAGLE skills:

- *I have had someone close to me come to me with suicidal thoughts and urges... with my knowledge from the training about dealing with mental health emergencies I was able to listen and direct this person to the resources I knew available in our community. Person is currently receiving help at the professional level.*

- *A family member mentioned that she was experience panic attacks and could not determine why. We talked and I suggested journaling as well as getting a check-up with her doctored and she really liked the journaling idea and has since also seen her doctor.*

- *I knew how to respond to someone contemplating suicide. And I knew how to use my body language with our First Nations people. It is different than the regular population, as well the eye contact. I hope my actions helped the individual. This person is still here with us today. As well, they confide in my completely. Thankful for MHFAFN.*

4.3.3 Stigma related outcomes

A total of 93.8% of course participants indicated in an online survey that they believed mental health stigma is a concern in their community. Of those who reported that stigma is a concern in their communities, they offered insight into what stigma in community looks like, commenting that oftentimes, the stigmatized topics focus on **substance misuse**, while mental health concerns around depression and anxiety are accepted illnesses within community. When asked to share more about stigma in their community, survey participants frequently identified both **social stigma** and **structural stigma**. Most frequently, survey participants spoke about how stigma is socially constructed within communities. In speaking about socially constructed stigma, participants shared that oftentimes those living with a mental illness are ignored, isolated and avoided by others. Further contributing to mental health stigma is how individuals use language and labels. For instance, survey participants spoke about how the misuse of mental health terms being used in derogatory ways diminishes the seriousness of mental illness. One participant commented:

- *Slang words are thrown around so openly that nobody takes the actual illness seriously. I find that because those titles are thrown around so openly that not a lot of people know that actual meaning and seriousness behind it.*

I would say they ALL have stigma. Anxiety: not taken seriously enough. Depression: ignored and people feel like one should just "get over it". Substance abuse: judged and ridiculed. Psychotic disorders: feared and isolated.

Other ways in which survey participants spoke about stigma being socially constructed was in the judgement that people pass on those living with mental illness, community hesitation and reluctance to discuss mental illness, and having unrealistic expectations of those living with mental illness. One survey participant shared, "*There can be times where judgement is often passed too easily with people struggling. [They're] seen as weak or crazy instead of sick and should be treated like something common like a cold.*" Furthermore, survey participants noted that oftentimes those living with mental illness are bullied and face lateral violence, blaming and shaming. Fear was also a common element in how mental health stigma is socially constructed; not only do people fear those living with mental illness perceiving them to be violent or dangerous, but there is also the fear that those living with mental illness face to talk about their mental illness. When mental health concerns are associated with gifts, often these gifts are discouraged.

When speaking about structural stigma within community, survey participants spoke about there being a lack of education and awareness about mental health, a lack of supports and services, and limited investments for the uptake of mental health awareness in communities (see Table 11 for a more detailed summary of how stigma is socially and structurally constructed in communities).

Table 11: Participant descriptions of what stigma looks like in their communities

Theme	Detail	n
Socially constructed stigma	Where people are ignored, isolated and avoided. Examples include being disregarded, ignored, or avoided (or not seen as a priority); or being isolated and ostracized (i.e., shunned)	20
	The use of language and labels. This includes labeling: "he's crazy" or "Addicts and alcoholics" or "schizophrenic vs living with schizophrenia;" using negative terms and the misuse of mental health terms as derogatory "psycho, schizo" diminishes the seriousness of mental health illness	14
	Where people are judged and viewed as different (looked down upon), uneducated, or seen as using too many drugs	12
	Hesitation and reluctance: includes community and family reluctance to discuss mental health concerns (ignoring the issue), individual reluctance by the person living with mental health problems to discuss mental health concerns (fear of judgement and labels), community members not wanting to come into the mental health department (fear of being labelled or judged), and declining services needed and available	11
	Expectations: a lack of understanding that they need assistance, seen as a sign of weakness and unable to cope, or not perceived as a real illness	10
	Bullying, such as name calling, pointing and snickering, lateral violence, jealousy, gossiping, negative talk, blaming, and shaming	8
	People are feared as being violent or dangerous	6
	Environment is not positive or toxic	4
	Fear and worry of being judged, talked about and thought to be weak	3
	Visions as gifts are discouraged or mental illness linked with bad omen or cursed	2
Structural stigma	Educational awareness: There is a lack of education on mental health concerns (makes the community look uneducated)	6
	Services and supports: There is a lack of access and services cannot keep up with disseminating information, a lack of support for those with mental health concerns or discrimination against people with mental health concern by the services	4
	Investments: Not enough resources, money and training regarding mental health	1
	Poverty	1

In thinking about the topics discussed in the MHFAFN course, survey participants shared which mental health concerns experienced the most stigma in their respective communities. Most frequently, survey participants noted substance abuse (i.e., alcohol, drugs, prescriptions, and methadone) and psychotic disorders as the most stigmatized mental health concerns. Often, participants contextualized their statements by noting that these mental illnesses are stigmatized due to a lack of understanding, ignorance and fear. Figure 9 below highlights the most stigmatized mental health concerns.

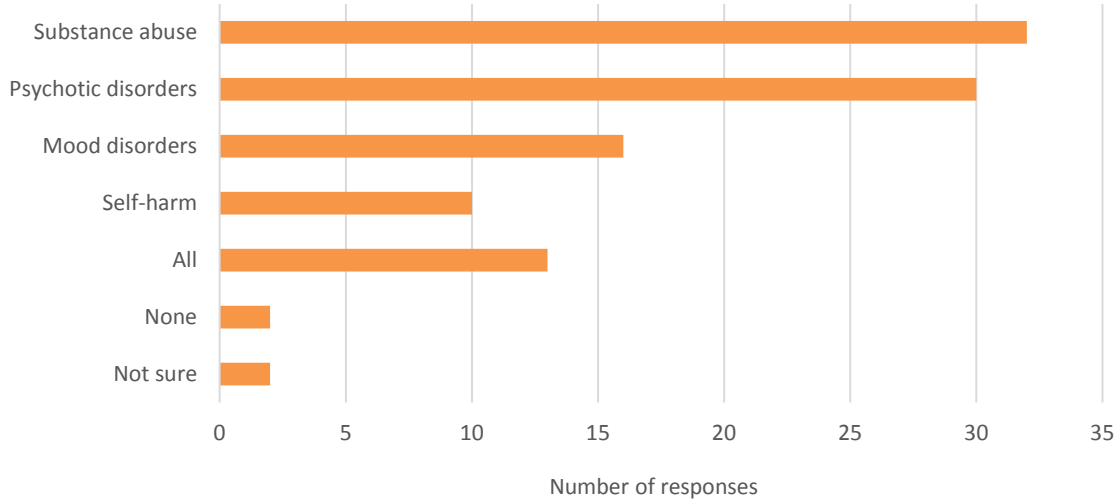


Figure 9: Most stigmatized mental health concerns in community

In looking at the self-reported ratings[5] related to stigma for the pre-test portion of the retrospective pre-post survey, there was a difference in stigma beliefs across the different training groups ($F(2,87) = 3.60$, $p = .03$). Tukey's post hoc tests showed that this was the only outcome where the 'other training' group had better pre-test scores (i.e., lower stigma beliefs) than the other two groups (i.e., post-secondary or no training). There was not difference between the post-secondary training group and the no training group on stigma beliefs.

Stigma beliefs decreased significantly from pre-course ratings ($M=2.09$, $SD=.53$) to post-test ($M=1.91$, $SD=.53$), where $t(89) = 4.83$, $p = .000$. Only two of the three groups reported significant decreases in stigma beliefs (i.e., for those with post-secondary training or other training), while the group with no previous training reported stigma beliefs to the same extent before and after the training. There was no significant interaction between gender and stigma beliefs between pre- and post-intervention ratings

In sharing feedback about the MHFAFN course, interview participants expressed stigma as an important and valuable element of the course. For instance, interview participants shared that discussing stigma is important to address within communities, as this teaches individuals to listen without judgement and the importance of not thinking about a person as the disorder. One interview participant shared that learning about stigma as it relates to mental health was the most valuable aspect of the course, sharing that "*a lot of our community members don't know about [mental health illnesses and diagnoses], so I think that's important which will break down the stigma within our communities and within our people*."

[5] Unlike the other subscales, higher stigma scores are considered a negative outcome, in that they represent higher levels of endorsed stigma-related beliefs.

Furthermore, interview participants spoke about the impact of the MHFAFN course, sharing that they have a greater understanding of their own stigmatizing behaviours, and they now know how to change their statements to be less stigmatizing. One interview participant noted their increased understanding of mental health and consequently a decrease in their stigmatized views of those living with mental illness, stating, "*my understanding of some of the issues that people have lived through or have to live with, my attitudes have softened. What surprised me most is my attitude, my softening of attitude toward the experiences of people living like this*."

During the follow-up survey, participants spoke about the ways in which the MHFAFN has impacted stigma. This included decreased personal stigma related to mental health, increased awareness of stigmatizing language, and reinforcing the need for organizations to work to reduce stigma. It was evident from participants' responses that a strategy like MHFAFN is only effective at reducing stigma if it reaches a saturation point. For example…
(include two quotes here – see webinar)

Most facilitators believed that the MHFAFN course had an impact on mental health stigma within communities, attributing impacts to the educational tools and conversations around mental health and stigma. They explained that they are seeing increased referrals, and are being approached more for courses; furthermore, facilitators noted that communities are more open and accepting of others, and have a desire help others. One facilitator commented, "*they understand it is hard to reach out for help if you are labelled and called names.*" While a majority of facilitators believed the course impacted stigma, one facilitator said they believed stigma has remained the same.

There is always going to be a stigma, but I didn't think it would be decreased as much as it has in the last two years. We have always wanted to break down stigma and get people talking, just with this course, it is breaking down the stigma without realizing it. That was an outcome I didn't expect, I had basic MHFA training and it wasn't breaking down stigma.

As part of the facilitator surveys, respondents noted a number of stigma-related outcomes when asked about the changes in participants that they have observed. One facilitator noted about the changes in community members where more people are listening without judgement: *"I hear less judgement about mental health issues and people are open to learning the skill of listening non-judgmentally."*

Another facilitator spoke to changes in police officers who participated in MHFAFN: *"The [community] police officers expressed that they now look at the individuals they must deal with through a different lens. The training reframed their thinking around things like substance misuse."* The facilitators also work through the course and learn how to reframe their thinking. These findings demonstrate decreases in stigma on multiple levels.

4.3.4 Unanticipated outcomes

In addition to the unanticipated knowledge increases described above, participants and facilitators identified other aspects of the course and shared personal impacts that surprised them. Both groups identified reflection as an outcome for participants that was unexpected. Participants noted that the

course allowed them to reflect on their personal experiences, as well as the ways in which they can apply the teachings to their work. Similarly, facilitators also noted that the participants were making both personal and historical connection with the course content.

Participants also spoke about learning from other participants in the room and the positive impacts that their shared stories had, including learning new strategies and traditional teachings from each other. They also noted the ways in which MHFAFN has contributed to their own healing journeys; for example, some participants noted that the group discussions provided important opportunities to talk about historical trauma, while others identified an increased desire to find balance and holistic wellness: "*What I've gotten from a day and a bit of this course is that it is important to sit and re-evaluate and try to find balance."* For one participant, their participation in a sharing circle through MHFAFN represented the first time that they felt safe to share in a group:

- *The residential school part triggered some stuff in me that I didn't think would. But it's a good thing. It's never happened to me before, I was avoiding it I guess. That's the first time I've said in a circle that I've been to residential school*

Additional unanticipated outcomes for participants included having increased empathy and understanding for what people with mental health concerns go through, and increasing their networks through making new friends at the MHFAFN training.

4.4 Cultural Relevance and Safety

This section includes findings related to the cultural relevance and cultural safety of MHFAFN, and touches on both strengths and challenges experienced by course participants and facilitators.

4.4.1 Cultural relevance

Interview participants across the sites visited were asked if they thought that the MHFAFN content was culturally relevant to their communities. The majority (89.41%) responded positively, and provided several examples of ways that the MHFAFN course is culturally relevant. Additionally, most of the facilitators who were interviewed reported that the course is culturally relevant.

Most commonly, participants cited specific **content or topic areas in the MHFAFN curriculum**; common examples included EAGLE, content on colonization and historical trauma, and cultural and traditional knowledge. For example, participants commonly spoke the importance of learning about historical trauma in terms of both understanding people in their communities, as well as themselves:

MHFAFN was largely experienced as culturally relevant and safe for both participants and co-facilitators

Nearly all participants and co-facilitators reported that the course is culturally relevant

- Aspects of the course content and delivery that help to enhance the cultural relevance of MHFAFN include: the two-eyed seeing approach, EAGLE, content on colonization and historical trauma, and traditional teachings
- Co-facilitators also highlighted the ways in which they incorporate culture into the delivery of MHFAFN

Those who reported that MHFAFN is not culturally relevant most commonly noted that there is insufficient cultural content in the course

- They spoke about the need for more teachings from Elders and First Nations-specific content on mental health

An overwhelming majority of participants also reported that the course was a safe space to discuss their culture and views

- The people present at the course help to promote cultural safety
- Time restrictions placed challenges in delivering MHFAFN in a culturally safe way

> *It speaks well to the historical trauma, the shared trauma that Indigenous people have gone through. To help understand why people act in certain ways that aren't healthy for them. It will help to build a lot more empathy for when a person is going through something. We can say that these are signs of trauma and we can't just expect to stop using their ways of coping overnight.*

When I was a younger, after coming out of residential school, I wondered why I drank, did drugs, it wasn't until later I realized the issues, residential school was never a topic in mainstream schools and the conditions and the impacts… this kind of training helps me understand the parts and the roots… the roots were cut off and the tree died when we were taken away, now we have to replant the seed so we grow re-vibrant again, that's what we're doing with this course – we're replanting; this course is one of those new roots, language revitalization is another root, culture is another root, then on the top we have the tree where we want to be.

Similarly, facilitators at two different communities also described **EAGLE** as a valuable, culturally relevant component of the curriculum: *"The ones [participants] who have taken the mainstream one have told us that they like EAGLE better."* One facilitator spoke about the relevance of the cultural components included in the curriculum; they reported that the cultural components can help to increase receptiveness to the content and community ownership over the curriculum. However, facilitators from two different communities also reported that the historical content could go into more depth given its importance within the context of mental health in Indigenous communities:

- *In community the historical section can turn into a whole day—it deserves a whole day. The other stuff I can go over quickly, it's important to spend a whole day and have Elders present. As it stands right now, it's only the morning. But history piece needs to be the whole first day.*

During the site visits, both participants and facilitators commonly emphasized the strengths of both western and Indigenous knowledges. Drawing on a **two-eyed seeing** approach, one facilitator shared, "*there is only so much that our culture can do and also so much that mainstream can do. We have to learn to walk in both and have awareness of everything out there.*" Similarly, participants also noted the need for more of a blend between traditional and western content for mental health content. One participant noted that they would like to see more specific teachings, but need to be careful about how these are shared.

The importance of offering cultural teachings was also noted by facilitators. They spoke about incorporating local First Nations' worldviews while remaining open to a diversity of perspectives within communities. Some also described their cultural process for course implementation, which included beginning each day with a prayer and smudge ceremony, and ending each day with a sharing circle.

Similarly, the importance of culture was also emphasized when facilitators were asked what has been helpful in lifting the MHFA course off the ground in their communities. Facilitators spoke about the importance of cultural components in MHFAFN have been critical components in its positive reception in community: *"It has taken off huge! We've had requests from all over…. Because the cultural aspects, everyone is seeing it as relevant."*

Some participants provided recommendations related to content expansion to increase the cultural relevance of the curriculum. Participants would like to see more content including more information on **intergeneration trauma and impacts of colonization** (e.g., how youth are effected, how this is connected to mental health). They also felt that the curriculum should discuss the relocation of

communities as this is a significant factor related to colonization and include more information on residential schools. They would also like to have information on how they can incorporate culture and traditions into our work, how to incorporate it in with clients.

- *The part about two worlds is important. I think important to share that information so that we can make better choices, to choose the way we want to be healed but recognize that the culture is very strong. If we would have heard that more often—emphasize that it is the reality that we need two worlds and we need the balance, but because of the fast world and their own identity is more on the long term, taking the time to listen and heal. We have to realize how strong culture and identity is.*

During the course delivery, participants from two different sites noted that the historical loss and trauma content could be reframed, as colonization is continual and should not be restricted to history. As well, trauma is also linked to poverty and violence within communities and, thus, remains current. In this sense, participants noted that it is important to consider both historical and current trauma.

Alternatively, those who reported that MHFAFN is not culturally relevant most commonly reported that there was **insufficient cultural content**. These participants commonly reported the need for more traditional models and First Nations-specific content. One participant noted that the content should include more teachings from Elders, as it is currently too similar to the MHFA Basic course. Another was expecting more First Nations content related to mental health. Comments included:

- *I found the content similar, it felt like a recertification, we took general then youth now this one, was looking for a little more FN content, teachings should have been more incorporated onto the content. It was misleading in regards to the content, first two, they seemed…. I felt a little disappointed, I think too. It doesn't make it First Nations just the art and the feathers on it. I feel like there is not a lot of content except referring to a spiritual leaders in communities you should refer to, not content.*
- *I think there should be more First Nations, they should touch on more of the FN content. Like I would like to see more traditional part of it, like we need to… we have people who don't believe in anything in our community, and we have Christians and we have people who believe in the traditional way, so maybe we could… for my community there should be more Christianity and traditional ways. There are teachings of suicide in our tradition, what happens when you commit suicide. I was trying to encourage the wellness workers, the addiction program, to use Elders to do teachings and storytelling.*

During the site visits, participants spoke about youth who have visions, who are misunderstood within the Western healthcare system, while in the past, people who had visions were respected. Similarly, in another community the facilitators emphasized, "*Our people have a different way of looking at a person with mental health differences. We see the voices as gifts, and as the voices and teachings of our ancestors*." These teachings helped to increase the cultural relevance of the curriculum, but facilitators from one of the communities reported that the MHFAFN course is not culturally relevant for their community. They referenced an imbalance between Western and Indigenous worldviews in the curriculum, where there is a strong emphasis on Western knowledge (e.g., the DSM V), which outweighs Indigenous worldview and experiences:

- *No, the first part fine (historical trauma, that is) but there's such a reinforcement of labels (anxiety, psychotic), it wipes out the worldview of First Nation and these are things happening in life. It's a lot of labelling … the other stuff was interesting but not really relevant, it was almost helping them put people in a box when you don't want to do that.*

Two participants also reported that the curriculum is based too heavily on Western Canada and is not applicable to Eastern Canada, as one person said, *"the content was heavy from Western Canada and things are not the same here… in BC they are light-years ahead of us in managing health services and self-governance."* During the course delivery, MHFAFN was often introduced as an evidence-based course that has had First Nations perspectives added in, suggesting that the Western knowledge is maintained as a foundation for mental health education.

The flexibility of the MHFAFN course was commonly reported as an enabler for cultural relevancy. Participants reported that the course could be culturally relevant in their communities, given its flexibility and the flexibility of facilitators. The course was also noted to be flexible in that it is suitable for anyone, including both First Nations and non-First Nations participants, as well as people with different levels of cultural connectedness:

- *Anyone can take this course. You don't have to practice ceremony, or go to church or not practice faith – you can take this course and it is in a non-judgmental way no matter what your beliefs are as a First Nations person. I come from a Christian region, not that I practice it, but I know the importance of healing and reconciliation and I think this course is nice. People get really offended and will leave if you only speak to one spirituality in a workshop.*

Participants also reported that while the manuals are not relevant to their specific communities, they are flexible enough to ensure adaptability to different contexts in order to respond to diversity between communities:

- *I don't think it's too specific to one culture in terms of First Nations communities and can be adopted and adapted if needed depending on the different culture in community. I definitely think it's culturally appropriate, safe and relevant.*

As long as we are aware that people are different, I think this is the course for that. Even in the facilitator manual, it emphasizes that and the need to be aware of what is acceptable in that community.

To this end, facilitators also spoke about the ways that they would adapt the curriculum when they deliver it in their own communities:

- *I think that as we go, we are going to add more to it, our communities are different and unique. We will adapt the medicine wheel to fit our needs but not change the content. We will learn more from our communities in their feedback. It is a great start, the stuff that is in there, things can be added that we will learn when we start to deliver the course.*
- *One I think that if we are delivering across Canada it needs to be sort of vague enough to make fit- there are things about us that are the same but also so some that are so different…. The manual and the training needs to be pan-ish Aboriginal so that it fits across the country – so that if someone does it in Cree they can fit their community, I can do it in my community and they will bring the specifics and the richness to. The communities create the richness of the data and the*

conversation of the relevance. Some may say it is vague, and it is, but it would make a dent in changing their biases but when you bring it into the communities that is where the richness will come in. I think we could add more but in doing so that just creates other issues, it might, in terms of getting stuck in specifics. We could talk about the reserve and Indian Agents but then we leave out Métis or those who are displaced, those who are moved from their lands. So, I think if we get too specific then we leave some First Nations people out.

Similarly, the facilitators also acknowledged the diversity between each community. When speaking to challenges that have come up in delivering the course in communities, facilitators from two different communities spoke about the diverse beliefs and values that different communities have.

Participants also provided **general positive feedback** related to the cultural relevance of the MHFAFN curriculum. They often noted that the curriculum was relevant without providing further comments. Other noted that the course is more meaningful and effective for First Nations communities than Basic MHFA. During one of the site visits, participants also shared that culture is the foundation for all healing work, and that cultural approaches can be used to reduce stigma around mental health in communities.

Participants reported various **activities** that were culturally relevant. The Circle of Support was helpful in situating the use of ceremonies, Elders, traditional healers as supports. It also helped to make the content relevant to communities by drawing on local resources. Relevant activities also included the sharing and talking circles, smudging, and using hands-on exercises and engaging activities. For instance, one participant stated, *"We are visual learners. First Nations people are more hands on than they are than learning by the book. We should keep the hands on training, the exercises, they mean more to our people."* Another compared their experience with MHFAFN to the Basic course:

- *I find it more applicable because there are things we can relate to both on a personal and professional level. I'm First Nations, my family has dealt with residential schools and 60s scoop…. Understanding the background and exercises, of what First Nations culture is to you; if we had regular MHFA might have felt more dry, [but] this felt more engaging.*

During the course delivery, participants also discussed the importance of the Circle of Support exercise, which will help people in crisis to identify their own supports, too, which is so important for those that are remote and lack a lot of the services that are available in urban centres.

Participants reported that MHFAFN takes and promotes a **holistic approach**, which is culturally relevant. One participant spoke about the value of situating mental health disorders and self-care within the medicine wheel. One participant commented:

- *The perspective of wholeness, that is what drew me to this place, everything else is compartmentalized in mental health, here it is more integrated. Wholeness is holistic wellness, the whole person approach rather than focusing on one part of the individual.*

MHFA FN can help an advanced helper such as a therapist be able to relate to someone spiritually, instead of being on the same level of doctors and nurses (clinical), but now can connect to clients on a holistic level.

Similarly, facilitators commonly conceptualized mental health as balance within the course. During the site visits, there was also important messaging around using a strengths-based wellness approach within the course delivery. MHFAFN was often as a "tool for restoring balance" as facilitators emphasized the

resilience and other strengths within First Nations communities. During the site visits, MHFAFN was also illustrated as a way of supporting the revitalization of traditional helping roles in communities. Participants also spoke about working together as whole communities to support people to regaining balance and mental wellness. These concepts are emphasized throughout the course discussion and activities (e.g., the Circle of Support).

4.4.2 Cultural safety

Participant safety and cultural safety
Overall, an overwhelming majority of participants reported that the course was a safe space to discuss their culture and views (96.6%). Archival data from the Mental Health Commission were utilized to provide another estimate with a larger sample. On a scale of 1 (not at all) to 10 (very safe), the mean score was 8.73 (*SD* = 1.5). Looking at the distribution of scores, 5.2% of participants provided a rating of 5 or lower, indicating that they felt neutral or negative about their safety. Collectively, these two sets of estimates identify a high degree of cultural and emotional safety among groups, but also highlight a smaller number of participants (approximately 3-5%) that does not experience the course as safe.

Elements of cultural safety
Participant survey findings showed that, given the diversity of group composition in course groups, different indicators of cultural safety arose across the different sites for participants. While some survey participants noted that having an all-Indigenous group contributed to safety, not all groups were comprised this way. Others spoke about group diversity as safety-enhancing, referring to both a combination of Indigenous and non-Indigenous participants, but also diversity across First Nations cultures.

Some survey participants spoke to the individual nature of cultural safety. For one participant, his safety hinged on where he was in his own healing journey, "*I have come to terms somewhat to my past trauma and can talk about it freely to anyone. My past was not my fault and I have released the heavy burden that I have been carrying all these years.*" Interestingly, one of the three participants who did not report feeling safe spoke to the legacy of colonization and trauma as underlying his lack of safety. The other two participants who reported feeling unsafe identified reasons related to course process or facilitation. In one case, the participant felt that facilitators "shut down" any challenges to the course content. In the other case, the participant felt that the facilitators' portrayal of low levels of mental health knowledge on reserves was negative and stigmatizing.

During the interviews, participants reported that the **people** that are present at the courses create cultural safety. This included sharing stories throughout the course, which reportedly enhanced the relevance and relatability of the course content. One person said, *"Having the stories shared by participants was valuable, the facilitators sharing their history too, it made it feel more real instead of being talked to for three days straight, it was a good experience."* During the site visits, the researchers also noted that the facilitators related the course content to their own lived experiences, demonstrating the importance of having First Nations facilitators who come from the same worldview as those who they are delivering the course to, noting: *"facilitators did an amazing job sharing personal experiences and stories that were relatable and directly link to the material. They also opened up and held a safe space for participants to share their experiences and stories through reciprocal learning."* The facilitators were also seen encouraging participants to incorporate their own teachings and reflections and interpretations throughout the training.

However, facilitators commonly spoke about the challenges that time restrictions place on delivering the course in a culturally safe way through honouring time to share between participants and facilitators, *"I feel like I should honour them by giving them the time to go over the material, but we aren't allowed to do that. Our hearts are tugging."* This issue was mirrored in one participant interview, which highlighted a lack of time for interaction and sharing, as well as a lack of attention toward cultural teachings and language:

- *Maybe it is because they are rushing so much, they are not really interacting or letting people share. When you are First Nations you get to share when you need to. There is no time limit to sharing, that is something that bothers me. When they are talking and someone is sharing, they are not recognizing the sharing it just jumps back into the slide show… they are not putting our culture in it, I can't believe that they didn't mention the sacredness to some parts… Anyone could present and learn from the book or the slides but if it is not coming from the heart or if you are rushing then it is not culturally safe.*

Similarly, this was echoed by two facilitators, who spoke about the need to adapt the structure to ensure that it is community and culturally responsive: by allowing for more time to share and allowing for make-up sessions or time where the facilitator can inform them what was missed.

Participants also reported the importance of having facilitators who are either from the community or have knowledge of the territory and the language: *"The presenters seem to have a good knowledgeable background about culture and tradition, even in the territory and area where it's delivered. It just seems to have that fit and can relate."*

Similarly, they spoke about the value of having an **Elder as a facilitator**. More broadly, one participant noted that the First Nations facilitators brought a necessary cultural, strength-based lens. Facilitators also spoke about the importance of having Indigenous facilitators and Elders present to share teachings. After delivering a course where an Elder was not present, one facilitator highlighted this as a critical oversight: *"We need an Elders point of view, no one can always deliver that, only an Elder can provide a traditional point of view."* Facilitators at another community spoke about being intentional selection of Elders to attend the course: *"We don't have just regular people come in, [the Elder facilitator] is recognized, he has gone through his ceremonies in the community with the traditions and the healing. We would request that someone has a similar history to come in and help us with the residential school stories and the smudging, you find the ones that are recognized in the community, we aren't just grabbing anyone, that is how we keep it safe."* While any form of Elder presence was noted to be valuable (e.g., for the opening, as a participant, for particular modules), both participants and facilitators spoke about the importance of having Elders present for support throughout the entire course if possible.

Facilitators also spoke about doing **intentional preparation and relationship-building** work with the community that they will be delivering the course in, prior to working there. They spoke about connecting with someone from the community beforehand; to learn the protocols of that community: *"You're not going to know every participant on a personal level or a professional level, but having some sort of idea or having a liaison to the community."* A facilitator from another community described this as a challenge as the course doesn't allow for adequate time for relationship building in other communities: *"it's fly in and fly out, we don't work that way, though it has happened in the past."* When asked for recommendations that they would provide to other communities or organizations to ensure that the course is delivered in a culturally safe way, facilitators spoke about several practices that they

use as well as lessons that they have learned through the implementation of this course, such as: building rapport, liaising with community representatives, and holding planning meetings with community contacts.

5.0 Conclusions and Next Steps

The findings that emerged from this mixed methods evaluation indicated that MHFAFN is an effective and feasible public health approach for mental health as it offers benefits to a wide range of participants across different community settings. These findings are strengthened through the high degree of convergence across multiple data sources and methods.

Facilitators and participants largely expressed high levels of satisfaction with the design and delivery of MHFAFN. However, despite the overall strength of Indigenous-specific content within the course curriculum, there is a need for invested efforts to address challenges in delivering MHFAFN to diverse communities across Canada.

Participants' increases in knowledge and skills were consistent with meta-analytic findings of MHFA Basic (Hadlaczky, et al., 2014); however, participants in this evaluation of MHFAFN described positive outcomes that went beyond knowledge of mental health signs and symptoms and skills to respond to mental health crises. Participants' responses suggest a meaningful, yet diverse, personal impacts, including a sense of safety to share their journey with others, deeper understanding of the links between colonization and mental health struggles, and self-awareness of stigmatizing beliefs and behaviours.

Further, the importance of cultural safety within the design, implementation, and evaluation of MHFAFN cannot be overstated. While evaluations of other mental health courses within First Nations communities—such as ASIST—have identified negative outcomes (Sareen et al., 2013), the MHFAFN course was largely experienced as culturally safe for both participants and facilitators. This is incredibly important given the legacy of colonization and its manifestation in mental health challenges among First Nations communities in Canada.

5.1 Recommendations

A number of recommendations are provided below. These recommendations are grounded in primary data, including evaluation interviews and surveys, as well as course observations.

1. **Review and modify the facilitator application process to reduce the burden for applicants.**
   - ✓ Participants shared that the facilitator application process is too in-depth for what the course includes and that it takes a great deal of time to complete.
   - ✓ Consider including the following important factors in an updated application process:
     - Applicant knowledge of First Nations history and cultures
     - Applicant resume and cover letter outlining interest, experience and reasons why they would make a good facilitator
     - A list of additional courses the applicant could indicate they have completed that could serve as a prerequisite (e.g., ASSIST)

2. **Continue promoting the MHFAFN course with an emphasis on the cultural components, and explore additional modes for garnering community buy-in for the course.**
   - ✓ Support facilitators to host consultations with communities to determine if the MHFAFN course matches the community or organization's priorities and objectives.

- ✓ Develop relationships with leaders and staff who may be influential in promoting the course to community members.
- ✓ Consider hosting an orientation presentation around the course to leaders and staff in the community to demonstrate the importance of MHFAFN.

3. **Evaluation participants suggested that the MHFAFN course should be targeted toward a wide audience including:**
   - ✓ All First Nations community members and youth
     - o Participants shared that the course should be delivered to more community members so that they can make a difference at the community level
   - ✓ First Nations Band employees
   - ✓ Those who may be considered a first responder to a mental health crisis in a community (e.g., volunteer critical response teams)
   - ✓ Frontline workers (e.g., addictions workers)
   - ✓ Sport and recreation staff
   - ✓ Police and RCMP
   - ✓ Health care professionals (e.g., physicians, nurses, hospital staff)
   - ✓ Community Health Directors
     - o Frontline staff requested that Health Directors participate in the course to bridge the understanding and communication gap between staff and directors

4. **Consider delivering MHFAFN course to different audiences for the purposes of promoting cultural safety within various workplace settings. For example, train hospital employees to promote cultural safety within the health care setting through increasing understanding of Indigenous values, culture and history; and sharing information on mental health from a different worldview.**
   - ✓ Some suggested audiences include:
     - o Staff of agencies and organizations who work with First Nations people
     - o Non-Indigenous peoples
     - o Health care practitioners
     - o Front line workers

5. **Consider allowing for exceptions for facilitators who are not able to deliver two course sessions each year (to a minimum of 12 participants in each course) as there may be fluctuating demand for the course across different regions.**

6. **Increase the number of MHFAFN Master Trainers in Canada to expand the reach of the course.**
   - ✓ Facilitators noted that there is a need for more facilitators to keep up with the demand for the course.
   - ✓ Increasing the number of facilitators will help to mitigate challenges of geography where weather and travel complicate course implementation.
   - ✓ Training more facilitators in rural and remote communities will further extend the reach of the MHFAFN course.

7. **Enhance representation of diverse First Nations cultural teachings and languages throughout the curriculum, as well as make space for local cultures (place-based).**
   - ✓ Some participants reported that the curriculum is based too heavily on Western Canada.

- ✓ Consider adding examples of diverse First Nations cultural teachings and languages and instructing facilitators to open a discussion about examples that are unique to the group.
- ✓ Consider creating additional space and flexibility for facilitators to include their community cultural teachings and languages.

8. **Consider specific revisions to the course curriculum, as suggested by participants across sites.**
   - ✓ Adjusting specific language and terminology within the curriculum, including:
     - o Changing language around suicide to ensure that it is neutral and not triggering
     - o Ensuring that peyote and ayahuasca are not conveyed as "traditional," as they are not traditional substances in Canada
     - o Ensuring that language around historical trauma conveys ongoing impacts
     - o Using the term "wholistic" rather than "holistic"
   - ✓ Participants also suggested updating any of the videos that are not First Nations-specific.

9. **Identify a process and timeline (e.g., every two years) for updating the training manuals to ensure the content and sources remain current.**
   - ✓ Course participants and faciliators indicated some spelling mistakes in the manual and discrepancies between the powerpoint presentation and the manuals; which they found to be distracting.
   - ✓ Modify the manual and slideshow presentation to ensure that slides mirror the manuals by providing the same information in the same order to increase the flow of course.

10. **Consider enhancing or expanding key topics within the course content, including:**
    - ✓ Discussing intergenerational trauma and impacts of colonization on mental health (and reframing these discussions to emphasize the continual impacts of historical trauma).
    - ✓ Discussing contemporary systemic racism such as the child welfare or justice system.
    - ✓ Talking about FASD in more depth.

11. **Consider adding additional topics to the course content, including:**
    - ✓ Covering issues related to lateral violence and trauma
    - ✓ Expanding the content on substance use disorders to include emergency procedures for overdose, such as Naloxone
    - ✓ Forming a module specifically on self-care
    - ✓ Focusing on LGBT2SQ people

12. **Consider adapting the MHFAFN course specifically for First Nations children and youth.**
    - ✓ MHFAFN could be adapted for child and youth audiences and the delivery of this course could help to empower children and youth in First Nations communities.

13. **Continue to utilize culturally relevant activities, including EAGLE and the Circle of Support.**
    - ✓ EAGLE was described as a culturally-relevant acronym for summarizing key actions within the MHFAFN curriculum.
    - ✓ The Circle of Support was also reported to be a key resource and activity in the course; however, participants also noted the importance of clearly explaining the medicine wheel that is used in the Circle of Support to ensure that there is a clear meaning for the heart, body, and mind.

14. **Develop additional resources for participants to enhance the application of knowledge when they return to communities, include:**
    - ✓ A quick reference card with the steps of EAGLE
    - ✓ Enlarge the Circle of Support and EAGLE posters
    - ✓ Pamphlets containing information on community supports and cultural resources
    - ✓ A copy of the Circle of Support developed collaboratively by the group so that it is relevant to that community

15. **Maintain the flexibility of the course curriculum to allow for storytelling and sharing components; the flexibility of the course was commonly reported as an enabler for cultural relevancy.**
    - ✓ Hearing about personal experiences from both facilitators and participants was described as one of the most valuable aspects of MHFAFN.
    - ✓ The facilitators also adapted the delivery of the course to each participant group, which was noted as a key strength of the course.
    - ✓ Facilitators noted the need for flexibility to make the course appropriate for each community

16. **Extend the MHFAFN course delivery to three full days.**
    - ✓ Participants and facilitators across sites consistently reported the need for more time to spend on the MHFAFN course; this would allow for more time to spend on digesting course content, having group discussion and debriefs, and offering more activities.
    - ✓ Restrictive timeframes were noted as a barrier to ensuring that the course is delivered in a culturally safe way, and extra time would allow for debriefing of sensitive topics and time for facilitators to describe activities in detail to ensure clarity.

17. **Encourage presence of an Elder for delivery of the MHFAFN course.**
    - ✓ Evaluation findings highlighted the spiritual and emotional support that Elders may provide during the course, as well as the value of storytelling and traditional teachings.
    - ✓ This could include having a trained Elder as a facilitator, or an Elder who is available to provide additional support throughout the course.

18. **Ensure that adequate supports are in place when participants are triggered by the course content.**
    - ✓ Discussions with content of residential school and suicide, as well as certain activities were triggering for some participants.
    - ✓ However, participants commonly reported that the course was delivered in a safe space, fostered by: a shared commitment to confidentiality and other shared guidelines, facilitators' cultural knowledge, the Elders present, relationships between participants, non-judgmental conversations, and cultural practices (e.g., smudging).
    - ✓ Safety could be further enhanced through providing support to facilitators to have a discussion with participants regarding words or situations that they are aware of that may trigger them.
    - ✓ Participants suggested that facilitators communicate potential triggers and heavy topics with participants before the course to give time for participants to prepare supports.

19. **Continue to offer a number of cultural, interactive, and experiential learning opportunities within the course delivery.**

- ✓ Strengths included the break-out group activities, role-playing, and group discussions
- ✓ The cultural relevance of MHFAFN was also enhanced through the integration of relevant ceremony and Indigenous knowledge in the course.
- ✓ Facilitators also noted the value of providing additional learning activities for participants based on the audience and their best style of learning; for example, one facilitator shared that they provide activities for tactile or kinesthetic learners.

20. **Add options for participants who are less comfortable with role playing to view a video of scenarios for participants to critique and discuss, or have focused case studies in groups.**
    - ✓ Some participants highlighted that the role-playing activities were anxiety provoking.

21. **Consider the location of course, to ensure that it is both accessible to participants and appropriate for promoting wellness during the course.**
    - ✓ For example, participants from one of the sites noted the importance of the peaceful location where they were surrounded by nature.
    - ✓ It is also important to ensure that the space is large enough to facilitate breakout groups for activities for participants to engage, interact and learn from one another.

22. **Consider re-convening a community of practice for MHFAFN facilitators to provide increased support and opportunities for facilitators to network with each other and share wise practices.**
    - ✓ A community of practice may gather over social media; however, there needs to be a platform that performs consistently, without technical glitches.
    - ✓ It may also be valuable to host an annual conference or community of practice event for MHFAFN facilitators to attend and share wise practices, challenges and opportunities, while also having an opportunity to debrief and share self-care practices.

References

Adelson, N. (2005). The embodiment of inequity: Health disparities in Aboriginal Canada. *Journal of Public Health, 96*(Suppl2), S45-S61.

Archibald, J. (2008). *Indigenous Storywork: Educating the Heart, Mind, Body and Spirit*. Vancouver, BC: UBC Press.

Ball, J. (2008). Cultural safety in practice with children, families and communities. Early Childhood Development Intercultural Partnerships, University of Victoria. Retrieved July 18, 2017 from www.ecdip.org/culturalsafety/

Boska, P., Joober, R., & Kirmayer, L. J. (2015). Mental wellness in Canada's Aboriginal communities: Striving toward reconciliation. *Journal of Psychiatry & Neuroscience, 40*(6), 363-365. doi: 10.1503/jpn.150309

Browne, A. J., Smye, V. L., & Varcoe, C. (2005). The relevance of postcolonial theoretical perspectives to research in Aboriginal health. *Canadian Journal of Nursing Research, 37*(4), 16-37.

Caza, M. (2010). *Final Report: Evaluation of the Mental Health First Aid Training in First Nations Communities in Alberta.* Final report prepared for Health Canada.

Commission on Social Determinants of Health. (2008). Closing the gap in a generation: Health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health. Geneva: World Health Organization. Retrieved from http://apps.who.int/iris/bitstream/10665/43943/1/9789241563703_eng.pdf

Corrigan, P., Druss, B., & Perlick, D. (2014). The Impact of mental illness stigma on seeking and participating in mental health care. *Psychological Science in the Public Interest, 15*(2), 37-70.

Creswell, J. W. (2013). *Research design: Qualitative, quantitative, and mixed methods approaches.* Los Angeles: Sage.

Dobson Brazzoni, C. (2013) Mental Health and Healing with the Carrier First Nation: Views of Seven Traditional Healers and Knowledge Holders (Doctoral dissertation). Retrieved from SFU Summit Institutional Repository (Accession No. etd8040).

First Nations Health Authority, Province of British Columbia, & Government of Canada. (2013). *A path forward: BC First Nations and Aboriginal People's mental wellness and substance use—10 year plan.* Retrieved from http://www.fnha.ca/Documents/FNHA_MWSU.pdf

First Nations Information Governance Centre (FNIGC). (2012). *First Nations Regional Health Survey (RHS) 2008/10: National report on adults, youth and children living in First Nations communities.* Ottawa: FNIGC.

Flynn, A., Wells, S., Graham, K., & Tremblay, P. F. (2013). *Researching health in Ontario communities: Findings from our first communities: Port Colborne and Welland.* Centre for Addiction and Mental Health. Retrieved from www.camh.ca/en/research/news_and_publications/reports_and_books/Documents/RHOC%20Port%20Colborne%20Welland%20Final%20Report%20202013.pdf

Fontaine, L. (2012). *Empathy, dignity, and respect : Creating cultural safety for Aboriginal people in urban health care.* Toronto, ON: Health Council of Canada.

Greenwood, M. L. & de Leeuw, S. N. (2012). Social determinants of health and the future well-being of Aboriginal children in Canada. *Paediatrics & Child Health, 17*(7), 381-384.

Hadlaczky, G., Hökby, S., Mkrtchian, A., Carli, V., & Wasserman, D. (2014). Mental Health First Aid is an effective public health intervention for improving knowledge, attitudes, and behaviour: A meta-analysis. International Review of Psychiatry. 26(4), 467-475.

Hallett, D., Chandler, M.J. & Lalonde, C.E. (2007). Aboriginal language knowledge and youth suicide. *Cognitive Development*, 22(3), 392-399.

Hart, L. M., Bourchier, S. J., Jorm, A. F., Kanowski, L. G., Kingston, A.H., Stanley, D. & Lubman, D. (2010). Development of mental health first aide guidelines for Aboriginal and Torres Strait Islander people experiencing problems with substance use: A Delphi study. *BMC Psychiatry, 10,* 78.

Health Canada. (2015). *First Nations mental wellness continuum framework: Summary report.* Retrieved from: http://www.thunderbirdpf.org/wp-content/uploads/2015/01/24-14-1273-FN-Mental-Wellness-Summary-EN03_low.pdf

Hirch, M. (2011). Self-determination in Indigenous health: A comprehensive perspective. *Fourth World Journal, 10*(2), 1-30.

Institute of Health Economics & Canadian Institute of Health Research – Institute of Aboriginal People's Health. (2011). *Aboriginal Peoples' Wellness in Canada: Scaling Up the Knowledge*. Summary Report from March 3-4, 2011 Roundtable. Ottawa, Canada.

Iseke-Barnes, J. M. (2008). Pedagogies for decolonizing. *Canadian Journal of Native Education, 31*(1), 123-148.

Iwama, M., Marshall, M., Marshall, A., & Bartlett, C. (2009). Two-eyed seeing and the language of healing in community-based research. *Canadian Journal of Native Education, 32*(2), 3-23.

Kelly, F. (2007, March). *Traditional and Contemporary Approaches to Youth Suicide Prevention.* National Youth Council, Assembly of Fist Nations.

Kelm, M. (1998). *Colonizing bodies: Aboriginal health and healing in British Columbia 1900-50.* Vancouver, BC, Canada: UBC Press.

Kirmayer, L.J., Brass, G.M., Holton, T., Paul, K., Simpson, C., & Tait, C. (2007). *Suicide Among Aboriginal People in Canada*. The Aboriginal Health Foundation Research Series.

Kirmayer, L. J., Sehdev, M., Whitley, R., Dandeneau, S. F., & Isaac, C. (2009). Community resilience: Models, metaphors and measures. *Journal of Aboriginal Health, 5*(1), 62-117.

Lavellee, L. F. & Poole, J. M. (2010). Beyond recovery: Colonization, health and healing for Indigenous people in Canada. *International Journal of Mental Health & Addiction, 8,* 271-281.

Morris, K. (2007). Re-examining issues behind the loss of family and cultural and the impact on Aboriginal youth suicide. *First Peoples Child and Family Review, 3*(1), 133-142.

National Collaborating Centre on Aboriginal Health (NCCAH). (2009). *Social Determinants of Health: Culture and Language as Social Determinants of First Nations, Inuit and Métis Health.* Prince George, BC: University of Northern British Columbia.

Potvin-Boucher, J., & Malone, J. (2014). Facilitating Mental Health Literacy: Targeting Canadian First Nations Youth/ Faciliter la littératie en santé mentale: Cibler les jeunes Canadiennes des Premières Nations. *Canadian Journal of Counselling and Psychotherapy (Online), 48*(3), 343-355.

Sareen, J., Isaak, C., Bolton, S. L., Enns, M. W., Elias, B., Deane, F., ... & Katz, L. Y. (2013). Gatekeeper training for suicide prevention in First Nations community members: a randomized controlled trial. *Depression and Anxiety*, *30*(10), 1021-1029.

Sinclair, R. (2004). Aboriginal social work education in Canada: Decolonizing pedagogy for the Seventh Generation. *First Peoples Child & Family Review, 1*(1), 49-61.

Smye, V. & Mussell, B. (2001). *Aboriginal mental health: 'What works best.'* Vancouver, BC: University of British Columbia.

Statistics Canada. (2014). Mental Health Profile, Canadian Community Health Survey - Mental Health (CCHS), by age group and sex, Canada and provinces, occasional (Number). Canadian Community Health Survey 2012. Retrieved April 11, 2016 from http://www5.statcan.gc.ca/cansim/a34?lang=eng&id=1051101&searchTypeByValue=1&mode=tableSummary&p2=35

Statistics Canada. (2015). *Aboriginal peoples survey, perceived mental health and suicidal thoughts, by Aboriginal identity, age group and sex, population aged 18 years and over, Canada, provinces and territories, occasional. Aboriginal Peoples Survey 2012.* Retrieved April 10, 2016 from http://www5.statcan.gc.ca/cansim/a34?lang=eng&id=5770013&searchTypeByValue=1&mode=tableSummary&p2=35

Stewart, S. L. (2008). Promoting Indigenous mental health: Cultural perspectives on healing from Native counsellors in Canada. *International Journal of Health Promotion and Education*, *46*(2), 49-56.

Talbot, J. A., ZIller, E. C., & Szlosek, D. A. (2017). Mental Health First Aid in rural communities: Appropriateness and outcomes. *The Journal of Rural Health, 33,* 82-91.

Tsuruda, S., & Shepherd, M. (2016). Reflective practice: Building a culturally responsive pedagogical framework to facilitate safe bicultural learning. *Advances in Social Work and Welfare Education, 18*(1), 23-38.

Turner, A. (2016). Living Arrangements of Aboriginal Children Aged 14 and Under. *Insights on Canadian Society.* April 13. Statistics Canada Catalogue no. 75-006-X

Vukic, A., Rudderham, S., & Misener, R. (2009). A Community Partnership to Explore Mental Health Services in First Nations Communities in Nova Scotia. *Canadian Journal of Public Health, 100*(6), 432-435.

Appendix A: Data Collection Tools

Process Interview with MHFAFN Participants

1. In your opinion, what aspects of the training program worked well?
2. What aspects of the training course would you change, if you could?
3. What were the top two most valuable aspects of the training program for you?
4. Have there been any unintended impacts of the training or outcomes that surprised you?
5. Do you think that the MHFA-FN content is culturally relevant to you and your community? Why or why not?

Participant Survey – Paper/Online

Participant Survey

Training start date: _____
Training end date: _____
Location of training: _____

1. How did you hear about this course?

2. What were your main reasons for attending this training?

3. Did you attend this training as part of becoming a trained facilitator?
   - ☐ Yes
   - ☐ No

4. What were the top two most valuable aspects of the training program for you?

5. How would you rate your satisfaction with the following items?

Question	Extremely dissatisfied	Somewhat dissatisfied	Neither satisfied nor dissatisfied	Somewhat satisfied	Extremely satisfied
5a. Overall satisfaction with the training					
5b. The topics covered					
5c. The facilitators that led the training					
5d. The quality of the program manual					
5e. The length of the training					

6. Do you have any comments about your above ratings?

7. Do you think this course has helped to increase your knowledge and understanding of cultural safety in Mental Health First Aid?
   - ☐ Yes
   - ☐ No

8. If you answered yes or no to the previous question, why or why not?

9. In your opinion, was the training a safe space to discuss your culture and your views?
   - ☐ Yes
   - ☐ No

10. What made you feel this way?

11. Are there any topics that you would like to see added to the training?

12. Is there anything that you would like to see changed for the training?

13. Please rate your knowledge about the following BEFORE and AFTER the training
    (1 = strongly disagree and 4 = strongly agree):

	BEFORE				AFTER			
I know about the impacts of colonization on self, family & community	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
I know about the link between culture and mental health								
I am aware of the supports that are available to me as an MHFA responder (e.g., Circle of Support)								
I can recognize the signs and symptoms of substance abuse								
I am aware of the different types of mood disorders								
I am able to recognize emergency situations for self-harm								
I am able to recognize signs and symptoms for anxiety								
I am able to recognize signs and symptoms for psychotic disorders								
I am able to recognize the risk factors for suicide								
I understand the importance of self-care								
I am confident in my skills as a Mental Health First Aider								

14. Is there anything else you would like to tell us about what you have learned?

The next set of questions are based on a scenario:

John is 30 years old. He has been feeling unusually sad and miserable for the last few weeks. Even though he is tired all the time, he has trouble sleeping nearly every night. John doesn't feel like eating and has lost weight. He can't keep his mind on his work and puts off making decisions. Even day-to-day tasks seem too much for him. This has come to the attention of his boss, who is concerned about John.

15. What would you say, if anything is wrong with John?

16. How do you think John could be helped?

17. If John was your friend, what would you say to him?

18. Please rate the following BEFORE and AFTER the training statements

(1 = strongly disagree and 4 = strongly agree):

	BEFORE the training				AFTER the training			
I would be comfortable meeting a person with a mental health issue	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
It is important to learn about mental health issues								
I am able to listen without judgement								
Having mental health issues like the ones talked about in the training are a sign of personal weakness								
Mental health issues like the ones we talked about in the training this week are not REAL medical issues								
People with mental heath issues like the ones we talked about in the training could snap out if they wanted to								
I would not be comfortable working with someone if I knew they had mental health problems								
We should do more to help people with mental health issues get better								

19. From your perspective, is stigma for mental health issues a concern in your community?
    - ☐ Yes
    - ☐ No

20. If so, what does it look like in your community?

21. Thinking about the topics discussed in training (e.g., substance abuse, mood disorders, depression, self-harm, anxiety, and psychotic disorders), does one of these areas experience more stigma in your community than others?

22. What cultural communities or Nations do you identify with?

23. What year were you born in?

24. What is your gender?

25. Have you had any previous training in areas of mental health? Please describe.

Thank you for participating in the survey! Please leave your name and email address for us to send you an electronic gift card!

Name: _____
Email: _____

Participant Follow up Survey

These questions touch on your experience with the Mental Health First Aid First Nations training course.

1. When and where did you attend the MHFA-FN training?
   - ☐ Prince George, BC: June 6-8, 2016
   - ☐ Winnipeg, MB: June 13-15, 2016
   - ☐ Eskasoni, NS: July 11-13, 2016
   - ☐ The Pas, MB: July 12-14, 2016
   - ☐ Lac Seul, ON: July 11-13, 2016
   - ☐ Heckla, MB: August 9-11, 2016
   - ☐ Ottawa, ON: September 26-28, 2016
   - ☐ Headingly, MB: January 24-26, 2017
   - ☐ Prince Albert, SK: February 6-8, 2017

2. Can you tell us about your role in the community (or your work or family)?

3. What were your main reasons for attending this training?

4. Following this training did you become a certified trainer for MHFA,FN?
   - ☐ Yes
   - ☐ No

5. For these next few questions, please think about whether you have had the opportunity to use your MHFA,FN skills, whether you tried them, and what happened.

6. Have you had any situations where you thought you could use your Mental Health First Aider skills?
   - ☐ Yes
   - ☐ No

Condition: No Is selected: Skip to: Overall, now that time has passed…

7. Did you try to use your MHFA skills?
   - ☐ Yes
   - ☐ No

   a. Please briefly describe the situation

   b. Did your actions help the situation? What was the outcome?

8. Have there been situations where you experienced challenges trying to apply your MHFA skills?
   - ☐ Yes
   - ☐ No

   a. Please describe:

9. Overall, now that time has passed, are there things you learned in MHFA, FN training that you use in everyday life?

- ☐ Yes
- ☐ No

a. Please describe:

10. What were the two most valuable aspects of the training for you?

11. Looking back, are there parts of the program that you wish the facilitator had spent more time on?
    - ☐ Yes
    - ☐ No

    a. If yes, which part of the training do wish had been longer?

12. Are there ongoing supports you feel are needed to best put your MHFA skills into practice?
    - ☐ Yes
    - ☐ No

    a. If yes, please comment:

Some people think that stigma is a big issue within mental health. Stigma involves the negative perceptions, attitudes and behaviours that people may have when they label others by their illness.

13. From your perspective, is stigma for mental health issues a concern in your community?
    - ☐ Yes
    - ☐ No

14. Has MHFA,FN had any impact on stigma in your community or organization? Please explain.

15. Do you have any other comments or suggestions about MHFA, FN in general based on your experience?

The last few questions are about you.

16. What is your gender?

17. What cultural communities or Nations do you identify with?

18. What year were you born in?

Thank you so much for working through these questions. They really help us to improve the training course so that we can create the best program for First Nations communities. If anything in this survey has made you feel upset or distressed in any way, please seek support from a trusted resource in your community such as a counsellor, mental health worker, Elder, or anyone else who would be helpful to you.

Facilitator Survey

1. For the MHFA-FN course that you just finished, please enter the start and end date, location, and number of participants. Please enter the dates in MM/DD/YYYY format.

2. Please complete the following statements about your overall satisfaction with MHFA-FN.
    a. Delivering MHFA-FN was a positive experience.
    b. I would recommend MHFA-FN to my co-workers.
    c. MHFA-FN is beneficial for my community.

3. Did you notice any specific benefits or changes among your participants as a result of MHFA-FN? If yes, please provide an example here.

4. Did you make any changes to MHFA-FN while you were delivering it? This can include customizing the content based on your community's unique history, people, and culture.
    - ☐ Yes
    - ☐ No

5. If you did make any changes, what changes did you make? Check all that apply
    - ☐ Shortened the course by dropping activities
    - ☐ Added new activities
    - ☐ Added new topics
    - ☐ Added additional resources (videos, speakers)
    - ☐ Added additional support services (Elders, community members)
    - ☐ Increased/extended time to discuss certain topics
    - ☐ Increased/extended time to discuss individual or community issues
    - ☐ Other, please describe _____

6. Please select your top two reasons for modifying the course.
    - ☐ Reduced or dropped activities to continue important discussions
    - ☐ Reduced or dropped activities to stay within time limits
    - ☐ Added supplementary resources to have more relevant and effective discussions
    - ☐ Modified activities due to group size
    - ☐ Modified activities for different communities
    - ☐ Other, please describe _____

7. Was there anything about the MHFA-FN course that made it difficult to deliver? Check all that apply.
    - ☐ Time frames were difficult to meet
    - ☐ Participants did not respond well to course material
    - ☐ I found some of the topics difficult to discuss with participants
    - ☐ I was uncomfortable discussing certain mental health concerns with participants
    - ☐ Instructions for some activities were unclear
    - ☐ Participants required extra time to debrief sensitive topics
    - ☐ Some activities triggered distress among some participants
    - ☐ Other, please describe _____

8. What advice would you give to someone delivering MHFA-FN for the first time?

9. Please indicate your satisfaction with your training experience.
   - ☐ Overall satisfaction with the training
   - ☐ Satisfaction with the topics covered
   - ☐ Satisfaction with the length of training
   - ☐ Satisfaction with your training instructor

10. How prepared did you feel to deliver MHFA-FN after your training?
    - ☐ Not at all prepared
    - ☐ Not very prepared
    - ☐ Neutral
    - ☐ Somewhat prepared
    - ☐ Very prepared

11. What were the two most valuable parts of your training?

12. Have you been trained in any other MHFA course? Check all that apply.
    - ☐ MHFA Basic
    - ☐ MHFA Basic - French
    - ☐ MHFA for Adults who Interact with Youth
    - ☐ MHFA Northern Peoples

13. How long ago were you trained in MHFA-FN?
    - ☐ Less than 1 year ago
    - ☐ 1 to 2 years ago
    - ☐ 2 to 4 years ago
    - ☐ 3 to 5 or more years ago

14. How many times have you delivered MHFA-FN?
    - ☐ Once
    - ☐ Twice
    - ☐ Three times
    - ☐ Four or more times

15. In your opinion, how much did participants in your MHFA-FN course...
    - ☐ ...enjoy the course?
    - ☐ ...participate in the course activities?
    - ☐ ...learn about mental health concerns?
    - ☐ ...learn the EAGLE steps?
    - ☐ ...improve strategies for helping someone with a mental health concern?
    - ☐ ...provide support to each other around difficult issues?
    - ☐ ...learn strategies for seeking help for themselves or someone else?

16. Has your community or organization delivered other MHFA courses in the past?
    - ☐ Yes
    - ☐ No
    - ☐ Not sure

17. Please complete the following statements.
    - ☐ Are there additional supports in your community or organization for you to deliver MHFA-FN?
    - ☐ How much does MHFA-FN match your community or organization's priorities and objectives?
    - ☐ Is there an identified person at the community or organization level to support delivery of MHFA-FN?
    - ☐ Have you established new community partnerships as a result of MHFA-FN?

18. Please share any other comments about MHFA-FN that you may have.

19. If you are willing to be contacted in the next 3 months about your on-going experiences with MHFA-FN, please leave your contact information below for the best way and time to reach you. All personal information will be held confidential by the research team.

Facilitator Interview

1. How many MHFA-FN courses have you had the opportunity to deliver so far?

2. (With the courses that you have facilitated so far), do you feel that the MHFA-FN program is reaching the right people in your community?

3. What has been helpful in lifting the MHFA course off the ground in your community? (i.e., what supports have promoted the course?)

4. Have you experienced any barriers or challenges to delivering the MHFA-FN training as you had originally planned? (Probe to understand the unique challenges in each of the communities)
    a. Do you have any recommendations for making this process easier?

5. Are there other priorities in your community that are competing for time and resources against MHFA-FN?

6. Within the community setting, can you tell us about any challenges that have come up?
    a. If so, have you been able to overcome them? How so?

7. How has the course been received in your community?
    a. How would you describe the level of 'community readiness' for the MHFA-FN course?

8. In your opinion, what aspects of the training program worked well?
    a. What aspects of the training course would you change, if you could?

9. How satisfied are you with the resources you have for delivering the course curriculum?

10. What supports would be helpful to make the course as successful as possible in your community?

11. Do you think that the MHFA-FN content is culturally relevant to you and your community?

12. What has helped you to ensure that the MHFA-FN is delivered in a culturally safe way? (e.g., organizational aspects, course materials, your leadership as a facilitator, etc.)
    a. Do you have any recommendations for other communities and organizations to ensure that the course is delivered in a culturally safe way?

13. What kinds of outcomes or impacts has the course had in your community or organization? (Probe: Have you seen any changes in the community as a result of this course?)

14. Do you feel that the MHFA-FN course has had any impact on stigma around mental health concerns in your community? Please explain.

15. Have you seen any outcomes from the course that surprised you? (e.g., unexpected outcomes)

16. In closing, do you have any other stories that you would like to share about your experience in delivering MHFA-FN so far?

Administrator Interview

Discussion Guide for call with Executive Directors and other Stakeholders

Selecting trainers:

1. How did you decide who would be trainers from your organization? (Probe: who decided? what process was used?)

2. To what extent did the following factors play a role in selecting trainers:

	Not at all	Not very much	Neutral	Somewhat	Very much
Personal characteristics of the individual					
Professional role in the organization					
Educational background					
Individual's interest in being a trainer					
Reputation among peers					
Role in the community					
Involvement as a trainer in other programs					
Availability / scheduling issues					
Complementary skills with other trainer					

3. What qualities do your facilitators have that have been helpful in delivering the MHFA-FN training in your organization?

4. Is there advice you would give new sites about selecting trainers?

Selecting Participants for the training:

5. How did you decide who would be participants in the course?

6. Looking back on those who have completed the MHFA-FN course, were there any characteristics or factors that you think make the program less appropriate for some individuals?

7. Is there advice you would give new sites about selecting participants?

Overall experience

8. What has helped you to ensure that MHFA-FN is delivered in a culturally safe way? (e.g. organizational aspects, course materials, your leadership as a facilitator, etc.)
    a) Do you have any recommendations for other communities and organizations to ensure that the course is delivered in a culturally safe way?

9. In your opinion, did the program have an impact on participants' knowledge and skills relating to the promotion of mental health?
    a) Has this knowledge impacted the community?

10. Did offering the course help to identify any other specific needs in the community?
    a) (If yes) Did you offer other supports (resources, mini-workshops, etc.) to fill gaps?

11. Were there any specific challenges to implementing the MHFA-FN program in your community/organization?
    a) How were you able to overcome these challenge?

12. Were there any specific benefits or successes to implementing the MHFA-FN program in your community / organization?

13. What have the outcomes of the MHFA-FN program been for your community / organization?

14. Were there any outcomes that surprised you?

Researcher Field Notes Template

Course Day	Researcher Field Notes
Day 1	
Cultural safety	
Implementation	
Impact	
Day 2	
Cultural safety	
Implementation	
Impact	
Day 3	
Cultural safety	
Implementation	
Impact	

MHCC Archival Data

Mental Health First Aid First Nations Course
Participant Feedback Form

Course End Date:
Venue:
Facilitators:

Please circle the number that best represents your opinion on a scale of 1 to 10.

1. How new was this material to you?
2. How easy was it to understand?
3. How well was the course content presented?
4. How safe did you feel to share and participate in the discussions?
5. How well did [facilitator 1] present the course?
6. How well did [facilitator 2] present the course?
7. How relevant was the content for you?
8. After completing the course, how confident are you as a Mental Health First Aider
9. What tools did you find most useful? Please explain.
10. What do you consider to be the strengths of the course? Please explain.
11. What do you consider to be the weaknesses of the course? Please explain.
12. Are there any other issues you think could be included in this course?
13. How did you hear about this course?
14. Any additional comments?

Thank you for your feedback. Please return this form to your facilitators. They will share your comments with Mental Health First Aid Canada to help improve this course.

Appendix B: Implementation Section – Qualitative Data Tables

Table 12: Terminology participants suggested to modify

Topic	Terminology change
Suicide	Change to "completed suicide" as it is neutral and not triggering
Substance use	Ensure peyote and ayahuasca is not conveyed as "traditional", as they are not traditional substances in Canada
Medicine wheel	Used to "emotional, physical, spiritual and mental" – if continue to use the MHFA version, it would be helpful to clarify how "heart and spirit" are different
More Indigenous terms	Could use more Indigenous languages to define terms (e.g., "mino pimatisiwin" = "the good life" and can be discussed in terms of mental wellness)
"History"	Change to current history – the historical context is our families present day reality (e.g., Indian Act continues to enforce oppressive policies and inequitable funding that impacts isolation, depression and hopelessness) – still experience racism and have lateral violence towards each other
"Holistic"	Change to "wholistic" represents the concept of wholism more accurately

Table 13: Components participants suggested adding to the design

Added components	Description
Training development	Decolonize the course further (e.g., have training options in local Indigenous language, such as Cree in Manitoba)
	The course could be modified for health professionals, where there would be less emphasis on symptoms of disorders/mental illness and increased focus on culture/history and techniques
	Course specifically for youth and children
Beginning of the course	Circle of introductions would help at the very outset
	Add a "teamwork agreement", where they agree on confidentiality, respect, protocols with cellphones, etc.
	Smudge at the beginning
	Add context about the course: • Clearly explain the purpose of MHFAFN and outline goals and expectations from the beginning • Explain how MHFAFN is different from the MHFA Basic course • Share that this is geared towards talking to adults • Explain the limitations with this course (e.g., does it apply to working with people who are under the influence?)
Throughout the course	Add audiovisuals and illustrations/visuals, such as videos of personal experiences
	Have ice-breakers and activities that bring humour into the course
	Give a written explanation for what to do in the breakout sessions
	Begin each module with an activity where participants do their own interpretive art on the module, and then share it back with the group
	More regular breaks
Topics	Lateral violence and how to deal with it in communities
	Bullying
	Substance related: • Naloxone, Narcan and overdose • Medical marijuana • Use of solvents • Harm reduction information to prevent illness or injury
	FASD
	Childhood experiences living with substance use and potential triggers in adulthood
	Autism/developmental issues
	Head injuries and traumatic brain injuries, as they often include symptoms of mental health challenges
	Disorders: • Obsessive Compulsive Disorder • Borderline personality disorders • Eating disorders • Schizophrenia – information about it being triggered by alcohol or marijuana
	Treatment information:

Added components	Description
	• Ongoing recovery support • Narrative therapy • Medications and their role in mental health (e.g., how do you know if they are beneficial)
Topics: First Nations related	More information about Canada's colonial history, as the impacts on mental health extend far wider than residential schools, the Sixties Scoop and sterilization
	Current realities (e.g., racism, child welfare rates and CFS apprehensions) that continue to perpetuate stress and inequities
	Cultural healing responses and practices to deal with mental illness
	Traditional views on "gifted" Indigenous peoples (e.g., "seers")
	Culturally relevant screening tools for assessing for anxiety, depression, etc.
	Incorporate small boxes of simple information (e.g., "did you know") about First Nations culture, traditions and teachings
	Incorporate cultural stories around EAGLE
Alternative activities	Have focused case studies as an option instead of role-playing if people are uncomfortable – each small group could share how they approached different scenarios (have multiple ones) to enhance learning opportunities
	Instead have a video to watch where participants evaluate and have a group discussion (e.g., about how they applied EAGLE)
	Have an activity where participants design or collage the way their community is structured with all of the services they identified
End of the course	Support participants to think about responsibility and long-term planning regarding the course and where it leads to
	Have a mentoring component by a role model in the community who has had experiences with mental health
Resources	Create pamphlets about the disorders with information for helplines, treatment options and facilities in communities • Have cultural resources to compliment these materials (e.g., present what they would do in First Nations culture, such as smudging)
	Have a quick reference card with EAGLE on it, with key questions to ask for each letter/step, to support recall after the course
	Have EAGLE posters available for trainees
	Have an appendix of the workbook contain tools on supporting community-level discussions and actions (e.g., medevac procedures and supporting primary care in the local level)
	Have the "We are the Children" movie as a course resource

Table 14: Components participants suggested modifying in the design

Modified components	Description
Length of time	Either lengthen the course to be 3 or 4 full days, or shorten the number of modules to be able to deepen discussion
	Could be done in two different parts/sessions – or have a 1 day version with the essential components
Cohort set up	Ensure that facilitators and participants have separate groups course sessions to streamline delivery and relationship building
	Incorporate Elders as participants – this is important for cultural knowledge
Room set up	Have Kleenex around the room
	Have chairs in a circle so that no one has their backs to each other – important when in circle
Role playing	Have more role playing as it helps to laugh and relieve heavy topics
	Have less role playing as it can be anxiety-provoking and fake
Scenarios	Instead of the scenario with the intoxicated man, do one about a child with suicidal thoughts or ideation because this is a real concern in communities (e.g., children as young as 6)
	Role play as a back-up if the videos don't work (e.g., have a script for participants to act out/improvise)
Activities	Liked the exercise where you draw your culture –that could have been expanded on to understand how culture is a protective factor
	Simplify activities – do not disconnect heart and spirit
Participant manual	Include more Indigenous and cultural images in the manual (e.g., moccasins, wigwams, teepees, shawls, sweet grass, fire, stones)
	Use provincial rates and statistics about First Nations peoples experiences with mental health etc.
	Reduce clinical terminology and consider the education levels of the course groups

Table 15: Components participants suggested modifying in the delivery

Modified components	Description
Support worker/Elder	Have an additional facilitator or Elder that is there for support
	Seek to include an Elder from the traditional territory
Slide delivery	The slides should be in the same order of the manual – flow is important (e.g., had difficulty following along)
	There wasn't a slide on FASD, when it is a big deal and there needs to be education on it
	Ensure information in the manuals mirror the slides
	Hand out the modules as the course progresses for participants to put each module in the binder themselves
	More stories from people with lived experience to bring heart to the material
Module delivery	Leave open space to talk after each module and scenarios
Activities	Spend more time on the activity about asking about suicide to enhance participants' comfort naming suicide and explicitly asking that question
	Spend more time on the "draw your culture exercise" to define community-specific and language-specific protective factors
	Spend more time developing the skills of responders and clarifying where a caregiver's role begins and ends
Surveys	Hand out surveys at the beginning of the course
General facilitation	Ensure facilitators do not cut off participants when they are speaking or sharing stories
	Facilitators need to be mindful of when people are uncomfortable and give breaks
	Facilitators should have more cultural teachings

Appendix C: Impacts Section – Quantitative Data Tables

Table 16: Retrospective pre- and post-test ratings on knowledge, and self-efficacy for whole sample and by training group

Scale	Sample size	Pre-test *M (SD)*	Post-test *M (SD)*	t (df)
Knowledge-MH (all)	n = 88	2.90 (.70)	3.60 (.43)	-11.50 (87)**
Post-secondary	23	3.20 (.64)	3.79 (.28)	-5.43 (22)**
Other training	35	3.06 (.64)	3.67 (.40)	-6.6 (34)**
No training	30	2.54 (.68)	3.44 (.50)	-8.09**
Knowledge – SDOH (all)	n = 89	3.12 (.65)	3.67 (.38)	-9.26 (88)**
Post-secondary	23	3.36 (.52)	3.77 (.29)	*ns*
Other training	36	3.20 (.63)	3.71 (.37)	-5.32 (35)**
No training	30	2.85 (.69)	3.54 (.43)	-6.99 (29)**
Self-efficacy (all)	n = 91			
Post-secondary	23	3.13 (.82)	3.78 (.33)	-4.29 (22)**
Other training	36	3.15 (.64)	3.75 (.41)	-6.57 (35)**
No training	30	2.55 (.70)	3.48 (.46)	-9.00 (29)**
Stigma (all)				
Post-secondary	25	2.08 (.58)	1.89 (.56)	3.01 (25)*
Other training	36	1.94 (.43)	1.74 (.32)	4.10 (35)**
No training	29	2.28 (.54)	2.14 (.64)	*ns*

Table 17: Use of EAGLE strategies in response to mental health scenario by gender

EAGLE Action	Examples	Overall (%)	Females (%)	Males (%)	χ^2
E Engage and Evaluate the risk of suicide or harm	*"I would ask John if I could speak with him and explain that I have noticed the change in his behavior and I am very concerned about him. I would ask him how he is doing and why he is feeling the way he is feeling, I would ask him if he has had thoughts about suicide because of how he is feeling…"*	79.1%	82.9%	68.4%	$\chi^2(1)= 1.93$, $p = .14$
A Assist the person to seek professional help	*"… ask if he would accept help from a mental health resource and help him find one he feels comfortable going to."*	46.2%	52.9%	26.3%	$\chi^2(1)= 4.22$, $p = .04$
G Give reassurance and information	*"That he is not alone (connect to resources, be available to talk). That there is help available. That in time, things will pass."*	51.7%	57.1%	36.8%	$\chi^2(1)= 2.47$, $p = .09$
L Listen without judgement	*"…listen, be present, and validate."*	60.4%	62.9%	57.9%	$\chi^2(1)= 0.16$, $p = .44$
E Encourage self-help strategies and gather community supports	*"…I would attempt to support John in a good way (if he is First Nations) possibly connecting him with Elders, Mental health councilors, Offering care support being encouraging and caring letting him know about other resources... I would acknowledge his gifts and see if I could build upon that.*	58.2%	64.3%	42.1%	$\chi^2(1)= 3.05$, $p = .07$