Evaluation and Program Planning 72 (2019) 188–196

Contents lists available at ScienceDirect

Evaluation and Program Planning

journal homepage: www.elsevier.com/locate/evalprogplan

The essential role of cultural safety in developing culturally-relevant prevention programming in First Nations communities: Lessons learned from a national evaluation of Mental Health First Aid First Nations

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ARTICLE INFO

Keywords:
Mental health
Promotion
Cultural safety
First Nations people
Mental Health First Aid

ABSTRACT

Mental Health First Aid is a population health approach that educates people to recognize and respond to mental health challenges. Since 2012, the Mental Health Commission of Canada has worked with six First Nations communities to develop a culturally-relevant version of the program called Mental Health First Aid First Nations (MHFAFN). This paper presents mixed methods, multi-informant data from a national evaluation to assess the extent to which the course was experienced as culturally safe by Indigenous participants, factors that contributed to these experiences, and ways in which cultural relevancy of MHFAFN can be improved. Our evaluation team conducted participant interviews and surveys, as well as facilitator interviews. Nearly all Indigenous participants (94.6%) experienced the course as safe. Participants and facilitators identified a range of factors that promoted cultural safety, including the knowledge and skills of the facilitators and the cultural components of the course. Participants that did not experience safety identified trauma-related factors and facilitation style. The findings suggest that MHFAFN may be situated in a way where shared cultural backgrounds are imperative to the success of the course. Further evaluation of the MHFAFN curriculum, with the goal of continual improvement, may help to further enhance participants' experiences in taking the course.

1. Introduction

In Canada, as well as in international contexts, deliberate suppression and elimination of Indigenous cultures and traditions created intergenerational trauma, the impacts of which are visible today in the disproportionate rates of social and mental health challenges experienced by many First Nations[1] communities (Hackett, Feeny, & Tompa, 2016; Wilk, Maltby, & Cooke, 2017). Although there has been growing consensus about the importance of cultural safety, there remain few articles that illustrate cultural safety with data from real-world projects. The purpose of this article is to present mixed methods data from a national mental health promotion project and its evaluation to describe the factors that either promoted or hindered cultural safety among First Nations participants. The mental health promotion program, Mental Health First Aid First Nations (MHFAFN), was the result of the Mental Health Commission of Canada (MHCC) and numerous partners coming together over a four-year period to develop a culturally relevant and safe version of the Mental Health First Aid course.

1.1. Mental Health First Aid course

The Mental Health First Aid (MHFA) course was originally developed in Australia to build capacity for individuals to offer immediate intervention for mental health emergencies at a community level (Mental Health First Aid, 2012). It applies a population health approach to mental health promotion by training people to recognize and respond to mental health problems and crises in others. The focal point of the MHFA course is the first aid action plan (ALGEE) that includes the following non-sequential actions: Assess the risk of suicide and/or harm; Listen non-judgmentally; Give reassurance and information to

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[1] In Canada, the term 'First Nations' is used to collectively refer to one of three constitutionally-recognized groups of Aboriginal peoples. Legally, the federal government divides First Nations people by their status under the Indian Act; this colonial legislation often determines access to federally-administered health funding and services. When First Nations people are referred to collectively with Métis and Inuit peoples, the term 'Indigenous' is used in this paper.

https://doi.org/10.1016/j.evalprogplan.2018.10.016
Received 31 December 2017; Received in revised form 5 October 2018; Accepted 18 October 2018
Available online 24 October 2018
0149-7189/

help instill hope; Encourage the person to obtain appropriate professional help; and, Encourage the person to obtain other supports (e.g., community, family, friends, Elders, clergy, self-help groups, etc.).

The MHFA training program has been evaluated in numerous countries and found to effectively increase participants' mental health knowledge, reduce stigma, and increase behaviours that support individuals with mental health issues (Hadlaczky, Hökby, Mkrtchian, Carli, & Wasserman, 2014). Cultural adaptation of the MHFA training program was first undertaken in Australia for training among Aboriginal and Torres Strait Islander peoples. An evaluation of this adapted program highlighted the importance of culturally appropriate and specific MHFA teaching materials (Hart et al., 2010). Early experience with the MHFA program in First Nations communities in Canada underscored a similar need for cultural adaptation; although participants indicated that they learned new information, they felt the program lacked cultural relevance (Caza, 2010).

1.2. Colonial impacts on mental health for First Nations communities

Mental health challenges within First Nations peoples and their communities are rooted within the context of colonization, oppression, and discrimination, the culmination of which is intergenerational trauma (Denham, 2008). Research has demonstrated direct links between intergenerational trauma and a myriad of mental health challenges and crises in First Nations communities, including high rates of depression, death by suicide, violence, and substance misuse (Elias et al., 2012; Hackett et al., 2016). Compared with national counterparts, First Nations people report higher rates of major depression (16% vs. 8%) (Government of Canada, 2006). More recent data from the 2012 *Aboriginal Peoples Survey* reports that more than one in five First Nations adults (18 years and older) living off-reserve reported having suicidal thoughts at some point in their life time (21.1%; Statistics Canada, 2016). To understand health outcomes for First Nations people living on-reserve, the First Nations Information Governance Centre (FNIGC) conducts a multi-phased community-driven national health survey, which includes questions related to suicide ideation and suicide attempts. In their 2012 report, the FNIGC illustrates similar rates of suicide ideation among participating First Nations adults, with 22.0% reporting that they have had thoughts of suicide at some point in their life (First Nations Information Governance Centre (FNIGC), 2012). These statistics demonstrate a disparity when compared to national rates for the non-Indigenous population in Canada, as the 2012 Canadian Community Health Survey reported that 11.9% of all Canadians (15 years and older) had experienced suicidal thoughts at some point over their lifetime (Statistics Canada, 2013). In recognition of the need to promote mental wellness, Indigenous leaders and academics have highlighted the importance of holistic, strengths-based, community-based wellness initiatives as approaches to promoting individual and community wellness (Restoule, Hopkins, Robinson, & Wiebe, 2015). The First Nations Mental Wellness Continuum Framework, for example, represents a shared national vision for supporting mental wellness for Indigenous families and communities, vis-à-vis a comprehensive continuum of appropriate services across jurisdictions (Health Canada, 2015). Indigenous youth have also led the way in creating life promotion strategies grounded in culture, resiliency, and hope (We Matter, 2018).

1.3. Cultural safety

The concept of cultural safety originated in New Zealand—developed by Irihapeti Ramsden, a Māori nurse—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). Cultural safety has been conceptualized as a component of a continuum, where cultural safety is viewed "as an extension of and improvement to competence" (Brascoupé & Waters, 2009, p. 10). In this sense, while cultural competency is understood as a required set of attitudes, knowledge and skills for professionals to effectively work with diverse populations (Isaacson, 2014), cultural safety builds on these skills but emphasizes the requirement of critical reflexivity around power and privilege within healthcare practice. Others have viewed cultural safety as a departure from cultural competency, given the requirement for challenging power dynamics between patients and health care providers (Isaacson, 2014), as well as the colonial relationships and inequalities that shape Indigenous peoples' health experiences (Browne et al., 2005). In order to challenge these power dynamics and bridge cultural differences, experiences of cultural safety are determined by the service recipients (Brascoupé & Waters, 2009). Similarly, values and practices related to cultural safety have been recognized as emerging concepts and best practices within research and program evaluation with Indigenous communities (Hood, Hopson, & Frierson, 2015).

The importance of culturally relevant and safe programming within First Nations communities has been echoed through the evaluation of other mental health training programs. An evaluation of the ASIST program—which is widely used as a form of "gatekeeper training" in First Nations communities (Sareen et al., 2013)—aimed to determine whether the training improved individuals' capacity to "intervene with people who are suicidal" and to assess if the training was "safe or whether it might increase distress and suicidal ideation among participants" (Sareen et al., 2013, p. 2). In terms of the efficacy of ASIST, the authors found that the results were negligible, meaning ASIST did not increase the trained individual's capabilities to intervene and help someone who is suicidal. Additionally, the study found a trend toward an *increase* in suicidal ideation among those in the ASIST group, while the control group (those who participated in a "Resilience Retreat" had no significant changes in suicidal ideation) (Sareen et al., 2013). While Sareen et al. (2013) do not state that a potential explanation is due to lack of cultural safety in ASIST, they do point out that there are some significant and important safety concerns that need to be further examined before rolling out ASIST broadly in First Nations contexts as a gatekeeper training. Although this study had a small sample size (i.e., n = 55), it highlights the need to evaluate any interventions that are being widely implemented in First Nations communities to ensure they are safe for the cultural context.

1.4. Development of the Mental Health First Aid First Nations Course

In 2011, the Mental Health Commission of Canada (MHCC) began working on a more culturally relevant and safe version of the MHFA course for use in First Nations contexts. The approach taken was consistent with culturally adapted interventions, in that cultural activities and content reflective of some aspects of Indigenous knowledge and perspectives were embedded in Western theories of mental illness and health (Allen & Mohatt, 2014). First Nations consultants were hired by the MHCC to assist in the adaptation of the MHFA curriculum. The MHCC also convened a guidance group of nationally recognized Indigenous leaders (including the seventh author of this paper), which oversaw the development of the new program. Initially this work was co-created with three, diverse community sites, including an urban Indigenous organization, an on-reserve regional health authority, and a First Nations child and family services organization. After the first round of pilot groups, an additional three communities were added to assist in further program development and evaluation.

There were several rounds of significant revisions prior to the Mental Health First Aid First Nations (MFHAFN) program being finalized. The resulting course is intended to run 20 h, although some facilitators have lengthened it to three full days to allow more time for discussion. MHFAFN differs from the MHFA Basic course in several ways. For instance, MHFAFN situates mental health challenges facing the First Nations peoples within structural determinants of health, with a focus on historical and systemic issues, and their impact on health and

wellness, within each module in the course curriculum. MFHAFN also utilizes a two-eyed seeing approach to discuss both First Nations' and Western perspectives around mental health and wellness (called *Walking in Two Worlds*).

The concepts of holism and balance, which are important aspects of wellbeing for many First Nations communities, are guiding concepts throughout the MHFAFN curriculum. These values are reflected in course activities, such as *The Circle of Support*, which guides participants through a mapping exercise that creates connections between the course content and available supports in communities (including both funded health services and natural healing supports). In addition, the ALGEE acronym that is used to help participants remember the First Aider actions has been changed to EAGLE to reflect the symbolic and functional importance of eagles in many First Nations cultures. MHFAFN also allows for opportunities for community-specific adaptations to ensure the content is relevant and respectful to the local context, compared to the MHFA Basic which requires full fidelity to the written curriculum regardless of where the training is offered.

The exploration of cultural safety within MHFAFN was a central component of the full program evaluation. Findings related to other program outcomes, such as changes in knowledge and skills, self-efficacy, and stigma beliefs, can be found elsewhere (Crooks et al., 2018). Using data provided by course participants and facilitators, we examine the following evaluation questions: 1) 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? 2) What contextual factors contributed to experiences of cultural safety (or lack thereof)? And, 3) How can the cultural relevancy of the course be improved to enhance cultural safety for participants?

2. Methods

A two-eyed seeing approach involves utilizing the strengths of both Western and Indigenous research methodologies (Iwama, Marshall, Marshall, & Bartlett, 2009). We selected this approach for our research, mirroring the MHFAFN course pedagogy, as well as the composition of our research team, which consisted of both Indigenous and non-Indigenous researchers across academic and non-academic organizations. This approach recognizes that Indigenous knowledge is neither static nor less valid that other ways of knowing; thus, rather than blending aspects of Indigenous knowledge into a Western framework, a two-eyed seeing approach equally honours dual ways of knowing (Iwama et al., 2009). This evaluation also utilized a concurrent mixed methods approach, with a stronger weighting placed on qualitative data, in recognizing the importance of Indigenous peoples' stories and experiences, which are too often overshadowed by deficit-based quantitative data (Auger, 2016).

2.1. Ethical considerations

The evaluation was guided by the principles of Ownership, Control, Access and Possession (OCAP™), developed and trademarked by the First Nations Information Governance Centre (FNIGC) (2014) to increase self-determination for First Nations individuals and communities over research. These principles were operationalized in this research through increasing participant-level ownership over data through sharing interview transcripts back with each participant (a process which also allowed for further feedback and revisions), providing accessible community-level summaries to sites within four weeks of our site visits, and ensuring that participants were empowered to understand the purpose of the research and their autonomy over choosing if and how their knowledge would contribute to the research. This research was also approved by The University of Western Ontario's Research Ethics Board and informed consent was obtained from all participants included in the study.

2.2. Participants

Demographics were available for participants who completed surveys. Of the 91 surveys that were submitted, 19 did not identify themselves as Indigenous and were excluded from cultural safety analysis. Of the remaining 72 Indigenous participants,[2] most were female (n = 56; 76%), the average age was 42.6 years (*SD* = 12.4; range from 19.0 to 73.0). Survey participants had completed the MHFAFN training in one of ten groups in cities and rural communities across four provinces: British Columbia, Manitoba, Ontario, and Nova Scotia. Training groups differed in terms of size and composition (see Table 1). Some trainings were offered within organizations (e.g., health authority, friendship centre), while other groups used open registration and resulted in highly diverse groups with respect to age, professional roles, and previous training.

Nine of the 14 facilitators from the sites we visited participated in interviews. Nearly all of the facilitators were Indigenous (13 of 14) and ten of the facilitators were female. All facilitators were working in the mental health field and in First Nations contexts.

2.3. Procedure

Significant changes were made to the evaluation procedure because of the low initial participation rates, and participation rates increased dramatically for the last seven site visits. Initially, the evaluation approach involved two members of our team attending each site and neutrally observing the course over two and a half days. During this time, team members introduced the evaluation, and, upon completion of the course, provided a link to the online survey for participants to complete once they returned home. Following the third site visit, we observed low response rates for the survey and decided to adjust our approach to increase engagement and participation rates. Recognizing the importance of providing an opportunity to participants to share their stories, we introduced an option for participants to do so through a one-on-one interview. This allowed the participants to reflect on their experiences at the time of taking the course and provide oral feedback, which generally led to more in depth answers than the paper survey was originally eliciting. The success in offering interviews was mirrored through high participation rates (i.e., 93%). We also provided the option to participants to fill out the survey in paper form at the end of the course rather than completing it online after the training. This provided participants with an opportunity to reflect on their experiences at the time of the course and write down their feedback. After these changes were made, the survey participation rate increased dramatically for the last seven site visits (i.e., from 32% for the first three visits to 76% during visits four through ten).

As a team, we made the decision to focus much more on relationship building with course participants and de-emphasize arm's length neutrality. From the fourth site visit onwards, we participated in the course, building relationships with the participants; this process was important to build trust with each of the groups that we were working with, which encouraged them to want to participate in the interviews and paper surveys. In our introductions, we shared information about the research, explaining the importance of gathering feedback and how participants' voices would be honoured and reflected in the evaluation. We remained engaged in the course throughout the duration of its delivery, intently listening to the participants when they expressed feedback over the two and a half days. We also shared meals with participants in the evening, when invited, which further helped to build rapport.

Facilitators were invited to participate in interviews near the end of the project, when most of them had the opportunity to facilitate MHFAFN several times. We asked for their feedback as they had unique

[2] This is inclusive of self-identifying First Nations and Métis participants.

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

Group Code	No. Participants	All Indigenous?	Participant Description
A	16	No	Healthcare providers who primarily work with Indigenous communities
B	15	No	Staff at an urban Indigenous organization
C	23	No	Community members from a local First Nations community, as well as both First Nations and non-First Nations participants from the surrounding areas
D	14	Yes	A diverse group of participants, hosted in an urban centre
E	9	Yes	First Nations leaders from one community
F	9	Yes	First Nations health directors from different communities in surrounding areas
G	16	Yes	Participants from the local First Nations community and the surrounding areas
H	15	Yes	Participants who were mainly frontline workers in mental health and substance misuse, hosted at an urban Indigenous organization
I	21	Yes	Participants from across the region, hosted in an urban centre
J	17	Yes	Participants from across the region, hosted in an urban centre

perspectives of the degree to which MHFAFN they had perceived as culturally safe, as well as recommendations for improving the course.

2.4. Measures

2.4.1. Participant surveys

The participant survey was a 37-item measure that was developed for this evaluation. Many of these measures are reported elsewhere (Crooks et al., 2018). For the purpose of this paper, participants were asked whether they felt that the training was a safe place to discuss their culture and views (yes/no) and were then asked to elaborate on their response. They were also asked open-ended questions about the most useful aspects of the course.

2.4.2. Participant interviews

The participant interviews consisted of five open-ended questions. The interviews assessed the overall strengths and challenges of the course, unintended participant outcomes, and the extent to which the course was considered culturally relevant and safe. Interview length varied from 5 to 45 min, reflecting diverse levels of participant engagement in the research.

2.4.3. Facilitator interviews

Facilitator interviews provided an additional line of evidence, eliciting feedback from people who had delivered the MHFAFN course. These interviews, which lasted between 25 and 105 min, consisted of 16 open-ended questions related to the course reach, design, implementation, and outcomes. These interviews included questions directly related to cultural safety and relevance (i.e., Do you think that the MHFAFN content is culturally relevant to you and your community? What has helped you to ensure that the MHFAFN is delivered in a culturally safe way?), as well as reception of the course within communities (i.e., How has the course been received in your community?). Facilitators were also asked for recommendations for future course delivery (i.e., Do you have any recommendations for other communities and organizations to ensure that the course is delivered in a culturally safe way?).

2.5. Data analysis

Quantitative ratings from participant surveys were analyzed in SPSS using descriptive statistics. Qualitative comments from the surveys were coded with the use of a codebook developed by two of the authors based on a review of the responses. The qualitative comments in the survey were relatively brief overall and straightforward to code. Responses to the questions on cultural safety were coded by one author and subsequently checked by another author. Participant and co-facilitator interviews provided much richer and more complex qualitative data. 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 (Saldaña, 2015). Following this, an abstraction process was used to describe the categories that arose. 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. After this initial procedure, team members coded individual portions of the data, with ongoing discussion around nuanced or complex data.

While both the voices of participants and facilitators are included within this paper, where their perspectives diverge, more weight is placed on the findings from course participants. This intentional weighting is done in recognition of the "fact that cultural safety can only be defined and determined to be a success by the service recipient of the service, underlining… the issues of power and control" (Brascoupé & Waters, 2009, p. 16); in this case, participants align with the service recipient role within models of cultural safety.

3. Results

3.1. 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?

Overall, an overwhelming majority of participants from site visits reported that the course was a safe space to discuss their culture and views (94.6%). While this proportion indicates that there was a high degree of cultural and emotional safety among groups, it is also important to note that a small number of participants (2.7%) did not experience the course as safe.[3] This section of the results presents components of MHFAFN that either promoted or hindered cultural safety within First Nations communities and organizations.

3.1.1. Cultural components

Throughout the interviews, course participants often identified cultural content in the MHFAFN curriculum in contributing to cultural safety. Participants cited examples of content or topics including: EAGLE, colonization and historical trauma, and cultural knowledge. For example, they commonly spoke about the importance of learning about historical trauma in terms of understanding people in their communities, as well as themselves:

> 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

[3] Note that two participants (2.7%) did not respond to this question.

> 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. (Female interview participant, Group A)

Similarly, facilitators commonly described EAGLE as a valuable, culturally relevant component of the curriculum. One facilitator shared that cultural components can help to increase receptiveness to the content and community ownership over the curriculum.

The importance of offering cultural teachings was commonly noted by facilitators, who spoke about incorporating local First Nations' worldviews while remaining open to a diversity of perspectives within communities. One facilitator stated, "when we go out to a community we give, we talk about this component from our point of view knowing that each nation has their own culture and traditions" (Female facilitator interview, Group C). Similarly, participants noted that they gained relevant cultural knowledge and discussed the importance of traditional knowledge within the course. They also described the value of participating in a cultural process for course implementation, which included beginning each day with a prayer and smudge ceremony, and ending each day with a sharing circle:

> The smudge and talking circle at opening and closing were wonderful to start and end the day. I felt that the training and space worked well with my cultural beliefs but the facilitators also, repeatedly spoke about praying in our own way and offered time to share our cultural stories. (Female survey participant, Group B)

Participants described the ways in which various activities helped to enhance cultural safety within the course. For example, the *Circle of Support* was helpful in situating the use of ceremonies, Elders, and traditional healers as supports, as well as enhancing the applicability of the course material by drawing on local resources. During the course delivery, participants discussed the importance of the *Circle of Support* exercise, which prepares participants to identify local supports that can assist individuals in the event of a crisis. This activity is particularly important for those that are remote and lack many services that are available in urban centres. One facilitator, however, noted the need for shifting from being reactive (i.e., to crises) to promoting wellness within communities: "they [discovered] the Circle of Support… I hope they [course participants] had insight and knowledge to collaborate and reach out and develop a strategy for wellness in the community rather than a strategy for responding to mental health crisis" (Female facilitator interview, Group E).

Participants also spoke about the importance of using hands-on exercises and engaging activities within MHFAFN; however, these were more commonly described as culturally relevant than culturally safe. 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" (Female interview participant, Group C).

3.1.2. Characteristics of facilitators and elders

During the interviews, participants and facilitators commonly reported that integrating personal experiences into the course delivery enhanced cultural safety. This included sharing stories throughout the course, which reportedly enhanced the relevance and relatability of the course content. One participant 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" (Female interview participant, Group D). Participants reported the importance of having facilitators who are either from the community or have knowledge of the local culture, territory and the language; for example, one person said, "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" (Male interview participant, Group E).

In their survey and interviews responses, participants spoke about the value of having Elders present to facilitate, participate in the course, and be available for emotional or cultural support. More broadly, one participant noted that the First Nations facilitators brought a necessary cultural, strength-based lens. Similarly, one survey respondent noted, "First Nations trainers are necessary [for their] community/cultural knowledge, real life experiences" (Female survey participant, Group H). Similarly, many of the facilitators spoke about the importance of having First Nations 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 Elder's point of view, no one can always deliver that, only an Elder can provide a traditional point of view" (Male facilitator interview, Groups A and F). While any form of Elder presence was noted to be valuable (e.g., available for a traditional opening and closing to the course), both participants and facilitators identified having Elders present for support throughout the entire course as the optimal situation.

3.2. Which contextual factors contributed to experiences of cultural safety (or lack thereof)?

Given the diversity of group composition, different indicators of cultural safety arose across the different sites for survey participants. For example, although nine survey participants (12.5%) 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 participants spoke to the individual nature of cultural safety, as personal healing journeys were often discussed within the interviews and surveys. 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 have released the heavy burden that I have been carrying all these years" (Male survey participant, Group E). In contrast, one of the two Indigenous participants (2.7%) who did not report feeling safe spoke to the legacy of colonization and trauma as underlying his lack of safety:

> I did not feel safe to discuss this because the topic of residential schools became a topic. I felt angry to talk about it. This part of cultural history has had a negative impact on the First Peoples of Canada and still affects the native population today… so no, I did not want to discuss it. (Male survey participant, Group I)

The other participant felt that the facilitators' portrayal of low levels of mental health knowledge in First Nations communities was negative and stigmatizing: "When participants asked questions or made comments, one of the co-facilitators constantly stated 'but when you deliver in communities they don't know the info'. I found that very negative and stigmatizing language about knowledge levels in community" (Female survey participant, Group H).

Facilitators spoke about doing intentional preparation and relationship building work with communities prior to delivering the course, to promote cultural safety. 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" (Male facilitator interview, Groups A and F). Another facilitator described this as a challenge as the course does not 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" (Female facilitator interview, Group B). Facilitators also spoke about several practices that they use through the implementation of this course, such as: building rapport, liaising with community representatives, and holding planning meetings with community contacts.

3.3. How can the cultural relevancy of the course be improved to enhance cultural safety?

Participants and facilitators provided recommendations for improving the cultural relevancy of MHFAFN, often touching on areas of the course content, the course adaptability and flexibility, and allowing for time and space for sharing.

3.3.1. Expanding course content

Both participants and facilitators, at times, recommended expanding content to increase the cultural relevance of the curriculum, such as on intergenerational trauma and the impacts of colonization (e.g., how youth are effected, how this is connected to mental health). They also noted 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. Similarly, during the course delivery, participants from two different sites noted that content on historical loss and trauma could be reframed, as colonization is ongoing 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.

Some participants reported the need for more traditional models and First Nations-specific content. While participants commonly emphasized the strengths of both Western and Indigenous knowledges, they noted the need for more of a blend between traditional and Western content with respect to mental wellness, as well as a stronger emphasis on balance:

> The part about two worlds is important. I think it is 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... We have to realize how strong culture and identity is" (Female interview participant, Group H)

One participant noted that the content should include more teachings from Elders, as MHFAFN is currently too similar to the MHFA Basic course. Another participant was expecting more First Nations content related to mental health. Additionally, two facilitators (both from the same community) 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, which outweighs Indigenous worldview and experiences:

> I think there should be more First Nations… content. Like, I would like to see more traditional part of it… 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. For my community there should be more [discussion of] 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. (Female interview participant, Group A)

Two participants reported that the curriculum is based too heavily on Western Canada and is not applicable to Northern Ontario, 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" (Female interview participant, Group H). One participant noted that in delivering the course, they could offer traditional teachings and experiential knowledge to fill the gaps within the curriculum:

> Where it might fall short we can bridge the gap with our experience we have already, the anxiety disorders are Western scientific, that part might be hard to teach the health workers in our community and we might have to bridge that gap with traditional knowledge and teachings. (Female interview participant, Group D)

3.3.2. Adaptability and flexibility

The flexibility of the MHFAFN course was commonly reported as an enabler for cultural relevancy and safety. Participants reported that the course could be culturally relevant in their communities, given its adaptability 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. (Female interview participant, Group D)
>
> I like the fact that it emphasizes that every community is different. This is true for us—we serve nine Cree communities and even they are not all are the same. There's some that are deeply religious and they have many fractions of different religion. There's still a lot of judgement. 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. (Female interview participant, Group H)

Participants reported that while the manuals are not relevant to their specific communities, the generalizability is required to ensure that the curriculum is adaptable and able to recognize diversity between communities. To this end, participants 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. (Female interview participant, Group D)
>
> It is not specific to my area but if I was to deliver it I would add our history, our realities, I would be comfortable with what is there – the major oppression, colonization – I would build on that to be specific to my base. (Female interview participant, Group H)

3.3.3. Time and space for sharing

Facilitators spoke about the challenges that time restrictions placed on creating space for story sharing: "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" (Female facilitator interview, Group C). This issue was discussed in a participant interview, which highlighted that the course felt rushed and lacked time and space for 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…. 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. (Female interview participant, Group C)

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

4. Discussion

The findings from this research speak to several core components

that contributed to experiences of cultural safety within MHFAFN. In particular, the people delivering the course, including co-facilitators and Elders, were integral to creating safety for participants. A key factor was their willingness to share stories and integrate personal experiences, as well as their encouragement of participants to reflect on their own experiences and creating the space for them to share. Interestingly, these findings do not fit within conceptions of cultural safety which are often located within the context of power differences among "cross-cultural relationships, between Aboriginal service-receivers and non-Aboriginal service deliverers" (Brascoupé & Waters, 2009, p. 7). The findings suggest that for MHFAFN to be safe and successful, Indigenous facilitators are required to deliver the course. However, in addition, the facilitators often spoke about the importance of rapport with other communities, before coming in to teach the course. This process also represents a form of relationship building—too often ignored throughout research, health service provision, and other forms of programming—that is critical to enhancing cultural safety (Health Council of Canada, 2012). Mutually beneficial, culturally safe relationships among First Nations communities, governments, and service providers have also been shown to promote self-determination, reciprocal accountability, and collaborative action in health promotion (Health Council of Canada, 2012).

Mundel and Chapman (2010) underscore that since colonization is the root of many health challenges within First Nations communities, effective approaches to address these inequities must be decolonizing in practice. Similarly, Kirkham, Baumcusch, Schultz, and Anderson, (2007) note that "cultural safety underscores the importance of acknowledging the historical sociopolitical context that shapes people's health and healthcare encounters" (p. 37). The evaluation findings indicate that MHFAFN has made significant strides toward embedding content on colonization, systemic barriers to wellness, and historical trauma. The curriculum, however, does not represent a significant departure from Western pedagogies and biomedical models to contribute toward decolonization. In this sense, while the course content was modified to make space for Indigenous ways of knowing and healing—and the findings demonstrate positive feedback around these modifications—both participants and facilitators recognized that MHFAFN remains an evidence-based course where Western knowledge is maintained as a foundation for mental health education. The findings suggest that this model of integration limited the curriculum's ability to truly blend First Nations and Western perspectives, and instead maintained a hierarchy of knowledge, which conflicts with the notion of cultural safety. This is a common issue across many disciplines and systems, as Smylie, Olding, and Ziegler, (2014) note that Indigenous knowledge remains rarely recognized as evidence equivalent to Western epistemologies within knowledge translation. The remaining rigidity of MHFAFN curriculum may hinder the cultural safety of the course, as the responsibility for integrating Indigenous knowledge and cultural teachings laid with the facilitators. Given the commonly shared cultural backgrounds between course participants and facilitators, there was less of a focus on this dimension of cultural safety. The findings suggest that MHFAFN may be situated in a way where shared cultural backgrounds are imperative to the success of the course. This suggests that while the vast majority participants stated that they felt that the course was culturally relevant, and that the environment in which they took the course allowed for them to feel safe in sharing their culture and perspectives, the absence of Indigenous facilitators may shift these experiences.

The unique social, political, economic, and environmental structures that shape First Nations communities and individual-level experiences require culturally safe prevention initiatives and interventions. Focusing on a cultural safety lens empowers community members to define what mental health and wellness means to them, and to understand how both traditional and Western supports can contribute to holistic health and wellness. A cultural safety framework is unique in its ability to impact systemic change "by exposing and confronting the discourses and assumptions that are used by the dominant structures and systems" (Downing & Kowal, 2011, p. 10). Similarly, Brascoupé and Waters (2009) note that "cultural safety as a concept incorporates the idea of a changed power structure that carries with it potentially difficult social and political ramifications" (p. 8). Thus, to effectively shift community approaches to focusing on prevention and upstream thinking, culturally safe programming is required to support shifts in both paradigm and practice. MHFAFN, however, may be limited in its ability to support such shifts in paradigm; however, the knowledge and tools gained by participants, in conjunction with the activities designed to promote connection to community resources may contribute to positive changes in local, frontline mental health practice.

4.1. Lessons learned

Overall, the findings of this evaluation underscore the importance of cultural safety across all stages of program planning and delivery, as well as throughout the program evaluation. The challenges that arose during the early visits (as described in the Methods) allowed for opportunities to reflect on our practices and the importance of community-driven evaluation. While the original evaluation approach was co-developed with members from the participating communities and organizations who recognized the utility of survey methods, offering multi-method opportunities for providing feedback and telling stories seemed to resonate strongly with the communities and training groups that we worked with. The application of the OCAP Principles (First Nations Information Governance Centre (FNIGC, 2014), through data sharing with individual participants and offering evaluation summaries to each site, helped to ensure validity in the qualitative evaluation findings. More broadly, the participatory approach to this evaluation allowed for a high level of community involvement throughout the process of the evaluation, which yielded shared benefits through ongoing engagement in the evaluation activities. Literature within the field of community-based participatory research with Indigenous communities also offers insights to the importance of offering culturally responsive methods for increased community buy-in (Maar et al., 2011), promoting co-learning among all partners involved in the project (Ritchie et al., 2013). We found that the site visits offered opportunities for enhancing trust and strengthening relationships, which in turn, contributed to increased engagement (i.e., higher response and participation rates in the evaluation activities). For future evaluations with Indigenous organizations and communities, we recommend collaboratively creating an evaluation that is rooted in the needs of the participating communities, while also employing a strengths-based approach that builds on the inherent strengths and capacities that communities hold.

4.2. Limitations

Given the smaller sample size of the participant surveys and interviews, there was a very small number of participants who reported experiencing a lack of safety (n = 2). While this is undoubtedly a positive result for the MHFAFN course, it limited our ability to identify patterns in the data or identify characteristics associated with a lack of cultural safety. Our survey also measured safety as a dichotomous variable, which may have masked nuances related to the degree of safety. Further, the changes to our methods made mid-point in data collection would have been more effective (with higher response and participation rates) if they had been implemented at the outset. Finally, there may be a sample bias in that individuals who did not feel safe may have chosen to not participate in the evaluation.

4.3. Conclusion

Given the legacy of colonization and its manifestation in mental health challenges among First Nations communities in Canada, there is

an immense need for culturally safe initiatives. There were several positive findings related to the cultural content, activities and delivery of the course, which largely suggest that MHFAFN is culturally relevant. MHFAFN may become increasingly effective as a tool for mental health intervention, with increasing awareness and ownership of the course across First Nations communities. However, the notion of cultural safety is nuanced and findings suggest that the model of MHFAFN may not neatly fit within common conceptualizations of cultural safety within the health field. This paper illustrates the need for ongoing research and evaluation, critical reflection, and continual improvement in the spirit of learning and meeting the needs of First Nations communities.

Funding

This research was funded by a grant from the Canadian Institutes of Health Research (#297664). The funding agent has had no involvement in the study design, data collection and analysis, interpretation of the data, writing of articles, nor decision to submit this article for publication.

Disclosure of potential conflicts of interest

Some of the authors were paid consultants on both the program development and evaluation components.

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