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INNOVATIONS IN POLICY AND PRACTICE

Supporting Indigenous families in the Cree territory: lessons from the Â Mashkûpímâtsît Awash initiative

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Abstract

Objective We describe the adaptation of an early childcare and development program to the Indigenous context of the Cree territory in Québec. We also share lessons on the challenging implementation of home visits by Indigenous family support workers (FSWs), which is a critical component of the intervention.

Participants Â Mashkûpímâtsît Awash (AMA) aims to enhance the health and well-being of pregnant mothers, young children, and their families by providing intensive interdisciplinary care and follow-up. Indigenous female FSWs from the community are the key frontline workers and cornerstone of the program.

Setting AMA is implemented as part of the multidisciplinary services provided by the Community Miyupimaatisiiun Centres (primary health care centres) in three pilot communities of Eeyou Istchee.

Intervention AMA builds on family centredness and cultural safety, integration of services, and creation of family-friendly communities. It emphasizes the role of female local Indigenous FSWs in providing culturally safe outreach services in the form of home visits.

Outcomes The main challenge was conducting home visits. FSWs' view of the pertinence of home visits, as well as their personal stories, seemed to influence their motivation to conduct home visits. Their level of experience appeared to facilitate home visits. Encouraging creativity, fostering autonomy, ensuring a step-by-step implementation, and promoting communication were found to create a supporting environment to facilitate home visits.

Implications Hiring local Indigenous workers is necessary to ensure that early childhood development programs are culturally safe. Success of such programs relies on team management, provision of culturally adapted training, and quality of the ongoing emotional support provided to the FSWs.

Résumé

Objectifs Cet article vise à décrire l'implantation d'un programme de soutien au développement de la petite enfance dans trois communautés pilotes en Territoire cri au Québec.

Participants Â Mashkûpímâtsît Awash (AMA) est un programme visant à offrir un soutien intensif adapté aux besoins des femmes enceintes et de leurs enfants dans le but de promouvoir la santé et le mieux-être des familles cries. Les intervenantes locales sont indispensables à la sécurisation culturelle de ce suivi octroyé sous la forme de visites à domicile.

Résultats De multiples défis furent observés dans le déploiement des visites à domicile par les intervenantes locales, incluant leur perception du manque de pertinence des visites, mais également leurs expériences tant personnelles que professionnelles en lien avec les difficultés vécues par les familles. Ainsi, le soutien concret offert aux intervenantes par le mentorat, ainsi que le respect de leur autonomie et créativité ont été observés comme des facteurs facilitant le déploiement de visites à domicile. De même, une

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communication ouverte et une approche graduelle dans l'implantation des changements furent identifiées comme supportant les intervenantes dans l'accomplissement de leurs tâches.

Implications Les intervenantes locales sont essentielles à la sécurisation culturelle des services de soutien aux familles en milieu autochtone. Le succès de ces approches repose sur la qualité du soutien apporté à ces travailleuses, tant sur le plan du développement professionnel (qui doit être adapté aux besoins et au mode d'apprentissage des intervenantes) que sur le plan personnel, afin de leur offrir le soutien émotionnel dont elles ont besoin dans le soutien des familles de leur communauté.

Keywords Health services, Indigenous · Maternal-child health services · Community health workers · Culturally competent care

Mots-clés Services de santé · Santé des autochtones · Services de santé de la mère et de l'enfant · Agents de santé communautaire · Compétence culturelle

Introduction

Pregnancy is an exciting transition in a woman's life and the lives of those around her. Yet, raising young children can become an extremely challenging undertaking, especially when parents are faced with the consequences of social exclusion, lack of access to good quality housing, lack of healthy food, or lack of culturally safe health care services (Ministère de la Santé et des Services sociaux 2004). In fact, such structural determinants are only some of the many challenges faced by Indigenous families across Canada (Irvine 2009; National Collaborating Centre for Aboriginal Health 2012).

Research has now shown that high-quality early intervention/education which addresses children's and families' needs and priorities can contribute to closing the health inequity gap between Indigenous and non-Indigenous populations (Sims 2011). Consequently, experts in Indigenous health are unanimously calling for increased investment in early childhood intervention programs that are developed *with* Indigenous families and communities so that they reflect their cultural realities and social contexts (Irvine 2009; Ball 2008; Mildon and Polimeni 2012).

Indeed, services have been shown to be more effective for Indigenous families when they respect cultural safety principles (Sims 2011) (see Table 1 for definition), which includes hiring Indigenous workers as primary caregivers (Sims 2011; Ball 2008; Mildon and Polimeni 2012). Local workers are best placed to establish trusting relationships with families (Mildon and Polimeni 2012; Durie 2003), not only because they often constitute the only stable personnel in remote Indigenous regions (Gauthier et al. 2009), but also because they are the only ones who can provide care to families in their own language, using approaches that are truly empowering and coherent with local culture and social expectations (McCulla 2004). Besides, programs using well-trained paraprofessionals have demonstrated positive impacts on children's immunization and breastfeeding rates, as well as rates of common illnesses in childhood (Minore et al. 2001; World Health Organization 2012), and now constitute an important approach to improving accessibility and efficiency of health care for Indigenous populations around the world (Lewin et al. 2008).

The main objectives of this article are to (1) briefly describe how an early childhood intervention (ECI) program for Indigenous families was developed in the Cree territory of Québec (Eeyou Istchee) and (2) share our understanding of the factors influencing the work of Indigenous family support workers (FSWs) recruited and trained as part of this program. Our main message is that Indigenous FSWs should be valued, recognized, and thus better supported for successful ECI programs in Indigenous contexts.

Participants, settings, and intervention

In the years prior to the development of the ECI program in Eeyou Istchee, several consultations were conducted with both families and health care workers in the region. These revealed that most of the services were based on a biomedical model not well suited to address many of the families' needs, particularly with issues around parenting and stress coping skills, family violence, and addictions, nor to help to break women's isolation (Sioui 2008). In addition, both staff and local community members described the impact of high staff turnover on poor continuity of care (Schinazi 2002).

As a result, the Cree Board of Health and Social Services of James Bay (CBHSS) decided to develop an ECI program named the Â Mashkûpímâtsît Awash (which means 'strong and healthy children' in Cree) program (AMA). The AMA program was meant to be deployed in Community Miyupimaatisiiun Centres (primary health care centres, see definition, Table 1) and aims at maximizing the health and well-being of pregnant women, young children, and their families by acting on the web of interrelated social determinants of Indigenous peoples' health (Fig. 1) (Loppie-Reading and Wien 2009).

The development of AMA was based on the results of literature review identifying core elements of ECI programs efficiency in Canada and around the world (Beauregard et al. 2010;

Table 1 Useful definitions

Cultural safety	Concept developed in nursing practice in New Zealand; the concept of cultural safety challenges the previously accepted standard of transcultural nursing by transferring the power to define the quality of health care to Indigenous patients according to their ethnic, cultural, and individual norms. Hence, the people most able or equipped to provide a culturally safe atmosphere are people from the same culture (source: National Aboriginal Health Organization (2009). Cultural competency and safety in First Nations, Inuit and Métis health care: fact sheet. Ottawa: National Aboriginal Health Organization. www.naho.ca/documents/naho/english/factSheets/culturalCompetency.pdf)
Cree Board of Health and Social Services of James Bay (CBHSS)	The CBHSS was created pursuant to the James Bay and Northern Quebec Agreement (JBNQA) of 1975, when the *Indian Act* was replaced by the *Cree-Naskapi* Act in Cree communities, and Cree values and traditions were formally recognized in relation to the development of health and social service delivery systems. These could however only be fully actualized with the CBHSSJB Strategic Regional Plan of 2004, which allowed the organization to operationalize the Cree notion of health and well-being articulated through the concept of *miyupimaatisiiun* as a function of all aspects of individual and social well-being (source: Cree Board of Health and Social Services of James Bay. http://www.creehealth.org/about-us)

Bouchard 1989). Adaptation of these core components to the context of Eeyou Istchee was then inspired by reviewing the results of the aforementioned consultations as well as the literature on similar adaptation initiatives implemented in other Indigenous contexts (Irvine 2009; National Collaborating Centre for Aboriginal Health 2012; Sims 2011; Ball 2008; Mildon and Polimeni 2012; World Health Organization 2012; Sioui 2008; Schinazi 2002) (this process is summarized in Table 2).

The resulting AMA program was developed building on three fundamental principles:

1. *Family centredness and cultural safety of services*: AMA aims at responding to the families' unique needs and priorities; services are essentially provided by Indigenous family support workers (FSWs) from the community as key care providers supported by an interdisciplinary team of community health nurses, family physicians, social

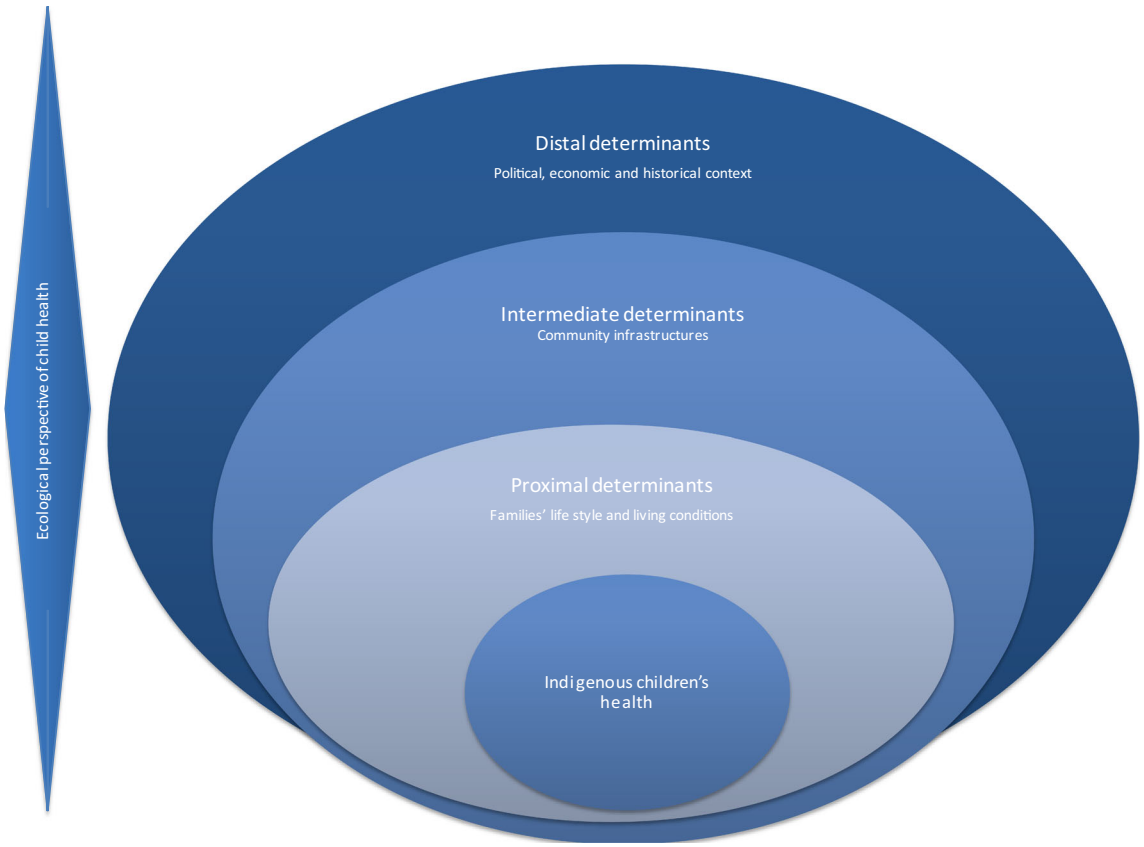

Fig. 1 Social determinants for Indigenous children's health and development (adapted from Loppie-Reading and Wien 2009)

Table 2 Development of AMA in response to Eeyou Istchee reality

ECI programs' core components (Beauregard et al. 2010; Bouchard 1989) What are the 'active ingredients' recognized as essential to the efficacy of ECI programs	AMA development process (Irvine 2009; National Collaborating Centre for Aboriginal Health (NCCAH) 2012; Sims 2011; Ball 2008; Mildon and Polimeni 2012; World Health Organization 2012; Sioui 2008; Schinazi 2002) How were the 'active ingredients' adjusted to fit the Cree families' contexts
Intervention precocity and intensity	
ECD programs have been shown to be more efficient when follow-up is initiated in early pregnancy and pursued on a regular basis afterwards.	AMA services are offered at the first prenatal visit and pursued on a regular basis afterwards. Frequency of visits can vary depending on the families' needs.
Quality of the relationship of trust between families and staff	
In order for programs to work, a relationship of trust needs to be established between the staff and the family.	Services are offered to all families, so as to avoid stigmatization of selecting families on the basis of 'high-risk criteria'. Services are entirely voluntary, which means that families can decline support offered from FSWs. FSWs are Cree in order to improve stability, continuity, and cultural safety of services.
Competency of the staff	
The follow-up provided to families with complex needs requires that the staff be competent in multiple domains, including prenatal and postnatal care, psychosocial support, and crisis interventions.	The professional support provided to FSWs includes formal trainings, as well as informal support from other team members and regional implementation team. Special attention is given to the prevention of compassion fatigue, which is likely to be high for FSWs working in small communities.
Services comprehensiveness	
In order to be efficient, ECI programs should provide support to families in all aspects of their lives (health, social, emotional, material, etc.).	In addition to home visits and clinic appointments, AMA promotes access to a vast array of community services that address various social determinants of health (including housing, employment, and food insecurity).

workers, and other health professionals with experience in care of families and young children.

2. *Continuity of care and integration of services*: the AMA program also ensures that families have access to a continuum of health and social services according to their needs and priorities.
3. *Creation of family-friendly communities*: finally, AMA supports the development of community-driven initiatives aimed at improving families' living conditions, as well as promoting healthy and safe development for children.

From 2008 to 2012, the AMA program was gradually implemented in three pilot communities and, in 2012, the CBHSS commissioned an evaluation of the pilot projects to provide a profile of AMA services and clientele, as well as recommendations for program adjustments prior to regional expansion of the services. The evaluation of the three pilot communities essentially showed that, while some of the clinic-based services appeared well deployed, important components of AMA still required improvements. One such area for improvement was the lack of integration of traditional practices in the care provided, and this was rapidly addressed by reviewing program and service guidelines with an elders' committee responsible for traditional practices in the region (for more details, see the complete report) (Richer and Robert 2016).

Another important finding of this evaluation was the need for increased support to the FSWs in providing outreach services to families in the form of home visits. Indeed, it was observed that the home visiting component of the program did not take place to the extent expected. This was found to be a matter of particular concern, since the clientele profile had confirmed the fact that many families were facing multiple difficulties and could have benefited from a more intensive follow-up than what the regular clinic visit schedule provided.

These findings led to a second component of the evaluation involving individual in-depth interviews ($n = 44$) and group discussions ($n = 2$) with FSWs, clients, health staff, and members of the implementation team with the goal of better understanding the reality and needs of FSWs. An Evaluation Advisory Committee made up of representatives of the program clientele and team members was formed to ensure that the evaluation took into account all of the knowledge users' concerns. Approval from the Directeur des services professionnels of the CBHSS was obtained.

Evaluation results

Interviews and group discussions allowed us to identify some of the challenges and facilitators which seemed to influence

the comfort level of the FSWs in conducting family home visits. They are summarized below according to two levels of analysis, individual and organizational factors.

FSWs and home visits: individual factors

The main individual factor which seemed to influence FSWs' readiness to conduct home visits related to their perceptions of home visits as an intervention. Indeed, when FSWs considered home visits as useful and appreciated by clients, they were more inclined to conduct them than when they considered them as culturally inappropriate, intrusive, or undesirable by the clients.

> If you go and knock on their doors, they're going to bring more resistance. Because that's how I would feel if somebody kept knocking (…) to check my home.

FSWs also emphasized the fact that the environment in which some families lived, such as overcrowded or dysfunctional homes, was not favourable to conducting home visits. Some indeed mentioned the lack of privacy for discussing sensitive issues with a client in such conditions. In addition, fear was mentioned by many FSWs as an important barrier to visiting some families in their home, fear which sometimes appeared to be based on past experiences of distress and/or violence.

> But I saw a few things that I couldn't even deal with myself. [...] That was a question I didn't like to ask because I'm also a - I'm a survivor.

On the other hand, a few FSWs did mention that in fact being able to relate to (and often share) their own personal story with clients sometimes facilitated the establishment of a therapeutic alliance with them.

> They know who I am, (…) I had a tough life [...] you're a role model for the community [...] I can compare with their [...] problems. [...] It's what I went through.

And finally, the complexity of home visiting as an intervention was also often reported as a significant challenge to implementing them; many FSWs mentioned feeling unqualified to deal with clients' complex needs.

> I wish I had more tools sometimes when I work with certain people. [...] Sometimes inside I get frustrated because I feel like I'm going nowhere (…).

By contrast, FSWs' increased level of experience appeared to facilitate home visits, as self-confidence and flexibility were often identified as key qualities for engaging with families.

Organizational factors

Factors which appeared to influence FSWs' work at the organizational level all related to the support provided through training and team collaboration. As a new program, implementation of AMA required that all staff follow multiple training sessions, and although these sessions were generally perceived by FSWs as important, they were felt to be too frequent, thus limiting ability to apply new knowledge into practice.

> As soon as we finish a training, it seems like there is another one right after.

FSWs also unanimously reported that trainings were too theoretical and not adapted to their daily realities. On-the-job mentoring sessions, on the other hand, were particularly appreciated as more helpful when encountering difficulties.

Several aspects of team dynamics were also reported as influencing FSWs' comfort in their role as part of AMA, including team stability and collaboration, as well as team management and conflict resolution styles. Indeed, the retention of FSWs within the teams, and the stability of the team members in general, seemed to play a significant role in the ability of FSWs to conduct home visits.

> We've been working together for so long, it's like we're all family.

Similarly, teams which seemed to demonstrate high level of collaboration and cohesion made FSWs feel they had the moral and practical support they needed, and indeed, team case discussions were often mentioned as an efficient way to build trust and collaboration among team members.

> So, if ever I have a problem with something that I need help with or something that I don't understand, I go see them, (they) give me a lot of support.

In contrast, team conflicts and communication difficulties often contributed to FSWs feeling isolated and not considered as equals by their non-Cree colleagues. Furthermore, team managers were also mentioned as essential to mediate occasional tensions and miscommunication within teams. Important qualities identified included the team managers' ability to foster open communication and constructive conflict resolution, as well as their ability to encourage creativity and autonomy.

> The team is very creative [...] If they're given the chance to grow and not to adhere to strict rules. Rules are very hindering.

Implications for practice

Establishing trust relationship with families

The development of a trusting relationship between program staff and families has repeatedly been identified as the fundamental 'active ingredient' of supportive family programs such as AMA (Beauregard et al. 2010; Bouchard 1989). Yet, developing trust relationships requires time, flexibility, and the possibility of meeting families where they can feel safe and comfortable to talk about sensitive issues. Some authors have emphasized that in Indigenous contexts, home may not be the place where clients have a sense of ownership and control, and that programs should use alternative community hubs, such as family houses, day care centres, or parks (Sims 2011). Consequently, flexibility in allowing the families to identify *where* they want to be met is likely to be more conducive to establishing trust relationships than insisting on home visits as the unique mode of providing intensive family support (Sims 2011; Poissant 2014).

Supporting Indigenous workers in all aspects of their work

To be successful in Indigenous contexts, early childhood intervention programs need to value the role of Indigenous paraprofessionals as prime support workers by providing them with the support they need in all areas of their work (Sims 2011; Poissant 2014; Wade et al. 1999; Gendron et al. 2013). According to our experience, support to FSWs should include competency development, as well as ongoing team support, and on-the-job mentoring. Teaching methods should emphasize observations and experiential teaching styles, rather than didactic types of training, favouring mentoring and role modeling, and taking advantage of local 'champions' (Best Start Resource Centre 2010).

Our interviews also highlighted some of the emotional and psychological challenges faced by FSWs when visiting families with complex psychosocial needs. Workers in prenatal and early childhood services are indeed known to be at risk for burnout because of the demanding nature of the work (McCulla 2004; Best Start Resource Centre 2012). Confronting such situations can be even harder for Indigenous FSWs who can at times be experiencing similar challenges in their own family (Goodleaf and Gabriel 2009). In addition, FSWs working in their community of residence can often feel personally involved, hence making them extremely vulnerable to vicarious trauma (Best Start Resource Centre 2012; Goodleaf and Gabriel 2009).

Factors that have been shown to improve workers' resilience in such situations include ability to ask for help, capacity to balance home and work, and development of self-care strategies (such as going on the land, meditating, and visiting family members) (Best Start Resource Centre 2012). Workers should be provided with the resources and tools to develop these skills, and managers should ensure their staff have access to psychological support when needed, including encouraging them to attend personal healing retreats (Goodleaf and Gabriel 2009).

Similarly, managers and non-Indigenous professionals practicing in Indigenous contexts need to understand the added level of stress and responsibilities faced by FSWs working as helpers in their own communities. Organizational-level strategies should be put in place to provide local workers with the resources they need, including (Best Start Resource Centre 2012; Goodleaf and Gabriel 2009):

- Creating opportunities to share the workload and allowing workers to have a mixed practice (i.e., some difficult cases with other less demanding tasks)
- Ensuring team stability and peer support: this also means that colleagues are able to detect workers dealing with stress early and provide support immediately
- Favouring a managerial style which is open to admitting errors and correcting them in due time, allows expression of appreciation, favours open and respectful communication, and where workers feel safe.

Conclusion

Working with local Indigenous people in ECI programs is essential to the quality of the services provided, from both a practical and cultural safety point of view. Therefore, the success of such programs is highly dependent on providing adequate support to these invaluable resources. Providing flexible employment patterns, such as part-time work and leaves, as well as culturally adapted training and psychological support can improve staff retention and service quality in the long term. Cultural safety of services for Indigenous families essentially relies on our capacity and willingness to employ and adequately support Indigenous health care workers.

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Compliance with ethical standards

Conflict of interest ER was paid as a consultant by the National Public Health Institute of Quebec (INSPQ) for the evaluation. MBF and FR were

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