Decolonizing Stepped Care Model 2.0

By

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Abstract

This capstone centres on Stepped Care 2.0 (SC2.0), an innovative approach to mental health service delivery with principles that are client-centric, strength-based, and recovery-oriented (MHCC, 2023). SC2.0 is a transformative model that has been shown to eliminate wait times to mental health services across Canada (MHCC, 2023). However, SC2.0 lacks culturally-safe care, and Indigenous worldviews and approaches. Through a comprehensive literature review, this capstone will address whether SC2.0 can meet the needs of Indigenous Peoples and their communities. This capstone will provide a critical analysis of Stepped Care models across multiple clinical settings. In addition, this capstone includes clinical applications that will provide an alternative, hypothesized version of Stepped Care model that is decolonized, Stepped Care 3.0. Recommendations will be provided for future research, highlighting the need for Indigenous-led research and the integration of traditional knowledge and teachings into mainstream research and clinical practice. The capstone will conclude with personal reflections. The overall intention of this capstone is to provide counsellors a guide to provide culturally-safe and trauma-informed care to Indigenous Peoples and their communities.

List of Acronyms

CCPA - Canadian Counselling Psychotherapy Association

GNWT - Government of Northwest Territories

IAPT - Improving Access to Psychological Therapies

MHCC - Mental Health Commission of Canada

NB - New Brunswick

NL - Newfoundland and Labrador

NWT - Northwest Territories

OAAT - One At-A-Time Counselling

SC1.0 - Stepped Care 1.0

SC2.0 - Stepped Care 2.0

SC3.0 - Stepped Care 3.0

TRCC - Truth and Reconciliation Commission of Canada

UK - United Kingdom

Dedication

I dedicate this capstone to my Cabrera-Barrios family. My family is the reason I strive to be a better human being. Mom, Amanda Barrios-Inarejo, your love and kindness, taught me how to love, support, and show up for others. Thank you for loving me unconditionally. Dad, Jose Luis Cabrera-Failla, your unconditional support and never-ending encouragement has taught me how to be brave, persevere and to always believe in myself. My brother, Enzo Cabrera Barrios, through thick and thin we have always had each other's back. I love you. To my maternal and paternal grandparents, thank you for creating such a strong, loving foundation. I love you.

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Chapter One

Stepped Care is a strength-based, client-centred, and recovery oriented mental health and addiction model which is used in Canada (Cornish, 2020). The first Stepped Care model was developed over 20 years ago in the United Kingdom (UK) with the objective to provide accessible and effective mental health services, lessen the burden of mental health concerns within UK society, and develop a model of care that was self-corrective by focusing on outcomes, accessibility, and efficiency (Cornish, 2020). Peter Cornish amended the original Stepped Care model to fit Canada's mental health care system, and this second version was known as Stepped Care 2.0 (SC2.0) (Stepped Care Solutions, 2023). Stepped Care 2.0 is considered a transformative mental health system that delivers evidence-based mental health and wellness programming (Cornish, 2020), and is currently used across Canada, including Nova Scotia, Newfoundland and Labrador, and Northwest Territories (MHCC, n.d.).

This capstone focuses on the following research question: How can Stepped Care 2.0 support decolonizing practices in Northern Indigenous Canadian Communities. Furthermore, this capstone explores whether SC2.0 can address areas of cultural safe programming, the inclusion of Indigenous worldviews, and specificity in applications of approaches in Canadian mental health care.

Counselling psychology was developed in a colonial culture and continues to reflect euro-western values (Fellner et al., 2020). Counsellors continue to assess, treat, and diagnose through Eurocentric models of therapy, assessment tools, and techniques which over-pathologize Indigenous Peoples with mental health disorders (Fellner et al., 2020). Counsellors working with Indigenous Peoples in the NWT need to be intentional and provide culturally-safe and trauma informed care (Calvez & Cummings, 2022). Counsellors and the counselling field need to capture Indigenous voices and provide care that aligns with Indigenous worldviews and values (Latimer et al., 2020). Making efforts towards

decolonizing SC2.0 is imperative because using non-Indigenous methods to provide counselling services to Indigenous clients can be considered a form of oppression and colonization (Stewart, 2008). Counsellors providing trauma-informed culturally-safe care can avoid re-traumatization of Indigenous Peoples (Tujague & Ryan, 2021). Therapeutic models have evolved and there is a rising interest in mental health to support decolonization efforts (Stewart, 2020). Indigenous knowledge and traditions are being explored to improve the relationship(s) between Indigenous Peoples, their communities, counsellors and the counselling field which aim to enhance the welfare of Indigenous Peoples and their communities (Stewart, 2020). This capstone explores support efforts to decolonize SC2.0 (Stewart, 2020).

The Northern Canadian Communities are home to the largest percentage of Indigenous Peoples (Canadian Northern Economic Development Agency; CNEDA, 2020). Northern Canadian Communities are made up of three territories: Yukon, the Northwest Territories (NWT), and Nunavut (Natural Resources Canada, 2017). These territories make up 40% of Canada's landmass and are home to the largest percentage of all Indigenous Peoples in Canada, which include the First Nation, Metis, and Inuit (CNEDA, 2020). Of these territories, Nunavut contains the largest percentage of Indigenous Peoples per capita (86%), followed by the NWT (51%), and finally the Yukon (23%) (CNEDA, 2020). Northern Canadian Communities are made up of remote, Indigenous communities that are facing complex intergenerational trauma which has given rise to elevated rates of suicide, substance abuse and mental health disorders due to their longstanding history of colonization including residential schools, systemic oppression and discrimination (Rural and Remote Mental Health in Canada: Evidence Brief on Best and Promising Practices 2023).

To avoid generalizations of Indigenous Peoples in Canadian Northern Communities, this capstone will focus on the Northwest Territories (NWT). The NWT is home to 33

communities (MHCC, 2023). Within these northern communities there are significant cultural differences influenced by local traditions and culture (Stewart, 2020). The Indigenous Peoples in the NWT comprise half of the total population (MHCC, 2023). In 2021, there were 20,040 individuals that identified as Indigenous in the NWT (NWT Bureau of Statistics, 2022a). As noted earlier, the NWT is home to First Nation, Inuit, and Metis Peoples (CNEDA, 2020). First Nations refers to large ethnic groups but can also be used to describe *bands* (The Canadian Encyclopedia, 2022). The Canadian government used the term band to refer to First Nation communities (The Canadian Encyclopedia, 2022). The First Nations in the NWT are pre-dominantly Dene (The Canadian Encyclopedia, 2022). There are 27 First Nations, 24 of them are self-governed or in negotiations to be self-governing (The Canadian Encyclopedia, 2022). The Inuit in the NWT are referred to as the Inuvialuit, which translates to *The Real People* (Inuvialuit Regional Corporation, 2022). There are 5000 Inuvialuits that reside in six communities along the Western Arctic in the NWT (Inuvialuit Regional Corporation, 2022). Metis refers to the individuals that are descendants of European fur traders and First Nation women (Northwest Territory Métis Nation, 2023). In the NWT, there are three communities that are home to the Metis (Northwest Territory Métis Nation, 2023). There are eleven official languages in the NWT, nine of which are Indigenous languages (MHCC, 2023), emphasizing the importance for a mental health system that addresses the culture, history and language diversity of Indigenous People and delivers decolonized services.

Indigenous Peoples living in the Northwest Territories require counselling approaches that are trauma informed and culturally-safe (Verniest, 2019). It is the responsibility of the counsellor to become informed and provide ethical counselling services that meet the needs of the population served (Verniest, 2019). Therefore, it is essential mental health professionals in the NWT take a decolonization and anti-oppressive stance and work

collaboratively to create trauma informed and culturally-safe spaces (Hart, 2002). Decolonization requires non-Indigenous counsellors to acknowledge the truth regarding Canada's colonial history, as well as recognize that colonialism has historically immobilised and oppressed Indigenous Peoples and continues to do so today (Joseph, 2023). Decolonization involves major modifications to the perception and treatment of Indigenous People (Joseph, 2023). This includes individual and collective effort to deconstruct government systems, organizations and professional counselling practices (Calvez & Cummings, 2022).

There are non-Indigenous counsellors who support Indigenous Peoples, and it is paramount that these counsellors promote justice and support reconciliation (Calvez & Cummings, 2022). Non-Indigenous counsellors need to ensure they are supporting Indigenous People's history, language, and culture when providing supports (Joseph, 2023). The literature confirms that Indigenous Peoples have been able to transcend their oppression through the application and practice of their Indigenous knowledge and culture (Hart, 2002). This process involves reinstating Indigenous culture, worldviews, and traditional practices, reclaiming Indigenous perspectives of history, and Indigenous Peoples claiming their families, culture, communities, and history that were removed by the Canadian government (Joseph, 2023). In addition, counsellors need to be trained on the history of Indigenous Peoples, including residential schools and intergenerational trauma (Latimer et al., 2020). Counsellors that are not aware of the history of Indigenous Peoples can potentially cause more harm and further strain relationship(s) between non-Indigenous Peoples and Indigenous Peoples (Latimer et al., 2020). Counsellors have an ethical obligation to repair and reconstruct a new relationship with Indigenous Peoples in Canada and it is the responsibility of counsellors working with Indigenous Peoples to embark on their own unique path towards reconciliation (Calvez & Cummings, 2022). It is imperative counsellors embark on the path

of reconciliation, as it enhances reciprocity, strengthens partnerships, and supports interconnectedness (Sylliboy et al., 2021). These values represent kinship, which is integral in the Two-Eyed Seeing Approach, Etuaptmumk (Sylliboy et al., 2021), which is considered best practice for counsellors when working with Indigenous Peoples (CCPA, 2020).

A major driving force regarding the choice of topic for this capstone is the recent class action settlement regarding residential schools in Canada (Crown-Indigenous Relations and Northern Affairs Canada; CIRNAC, 2022). The class action, *The Indian Residential Schools Settlement Agreement* (CIRNAC, 2022), was the first step towards reconciliation between Canadians and Indigenous Peoples of Canada. Involved in this settlement was the Truth and Reconciliation Commission of Canada (TRCC), developed in 2008, which focused on gathering stories from survivors and their families before releasing the *Truth and Reconciliation Report* in 2015 (TRCC, 2015). The TRCC report provided an overview of the residential school system as well as the historical and current policies and legislation that continue to marginalise and oppress Indigenous Peoples in Canada. Proceeding the report, the Government of Canada accepted responsibility for the harm done and agreed to focus on restoring relationships between the government and Indigenous Peoples (CIRNAC, 2022). As one of the final steps of this process, the TRCC released 94 Calls to Action, which held specific recommendations for the public sector, including the child welfare system, education, language, culture, legal system, health and mental health sectors (TRCC, 2015).

The TRCC released specific Calls to Action pertaining to Canada's health and mental health sectors (TRCC, 2015). There are seven Calls to Action which address this capstone's research question. First, Calls of Action to territorial, provincial and federal governments are to recognize that the current state of Indigenous health and mental health in Canada is a consequence of Canadian government policies including residential schools, and to acknowledge and integrate Indigenous health care rights (TRCC, 2015). Second, Calls to

Action to Canadian government(s) are to consult with Indigenous Peoples and set measurable health and mental health goals (TRCC, 2015). As part of this process, there is a requirement to conduct longitudinal studies to assess health and mental health outcomes for Indigenous Peoples and their communities (TRCC, 2015). The indicators that most prevalent to the counseling psychology field are suicide, mental health, substance use, and availability of health and mental health services (TRCC, 2015). Third, Calls to Action relevant to Northern Indigenous Communities speaks to the importance of recognizing the unique health needs of Indigenous Peoples living on and off reserve(s) (TRCC, 2015). Fourth, there are Calls to Action for funding for Indigenous healing programs which specifically address the need for funding in Northwest Territories and Nunavut (TRCC, 2015). Fifth, the Calls to Action specific to the health and mental health care system are to be cognizant of Indigenous healing practices and to utilize them in collaboration with Indigenous Elders and healers (when requested by Indigenous People) (TRCC, 2015). Sixth, there are Calls to Action to increase the number of Indigenous professionals in health and mental health sectors in Indigenous communities (TRCC, 2015). Lastly, Calls to Action speak to the health and mental health field to provide cultural competency training for all professionals, including training specific to colonial history and residential schools (TRCC, 2015). This training should include intercultural competency training, human rights and anti-racism discourses (TRCC, 2015).

The Canadian Counselling and Psychotherapy Association (CCPA) and its members adhere to a Code of Ethics and a Standards of Practice, documents which communicate the principles, values, and recommendations for professional conduct to members (CCPA, 2020; 2021). Specifically, the Code of Ethics promotes values such as integrity, competence, responsibility, and respect for diversity, social structures, and systemic concerns (CCPA, 2020). In response to the TRCC, the CCPA amended their Code of Ethics in 2020 to ensure all counsellors are aware of the ethical responsibilities when working with Indigenous

Peoples and their communities (CCPA, 2020). It is critical for counsellors to acknowledge Canada's colonial history as well as the current impact of that history (CCPA, 2020). CCPA members are encouraged to be aware of the historical trauma, and also be aware of the strength and resilience of Indigenous Peoples and their communities (CCPA, 2020).

The literature suggests that without an acknowledgement of colonization, decolonization is not possible (Roy, 2023), and so acknowledgement is a critical first step when working with Indigenous Peoples (Roy, 2023). In addition, CCPA members are instructed to approach Indigenous Peoples and their communities with a *Not Knowing* approach and humility; the *Not Knowing* approach allows counsellors to embody the role of a learner when interacting with Indigenous Peoples and Indigenous communities (Roy, 2023). Humility encourages counsellors to ask for permission from Indigenous Peoples and to show appreciation when receiving traditional knowledge (Roy, 2023). The CCPA also encourages members to utilise the Two-Eyed Seeing Approach, Etuaptmumk, as an instrument to help counsellors perceive the world through multiple perspectives (CCPA, 2020). This capstone utilizes Etuaptmumk as the theoretical framework. CCPA acknowledged these amendments and consideration for Indigenous Peoples as the initial step forward towards better understanding and decolonization (CCPA, 2020). These recent changes in the CCPA Code of Ethics supports decolonization efforts in the counselling field and are fundamental for counsellors working in Northern Canadian Communities.

Problem Statement

Indigenous Peoples have been forced to carry the burdens of colonial violence, and there needs to be acknowledgement of this heaviness and profound effects of colonization (Dupuis-Rossi, 2020). Counselling psychology is embedded in Eurocentric epistemologies that have formed models of therapy reflecting the superiority, power, and enforcement of colonial views regarding health and healing (Fellner et al., 2020). These epistemologies often

impose euro-centric values which can be incompatible to Indigenous values and ways of living (Fellner et al., 2020). As a result of developing counselling theory within a colonial culture, the assessments, diagnostics, treatments, and techniques used continue to reflect euro-western values that, regrettably, over-pathologize Indigenous Peoples with mental health disorders (Fellner et al., 2020). Therefore, as counsellors working in the Northwest Territories, we need to be aware of how these euro-western therapeutic approaches impact Indigenous Peoples (Roy, 2023). This awareness and openness to change is imperative as we explore *how Stepped Care 2.0 can support decolonizing practices in Northern Canadian Communities.*

It is important to consider social determinants of health when assessing the mental health of Indigenous Peoples residing in the NWT (Mental Health Commissioner of Canada; MHCC, 2020; NCCIH, 2020). Social determinants of health refer to a full range of health determinants that impact individual health and mental health (Canada, 2023). The main determinants of health include income, employment, education, childhood experiences, social supports, health enhancing behaviours, physical conditions, biological and genetic composition, culture, gender and race/racism (Canada, 2023; NCCIH, 2019). Due to colonization, the Indigenous Peoples in the NWT have experienced significant challenges such as loss of autonomy, displacement, oppression and government control that continue to shape their social determinants of health (Elman et al., 2019). Additionally, many communities in the NWT do not have access to clean water, sufficient food, lack housing and transportation, and are in isolated areas accessible intermittently by air (Mental Health Commissioner of Canada; MHCC, 2020). Individuals living in these communities often must travel an extended distance to access employment, education, and health services, including mental health services. These remote communities have limited economic opportunities which result in low incomes and higher levels of unemployment/ underemployment, often

causing distress (MHCC, 2020). Regrettably, these challenges manifest as elevated rates of mental health disorders and substance use disorders, high rates of suicide, homelessness, and poverty (Elman et al., 2019). There is no indication of what Stepped Care 2.0 has done to address the social determinants of health for Indigenous Peoples or their communities. Therefore, the problem to be addressed in this capstone is the lack of culturally-safe and trauma informed counselling resources in the NWT, the counselling resources that exist within the SC2.0 model require decolonization efforts.

Rationale & Significance

When accessing health and mental health services, Indigenous Peoples encounter a high rate of abuse, racism, low quality care, and a complete negligence of trauma-informed care (Allen et al., 2020). Mental health services are often culturally unsafe and treatment models fail to align with Indigenous worldviews and values, which discourages Indigenous clients from accessing support (Allen et al., 2020). Intergenerational trauma (a.k.a. historical trauma) is trauma that goes beyond one lifetime; it is intergenerational and grows over time, encompassing the existing grief and depression started at birth and compounded throughout life (Duran et al., 1998). Indigenous Peoples experiencing intergenerational trauma have an increased risk of chronic health and mental health diseases(s), strained attachments and high risk of re-traumatization (Tujague & Ryan, 2021). Neurological research suggests unresolved trauma remains within the body as memories, leading to significant distress, discomfort and dissociation (Tujague & Ryan, 2021). Recent epigenetic research highlights the negative impacts of trauma on gene expression (Tujague & Ryan, 2021). In addition, Indigenous Peoples who experienced intergenerational trauma have a higher likelihood of developing negative coping mechanisms such as substance abuse disorders, suicidal ideation, self-harm, and hypersensitivities (Tujague & Ryan, 2021).

Along with over-representation in correctional institutions and children and family services (Tujague & Ryan, 2021), Indigenous children are 17 times more likely to be apprehended by the child and family welfare system than non-Indigenous children (McQuaid et al., 2022). Intergenerational trauma stemming from colonization requires care that exceeds Eurocentric models of care, instead requiring collaboration with Indigenous healers including Elders and knowledge keepers who are aware and understand Indigenous cultural worldviews (Allen et al., 2020). Stepped Care and the current model, Stepped Care 2.0, are Eurocentric and stem from colonial worldviews and values (Allen et al., 2020). Stepped Care needs to be re-evaluated alongside Indigenous Peoples/their communities and shifted to represent and align well with Indigenous epistemologies and values (Allen et al., 2020). It is vital that counsellors and all allies of Indigenous Peoples support clients and communities in reconnecting with their own traditional ways of healing (Allen et al., 2020). This may require working within and adjusting an existing system, such as the Stepped Care model.

In the NWT, mental health services are delivered across federal, territorial, regional and local communities (Elman et al., 2019). There is a complex system within the NWT Health and Social Services that aim to provide prevention, assessment, interventions, and treatment of mental health and substance use disorders in the NWT (Elman et al., 2019). However, despite government(s) best intention at providing promotion, prevention and community mental health initiatives, there continues to be significant mental health and substance use issues (Elman et al., 2019). These mental health disparities within the NWT Health and Social Services can be attributed to the remoteness of communities, insufficient infrastructure, widespread population and scarcity of mental health providers which limits access to quality care (Elman et al., 2019). Unfortunately, these mental health disparities are felt heavier in smaller communities (Elman et al., 2019). In the NWT, there is an alarming rate of suicide rates in smaller communities compared to Yellowknife (capital of the NWT)

(Elman et al., 2019). This supports the sentiment that Stepped Care 2.0 needs to align with Indigenous values and worldviews and need to be modified to meet the unique needs of Indigenous Peoples in the NWT (Elman et al., 2019).

Theoretical Framework

The Two-Eyed Seeing Approach, Etuaptmumk, will be used as the theoretical framework in this capstone (Institute for Integrative Science & Health, n.d.). Elder Albert Marshall from the Mi'kmaq Nation provided the Two-Eyed Seeing Approach, a framework that allows readers to incorporate western and Indigenous strengths (Hatcher et al., 2009) and can be used towards the goal of decolonizing Stepped Care 2.0. The Two-Eyed Seeing Approach originated from an Indigenous teaching from the late Mi'kmaq Chief Charles Labrador from Acadia First Nation in Nova Scotia (Forbes et al., 2020). Labrador was a spiritual leader and healer, and one of his many teachings referenced the trees in the forest (Forbes et al., 2020). Labrador explained that all the different trees in the forest are holding hands underground and that all humans, despite differences, should also be united (Forbes et al., 2020). Sequentially, Elder Albert Marshall was inspired by the tree analogy and set forth Two-Eyed Seeing as a theoretical framework (Forbes et al., 2020). The Two-Eyed Seeing Approach is grounded in an *us* mindset which allows us to capture strengths of multiple perspectives for a healthier and desirable world (Forbes et al., 2020). The us mindset is critical as we continue to explore how Stepped Care 2.0 can support decolonizing practices in Northern Indigenous Canadian Communities. It is imperative to integrate Indigenous and western Eurocentric epistemologies as equals (Hatcher et al., 2009) and to cultivate a culture of community and collaboration among counsellors and Indigenous Peoples and their communities.

An important guiding principle in the Two-Eyed Seeing Approach in research is the concept of ethical space (Forbes et al., 2020). Ethical space in research sets boundaries that

support ethical conduct when multiple perspectives come together (Forbes et al., 2020). Ethical space can be used within the counselling space to foster harmony, mutual respect and reinforces a neutral space between distinct perspectives (Forbes et al., 2020). Cultivating an ethical space makes room for cultural and philosophical differences (Forbes et al., 2020). Ethical space translates into ethical conversations and eliminates potential disparities and discrimination (Forbes et al., 2020).

The Two-Eyed Approach was created to inspire change and meant to act as a guiding principle that prompts self-reflection and profound shift in mindset and approach (Forbes et al., 2020). This is essential in decolonizing efforts as it will require significant individual and collective efforts to provide culturally-safe and trauma informed care to Indigenous Peoples (Verniest, 2019). Furthermore, exploring Indigenous Peoples' worldviews will lead us to a counselling approach that can best support Indigenous Peoples and their communities (Hart, 2002). NWT is home to such a large percentage of Indigenous Peoples (MHCC, 2023) therefore, it is an ethical obligation to meet the mental health needs of Indigenous Peoples and their communities. As it stands, Stepped Care 1.0 and Stepped Care 2.0 do not have Indigenous considerations and does not address culture, language, history of Indigenous Peoples. The Two-Eyed Seeing Approach can be integrated throughout the Stepped Care model to encompass Indigenous Peoples worldviews and values. This can be accomplished by taking a systems approach to change (Observatory of Public Sector Innovation, 2019). The systems approach will require that each section of the Stepped Care Model reflect Indigenous values (Wesley-Esquimaux & Snowball, 2010).

Definition of Terms

The following section includes important key terms to help understand this capstone.

Colonialism: Refers to the conquering of other nations using military force, imposing harsh conditions on the conquered, and completely withdrawing all resources from the

conquered nation (Katz, 2017). Colonialism relies on racism, which causes the oppressed to feel inferior to the colonizers, which makes them appear in need of being rescued (Katz, 2017).

Decolonization: The dismantling of colonial ideologies and deconstruction of the privilege of western Eurocentric thoughts and approaches; which includes breaking down structures that sustain the status quo, challenging power imbalances, and honouring and embracing Indigenous knowledge and ways of life (Cull et al., 2018).

Genocide: Acts intended to disrupt segments or an entire ethnic, racial or religious group, or nation (Matheson et al., 2022). Intentionally inflicting harm on these groups (Matheson et al., 2022).

Indigenous Peoples: The original people to inhabit parts of the world (Katz, 2017).

Indigenization: The process of incorporating Indigenous knowledge, concepts, and practices into post-secondary education, organisations, policies and law, highlighting the importance of maintaining respectful relationships with Indigenous Peoples and ensuring Indigenous Peoples see themselves as represented and respected within spaces (Cull et al., 2018). This is a relatively new term.

Intergenerational/Historical trauma: Trauma that goes beyond one lifetime; it is intergenerational and grows over time (Duran et al., 1998). This trauma includes grief and depression that is taken in at birth and continues throughout life (Duran et al., 1998).

One-at-a-Time: One-at-a-Time (OAAT) is a form of brief therapy model (Harris-Lane et al., 2023). OAAT treats every encounter with a service user as it may be last; this is achieved by optimising each session and making the most of each session (Cornish, 2020).

Stepped Care: Stepped Care is a strength-based, client-centred, and recovery oriented mental health and addiction model (Cornish, 2020).

Positionality

There are multiple potential biases and tensions that can be expected throughout the research project. I am a woman of colour, and I identify as a Chilean/Latina woman. I immigrated to Canada as an infant with my maternal and paternal family. My family immigrated in pursuit of a better life: We chased the colonial dream, striving for financial opportunities at the expense of loss of language, culture, community, and our home country. We quickly started to experience the strong forces of displacement, oppression, and hardships that come with being a non-white immigrant in Canada. These experiences lead me to pursue a career in social work and later counselling.

For the last two years, I have been working in the Northwest Territories (NWT) as a mental health and addiction counsellor supporting Indigenous clients and their communities. As part of my role as a counsellor in the NWT, I work within the Stepped Care 2.0 (SC2.0) model. For this capstone, I chose to focus on SC2.0 because of my own inconclusive thoughts about the model: While I am aware of the many benefits within the model, I have my reservations about whether the model appropriately meets the needs of Indigenous Peoples. To mitigate risk of bias, I will be intentional to keep an open mind, and will provide a comprehensive literature review highlighting multiple perspectives.

This capstone is my small contribution towards reconciliation and supporting TRCC efforts. I have worked alongside Indigenous Peoples for over 12 years and will continue to decolonize my approach and practice. My personal experiences, compounded with my profound professional work experience, has inspired my passion and lifelong commitment to being an ally to Indigenous Peoples. This can be seen both as a strength and as a major risk of bias. This will be mitigated by implementing critical thinking skills throughout the capstone, and in integrating a range of research articles that highlights both the strengths and limitations of SC2.0. In addition, despite my best intentions as an Ally of Indigenous Peoples, I am

aware and have fully accepted the fact there will always be limitations and gaps within my awareness and practice (Gone, 2021). I am aware that I will never be an expert in this area of research (Gone, 2021).

Overview of Chapters

Chapter one provides an overview of Northern Canadian Communities and an emphasis on why decolonizing SC2.0 is important and pertinent to the counselling field. Chapter two will focus on the research methodology. Chapter three will centre on the literature review. Chapter four will explore clinical applications and a proposal for a decolonized version of Stepped Care, Stepped Care 3.0. Chapter five will include recommendations and reflections on the process of this capstone. Each chapter will highlight the importance of addressing decolonizing practices within the Stepped Care model for counsellors and the counselling field.

Chapter Two

This chapter provides a comprehensive overview of the literature search process. This chapter outlines research parameters that address this capstone's research question: How can Stepped Care 2.0 support decolonizing practices in Northern Indigenous Canadian Communities. This chapter concludes with obstacles faced in the literature search process.

Research Parameters

In the following section, an outline of the databases and search methods used to gather the components of the literature review are explored. Furthermore, an overview of the search terms, including inclusion and exclusion criteria, along with how research was refined, is outlined below.

Databases and Search Methods

The search engines and databases utilized throughout this capstone were the City U online Library, Google Scholar, and the search engine Google. As an effective literature review search strategy, the search was limited to full articles published within the last five years. Journal and peer reviewed articles were sought for this literature review. City U Online Library provided a resource to locate the majority of the literature for this capstone. Articles within the data collection were separated into several different themes, inclusive of Stepped Care 1.0, Stepped Care 2.0 in Canada, and decolonization. Google Scholar was also utilized to locate research for this capstone.

Search Terms

To locate literature on Stepped Care 1.0, the following search parameters were used with the City U online database. Search term "Stepped Care" yielded over 15,000 results. As a strategy to refine the search, additional searches combined "mental health" with "Canada", "UK", and "Australia" to obtain literature related to the research question. The search parameters were updated to the include "Stepped Care in Mental Health" which yielded 605

articles. “Stepped Care in Canada” yielded 201 articles. “Stepped Care in UK, Mental Health” yielded 108 articles. “Stepped Care in Australia, Mental Health” yielded 84 articles. Despite the plethora of research that was generated through these searches, some of these articles were not deemed helpful to address this capstone’s research question.

To locate literature on Stepped Care 2.0, the following search parameters were used with the City U online database: “Stepped Care 2.0” yielded 11 results and several were used within this capstone. “Stepped Care 2.0 in the Northwest Territories” yielded 0 results. Interestingly, no articles were found related to SC2.0 in the NWT.

To locate literature on decolonized Stepped Care models, the following terms were used: “Decolonized Stepped Care” resulted in 0 articles, and “Stepped Care 2.0 for Indigenous Peoples” yielded 1 article that was deemed unsuitable for this capstone. In addition, the book *Stepped Care 2.0: A Paradigm Shift in Mental Health* by Peter Cornish (2020) was used throughout this capstone. Stepped Care Solution’s (2023) website, https://steppedcaresolutions.com/about-us/, was also utilized in this capstone for definitions and an overview of the Stepped Care 2.0 model.

To locate literature on decolonization in counselling and mental health, the most useful search combination was “Decolonizing Counselling in Canada” which resulted in 3 articles. One out of these three articles were utilized throughout this capstone. The phrase “Decolonizing Mental Health in Canada” resulted in 20 articles. However, only one article was deemed appropriate for inclusion in this capstone.

To locate literature on Northern Canadian Communities, the following search combination was used with the City U Library and Google Scholar: “Mental Health in Northern Canadian Communities” produced 63 articles, with several useful articles utilized in this capstone. However, several of the articles were not useful to the counselling field, the articles centred around e-MH platforms and the medical field including psychiatry. In

addition, the northern communities that came up on the searches were related to Northern British Columbia and Northern Ottawa, not the NWT. “Counselling in Northern Canadian Communities” yielded 8 results. None of the articles were used as they were not deemed appropriate for use in this capstone. For example, these articles shed light on FASD and physical illnesses rather than mental health.

To locate research about Two-Eyed Seeing Approach, the following terms were used on City U and Google Scholar: “Two-Eyed Seeing Approach” yielded 79 results and provided research from multiple disciplines as well as an overview of how different areas of study are implementing Two-Eyed Seeing Approach. A search on “Two-Eyed Seeing Approach in Counselling” yielded 2 results, with one article was deemed appropriate for use in this capstone.

To locate research about indigenization, the following terms were used: “Indigenization” yielded 302 results. This search was too broad and thus narrowed to include “Indigenizing Counselling” which yielded 5 results. Two out of the five articles were used in this capstone. These articles provided definitions and relevant information used in the recommendations section. The three that were not deemed appropriate to use in this capstone for several reasons including a lack of relevance to Canadian population and beyond the scope of counselling.

To locate research about Indigenous worldviews and epistemologies, the following terms were used: “Medicine wheel” resulted in 3,575 articles. This search was extensive, therefore as a strategy to narrow the search and ensure it addressed this capstone, the search terms used were changed to “Medicine Wheel in Counselling” which resulted in 35 results and one article was exclusively utilized to address the capstone research question. The terms “Indigenous healing” produced 902 results, and “Indigenous healing in counselling”

produced 31 results. This combination of terms resulted in sufficient results. The articles located using these search terms yielded relevant Indigenous Peoples research.

Fortunately, the textbooks that came up on City U Library search were already utilised as resources from within the Master's in Counselling program. The textbook by Katz (2017), *Indigenous Healing Psychology*, was helpful and was used in this capstone. An audible book that was used within this Capstone was *Healing the Soul Wound: Trauma Informed Counselling for Indigenous Communities* by Eduardo Duran (2019). This audible book was helpful due to it's inspiration and helped me stay focused on the project,

Google Scholar was helpful when locating Canadian and Australian statistics. The search terms utilized were: "Indigenous Peoples in Canada", "Indigenous Peoples and chronic pain", "Indigenous Peoples and Suicide Rates", "Indigenous Peoples in Northern Canada". "Australian Statistics" and "Australian Indigenous Languages". These search terms helped locate several statistical information and social determinants of health information. At times, the research articles located through City U and Google Scholar searchers were not freely available and/or were only partially available. Multiple articles required a membership account to access and/or required payment. There were approximately twenty articles that were not available.

The Google search engine was used to locate specific websites. The following search terms were used: "Canadian Counselling Psychotherapy Association", which provided the CCPA website and provided relevant information regarding the CCPA's Code of Ethics. Using "Mental Health Commission of Canada" provided information that supported this capstone. Searching for "Truth and Reconciliation Commission of Canada" provided a website with information pertinent to the Truth and Reconciliation Commission of Canada and Calls to Action which were fundamental in this capstone.

Google was used to search for information pertaining to Eduardo Duran. This yielded one helpful article. Google was also used to search for information on systems change using terms “Systems Change in Counselling”. This search yielded a helpful article that was referenced in this capstone.

Challenges

There were challenges encountered in locating pertinent literature for this capstone specific to the counselling field and decolonizing mental health. It was necessary to understand developments from other disciplines that were taking the lead in decolonization and apply this knowledge to the counselling psychology field. Additionally, there was no empirical research on how to decolonize Stepped Care models, and there was minimal research on counselling methods used in northern communities in Canada. These gaps in the research highlight the need to prioritise research topics involving decolonizing for Indigenous, northern Canadian communities.

The goal of SC2.0 in the NWT is to increase the number of culturally safe, community-based mental health and addiction services (MHCC, 2023). However, without research pertaining to Indigenous Peoples or decolonization efforts, it is difficult to determine whether SC2.0 is a culturally-safe and trauma-informed model. This challenge further supports the exploration of the capstone’s research question, whether Stepped Care 2.0 can support decolonizing efforts in the NWT and provide Indigenous Peoples culturally-safe and trauma informed mental health care.

Chapter Three

The literature review explores research into the Stepped Care Model 2.0 (SC2.0) to identify whether it is a culturally-safe and trauma-informed clinical practice in Northern Canadian Communities (Cornish, 2020). The Two-Eyed Seeing Approach, Etuaptmumk, is applied throughout this capstone (Hatcher et al., 2009). The literature review addresses the following research question: How can Stepped Care 2.0 support decolonizing practices in Northern Canadian Indigenous Communities. This question is separated into the following sections: An overview of the state of affairs in northern Canada, research on Stepped Care 1.0, and the development and research into Stepped Care 2.0. It is expected that the findings from this literature review will identify that the impacts of colonization continue to affect Indigenous Peoples in Northern Canadian Communities. It is that imperative counsellors use this information to reflect on their clinical approach and ideologies.

The Northwest Territories

Canada's North has three territories: Yukon, the Northwest Territories (NWT), and Nunavut (Natural Resources Canada, 2017). Of these provinces, Nunavut contains the largest percentage of Indigenous Peoples per capita (86%), followed by the NWT (51%), and finally the Yukon (23%) (CNEDA, 2020). As noted earlier, the Northwest Territories is of interest for this capstone. The NWT is sparsely populated even though it is the third largest province or territory in Canada (Government of Northwest Territories, 2014). NWT is comprised of 33 communities (Government of Northwest Territories, 2018) and is home to 20,040 Indigenous Peoples (NWT Bureau of Statistics, 2022a) which is approximately half of the population in the NWT (CNEDA, 2020; NWT Bureau of Statistics, 2022b). Of these Indigenous population, the largest are First Nations (57%), followed by Inuit (21%), and finally Metis People (19%) (Elman et al., 2019).

The Northwest Territories is facing complex intergenerational trauma (MHCC, 2020). The longstanding history of colonization includes residential schools, systemic oppression, and discrimination, which resulted in the intergenerational trauma encountered by Indigenous peoples in the NWT today (MHCC, 2020). This has given rise to elevated rates of mental health and substance abuse disorder, and high rates of suicides, poverty and homelessness (Elman et al., 2019). In addition, these communities face significant challenges when accessing mental health support, and research confirms how vital it is to implement mental health programs that meet the cultural needs of specific communities (MHCC, 2020). Given the mental health discrepancies that exist in Canada, it is important that counsellors can access training for and provide trauma-informed care in the NWT (Tujague & Ryan, 2021).

Stepped Care

This section will critically evaluate Stepped Care by discussing an article released by the Mental Health Commission of Canada (MHCC), and will include an overview of Stepped Care 1.0 and Stepped Care 2.0 and their implementations. The literature emphasizes Peter Cornish's work, the developer of Stepped Care 2.0 and author of *Stepped Care 2:0: A Paradigm Shift in Mental Health* (2020). There are multiple sources used throughout the capstone to ensure this review is accurate.

Mulan (2023) observed that Indigenous Peoples experience multiple barriers in the current mental health system, which often discourages them from accessing mental health services (Gardner, 2023). The Canadian mental health system has been described as a revolving door, often treating multiple clients without addressing the root cause (Gardner, 2023). The mental health care system has failed to recognize intergenerational trauma as a main cause of Indigenous persons' mental health problems (Gardner, 2023). Finally, there are significant barriers to accessing care, including high appointment costs, inaccessible mental health services, and extensive wait times (Moroz et al., 2020). The MHCC identified Stepped

Care 2.0 (SC2.0) as the solution to address roadblocks to care, such as wait times for mental health services (Gardner, 2023). SC2.0 is currently used across Canada, including Nova Scotia, Newfoundland and Labrador, and Northwest Territories (Gardner, 2023). The counselling field recognizes that SC2.0's efficacy is due to its focus on providing efficient mental health services, which can help prevent minor mental health symptoms from developing into serious conditions (Cornish, 2020). However, prior to fully understanding SC2.0, it is essential to explore the first Stepped Care Model 1.0.

Stepped Care 1.0

Stepped Care 1.0 (SC1.0) is a strength-based, client-centred, and recovery oriented mental health and addiction model (Cornish, 2020). The first Stepped Care model was developed in the United Kingdom (UK) to provide accessible and effective mental health services, with the objective to lessen the burden of mental health concerns within UK society (Cornish, 2020). The UK continues to utilize and strongly promotes the use of Stepped Care as mental health delivery model (Boyd et al., 2019), and the UK's national federal *Improving Access to Psychological Therapies* (IAPT) strategy continues to support Stepped Care as a mental health delivery service model (Boyd et al., 2019). The IAPT is a government service that provides resources and training aimed at improving counselling for non-serious mental health disorders, including anxiety and depression (Boyd et al., 2019). IAPT's target is to improve UK's mental health and financial goals in reference to return to work initiatives (Boyd et al., 2019). Furthermore, European health officials endorse the Stepped Care approach for use in child and youth mental health care (Wolf et al., 2021). European health officials favoured less intense interventions, in hopes to reduce national costs and time burdens for families (Wolf et al., 2021).

SC1.0 was described as a stage model in that it presumes that symptoms are a good indicator of treatment outcomes; service users have their symptoms assessed and then

assigned a step level from zero to four, with less severe symptoms assigned lower steps and more severe symptoms assigned higher steps (Cornish, 2020). SC1.0 was developed on three foundational assumptions: The first assumption was that the UK mental health system was inefficient and overly dependent on expensive specialised interventions including therapy and pharmaceuticals, and SC1.0 aimed to provide efficient, and inexpensive care options (Cornish, 2020). The second assumption was that the UK's mental health system did not provide service users adequate care and only offered two treatment options, therapy or psychopharmacology treatment, and so SC1.0 aimed to provide client-centred care and a range of options for service users (Cornish, 2020). The final assumption was that the success of SC1.0 depended highly on service users' ability to self-correct, as the model accepts that the initial treatment option may not work and allows for adaptation and treatment course correction (Cornish, 2020). Overall, the SC1.0 model was created to address these assumptions of the UK's mental health system while also being able to increase the intensity of care should an intervention not be initially successful (Cornish, 2020). While SC1.0 has been in effect in the UK for several years, there is insufficient evidence regarding its efficacy (Boyd et al., 2019), and there seems to be inconsistent definitions of the model throughout the UK, with distinct model implementations both in research and practice; therefore, further research is needed to determine whether Stepped Care is appropriate to treat all mental health concerns (Boyd et al., 2019).

Stepped Care 1.0: Australia

Australian Aboriginal/Torres Strait Islanders have experienced an extensive history of colonization, trauma, and grief (Australian Department of Health and Aged Care, 2023). Aboriginal/Torres Strait Islanders experience higher rates of mental health disorders than non-Aboriginal/Torres Strait Islanders in Australia (Dudgeon et al., 2016). Despite the considerable need for mental health services, Aboriginal/Torres Strait Islanders experience

significant mental health disparities in the healthcare system (Dudgeon et al., 2016). These mental health disparities include prejudice, racism, and discrimination from healthcare providers (Dudgeon et al., 2016). In addition, Australian mental health services are not considered culturally safe, creating a major roadblock to accessing and treating mental health disorders (Dudgeon et al., 2016). As of 2020, Australian statistics indicate there are 983,700 Aboriginal/Torres Strait Islander's (Australian Bureau of Statistics, 2021). Taking into consideration the similar colonial history among Indigenous Peoples in Australia and Indigenous People in Canada, there is merit in exploring the impact of SC1.0 in Australia for comparison and contrasting purposes.

In 2020, Australia health officials reported that 12.4% of all medical visits were related to mental health (Bell et al., 2020). The most common mental health concerns reported were depression, anxiety, and sleep issues, with pharmaceuticals being the most common treatment option (Anderson et al., 2020). In 2015, the Australian Government decided to implement SC1.0 in all primary care clinics to increase the mental health options available to patients, including in-person care and online resources (Anderson et al., 2020). Considering General Practitioners (GPs) are often the first point of contact for patients, GPs were responsible to provide the SC1.0 model for patients experiencing mental health concerns. As part of the implementation process, the SC1.0 standards of practice were as follows: Patients experiencing mental health concerns were asked to complete depression and/or anxiety self-assessment tools in the waiting room (available on a tablet), such as the Patient Health Questionnaire-9 (PHQ-9) and the Generalized Anxiety Disorder-7 (GAD-7), as well as assessments for risk of suicide/suicidal ideation and social risk factors (Anderson et al., 2020). The results of these assessments were available to the patient, and their GP's received results and a series of recommendations based on severity of symptoms; if patients reported mild, moderate, or severe depression or anxiety symptoms, they were asked to

complete regular monitoring for eight weeks, with those assessments sent to their GP's (Anderson et al., 2020). When patients screened as high risk for suicide and/or other mental health concerns, they were sent recommendations and contacted for a crisis follow up, and their physicians had the option to refer clients to mental health clinics or online/over the phone psychiatry (Anderson et al., 2020). Despite the efficacy of these practices, it is important to review the ethical considerations, as regrettably, Indigenous Peoples continue to be assessed, treated, and diagnosed through Eurocentric models of therapy, assessment tools, and techniques which over pathologize Indigenous Peoples with mental health disorders (Fellner et al., 2020). Insufficient access to culturally-safe mental health services and assessments has been a long-standing obstacle for Indigenous Peoples which negatively impacts access to service(s) and effective treatment (Dudgeon et al., 2016).

In the Anderson and colleagues (2020) Australian study, GPs and patients were interviewed or provided questionnaires to assess the usefulness of SC1.0 in primary care; responses were used to identify that, overall, service users reported SC1.0 was an acceptable form of treatment. GPs reported that SC1.0 helped them when screening for depression and anxiety and identified SC1.0 as most suitable for low moods or worries (Anderson et al., 2020). Service users were less confident than GPs that Stepped Care was a suitable treatment model for worries or low moods though, and when clients had co-occurring disorders and/or lack of motivation, Australian GPs reported that SC1.0 was difficult to implement; however, 64.8% of service users still specified that they would recommend the SC1.0 model to others (Anderson et al., 2020). Anderson and colleagues (2020) showed several strengths within SC1.0, particularly the positive feedback from participants and GPs. Based on the data gathered, SC1.0 can be considered feasible, acceptable and can support GPs in treating anxiety and depression (Anderson et al., 2020). In addition, having access to mental health services at a primary clinic can provide early detection and interventions. However, this study

had limited participants, therefore results may not be an accurate representation of the population, and the authors did not share their participants' demographic information which makes it difficult to decipher which population was/not represented and challenging to conclude which population benefits from these services. In addition, there was no indication of the languages available in these assessments used, which is alarming considering there are over 250 Indigenous languages and 800 dialects (Australian Institute of Aboriginal and Torres Strait Islander Studies, 2023). Despite the significant need for culturally-safe services there was no indication of how SC1.0 was modified to meet the needs of the Aboriginal/Torres Strait Islanders, and there was no indication of Aboriginal/Torres Strait Islanders workforce representation (Dudgeon et al., 2016). Therefore, results from Anderson and colleagues (2020) are not conclusive, which makes it difficult to determine whether SC1.0 was culturally-safe to use with Indigenous Peoples in Australia. Despite the government's intention to improve mental health in Australia and Canada, Indigenous Peoples mental health needs continue to be unmet and there continues to be a lack of culturally-safe treatment options for Indigenous groups (Dudgeon et al., 2016).

Stepped Care 2.0

Dr. Cornish helped develop a second iteration of SC1.0, Stepped Care 2.0 (SC2.0), at Memorial University in Newfoundland in collaboration with the Mental Health Commission of Canada (MHCC) and the consultant team at Stepped Care Solutions (MHCC, n.d.). Despite the model originating in the United Kingdom (UK), SC2.0 deserved careful consideration to provide better mental health care to Canadians. Dr. Cornish described Canada's mental health care system as inaccessible and ineffective (Cornish, 2020). This is supported by Canadian mental health statistics indicating that in 2018, there were over 5 million Canadians needing mental health support (Moroz et al., 2020). Out of these 5 million, 1.2 million identified their needs were moderately met, and 1.1 million identified their needs

were not met at all (Moroz et al., 2020). The obstacles to access mental health services included long wait times, shortage of mental health resources, insufficient information, culture and language barriers, geographic barriers, financial burdens, insufficient mental health insurance coverage and stigma (Moroz et al., 2020). SC2.0 is now offered across Canadian provinces and Territories including Nova Scotia, Newfoundland and Labrador, and Northwest Territories (MHCC, n.d.), with the Stepped Care Solutions consultant team aiming to provide organisations, institutions, and communities with innovative care models (Stepped Care Solutions, 2023). A closer examination of the progression from SC1.0 to SC2.0 will be explored below, along with the major shifts within the paradigm.

SC2.0's guiding philosophy suggests the gold standard intervention is the one that fits the service user and oftentimes minimal interventions can produce life-changing outcomes (Cornish, 2020). SC2.0 aims to provide effective mental health services, in a timely manner (King et al., 2023). This is carried out by SC2.0's same-day service and SC2.0's One-at-a-Time therapy (OAAT) (King et al., 2023). OAAT is a brief therapy model (Harris-Lane et al., 2023) and treats every encounter with a service user as it may be last; this is achieved by optimising each session and making the most of each session (Cornish, 2020). This is fulfilled by inspiring hope and belief that change can occur with one session (Cornish, 2020). Service users are active participants in the session and treatment plans are based on client readiness which includes service user's autonomy, willingness, and level of engagement (King et al., 2023).

SC2.0 is a progressive model, rather than a stage model, and counsellors using SC2.0 start clients with low intensity interventions despite severity of symptoms (Cornish, 2020). Progressive models have been seen as effective clinical models (Boyd et al., 2019). Progressive models have been seen to be 1.5 times more successful in treatment outcomes compared to stage models (Boyd et al., 2019). In addition, progressive models have

demonstrated to be cost efficient (Boyd et al., 2019). SC2.0 is a collaborative model that incorporates recovery-oriented principles in order to nurture service user responsibility, individual choice, and resilience (Cornish, 2020). The MHCC endorsed recovery-oriented principles as fundamental in Canda's mental health policies and clinical practice (MHCC, 2013). Recovery-oriented principles have been integrated across Canadian provinces and territories (MHCC, 2013). The goal is to build on individual and community strengths by increasing access to resources (MHCC, 2013).

Recovery-oriented principles assume that illness and functioning are separate facets of a person, in that one individual can be mentally unwell and fully functional whereas another person may not be mentally ill but does not function well (Cornish, 2020). A recovery model examines much more than a client's deficits but rather focuses on client capacities and expertise, assuming that the service user is aware of what they want to address in session and aiming towards the identification of their strengths and solutions, and to cultivate resilience (Cornish, 2020). The overall intention of recovery-oriented principles is to increase hope and enable individuals to live purposeful and satisfying lives (Waldemar et al., 2016).

SC2.0 is more focused on client-centric care compared to the original SC1.0 model, prioritising service user needs by integrating their preferences and choices (Cornish, 2020). SC2.0 focuses on service user strengths, encouraging them to start simple and strong so that they are encouraged to keep the issue they want to address straightforward, and can be achieved if service providers ask them about their greatest concerns of the day or what they would like to have changed today as a result of the session; the goal is to have service users envision solutions to their problems (Cornish, 2020). If solutions are not available, then service providers can aid users in examining their issues deeper, but only if necessary (Cornish, 2020).

The *start simple and strong* approach within SC2.0 heavily relies on developing a rapid working alliance between the service user and provider (Cornish, 2020). Rapid working alliance aims to develop trust rather quickly and to start working towards goals (Cornish, 2020). Developing a rapid working alliance conflicts with traditional therapies, which spend substantial time and effort building a therapeutic alliance (Cornish, 2020). SC2.0 is cognizant that the rapid working alliance comes with some potential therapeutic risks in that service users may not be ready to come up with solutions on the spot (Cornish, 2020). In addition, service users may not appreciate that the counsellor does not have all the solutions readily available or does not appreciate the emphasis of trial and error which can promote shared responsibility and risk taking between service user and service provider, but SC2.0 introduced the concept of fail forward, which is described as the idea that no one can learn or grow without struggle or feeling confused about a situation (Cornish, 2020). SC2.0 is aware there are risks involved in this approach, however it does not examine them (Cornish, 2020). On the contrary, SC2.0 suggests this approach enables client empowerment and therefore mitigates the risks, and in the circumstance that risks arise, SC2.0 allows for flexibility and encourages services users to return for follow up appointments if needed (Cornish, 2020).

SC2.0 access is available through an online portal which provides a wide range of E-Mental Health programming, and access is also available over the phone or through same-day local drop-in centres (Cornish, 2020). The service provider shares information regarding all treatment options and based on that information; service users decide what works best for them. While the original SC1.0 had four step levels, SC2.0 offers nine step levels of care based on service user readiness for change based on the assumption that service users seeking help are at different stages of readiness to make changes to improve their lives; as the levels increase, intensity of treatment increases, and resources including time and effort, cost increases (Cornish, 2020). In addition, as the step levels increase, service users must be ready

to engage in more work and relinquish some autonomy which emphasises the importance of fostering client autonomy in treatment planning (Cornish, 2020).

Stepped Care 2.0 in Atlantic Canada

Stepped Care 2.0 was first introduced in Atlantic Canada due to record high suicide rates in 2016-2017, when there were 14 suicides within a span of 16 months in Newfoundland and Labrador (NL) alone (Cornish, 2020). Unfortunately, high rates of suicide among Indigenous Peoples are three times higher than non-Indigenous People (Kumar & Tjepkema, 2019). This article, centered in Atlantic Canada (Harris-Lane et al., 2023), will provide valuable information that can help determine whether SC2.0 can help prevent or reduce suicide among Indigenous Peoples.

The Government of NL, along with the Mental Health Commission of Canada (MHCC), responded to the mental health crisis by increasing resources (Harris-Lane et al., 2023). After ongoing collaboration with community members, it was decided that the best approach for preventing suicides was to increase rapid access to basic mental health care for all residents (Harris-Lane et al., 2023). SC2.0 was implemented in 2021 in NL and later New Brunswick (NB) as a response to extensive mental health wait times, with over 2000 people waitlisted for mental health services between April to September 2021(Harris-Lane et al., 2023). Considering the demographics of NL and NB are similar, it would be easy to assume similar positive outcomes in each region.

SC2.0 aimed to address substance and mental health issues by prioritising individual health needs, enhancing opportunities to care, reducing drug-related harms, implementing earlier interventions, and aligning individuals with adequate levels of care (Harris-Lane et al., 2023). NB health officials choose SC2.0 because the model acknowledges that one treatment does not fit all people when it comes to mental health and addiction services, and aimed to prioritise individual needs by meeting them where they are at, build on client strengths, and

assess level of readiness (Harris-Lane et al., 2023). NB systemic reviews have demonstrated positive treatment outcomes for individuals experiencing anxiety, depression, and substance abuse (King et al., 2023). The Government of NB reported that since the launch of SC2.0, NB residents now have accessible mental health services and resources that can be either formal or informal, with low intensity to high intensity interventions on a nine-step scale (Harris-Lane et al., 2023). However, these are government statistics and subject to bias.

There has been ongoing evaluation by the Government of NB and health officials to ensure that the SC2.0 model is a good fit for the province, and a mixed mode research study was conducted within the first six months of launching SC2.0 (Harris-Lane et al., 2023). The SC2.0 data collected from October 2021 to March 2022 confirmed there were a total of 3,600 SC2.0 therapy sessions with waitlists improving by 64.1% (Harris-Lane et al., 2023). Depression and anxiety were the most common concerns reported (Harris-Lane et al., 2023). Out of the 3,600 SC2.0 sessions, 89.5% of service users attended a single session, 8.3% returned for a follow up session, and 2.2% returned for additional 3-5 sessions (Harris-Lane et al., 2023). Despite the positive numbers of sessions attended, there needs to be more research to explore waitlist improvement with therapeutic benefits.

The Government of NB and health officials released additional supplementary data that indicated that among those who completed the survey, 90% felt satisfied with the session, 75% felt worried before the session, 16% felt worried after the session, 58% felt confident about their ability to manage issue, and 92% felt their main issue was addressed in the SC2.0 session (Harris-Lane et al., 2023). This data suggests that a single session was helpful to the small group of individuals who chose to complete the survey. In the comment section available, 224 service users provided feedback, with six themes identified among responses; these themes suggested that the session was positive (n = 112), service users were grateful for the session (n = 52), the session enhanced well-being/felt session was useful (n =

43), clients developed a plan and acquired knowledge, skills, and resources (*n* = 32), clients appreciated rapid, open, and flexible access (*n* = 17) and the session did not meet client needs (*n* = 15) (Harris-Lane et al., 2023). It's important to note that the data was collected by observational design, so causation was not identified (Harris-Lane et al., 2023). Despite the inclination to accept positive feedback, the data should be analyzed with caution due to low response rate. Not to mention, there was a risk of sampling bias because the surveys required that service users read and write English or French, therefore these results are not representative of the entire population and at risk of producing inaccurate results (Chiang et al., 2015). In addition, this data fails to capture the experiences of individuals who could not access these services (King et al., 2023). There are significant barriers to access mental health services such as socioeconomic barriers, including transportation, and inadequate technology to access SC2.0's online and over the phone options (King et al., 2023).

Furthermore, the NB government health officials that conducted the research indicated that SC2.0 is not appropriate for all service users (Harris-Lane et al., 2023). SC2.0's service providers shared concerns about the universality of SC2.0, reporting that they felt uncertain about the efficacy in treating complex mental health disorders (King et al., 2023). Providers identified that some service users preferred and expected long-term psychotherapy and/or required higher intensity treatment which conflicted with the SC2.0 model (King et al., 2023). In addition, there was no development of a lived experience advisory committee as part of this research study, which limits the ability to address the gap between research and real-world experiences. SC2.0 sounds promising, and it would be easy to accept this model as an excellent fit for all provinces/territories, however there are limited studies related to the implementation of SC2.0 in Canada. Therefore, NWT and other remote communities should be aware that SC2.0 may not be appropriate for all populations.

There is research that suggests early mental health interventions enhance treatment outcome and prevent minor health issues from developing into serious mental health disorders (King et al., 2023). SC2.0 provides a range of mental health services that meet the mental health needs of certain populations (King et al., 2023). Research suggests that the populations that benefit from SC2.0 are individuals with lower complexities and higher socio-economic status (Lints-Martindale et al., 2018). These findings are relevant to Northern Canadian Communities considering that there is a high rate of poverty in remote northern communities (Lints-Martindale et al., 2018), suggesting that SC2.0 may not be the most effective model for those communities. In addition, Indigenous Peoples made up 9.3% of Atlantic Canada's population and 4.4% of New Brunswick (Harris-Lane et al., 2023), whereas Indigenous Peoples in the NWT make up half the population (CNEDA, 2020). In addition, it is not evident whether Indigenous Peoples have accessed SC2.0, therefore, it makes it even harder to determine whether Indigenous Peoples would benefit from a SC2.0/OAAT session. It is important that when counsellors interpret information, to critically analyse the research data and scales for reliability, validity, and inclusivity.

Stepped Care 2.0: Ottawa's Chronic Pain Management Settings

Prior to the introduction of SC2.0, Ottawa's chronic pain management care had a four-year waitlist (Bell et al., 2020). Chronic pain is considered a long-term disease that makes individuals uncomfortable and emotionally strained due to actual or potential tissue injury (Bell et al., 2020), and impacts approximately one in five Canadians (Health Canada, 2020). According to Health Canada, Indigenous Peoples are disproportionately impacted by chronic pain and are faced with distinct challenges to access culturally-safe and trauma-informed chronic pain management care (Health Canada, 2020). Regrettably, Indigenous Peoples continue to experience prejudice, racism and discrimination when accessing chronic pain management care which impacts the care they receive, assessment and treatment options

(de Oliveira et al., 2023). As a result, Indigenous Peoples avoid seeking care and/or discharge themselves prematurely which increases their suffering and/or places them at greater risk of mortality (Ghoshal et al., 2020).

Chronic pain is best understood by considering biological, psychological, and social components (the biopsychosocial model) that examines the experience of pain (Bell et al., 2020). The best practices addressing chronic pain are multidisciplinary and include specialists in medicine, psychology, social work, nursing, physiotherapy, and/or occupational therapy (Bell et al., 2020). The biopsychosocial model is supported in the research for chronic pain management because it examines multiple perspectives that can help understand cause, impact and treatment options (de Oliveira et al., 2023).

Despite the advances in chronic pain management, there continues to be a gap in knowledge pertaining to culture and the experience of pain (de Oliveira et al., 2023). Indigenous Peoples hold a deeper meaning of pain that goes beyond western bio-medical interpretations (de Oliveira et al., 2023). Thus, prior to assessment and treatment of chronic pain of Indigenous Peoples, it's imperative to consider cultural background, history of colonization, oppression, and health and mental health disparities (de Oliveira et al., 2023). Furthermore, research suggested a strong correlation between chronic pain and trauma therefore it is critical health care providers gather adequate information from Indigenous Peoples to provide culturally-safe and trauma informed care (de Oliveira et al., 2023).

Additionally, literature has shown that prolonged wait times correlate with negative health outcomes, such as physical functioning, mental health, and overall well-being, and individuals who are expected to wait more than six months to access care often endure a decline in their quality of life (Bell et al., 2020). Thus, extensive wait times to access care is unethical and medically inappropriate (Bell et al., 2020). As a response to these extensive wait lists, SC2.0 was implemented across multiple chronic pain management clinics in

Ottawa and in the Ottawa Hospital specialised pain clinic, which transitioned from a multidisciplinary framework to a SC2.0 and an interprofessional model of care (Bell et al., 2020). Interprofessional model of care refers to a collaborative multidisciplinary approach to health care (Bell et al., 2020). Before the implementation of SC2.0, medical professionals would be making multiple referrals to different professionals (occupational therapy, physiotherapy, psychology, social work), who would all work independently and on occasion consult with one another regarding complex clients; after the shift to the SC2.0, the interprofessional chronic pain management approach made a significant improvement in client care (Bell et al., 2020).

The specific aspects of this shift were led by Cornish and his colleagues, who modified SC2.0 to fit the unique needs of individuals with chronic pain and to align well with resources available in Ontario (Bell et al., 2020). In line with other Stepped Care models, individuals with chronic pain were offered the least intrusive treatment plan based on their individual needs and preference, and this transition led to improved care for clients and greater collaboration among professionals, which allowed for more consistent care among all disciplines (Bell et al., 2020). Restructuring health care systems is necessary, and these changes in services need to be centred on service delivery as well as on service user benefit (Gellatly et al., 2018). There was no indication of service patient improvement in this research study. In addition, despite the research suggesting Indigenous Peoples continue to experience racism in chronic pain management, there was no indication of how SC2.0 was modified to meet the needs of Indigenous Peoples within the Ottawa Pain clinic model (Ghoshal et al., 2020). This speaks to the gap in research regarding SC2.0's efficacy and validity (Bell et al., 2020), in particular to treating Indigenous Peoples. This is concerning, considering the current research that indicates how Indigenous Peoples are suffering due to inadequate culturally-safe chronic pain care (Ghoshal et al., 2020).

Nonetheless, it does appear that SC2.0 is highly applicable and flexible in different environments, therefore, it can be modified to fit the needs of Indigenous Peoples in the NWT with decolonizing efforts. However, it is critical to consider the significant discrepancies between Central Canada and Northern Canadian Communities: Counsellors working in northern communities often experience isolation from colleagues and opportunities to collaborate are limited compared to the rest of Canada (Lints-Martindale et al., 2018). Therefore, interprofessional approaches might not be feasible. In addition, the NWT has unique cultures, challenges, and economies therefore further research is needed to determine whether SC2.0 is a viable mental health option in the territories. Understanding the disparities among Canadian regions is critical for counsellors to provide effective counselling in a variety of settings, particularly northern communities (Lints-Martindale et al., 2018).

Stepped Care 2.0 in the Northwest Territories

Canada's Northwest Territories (NWT) is made up of 33 communities, with Indigenous Peoples composing half of the total NWT population (MHCC, 2023). There are eleven official languages in the NWT, nine of which are Indigenous languages (MHCC, 2023). The Government of Northwest Territories (GNWT) has acknowledged colonization and the perpetual impact of that colonization that continues to impact Indigenous Peoples, contributing to their elevated rates of social issues and struggles. In addition, Indigenous Peoples have their own beliefs about mental health and well-being influenced by their cultural background, worldviews, values and colonization (Wright et al., 2021). The GNWT collaborated with the Mental Health Commission (MHCC) and Stepped Care Solutions (SCS) to launch SC2.0 in the NWT in March 2020, with a goal of increasing the number of culturally safe, community-based mental health and addiction services that will yield positive results to communities (MHCC, 2023). Due to limited research available pertaining to Stepped Care 2.0 in the NWT, the majority of the research in this section comes from

government officials which speaks to the importance of ongoing evaluation and longitudinal studies.

The GNWT launched SC2.0 after extensive research and engagement with residents, including individuals with lived mental health and addiction experience, government workers, non-government workers, and Indigenous groups (MHCC, 2023). Considering the high rate of Indigenous Peoples in the NWT, it was essential that government officials consulted with Indigenous Peoples throughout the development and integration stage of mental health services (Wright et al., 2021). The GNWT did not disclose information in regard to which Indigenous groups were consulted with nor to what extend the information gathered informed their decision to implement SC2.0. The GNWT reported SC2.0's values of self-direction, peer-support, empowerment, strength-based, hope, and respect aligned well here with the values of northern residents (MHCC, 2023). Despite the GNWT's best intentions, there was no indication of how SC2.0 meet the needs of Indigenous Peoples. This is imperative when integrating a new system of delivering mental health services in Indigenous communities (Wright et al., 2021).

It is also imperative to research what and how adaptations need to be made to ensure Stepped Care is culturally-safe and sensitive to Indigenous Peoples (Lints-Martindale et al., 2018). The GNWT main goal was to improve access to mental health and addiction recovery options by lowering and/or eliminating wait times, increase options to care, and decreasing barriers to care (MHCC, 2023). It was identified that, through training, community engagements, and service improvements, SC2.0 could transform access, resources, and delivery of mental health services and addiction services in the Northwest Territories (MHCC, 2023). To achieve their goal of improving access, the GNWT provided counsellors online training to SC2.0 and OAAT, developed by Stepped Care Solutions (MHCC, 2023).

Within NWT, SC2.0 was delivered using the Community Counselling Program (CCP) that was developed in 2004 and provided NWT residents free mental health and addiction support (MHCC, 2023). This CCP was under the department of the Northwest Territories Health and Social Services Authority and was employed by counsellors, which was an avenue that NWT residents could use to find counselling professionals (Elman et al., 2019). As part of the launch of SC2.0, the CCP developed a care first, assess later triage process (MHCC, 2023). Care first, assess later speaks to the importance of providing rapid access to mental health care, and only using assessments if needed (MHCC, 2023). Intake processes were simplified, and clinics adopted a one-at-a-time model (OAAT), in which a single-session therapy model that aims to maximise treatment outcome in that session (MHCC, 2023). OAAT allows service users to utilise as many single sessions as would be needed by attending one single session, or pre-scheduling regular single sessions (MHCC, 2023). Following the implementation of SC2.0 and the OAAT model, the GNWT reported waitlist improvements and that the simplified intake process had helped people access care sooner with fewer barriers (MHCC, 2023). The literature suggests mainstream mental health services do not fulfill the mental health needs of Indigenous Peoples and their communities (Wright et al., 2021). Not to mention, the GNWT did not release the demographics of the service users, which make it difficult to decipher whether Indigenous Peoples specifically benefited from this simplification of the intake process.

SC2.0 in the NWT provides service users a wide range of E-Mental Health (e-MH) treatment options, which are online mental health services such as the Breathing Room, 7 Cups, Root'd, Wellness Together Canada, Strongest Families Institute, Stronger Minds, and Edgewood Health Network Wagon (MHCC, 2023). These online resources are free to download and use for all NWT residents, and the GNWT reported all the e-MH resources were evidence-based and reviewed by the mental health and addiction advisory group

(MHCC, 2023). This advisory group is discussed below. Within the NWT study, the GNWT report indicated that 81% of service users who accessed the online mental health options, 30% used video counselling, and 3% used E-Mental Health apps and virtual based tools (MHCC, 2023). Despite these positive results, it was difficult to endorse the effectiveness of e-MH for Indigenous Peoples in the NWT for several reasons. First and foremost, none of the e-MH apps were designed specifically for Indigenous Peoples, and second the lack of culturally-safe mental health services (including screening tools) is problematic (Sam et al., 2022). Indigenous designed e-MH will be explored in the counselling implications in a later chapter of this capstone. Third, there were areas in the NWT with poor reception, therefore the e-MH only benefited those that had access to reliable internet (Dudgeon et al., 2016). There are many NWT communities that lack infrastructure that is needed to sustain e-MH (Dudgeon et al., 2016). Finally, only those that can understand English or French and have the skill set to download and use the app benefit from these resources. For these reasons, e-MH services may not be inclusive to all NWT residents, therefore do not benefit all NWT residents which further exacerbates mental health disparities (Wright et al., 2021). For counsellors, this emphasises the importance of promoting culturally-safe resources when working with Indigenous Peoples. Culturally-safe resources are critical in the NWT, as many northern communities are underserved (Wright et al., 2021).

As part of the SC2.0 launch in the NWT, the mental health and addiction working advisory group was developed (MHCC, 2023). This advisory group was comprised of NWT residents who gave their own experience and expertise with mental health and addiction recovery, though no information was provided on the demographics and how many participants were part of this working group, making it is difficult to determine whether this group fairly represents the NWT Indigenous Peoples (MHCC, 2023). To support decolonization efforts, this working group should have had high representation of Indigenous

People's or else the findings could be considered inconsistent with community needs (Wright et al., 2021). In addition, it is imperative to indicate how cultural safety was fostered within these groups, and whether data has been collected in a way that aligns with Indigenous values including Indigenous methodology. Indigenous methodology favours holistic epistemology, centred around storytelling, experiential and honour Indigenous ways of acquiring knowledge, and attention to colonial impact (Sam et al., 2022).

As noted earlier, there is a significant research gap pertaining to Stepped Care 2.0 in the NWT, as the only data available at the time of this literature review are public reports from the GNWT (MHCC, 2023). The GNWT indicated that since 2020, there have been ongoing evaluations through surveys, focus groups, monthly statistics reports, file reviews and reports from E-Mental Health partnerships, and is based on three themes: First, *reach*, which is based on all options offered and utilised by service users (MHCC, 2023). Second, *impact,* which encompasses overall satisfaction, wait times, and outcomes, and finally, the theme of *lessons learned* identifies learning curves and barriers (MHCC, 2023). The evaluation framework was created by members from the GNWT, MHCC, Stepped Care Solutions, and the mental health and addiction advisory group (MHCC, 2023). Findings from this evaluation confirmed that from 2020-2022, there were 47,563 counselling sessions completed, of which 34,563 were pre-scheduled and 13,000 were drop-ins/unscheduled sessions (MHCC, 2023). Within the scheduled counselling sessions, 94% were individual sessions and 6% were group/family/couple sessions (MHCC, 2023). This data suggests that SC2.0 is widely used in the NWT and therefore, counsellors working in the NWT may encounter or work within an organisation implementing a Stepped Care model.

Regrettably, mainstream evaluation instruments are often incompatible with Indigenous People's needs, often inhibiting Indigenous participation and contribution (Wright et al., 2021). Additionally, it is unclear whether the GNWT involved Indigenous Peoples in

the evaluation process (Wright et al., 2021). Indigenous engagement in the evaluation stage is paramount to enhancing mental health services; it is vital to evaluate how well mental health services are meeting the needs Indigenous Peoples and how well mental health services align with Indigenous Peoples and their communities (Wright et al., 2021).To support decolonizing SC2.0 efforts, co-designing evaluations between the GNWT and Indigenous can empower, enhance and provide a sense of self determination and control for community members (Wright et al., 2021). In addition, supporting Indigenous engagement in the evaluation stage enables valid, reliable and meaningful results, which is representative of the community served (Wright et al., 2021).

It appears that the majority of service users in this study are regular clients, which suggests that single sessions do not work well in this population (MHCC, 2023). There was no information provided in the analysis about whether or how many service users were Indigenous or non-Indigenous, however, the report indicated Indigenous Peoples reported slightly less satisfied than non-Indigenous Peoples in areas such as their ability to communicate in a language they feel comfortable with (91%), the respect of their individual needs (72%), and the safety of the counselling environment (81%) (MHCC, 2023). This is a significant issue considering the high rate of Indigenous Peoples in the NWT and the ethical obligation to provide culturally-safe treatment options to Indigenous Peoples (Elman et al., 2019). This information is important for counsellors because it emphasises the need to increase culturally-safe treatment options (Elman et al., 2019). Despite the GNWT commitment to address colonization and the impacts, there was no indication of attempts of decolonization within SC2.0 and, despite the objective to increase cultural supports, there was no indication whether this was achieved or whether it was successful (MHCC, 2023). As part of decolonization efforts, mental health services need to integrate Indigenous culture and

need to align with the worldviews and values of Indigenous Peoples and their communities (Elman et al., 2019).

Decolonization efforts are imperative in the NWT. As discussed earlier, decolonization efforts involve dismantling colonial ideologies and deconstructing privilege of western Euro-centric thoughts and approaches (Biin et al., 2018). This includes breaking down structures which sustain the status quo and challenge power imbalances, honouring and embracing Indigenous knowledge and ways of life (Biin et al., 2018). Decolonization in the NWT requires counsellors and mental health providers to consider Indigenous Peoples worldviews and start shifting their practice to meet the needs of Indigenous Peoples and their communities (Verniest, 2019). Decolonization is a complex process and despite the positive outcomes for Indigenous Peoples and their communities, it can create discomfort and emotional reactions among non-Indigenous Peoples (Calvez & Cummings, 2022).

Indigenous literature suggests intergenerational trauma stemming from colonization, requires care that surpasses Euro-centric models of mental health care which speaks to the importance of collaborating with Indigenous healers including Elders and knowledge keepers (Allen et al., 2020). Indigenous literature emphasize that culture is the cure, and so mental health interventions need to be representative of traditional knowledge and practices (Allen et al., 2020). It is essential that counsellors acknowledge the value of Indigenous healing modalities and integrate them in the treatment of Indigenous Peoples, in collaboration with Indigenous Elders and knowledge keepers (Josewski et al., 2023). For instance, The Wise Practice Model can be used to support decolonizing SC2.0 efforts, as it is described as a humane process that allows for the expression and implementation of traditional knowledge; this enables self-efficacy and community strength among Indigenous Peoples and their communities (Wesley-Esquimaux & Snowball, 2010). A humane process is an approach that embodies tradition and culture, which aims to elevate morale rather than condemning and

ostracising individuals (Wesley-Esquimaux & Snowball, 2010). The Wise Practice model integrates the traditional seven values: Courage, honesty, humility, respect, truth, love, and wisdom (Wesley-Esquimaux & Snowball, 2010). These seven values could be weaved into micro, mezzo, and macro systems to initiate profound change (Wesley-Esquimaux & Snowball, 2010). The following chapter will explore how these teachings could be integrated into the SC3.0 model including essential counsellor skills, intake process, counselling sessions, and community collaboration. Integrating these seven teachings could address a decolonizing attempt at a system of support for Indigenous persons living in Northern Canada.

Chapter Three Conclusions

This chapter began with a review of Canadians Northern Communities, which highlighted a high rate of complex intergenerational trauma (MHCC, 2020). The history of colonization has resulted in intergenerational trauma which has given rise to high rates of suicide and substance abuse (MHCC, 2020). This speaks to the importance of providing culturally-safe and trauma-informed mental health services to Indigenous Peoples and their communities. Following this, an exploration of the origins of Stepped Care and the integration of the Stepped Care model throughout multiple clinical settings revealed that, in Australia, SC1.0 made a significant improvement in mental health options in primary health clinics (Australian Department of Health and Aged Care, 2023), and in Atlantic Canada, SC2.0 helped reduce wait times for substance abuse and mental health services (Harris-Lane et al., 2023). In Ottawa, the literature indicated that Stepped Care was successfully integrated in a chronic pain management clinic (Bell et al., 2020). Lastly, the data in the NWT highlighted that SC2.0 has provided NWT residents rapid access to mental health services (MHCC, 2023). These findings confirm that Stepped Care is expanding in Canada and considering all the positive outcomes from these research studies, it is likely there are

counsellors that will work within a Stepped Care model. As the Stepped Care model has been used throughout the NWT, it is important for counsellors to familiarise themselves with this model and imperative that they consider the clinical implications and recommendations that will be shared in the following chapter to ensure they are providing culturally-safe and trauma-informed care when working with Indigenous Peoples and their communities. All of the research about Stepped Care points to the intersectionality of the model and can support the research question, how can Stepped Care 2.0 support decolonizing practices in Northern Canadian Communities.

Chapter Four

This capstone illustrates the significance to counsellors working with Indigenous Peoples. Included is a short review of Stepped Care 2.0 (SC2.0) in Canada, a reiteration of reasons to decolonize SC2.0, and a proposal for Stepped Care 3.0 (SC3.0) as an evolution of SC2.0 that accommodates decolonization. In March 2020, SC2.0 launched in the NWT to decrease barriers to mental health as well as to lower and/or eliminate wait times to mental health care (MHCC, 2023). Currently, SC2.0 provides NWT residents access to same day, in-person and over the phone mental health services, in addition to a wide range of E-Mental Health options (MHCC, 2023). The Government of NWT had a goal of providing increased mental health access to its residents and between 2020-2022, a total of 47,563 mental health sessions were attended (MHCC, 2023). Available data regarding Indigenous Peoples and access to mental health indicated of those who attended these sessions, Indigenous Peoples experiences were reported as slightly less satisfied than non-Indigenous Peoples in their ability to communicate in a language they feel comfortable with (91%), the respect of their individual needs (72%), and the safety of the counselling environment (81%) (MHCC, 2023). These statistics highlight how SC2.0 may not be addressing all of the needs of Indigenous Peoples and communities in a maximized or consistent manner. Therefore, there exists opportunities to embed Indigenous culture and reflect Indigenous worldviews and values in NWT mental health services (Elman et al., 2019). SC2.0 fails to identify how the model aligns with Indigenous People's culture in the NWT (Elman et al., 2019). This poses a significant ethical concern when considering that NWT is home to the largest percentage of Indigenous Peoples in Canada (CNEDA, 2020), and counsellors have an ethical obligation to provide culturally-safe and trauma-informed mental health services to Indigenous Peoples (CCPA, 2020).

Counsellors and the counselling field are ethically obligated to make individual and collective efforts to repair and reconstruct a new relationship with Indigenous Peoples in Canada through decolonization (Calvez & Cummings, 2022). This can be achieved by reflecting on the western euro-centric therapeutic treatments and approaches used within Indigenous Peoples and their communities (Verniest, 2019). The proposal for SC3.0 will provide an example of how Indigenous worldviews and values can be integrated into existing Stepped Care model.

Ethical Considerations

Decolonizing Stepped Care 2.0 (SC2.0) is imperative because providing counselling services to Indigenous clients using non-Indigenous methods can be considered a form of oppression and colonization (Stewart, 2008). Stepped Care 2.0 was created by Peter Cornish, a non-Indigenous person, therefore as part of decolonizing Stepped Care, consultations with Indigenous Peoples and their communities would be considered best practice (Allen et al., 2020). As noted earlier in this capstone, the CCPA amended their Code of Ethics in 2020 to ensure that all counsellors are aware of their ethical responsibilities when working with Indigenous Peoples and their communities. These ethical obligations include acknowledging Canada's colonial history and the current day impacts of that history (CCPA, 2020). The Stepped Care model provides users access to rapid mental health services which is lacking in the NWT (MHCC, 2023). Indigenous People have identified culture as the foundation for their healing, therefore it is imperative that counsellors address decolonizing SC2.0 and integrate cultural knowledge into their practice (Elman et al., 2019). It is possible to provide culturally-safe and trauma-informed rapid mental health services in a manner that promotes cultural preservation and Indigenous Peoples' health and well-being by adapting the current Stepped Care model.

More specifically, there are aspects of the Stepped Care model and SC2.0 that lack attention to Indigenous People's needs, including insufficient integration of Indigenous epistemologies, collaboration, clinical approach, and delivery of mental health services (Roy, 2023). Therefore, to address the shortcomings of SC2.0 and highlight the need to decolonize the current Stepped Care model, a proposal for Stepped Care 3.0 is explored in the following sections.

Proposal

The proposal within this capstone is to decolonize SC2.0, and it is recommended to create Stepped Care Model, SC3.0. This shift could be accomplished by taking a systems approach to change, which understands that each part of the Stepped Care system is related to each other and would gradually create profound change (Observatory of Public Sector Innovation, 2019). SC3.0 would integrate the Wise Practice model with its traditional seven values to explore how each part of the Stepped Care model can be modified to reflect Indigenous values (Wesley-Esquimaux & Snowball, 2010). The Wise Practice model and traditional seven values are explored below.

Stepped Care 3.0

Hypothetically, decolonizing the Stepped Care model and Stepped Care 2.0 (SC2.0) is possible. Stepped Care 3.0 is proposed in this capstone as a reimagined, improved model of therapeutic support that focuses on a systems' change approach and improved clinical practice by focusing on providing Indigenous Peoples culturally-safe and trauma-informed care. The following section can be used as a guiding model that will support the creation of the best practices for counsellors in their decolonizing efforts. As part of this system's approach to a decolonized Stepped Care, the seven traditions of the Wise Practice model (Wesley-Esquimaux & Snowball, 2010) will be interwoven with the SC2.0 model (Cornish,

2020). Each subheading will include the specific sections of the SC3.0 model and one of the seven traditional principles that could encompass it.

SC3.0 Initial Steps and Courage

This section focuses on the initial steps that can be taken towards decolonizing SC2.0, and the themes covered in this section may be useful for staff onboarding and/or part of ongoing supervision. This section covers the importance of acknowledgement within the counselling field, followed by research that highlights potential emotional responses and recommendations for counsellors (Calvez & Cummings, 2022).

As we shift towards the inception of SC3.0, counsellors and government bodies would need to acknowledge the impact of colonization on Indigenous Peoples (Dupuis-Rossi, 2020). Counsellors need to acknowledge that colonization continues to be a reality for Indigenous Peoples (Calvez & Cummings, 2022). Acknowledgement speaks to the importance of courage, which is one of the seven traditional teachings within the Wise Practice Model and contributes towards inner strength (Wesley-Esquimaux & Snowball, 2010). In addition, acknowledgement of colonization helps Indigenous Peoples externalize the impacts of colonialism and can help them reconnect to themselves and their Indigenous identity (Dupuis-Rossi, 2020). Acknowledgement of colonial violence can help divulge the often-unseen obscured colonial forces that impact an individual's self-worth (Dupuis-Rossi, 2020).

Acknowledgement is the first step towards decolonization by reflecting on all the deficiencies in mainstream therapeutic modalities (Dupuis-Rossi, 2020). Calvez and Cummings (2022) reported non-Indigenous counsellors' specific recommendations when starting to walk the path of decolonization; these recommendations are extremely helpful in deconstructing SC2.0 and developing SC3.0. These authors forewarned counsellors of the potential reactions to decolonization such as fear, intolerance of uncertainty, and defence mechanisms, which are often a result of being uncertain about where to begin, feeling

overwhelmed by all the options and potential outcome(s), being unaware of personal benefits or fear of having privilege challenged, and/or the fear of failure (Calvez & Cummings, 2022).

Calvez and Cummings (2022) further defined fear, intolerance of uncertainty, and defense mechanisms. *Fear* is described as a core human experience and often a reaction to the unknown; as this fear develops, it is common for individuals to prefer an adverse outcome as a method to alleviate intolerable uncertainty (Calvez & Cummings, 2022). *Intolerance uncertainty* is described as another aversive reaction to not having sufficient information about a situation or experience and often results in elevated levels of anxiety, threats and perceived inability to cope (Calvez & Cummings, 2022). *Defense mechanism(s)* can also be another common reaction to decolonization and are unconscious responses to emotional threats which show up as rationalization, intellectualization, and reaction formation, which are all aimed at reducing stress and avoiding discomfort (Calvez & Cummings, 2022).

Calvez and Cummings (2022) provided specific culturally-safe recommendations to help non-Indigenous mental health professionals overcome these initial reactions to decolonization. These recommendations are helpful because there are non-Indigenous counsellors providing counselling services to Indigenous Peoples in Northern Canadian Communities. The first recommendation that foster cultural safety that Calvez and Cummings make is how imperative it is that counsellors become aware of and understand their *positionality*, which entails being cognizant of their personal cultural identity, or awareness of where family/ancestors originate from (2022). In the case of SC3.0, an important part of this acknowledgement could be the inclusion of the cultural background of all non-Indigenous persons, which could highlight the correlation of newcomers to Indigenous land, culture, and Indigenous history prior to the arrival of colonizers. *Self-reflection* allows for individuals to understand themselves in relation to others which often results in less judgement and acceptance of others, which improves counsellors' ability to

understand others and leads to greater cultural humility and capacity to support others (Calvez & Cummings, 2022). In Stepped Care 3.0, opportunities for self-reflection could be incorporated in team meetings and included in clinical supervision. This ability to understand others would be necessary to help support Indigenous Peoples and in understanding co-workers who are resistant to change and have not yet embarked on their own path of reconciliation (Calvez & Cummings, 2022). In addition, self-reflection allows counsellors to understand that despite their best intentions, most counsellors are contributing to colonial scripts and worldviews (Calvez & Cummings, 2022).

Another critical element in decolonization is *knowing the space you engage in with others*, which is defined as cultural awareness (Calvez & Cummings, 2022). Cultural awareness enables counsellors to view themselves as cultural beings, which allows them to be open to cultural differences and learn from Indigenous Peoples and their culture, worldviews, and history (Calvez & Cummings, 2022). Cultural awareness prompts cultural sensitivity and greater openness to differences; this increases counsellors' potential to be reflective and respectful as differences arise to overcome any discomfort and dissonance that arises (Calvez & Cummings, 2022). This process of self-reflection and increased understanding leads to increased sensitivity over time. *Cultural competency* is developed once an individual is able to acknowledge, accept, and appreciate cultural differences, expanding their ability to relate to people from diverse cultural backgrounds in a positive manner (Calvez & Cummings, 2022). Additionally, *cultural safety* is one of the main objectives of reconciliation and is developed once individuals develop an awareness of their own cultural values, beliefs, and worldviews in relation to others (Calvez & Cummings, 2022).

In Stepped Care 3.0, there could be moments for counsellors to share, learn by engaging in cultural activities, and embrace diversity (Roy, 2023). Individuals need to be aware how they may have intentionally or unintentionally harmed Indigenous Peoples

(Calvez & Cummings, 2022), and counsellors need to respond in ways that help create safe and equitable spaces for Indigenous People. In Stepped Care 3.0 this can be accomplished by providing snacks, water, and tea/coffee in the waiting area, which would be representative of Indigenous values including reciprocity and respect for others (Roy, 2023). *Good relations* speak to the importance of building a relationship with reconciliation, and the authors stressed how non-Indigenous mental health professionals need to take the lead and build relations with other allies and start conversations and movements towards reconciliation in order to generate social and professional transformation (Calvez & Cummings, 2022). In Stepped Care 3.0 this could include counsellors taking part in ceremonies and cultural gatherings (Roy, 2023). Participation in ceremonies is missing in mainstream mental health services and often creates a barrier to provide culturally-safe support Indigenous Peoples and their communities (Roy, 2023).

Psychological Flexibility is the ability to be present as a conscious being and shift in ways that allow for improved flexibility and openness to new information and respond in ways that align with our values (Calvez & Cummings, 2022). This process allows for flexibility and adaptability when interacting with Indigenous Peoples and allows individuals to walk the path of reconciliation (Calvez & Cummings, 2022). In Stepped Care 3.0, this can be embodied in the counselling office through storytelling, sharing circles, traditional teachings, and relationships with Elders and cultural leaders (Roy, 2023). *Committed Action* speaks to the importance of shifting mindsets as well as behaviours when working towards reconciliation; the authors stressed reconciliation shows up as actions (Calvez & Cummings, 2022). As part of Stepped Care 3.0, it would be important to encourage the hiring of Indigenous counsellors and allow them to work within their own traditional frameworks (Roy, 2023).

These recommendations are the initial steps for consideration and fundamental in SC3.0. These recommendations would provide increased opportunities for self-reflection and discussion and careful examination of clinical practices and approaches to ensure they align with Indigenous worldviews and values (Roy, 2023).

SC3.0 Mental Health Treatment Options and Honesty

This section focuses on which Stepped Care options should be included in SC3.0. Stepped Care is known to provide a wide range of care options, including same-day drop in options at a community counselling program, available both in-person and over the phone, e-MH options, access to out of territory residential treatment options, and 24-hour crisis lines (MHCC, 2023). These services need to embody honesty, another of the Wise Practice model's traditional seven teachings, which requires an openness to new ideas and perspectives (Wesley-Esquimaux & Snowball, 2010). Honesty requires that counsellors and all GNWT administration staff work towards a good state of mind, the process of which involves self-reflection and developing mental health services that are culturally-safe and align with the values of Indigenous Peoples (Wesley-Esquimaux & Snowball, 2010).

Culturally safety and flexible mental health services become Wise Practice if they support and meet individual and community needs (Wesley-Esquimaux & Snowball, 2010). There needs to be collaboration and integration of traditional knowledge and practices when providing health and mental health services to Indigenous Peoples and their communities (Allen et al., 2020). Allen and colleagues (2020) highlighted specific favourable outcomes when integrating traditional practices into western healthcare systems across Canadian healthcare systems. The practices could be easily integrated into the SC3.0 model and could include access to cultural programming, traditional counselling, and providing access to healing and health promotion circles, on the land programming, ceremonies, and providing

service users the option to use Indigenous language translators and cultural interpreters (Allen et al., 2020).

As part of SC2.0, there is a wide range of E-Mental Health (e-MH) options for service users (Sam et al., 2022). As noted earlier, there is a lack of culturally-safe e-MH options and these apps are not designed for Indigenous Peoples (Sam et al., 2022). There is a significant research gap pertaining to indigenizing e-MH resources. As part of SC3.0, it would be imperative to utilise the Two-Eyed Seeing Approach when integrating Indigenous perspectives with human computer technology to co-create e-MH app(s) (Sam et al., 2022). This can be achieved by interviewing Indigenous Peoples and using their responses to design an e-MH app that is Indigenous-friendly and meets the cultural needs of Indigenous Peoples and their communities (Sam et al., 2022). It is also important that counsellors are mindful of connection issues that are prevalent across the territories and that counsellors are not overly reliant on e-MH resources that might not be accessible to all NWT residents.

SC3.0 Intake and Humility

This section focuses on the intake process and the importance of humility. SC3.0 needs to be rooted in humility which starts at initial contact. As part of SC3.0, service providers need to keep in mind the shaming that occurred in residential schools, and this has developed into significant mistrust and reservation (Wesley-Esquimaux & Snowball, 2010). This speaks to the importance of using culturally-safe language in the referral and intake process to ensure it is not supporting biased, colonial perspectives, and stereotypes which do not support Indigenous Peoples (Roy, 2023). The process of service providers being able to obtain and transfer knowledge is considered a wise practice (Wesley-Esquimaux & Snowball, 2010). This is imperative as service users reach out to CCP to access services.

SC3.0 Service Delivery and Respect

Respect is fundamental in SC3.0 service delivery and entails equality, fairness, and recognition of all individuals and their inherent value (Wesley-Esquimaux & Snowball, 2010). Respect also speaks to the sameness between all individuals (Wesley-Esquimaux & Snowball, 2010). Reciprocity and respect enable a sense of connectedness between Indigenous Peoples and service providers (Roy, 2023). Reciprocity eliminates the sense of separateness or isolation that is so prevalent in Indigenous communities (Roy, 2023).

Respect and reciprocity speak to the importance of the relationship between counsellors and service users, and counsellors need to keep in mind that colonization significantly impacted trust for Indigenous People's relationships (Wesley-Esquimaux & Snowball, 2010). In particular, Indigenous Peoples struggle with trusting healers and teachers and it will take time to improve these relationships (Wesley-Esquimaux & Snowball, 2010).

The therapeutic alliance was not a priority in SC2.0, instead focusing on identifying solutions during the session rather than establishing a therapeutic alliance (Cornish, 2020). This can be detrimental when it comes to working with Indigenous Peoples as Indigenous Peoples value connection and unconditional support and love (Dupuis-Rossi, 2020). SC3.0 would integrate love as an essential component for healing and recovery. Regrettably, Indigenous Peoples' right to be loved and cared for was taken from them and this needs to be recovered (Dupuis-Rossi, 2020).

SC3.0 Counselling Approach and Truth

Mainstream psychology and counselling primarily focus on problems and pathologies (Katz, 2017). There is an emphasis on counsellors helping clients fix their problems and/or improve their symptoms (Katz, 2017). This is reflected in the SC2.0 model, which focuses on client concerns and within one session aims to provide service users solutions to their problem (MHCC, 2023). There are several issues with focusing on the problem(s) in

counselling, such as that people focus on what is wrong with them or what is broken, which often shows up individual neuroses and social inadequacies (Katz, 2017). The goal in SC3.0 is to shift from narratives that limit and pathologize Indigenous Peoples to narratives that uplift and embrace Indigenous Peoples and their communities (Roy, 2023). Another negative consequence is medicalization, where oftentimes regular life issues and struggles are defined as medical problems or mental health issues that need treating by a mental health professional (Katz, 2017). The final concern with pathologizing service users is that psychology undermines human potential and takes away from natural experiences of growth and development, which dampers the creative potential of human beings (Katz, 2017). Instead, counsellors using the decolonized version SC3.0 with Indigenous Peoples should honour the courage and strength it takes for Indigenous Peoples to show up and continue fighting to survive despite the profound impact of colonization and reoccurring colonial violence (Dupuis-Rossi, 2020).

Counsellors need to help Indigenous Peoples reconnect with themselves as resilient, courageous people (Dupuis-Rossi, 2020). It is important for counsellors to be aware of complex trauma when working with Indigenous Peoples, as research suggests complex trauma survivors are often left with immense fear and despair, and if counsellors want to cultivate a safe environment for healing, then survivors need to feel seen, heard, and need to be provided unconditional support (Dupuis-Rossi, 2020). Counsellors need to show up as human beings and provide good medicine, which is the act of listening, giving space, and being present (Dupuis-Rossi, 2020). Therefore SC3.0 could engage in active listening, presence and move away from solution-oriented care. In addition, SC3.0 counsellors should foster self-determination when working with Indigenous Peoples (Roy, 2023). Self-determination enables resiliency and helps to develop self-worth and self-respect among Indigenous Peoples and their communities (Roy, 2023).

In SC3.0 counsellors need to embrace humility and proceed with gentleness rather than trying to maximise treatment outcome (Cornish, 2020). Counsellors need to be able to slow down and capture moments of wisdom and expertise that come alive in the context of a safe therapeutic alliance (Dupuis-Rossi, 2020). Counsellors need to support Indigenous Peoples, and help them reconnect with their own knowing, resilience, and power as well as to release the need to direct clients in their treatment plans (Dupuis-Rossi, 2020). In SC3.0, rather than assuming OAAT is best practice, counsellors could check in regularly with Indigenous Peoples and inquire which approach works for them. This process prioritises Indigenous Peoples unique needs and cultivates self-determination which can be considered an act of decolonization (Dupuis-Rossi, 2020).

In the case of assessments, counsellors utilising SC2.0 can use assessments if service provider and user believe it is beneficial in later sessions (Cornish, 2020). SC2.0 research suggests that exploration of underlying issues or psychopathology is considered only if a strength-based approach does not achieve desired outcome (Cornish, 2020). In SC3.0, only assessments that have been reviewed by Indigenous Peoples and their community should be integrated as part of Indigenous Peoples mental health care.

SC3.0 Integration of Indigenous Knowledge and Love

Learning to embrace and cultivate the feeling of love and nurture positive regard to ourselves and others is paramount (Wesley-Esquimaux & Snowball, 2010). Indigenous Peoples have been significantly impacted by colonization, so the path of love can be difficult; however, it is essential for healing and rebuilding communities (Wesley-Esquimaux & Snowball, 2010). Love can be described as acknowledging and embracing strengths, abilities and fostering self regard among individuals, communities, nations (Wesley-Esquimaux & Snowball, 2010).

Richard Katz integrated traditional knowledge into his clinical research and approach, capturing the voices of Indigenous Peoples and focusing on shifting mainstream psychology to make space and explore the great wisdom of Indigenous People and their culture (Katz, 2017). Katz has introduced the concept of Indigenous healing psychology, and described Indigenous Peoples as the original psychologists with wisdom and knowledge (such as spirituality) in areas that are often overlooked in mainstream western psychology (Katz, 2017). These original psychologists are often referred to as Elders and traditional healers (Katz, 2017). Indigenous healing psychology strongly emphasised healing and perhaps an important shift in SC3.0 is to focus on healing rather than recovery. The idea of healing means to focus on balance, connection, and wholeness (Katz, 2017). Perhaps Katz should be consulted when building SC3.0.

Verniest (2019) emphasised that Indigenous Peoples are returning to their traditional ways of healing. Therefore, it is critical that counsellors support clients in reconnecting with their spirituality, and Verniest explained that oftentimes Indigenous healing journeys involve spiritual healing and to disregard spirituality in their treatment can be a disservice to the clients served (Verniest, 2019). Verniest discovered that the medicine wheel allows for the exploration of spirituality with clients, describing how the medicine wheel is a sacred Indigenous symbol with four domains: Spiritual, mental, emotional, and physical states of being (Verniest, 2019). Verniest explained the medicine wheel has been traditionally used as a healing tool and proposed it can also be used by mental health professionals to better understand clients' state of being, and clients' relationship to themselves, families and communities (Verniest, 2019). In addition, Verniest found using the medicine wheel in clinical practice helped Indigenous clients interpret their realities in ways they could understand and appreciate which helped create culturally-safe spaces for Indigenous Peoples (Verniest, 2019). Verniest emphasised the importance of using culturally appropriate tools

rather than tools derived from western based medically driven ideologies which often contradict Indigenous ideologies (Verniest, 2019). This research confirmed that Indigenous epistemology has much to offer the counselling psychology field and it is essential counsellors start to explore Indigenous worldviews (Verniest, 2019). Perhaps Verniest should also be consulted for Stepped Care 3.0.

SC3.0 Community Collaboration and Wisdom

Wisdom encompasses the act of learning, accepting and integrating multiple truths, and walking in wisdom describes the idea that we are all lifelong learners, and it is imperative to give and receive knowledge (Wesley-Esquimaux & Snowball, 2010). SC3.0 could involve understanding and sharing the seven teachings (Wesley-Esquimaux & Snowball, 2010). As non-Indigenous counsellors work in northern Indigenous communities, it is imperative that they reach out and collaborate with indigenous Elders and community members to gain knowledge and a deeper understanding of these and other traditional teachings (Dupuis-Rossi, 2020). Relationships are highly valued in Indigenous culture and the idea of developing a circle of care is pertinent to Indigenous health and wellness (Dupuis-Rossi, 2020). The circle of care is defined as support from Elders, participation in Healing Circles, ceremonies, drum groups, and other traditional activities (Dupuis-Rossi, 2020). The circle of care helps Indigenous Peoples connect to their culture and develop a positive sense of self, which lead to the safety and stabilisation that is imperative in trauma treatment (Dupuis-Rossi, 2020).

Decolonizing the Stepped Care model requires culturally-safe and trauma-informed care. The seven teachings were referenced in CCPA's Code of Ethics (2020) and counsellors have been encouraged to learn and reflect on these principles. These teachings are considered best practice for Indigenous Peoples therefore should be considered when working with

Indigenous Peoples (Wesley-Esquimaux & Snowball, 2010). These teachings are fundamental in decolonizing Stepped Care 2.0.

Challenges

Decolonizing counselling will be complex. Robertson (2021) explained that integrating Indigenous concepts into research and/or into counselling practices can be extremely complicated. Robertson (2021) identified that many Indigenous concepts are often deep and meaningful constructs that cannot be properly translated into western Eurocentric concepts, and culture is such an abstract idea that cannot be measured or conceptualised. Robertson (2021) stressed the importance of shifting in ways that are appropriate to local culture which accurately represent Indigenous culture and knowledge, and advised clinicians to be mindful of the Indigenous material shared with clients and suggested Indigenous knowledge should come from Indigenous sources such as Elders and local community members. Robertson (2021) also highlighted that, as we move towards decolonizing counselling models, it is essential to collaborate with local Indigenous organisations before integrating traditional practices into the model. This should be done by avoiding any generalisation of Indigenous Peoples and not assuming all Indigenous Peoples share the same worldviews or way of life or have these worldviews imposed on Indigenous clients (Robertson, 2021). This speaks to the importance of collaboration between counsellors and Indigenous Peoples and their communities (Roy, 2023). Collaboration is paramount in the decolonizing efforts of SC2.0. The following chapter will focus on recommendations for counsellors/counselling field.

Chapter Five

This capstone explored how Stepped Care 2.0 can support decolonizing practices in Canadian Communities. Chapter five summarises the findings and presents recommendations for future research, and concludes with a personal reflection. As noted throughout the literature review, there is limited research pertaining to decolonizing counselling and even less research related to decolonizing counselling in northern Indigenous communities. There were various Stepped Care models presented within the fields of counselling and chronic care, illustrating the flexibility of the model. As explained, Stepped Care 1.0 (Cornish, 2020) evolved into Stepped Care 2.0 (Cornish, 2020), which is a systems model for care that is currently being used in Northern Indigenous communities. Counsellors working in the NWT will likely encounter the Stepped Care Model 2.0, therefore it is important that this model becomes common knowledge for current and future counselling practitioners.

Stepped Care has both benefits and challenges. Briefly, the benefits of Stepped Care include the improved accessibility and efficiency of mental health services and shorter wait times (Cornish, 2020). Stepped Care incorporates recovery-oriented principles which fosters service users' responsibility, choice, and resilience (Cornish, 2020). Stepped Care is a strength-based approach and focuses on clients' strengths and skills (Cornish, 2020). Briefly, the challenges of Stepped Care are the limited amount of research regarding decolonized Stepped Care, or Stepped Care for Indigenous Peoples, so it is hard to decide whether SC2.0 meets the needs of Indigenous Peoples. In addition, there is no research indicating this model is trauma-informed and/or can meet the needs of those experiencing intergenerational trauma.

It is important to note that Indigenous Peoples have their own traditional knowledge and there are many individuals and communities that rely on this knowledge for their own healing and well-being (Sylliboy et al., 2021). Indigenous knowledge is valuable and sacred and it is imperative that Indigenous Peoples voices are heard and mental health aids reflect

their values and perspectives. There is a major gap in research pertaining to SC2.0 and culturally-safe programming that incorporates Indigenous worldviews and approaches to mental health care. Counsellors and mental health providers need to consider Indigenous Peoples' worldviews and start shifting their practice to meet the needs of Indigenous Peoples and their communities (Verniest, 2019). Not all counsellors in the NWT will be Indigenous, so it is imperative that all counsellors become familiar with decolonizing and best practices as outlined in the Code of Ethics (CCPA, 2020). The Code of Ethics highlights the importance of counsellors in familiarising themselves with Indigenous values, beliefs, and practices that are pertinent to the community they are serving (CCPA, 2020). In addition, the Code of Ethics suggests counsellors should engage in Indigenous training and, if appropriate, utilise traditional practices (CCPA, 2020). SC3.0 could be designed to embody decolonizing values and to demonstrate that decolonizing efforts can be successful in clinical models and settings. (CCPA, 2020). SC3.0 could promote Stepped Care's rapid access to mental health services (MHCC, 2023). It could also cultivate decolonizing aspects by integrating The Wise Practices which embodies the traditional seven values: courage, honesty, humility, respect, truth, love, and wisdom (Wesley-Esquimaux & Snowball, 2010). These Wise Practices that were referenced in the CCPA (2020) Code of Ethics are integral in efforts to decolonize SC2.0. Decolonizing Stepped Care requires counsellors and scholars to take a critical review of Indigenous worldviews and start shifting clinical practice and approach to meet the needs of Indigenous Peoples in Northern Canadian Communities (Roy, 2023).

Recommendations for Future Research

Indigenous Peoples and their communities have much to offer the counselling field. Indigenous knowledge is valuable and sacred, and it is imperative that Indigenous Peoples take the lead in research to ensure their voices are heard and studies reflect their values and perspectives (Sylliboy et al., 2021). Currently, there is a large body of research supporting

decolonization, however there is limited research pertaining to methods that allow for the decolonization of counselling and even less research related to how counselling can be decolonized in northern Indigenous communities. There needs to be more focus in this area of study. Furthermore, there needs to be research on indigenization in counselling. Indigenization is a relatively newer term which is the process of incorporating Indigenous knowledge, concepts, and practices into post-secondary education, organisations, policies and law (Cull et al., 2018). Indigenization promotes the importance of maintaining respectful relationships with Indigenous Peoples and ensuring Indigenous Peoples are represented and respected within all spaces (Cull et al., 2018). Indigenizing does not aim to replace western science with Indigenous culture and spirituality but to connect western knowledge to Indigenous knowledge (Robertson, 2021).

The literature highlights that the majority of research studies that have been conducted on western individuals, reflecting western ideologies, and this still only represents a small fraction of western society (Koç & Kafa, 2018). Psychology models, techniques, diagnostic tools, and treatment plans typically meet the needs of western individuals (Koç & Kafa, 2018), and do not align well with Indigenous Peoples values, worldviews, and culture. Indigenous Peoples need to be respected as individuals with their own cultural and personal perspectives, interpretations, and perception of normal and abnormal behaviour (Koç & Kafa, 2018). This stresses the importance of Indigenous-led research and expanding opportunities for greater collaborations between Indigenous and non-Indigenous groups and organisations (Koç & Kafa, 2018). Therefore, non-Indigenous researchers have an obligation to inform themselves about Indigenous research processes and must work towards building relationships with Indigenous Peoples (Allen et al., 2020). Indigenous-led research will help counsellors better understand counselling approaches that can best support Indigenous Peoples and their communities (Allen et al., 2020).

There needs to be an increase of collaboration and integration of traditional knowledge and practices when providing health and mental health care services to Indigenous Peoples and their communities (Verniest, 2019). The literature highlights that mental health services are often culturally unsafe and treatment models fail to align with Indigenous worldviews and values, which discourage Indigenous clients from accessing support (Allen et al., 2020). This is a serious issue in the NWT, especially considering that the NWT is home to such a large percentage of Indigenous Peoples (CNEDA, 2020). Indigenous-led health partnerships enhance access to care and improve health outcomes for Indigenous Peoples and communities, which speaks to an emerging theme in Indigenous health literature that culture is the cure; therefore, health interventions need to be representative of traditional knowledge and practices (Allen et al., 2020). Qualitative research is more appropriate and representative of Indigenous voices, understanding that many Indigenous concepts are often deep and meaningful constructs that cannot be properly translated into western Eurocentric concepts or into quantitative research (Tanner et al., 2022). Research needs to be structured in a way that aligns with Indigenous values and methodology, which favours holistic epistemology, is centred around storytelling, is experiential in nature, and honours Indigenous ways of acquiring knowledge and attention to colonial impact (Sam et al., 2022).

Lastly, non-Indigenous researchers or clinicians should never assume the role of expert but should rather present themselves as an ally, which speaks to the importance of anti-racism and anti-colonial research studies (Sylliboy et al., 2021). The literature suggests anti-racism and anti-colonial research is the gateway to motivate structural changes (Sylliboy et al., 2021). There is a need for Stepped Care 3.0 that aligns with Indigenous Peoples and their communities. Indigenous led research is needed to address the health and mental health disparities in Indigenous communities (Roy, 2023). Therefore, Indigenous communities should partake in the development of SC3.0, and there should be a longitudinal study on

SC2.0 that is not conducted by government officials.

The goal is that, moving forward, research will support decolonization efforts by encouraging Indigenous-led research and allowing for this knowledge to influence the counselling psychology field so that it may gradually integrate traditional knowledge in order to create culturally-safe and trauma-informed clinical spaces in northern Indigenous communities. Essentially, counsellors and the counselling field have ethical obligations to repair and reconstruct new relationships with Indigenous Peoples and embark on their own unique path towards reconciliation (Calvez & Cummings, 2022).

Self-Reflection & Conclusions

This capstone heightened my awareness of the complete negligence of culturally-safe and trauma-informed mental health care available to Indigenous Peoples (Allen et al., 2020). The therapeutic treatment model currently in place, Stepped Care, fails to align with Indigenous worldviews and values which often discourage Indigenous Peoples from accessing support (Allen et al., 2020). Indigenous Peoples are experiencing significant mental health disparities, and it is imperative as a counsellor in the NWT to reflect on my clinical practice, and start shifting my practice to meet the needs of Indigenous Peoples. I need to learn and gain a better understanding of Indigenous Peoples worldviews, which will help my ability to provide culturally-safe counselling to Indigenous Peoples (Hart, 2002). This capstone emphasised the importance of using culturally appropriate tools rather than tools derived from euro-centric ideologies (Verniest, 2019). This capstone confirmed to me that Indigenous epistemology has much to offer the counselling psychology field and it is essential counsellors explore Indigenous worldviews. In addition, this capstone was a reminder of the importance of collaboration and I plan to prioritise collaborations with local Indigenous groups in the future.

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