Moving Toward Wellness: A Transformative Approach to Addressing Inadequacies in Mental Health Supports for Indigenous Youth in Residential Treatment Resource

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Abstract

Indigenous youth are overrepresented in the child welfare system in Canada. Organization X, a Ministry of Children and Families program provider, has made significant efforts to address the needs of Indigenous youth in care, including creating the Residential Treatment Resources (RTR) program. While behavioural-focused RTR program is an important step in the right direction, the program fails to address the causal mental health needs, which has resulted in high numbers of recidivism among Indigenous youth after discharge. After careful review of the literature, the possible solutions revealed mental health counselling is a vital supportive resource required for this population. Additionally, counselling must be culturally sensitive, include traditional practices, be client centred, and be collaborative with both the youth and the Indigenous department, which is a part of Organization X. The lens of this organizational improvement plan (OIP) is transformative and centres on marginalized Indigenous youth. The theoretical lens that works in conjunction with this is critical race theory, which examines race, racism, and power. Specifically brought to bear is the critical Indigenous research methodology. The paradigm and theoretical perspective complement the two leadership approaches that will guide the change. Transformative leadership and distributive leadership will motivate and empower stakeholders to actively and enthusiastically engage in the change process. The change implementation plan draws from and is guided by the four steps of Deszca et al.’s (2020) Change Path Model: awakening, mobilization, acceleration, and institutionalization. Also presented in this OIP are plans for monitoring, evaluating, and communicating the change process.

Keywords: transformative leadership, distributed leadership, change path model, recidivism, mental health
Executive Summary

Organization X serves youth who have complex care needs and require specialized treatment. Identified as the problem of practice (PoP) is the high level of recidivism amongst Indigenous youth after completion of residential treatment resource (RTR). Community caregivers, including parents, foster parents, and group homes, are seeing regression in behaviour which can cause community supports to break down. This in turn feeds the cycle of Indigenous overrepresentation in the child welfare system (Giroux et al., 2017). The purpose of the organizational improvement plan (OIP) is to address this concern using secondary research.

Chapter 1 details the organizational context, the responsibility required to care for the most vulnerable population in British Columbia (BC), and articulates the identified PoP. Subsequently, the perspective lens and a primary leadership position are identified. As a change leader with an Indigenous worldview, I crafted the direction of this OIP. Key theories used to contextualize the problem include critical race theory (CRT) and critical Indigenous research methodology (CIRM). CRT deconstructs the Western view (Delgado & Stefancic, 2013), which allowed opportunity for culturally appropriate Indigenous methods of healing to be explored. I present two leadership approaches, transformative and distributed leadership, which I discuss in detail in the OIP. I examine the gap between current practices and the desirable state. Analyzing the problem using a political, economic, social, and environmental (PESTE) analysis tool, I highlight the need for change. I discuss the leadership focused vision for change and explain why Organization X is ready for change.

Chapter 2 explores planning, development, and how I approach leadership. I discuss transformative and distributed leadership and its relationship to this OIP. The five tenets of CRT and four R Strategies of CIRM were used as a framework for leading change. I review Deszca et al.’s (2020) Change Path Model, which I determined to be the best framework for leading change using the five tenets of CRT and four R Strategies of CIRM. I analyze the organization using Nadler and Tushman’s (1989) congruence model. I present four possible solutions and
select one solution, which I determined to be best practice. Lastly, leadership ethics in organizational change considerations are discussed with a focus on transformative leadership and ethics in counselling and applied in implementation of OIP.

Chapter 3 focuses on implementation, evaluation, and communication within the change plan. The change implementation plan looks at both the current and envisioned state. I determine the following OIP goals are attainable: (a) implement mental health services, (b) provide culturally sensitive modalities, and (c) collaborate with stakeholders.

The change implementation timeline is built using Deszca et al.’s (2020) Change Path Model, the five tenets of CRT, and four R Strategies of CIRM. Chapter 3 addresses the importance of understanding stakeholders’ reactions to change and determines which stakeholders will empower the change. Details such as supports and resources required in the implementation process are identified. Monitoring and evaluating the implementation plan is vital; this will be accomplished by using two tools: developmental evaluation (Patton, 1994) and the system’s change evaluation (Latham, 2014). Clear communication is of primary importance to ensure the change implementation plan is executed correctly.

Future considerations focus on adding and increasing counselling once Indigenous youth are discharged into their community. In addition, Organization X may wish to provide this service to caregivers who are struggling emotionally and to all youth requiring counselling services at RTR.
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As I was going to school back home in Tigray, my place of birth, the Ethiopian government was waging a war. My life shifted during this time, as I was confronted with worry for my loved ones and all the people of Tigray. I had to become an advocate for my people. This experience taught me how resilient the people of Tigray are. I also learned how resilient I am. I look forward to helping my people rebuild in Tigray.

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List of Acronyms

ABA (Applied Behaviour Analysis)
ACE (Adverse Childhood Experiences)
AFN (Assembly of First Nations)
BC (British Columbia)
BCACC (British Columbia Association of Clinical Counselling)
BCASW (British Columbia Association of Social Work)
BCPA (British Columbia Psychological Association)
CCPA (Canadian Counselling Psychological Association)
CCU (Complex Care Unit)
COVID-19 (Coronavirus Disease 2019)
CIRM (Critical Indigenous Research Methodology)
CRT (Critical Race Theory)
DL (Distributed Leadership)
MCFD (Ministry of Children and Family Development)
OIP (Organizational Improvement Plan)
PDSA (Plan Do Study Act) Cycle)
PESTE (Political, Economic, Social, Technological, Environmental) Analysis)
PoP (Problem of Practice)
RTR (Residential Treatment Resource)
TL (Transformative Leadership)
TRC (Truth and Reconciliation Commission of Canada)
Glossary of Terms

*Care:* A term used to describe resident services, foster care services or group home services that take on the role of caregiver.

*Clinicians:* Are involved in referral processes, provide direct support in community, and develop treatment plans. Clinicians can have various educational backgrounds from social work and counselling psychology.

*Residential Treatment Resource:* Is a provincially funded facility that supports children 7–18 years of age who have been identified as having complex care needs requiring specialized treatment. Youth stay at residential treatment for a period of 3 months.

*Recidivism:* Community breakdown after youth have been discharged from RTR.

*Staff:* Individuals who work in the Residential Treatment Resource program in various capacities.

*Stakeholders:* Individuals or groups who have a connection to and invested interest in Organization X.

*Youth:* Children who have a continuing care agreement or special needs agreement and are placed in the organization’s care for treatment and support.
Chapter One: Introduction and Problem

Indigenous youth in the child welfare system have been a pressing matter since colonialism. When the Europeans first arrived in the Americas, in what would become Canada, Indigenous peoples were first seen as partners to the newcomers (Denis, 2019). They began as senior partners, becoming gradually equal, and then progressively subordinated. In 1876, Canada adopted the Indian Act, and Indigenous people, perceived as unable to care for themselves, became wards of the Canadian government (Denis, 2019; Smith, 2014). The true intent of this act, however, was the assimilation of First Nations people to European ways (Denis, 2019). The Indian Act (1985) has had a tremendous impact on Indigenous people that is still felt today. Removal of youth from their community and placing them in government care was and is still common practice. In defining Indigenous people in Canada, the Government of Canada (2017b) explained, “Indigenous peoples’ is a collective name for the original peoples of North America and their descendants” (para. 1). Indigenous youth in particular are the focus of this organizational improvement plan (OIP) because Organization X (a pseudonym) disproportionately services this population. Factors causing this will be explored in depth further along in the chapter.

This opening chapter provides a complete look at the problem of practice (PoP). I first examine the structure of Organization X, a residential treatment resource (RTR) program offered by the Ministry of Children and Family Development (MCFD), by looking at the political, economic, social, and cultural contexts impacting services provided to Indigenous youth. This OIP will align the PoP to the vision, mission, and purpose of the organization. I then present my leadership position and lens statement, which has led me toward the PoP. I utilize the critical race theory (CRT) and critical Indigenous research methodology (CRIM) organizational theories to ensure Indigenous voices are centred throughout the report. This chapter also investigates three guiding questions that emerged from the PoP: what services are needed, what change is needed, and how can Organization X incorporate culturally appropriate services during the
change process. I explore the leadership-focused vision for change by discussing the current and future state. Lastly, this chapter reviews the organization’s readiness for change. This chapter also serves to provide the groundwork for understanding Organization X, exploring the PoP, which this OIP addresses, and introducing my position as a change leader.

**Organizational Context**

Organization X was created in 1969 and is provincially funded and under the umbrella of the MCFD. Organization X is an accredited facility offering specialized services to support young people between the ages of 7 and 18 years who have mental health or behavioural concerns. Youth are assessed and placed into one of four specialized programs. The program focuses on improving mental health by providing an assessment and care plan as well as providing direct interventions that address everything from anxiety and depression to suicidal thoughts. The program also provides community-based interventions, wherein staff enter the community to provide support. Lastly, Indigenous programming is woven into the fabric of the organization and its approach.

In 2014, MCFD created an additional program, the RTR, that addresses the complex care needs of youth across British Columbia. The RTR program supports youth between the ages of 7 and 18 years by employing what they refer to as special needs agreements or continuing care agreements. Youth with mental health challenges require a combination of services, including developmental and behavioural supports. The RTR program has been developed to address the needs of youth who have persistent mental health, developmental or behavioural needs that affect their ability to function in daily life. This program develops a positive behaviour support plan for each youth and teaches the community and caregivers how to put the plan in place (Government of British Columbia, MCFD, 2015). The RTR program addresses youths’ needs through behavioural interventions, which is accomplished by assessing situations and consequences related to the problem behaviour and creating programs that target positive behaviour outcomes (Holburn, 1997). This can be done by manipulating identified variables and
controlling the challenging behaviour (Holburn, 1997). The positive behaviour support plan is the vehicle to modify the identified variables by antecedent control, which removes stimulation by adapting the environment (Johnston et al., 2006), creates and implements predictable routines to reduce youths’ anxiety, and often relies on visuals as a tool to explain concepts to youth. Positive behaviour support simplifies applied behaviour analysis that is often rigid and hard to teach to community caregivers with less experience. Another large component of a positive behaviour support plan is support. According to Johnston et al. (2006), support involves increasing “the range of an individual’s activities, and implies that supports can substitute for training or skill development” (p. 56). RTR examples of support include teaching youth hygiene skills, how to clean rooms, make food, friendship skills, and how to be successful in school.

**Political Context**

In 2012, the Government of British Columbia (BC) announced a hiring freeze across all public sectors due to a deficit of more than 1 billion (Fowlie, 2012). Simultaneously, there was also a highly publicized criticism of MCFD by the media around the government’s inability to care for the most vulnerable youth in BC. The highly negative news stories prompted Mary Ellen Turpel-Lafond, the former British Columbia Representative of Children and Youth, to commission a report. The report depicts the MCFD as failing the youth in their care. Mary Ellen Turpel-Lafond’s review of residential facilities and recommendations was the catalyst and blueprint for creating the RTR (Government of BC, MCFD, 2018). Despite the hiring freeze, the provincial government acted and implemented the recommendations.

**Political Context of Indigenous Population**

The creation of the RTR was the result of the politicization of treatment and care of youth in the child welfare system. Children in the BC welfare system are disproportionately Indigenous, and 40% of the Indigenous youth are in residential programs, such as Organization X (Farris-Manning & Zandstra, 2003). In 2018, Indigenous children represented 52.2% of those
in the child welfare system but only accounted for 7.7% of the overall Canadian child population (Government of Canada, 2018). The Assembly of First Nations (AFN) states that negative mental health outcomes result from the removal of Indigenous youth from their community (Aboriginal Children in Care Working Group, 2015). The Aboriginal Children in Care Working Group (2015) stated, “55% of children living out of their parental home in the province are Indigenous. One in five Indigenous children in the province will be involved with child welfare at some point during his or her childhood” (p. 7). Indigenous and colonial relations, intergenerational trauma and failed policies that systemically target Indigenous communities have led to the overrepresentation of Indigenous youth in the child welfare system.

**Economic Context**

Youth in RTR often come from unstable living environments, both in their community and in the child welfare system, such as foster care or group homes. Several factors impact Indigenous youths’ families in RTR; as Banerji (2012) noted, “Indigenous families tend to have lower incomes, less education and higher unemployment compared with other Canadians, while being generally younger and more likely to live in a rural area” (para. 5; see also Tjepkema, 2005). Indigenous families are more likely to live in unsafe, substandard housing, and to encounter shortages in health care (Banerji, 2012). Banerji (2012) went on to state, Historical inequities, cultural alienation and loss of connectedness with the environment, as well as the grim legacy of residential schools, has contributed to depression, to alcohol and substance abuse and associated risk-taking behaviours, and to inadequate parenting skills for some. (para. 5)

These factors have led to high numbers of Indigenous youth in the child welfare system. Indigenous youth who have gone through the welfare system are overrepresented in the justice system (Baidawi, 2020), often due to placement breakdown caused by caregiver inability to manage behaviours. Unstable placements both in the community and in the child welfare system have significant economic costs on various government systems.
Social Context

On a macro level, Indigenous youths’ lived experiences are causing mental health concerns which are gaining recognition as a serious concern for the Indigenous population. Mental health-associated secondary diagnoses that Organization X addresses include: attention deficit hyperactivity disorder, oppositional defiant disorder, and conduct disorder (Mental Health Commission of Canada, 2016). While discussing youth in residential settings congruent with RTR, Caldwell et al. (2020) stated, “It is estimated that between 30–70 percent of youth with developmental or intellectual disabilities also experience co-occurring behavioural and/or emotional challenges” (p. 62). Additionally, research stated that service providers have faulty beliefs about youth with co-occurring intellectual and developmental disabilities and behavioural disabilities. Caldwell et al. (2020) asserted, “These ‘myths’ include: youth with intellectual and developmental disabilities and behavioural disabilities cannot engage in mental health treatment” (p. 62). Other myths include “Standard mental health treatment is ineffective with children with developmental disabilities; behaviour modification is the only option; and IQ scores are static and cognitive improvement is not possible” (Caldwell et al., 2020, p. 64). These myths are a barrier to addressing recidivism.

Cultural Context

On a micro level, the guiding principle of Organization X is to do no harm. This principle and the desire to deliver the best possible service guide the staff at Organization X. Acknowledging the unique needs of every youth has driven the organization to be flexible and constantly improve. As Aitken (2007) noted, “Leadership requires shifting and adjusting based on the clients and organization” (p. 19). Leadership within Organization X, has been able to adapt. Over the 7 years it has been in operation it has evolved significantly. While the organization is hierarchical in structure, a culture of teamwork is valued and encouraged, although not always employed. Currently, all decision making comes down to the director and
senior management. This has resulted in a disconnect between leadership and stakeholders, whose voices within the organization are not being sufficiently heard.

**Vision, Mission, Values, Purpose, and Goals**

The organizational mission, values, purpose, and goals are centred on youth success. Kemp and Dwyer (2003) explained, “A mission statement broadly charts the future direction of an organization” (p. 635). The RTR’s “mission is to assist communities across British Columbia in recognizing and developing their ability to plan, as well as care for children and youth with mental health concerns, including severe mental illness and behavioral conditions” (RTR Staff, personal communication, March 13, 2015). This focus also reflects the values of Organization X (Ozdem, 2011). Moreover, the *Complex Care Unit (CCU) Policy and Procedure Manual* explained, “RTR’s vision is to provide a nurturing environment with sound interventions based on up to date research. Promote, consult, and collaborate with the community and build community capacity to care for the clients” (CCU Staff, personal communication, March 13, 2015). The organization’s purpose is to continue developing and improving various techniques to serve the individual (CCU Staff, personal communication, March 13, 2015). The goal of RTR is to improve the quality of life for youth. The theoretical models of practice used to support this include: “Applied Behaviour Analysis, Positive Behavioural Support, and Complex Care Intervention and are improved by applying social learning theory, attachment theory, and [the] trauma-informed lens” (CCU Staff, personal communication, March 13, 2015). The OIP goals align with the organization’s mission, which is to improve the youths’ overall well-being to ensure a successful outcome after discharge.

**Structure and Practices**

An organization is a planned, coordinated, collective functioning to pursue a common goal (Burton & Obel, 2012). Organization X operates under a hierarchical/vertical framework in which RTR operates through a functionalism paradigm (Barton et al., 2004; Spencer, 1899; Urry, 2000). The origins of structural-functionalism emerged in the 1800s to better understand
society (Potts et al., 2016) and analyze the interdependence of institutions in a particular society (Lessnoff, 1969). Herbert Spencer explained society as body “organs” that work toward proper functioning (Boisson de Chazournes, 2015). When proper functioning does not occur, an institution is dysfunctional because it hampers the success of a function (Lessnoff, 1969).

Functionalism has been utilized within Organization X, while ultimate accountability falls on management. Management must provide services that work and their approach is to use functionalism to reach organizational goals and ensure accountability. Staff also have a role within the function of the organization and must work in concert with management. Northouse (2019) explained, “Management takes on leadership roles because they strive towards reaching goals” (p. 13). Within the organization, leadership is a process of interaction between leaders and followers. Northouse (2019) stated, “The leader attempts to influence followers to achieve a common goal” (p. 6). Northouse (2019) explained, the “role of leadership is to ensure tasks are completed, goals are being met, and the organization operates to its full potential. Leaders display conceptual skills, the ability to work with ideas” (p. 45). Currently, leadership style is autocratic and decisions are made at the top and funneled down, which can lead to disempowering followers.

As identified in Appendix A, the provincial government’s vertical organizational structure is funded by the MCFD. There are three departments in the organization that I will be focusing on, including RTR, the Clinical Team and the Indigenous department. The hierarchical structure of Organization X starts with the director, who oversees the organization, program, and staff. Division of labour is allocated by the director while senior management oversees the various programs, funding, policy, and overall operations. As identified in Appendix B, within this hierarchical framework, there are specialized teams that are the backbone of the OIP. These include the team leader, who oversees the residential care facility; supervisors, who support frontline staff; clinicians, who are responsible for community outreach and creating individual programing for youth; and case workers, who work directly with youth and the Indigenous
department, which provides an Indigenous perspective and brings traditional healing practices to client care. In order to build upon and improve programming in RTR future state, I need to demonstrate a rich understanding of my leadership position and lens, which I explore in the next section.

**Leadership Position and Lens Statement**

As an emergent leader within RTR, I have a responsibility to challenge the program provided to Indigenous youth in order to move Organization X toward a continuing improvement of services. Recognizing and reflecting on historical facts impacting Indigenous youth, systemic racism embedded in structures and practices (Salter et al., 2018) and the impact that racism plays has encouraged me to approach leadership through a social justice perspective. In this portion of the OIP, I describe the historical context in relation to my personal position and worldview, highlighting my position within the organization, and lastly, sharing the theoretical lens to leadership practice.

**Personal Position Context**

The objective of this OIP is to examine the PoP and conclude with possible solutions; for this, I have chosen an Indigenous paradigm. A discussion of this requires a definition of the term paradigm. According to Kuhn (1983), a paradigm is “the set of beliefs, recognized values and techniques that are common to the members of a given group” (p. 238). Ellington (2019) described it as “a worldview that guides the researcher” (p. 31). My worldview in this OIP is informed by the Indigenous paradigm, which is congruent with transformative leadership (TL) and distributed leadership (DL).

Indigenous knowledge has been around for hundreds of years, but only in recent decades has it been acknowledged by those in the Western world as a paradigm (Ellington, 2019). Indigenous worldviews focus on addressing relational accountability, spirituality, and are informed by Indigenous knowledge (Romm, 2018). Stakeholders and I will look at how this OIP can incorporate these ideals in planning. Knowledge is holistic and relational and, therefore, it
cannot belong to one person (Ellington, 2019; Owusu-Ansah & Mji, 2013; Romm, 2018; S. Wilson, 2008). The value of collaborative nature can be honoured through the use of distributed leadership in the planning process. Moreover, Indigenous perspectives differ from the Western view, which separates society. Identifying the problem also includes educating Organization X on new ways of improving services and outcomes. The Indigenous paradigm “conceive[s] the individual as part of an ecosystem, shared with other life forms where nothing is at the top of any hierarchy” (Ellington, 2019, p. 35). I chose the TL and DL leadership approaches because they align with the beliefs of Indigenous worldview and are focused on relationships that can open possibilities for learning and healing to occur.

Recognizing I am not Indigenous to Canada, bias is hard to avoid; I have therefore, chosen to centre the worldviews of the various Indigenous populations to help mitigate unconscious bias. As Cherrington (2018) suggested,

Researchers should not shy away from recognising their influence in shaping the world of which they are part (and not a part); it is this recognition that should prompt them to try to energise action (their own and that of others) in a responsible way, rather than denying that research is already-wittingly or unwittingly- an impactful event. (p. 147)

Acknowledgment of power dynamics at play is a starting point for ethical consideration and will facilitate discussion with Indigenous communities to build trust and reduce power imbalance. Indigenous paradigm moves away from “othering” this community which, S. Wilson (2008) explained can have political, cultural, and social implications. This worldview will help recognize the diversity of Indigenous people and communities (Ellington, 2019) by utilizing their knowledge through relationship.

There are two main reasons for choosing Indigenous paradigms. The first is due to my lived experience and educational background and the second is because of the importance of centring this OIP around Indigenous perspectives. I immigrated to Canada from Tigray as a
child. As a visible minority with English as my second language, I stood out. Growing up I carried the labels of immigrant and black. Navigating different government systems was a complex and often intimidating process for my family. These experiences allowed me to reflect on what it means to struggle, navigate Western systems, and overcome obstacles. Further, how difficult it is to be away from norms and customs that gave me purpose and meaning. I have a sense of the impact of not following my tradition and the empowerment I experience when I have cultural traditions and customs in my life, including being with family. It also taught me compassion for others and their often-unseen battles. I respect the importance of centring Indigenous paradigm, theories in my research from my own experiences of losing my culture when I immigrated and the healing that occurred when I was able to find a Tigray community in Canada. I also find it important to use leadership approaches that align with the community’s views. This culmination of experience led me to social work.

I hold a bachelor’s degree in child and youth care counselling and a master’s degree in social work. Healy (2008) stated, “Social work is a human rights profession which aims to promote equitable social structures that upholds peoples’ dignity” (p. 736). The goal of the British Columbia Association of Social Work (2020) is to advocate for social justice. I believe and follow their social worker’s ethical code of conduct (British Columbia Association of Social Work, 2020), which stated, “Social work should always have the best interest of the child as the focus of professional obligation” (para. 2). In my practice, I am open to different viewpoints and aim to learn from others’ worldviews, which improves my practice. Lastly, I am aware that Indigenous peoples’ experiences with social workers have historically been traumatizing; it is my hope that making relational connections in an effort to understand Indigenous views will open the doors of communication and healing.

This OIP centres the Indigenous worldview in creating the plan in Chapter 2 and the implementation plan in Chapter 3. This worldview is also used to understand the PoP. The
paradigm works well with the theoretical underpinnings of this OIP of CRT and CIRM, which I discuss further in this chapter.

For this OIP, the Indigenous paradigm protects and honours those who are Indigenous to Canada. Further, it provides a lens in which both the PoP, but more importantly, the solution are seen through. In Chapter 1, the Indigenous paradigm is used to explain the PoP and it helped in selecting the theoretical frameworks CRT and CIRM used in this OIP. In Chapter 2, this paradigm through CRT and CIRM is used to understand organization, possible solutions, and the best approach to address change. In this case, the model is not as significant as incorporating the theoretical lens that will help the change to be successful. In Chapter 3, through the use of CRT and CIRM, the Indigenous paradigm guides decisions in the change implementation plan.

**Personal Position Within Organization**

As a change leader within the organization, I have taken on short-term leadership and management contracts as a supervisor within the organization. My role as a case worker is to execute, develop, monitor, and adapt the treatment plan for youth at the RTR. The direct clinical work I implement has allowed me to see both the strengths and areas requiring improvement within the organization. In my current supervisory role, which is middle to upper management, I facilitate and support staff and management. Both of my roles within the organization require leadership and followership (active participant) skills.

For this OIP, I act as a change leader. I will have some influence in sharing ideas with internal and external stakeholders; however, decisions will be made by senior management and the director. I will share the change implementation plan with senior management, director, Indigenous department, and Indigenous stakeholders who along with myself will support the implementation of the change plan detailed in Chapter 3. I have shared my plan to create this OIP with senior management, and they welcomed my research. I have also been in contact with the Indigenous department (comprised of Indigenous identifying staff) staff to request feedback,
which has helped me refine the OIP. As a change leader, I will share the research, explain the problem, identify possible solutions, and make recommendations to senior management; senior management will share information with the director. Once the outline of the plan has been approved by the director and senior manager it will be shared with Indigenous department by senior management, team leader, and I. The Indigenous department will reach out to Indigenous community stakeholders to ask them to review the OIP in collaboration with internal stakeholders, they will make their recommendations, which I have included in the final plan in Chapter 3.

Organization X is highly motivated by improving programs and values collaboration with Indigenous stakeholders. Further, Organization X has relationships with Indigenous stakeholders through relationship building mandates set in organizational policy. This OIP will be welcomed by senior management; however, I anticipate that the OIP will need to be adapted after consultation with Indigenous stakeholders, which is part of the planning and implementation process in Chapter 3. The leadership traits I display that will be beneficial when implementing this OIP include transparency, communication skills, trust, and knowledge sharing, which are aspects of the Indigenous paradigm.

**Personal Values and Transparency**

Taştan and Davoudi (2019) stated, “Transparency ... [is a] critical leadership ... [trait], which strengthens qualification ... and improves ... [an] organisational ethical climate” (p. 291). I view transparency as an ethical approach to solving problems and have operated from the perspective of sharing all the information I have. What transparency looks like in the OIP is communicating the need for the organization to consider what change is required to better support youth.

**Personal Values and Communication Skills, Trust, and Knowledge Sharing**

Communication is vitally important in building trusting relationships. Trust is a foundation for building a productive relationship between followers and leaders (Bjugstad et al.,
2006). I have a strong relationship and sense of trust with the organization’s management team, allowing for the sharing and implementation of new ideas. Organization X values knowledge sharing and two-way communication. It recognises that when employees share knowledge it improves the whole organization (Gerpott et al., 2020).

**Key Organizational Theories**

In this section, I explain the theoretical approaches that inform this OIP. CRT and CIRM are used to both understand the PoP and create the change implementation plan. I share how this pair will enhance and improve the outcome.

**Critical Race Theory**

Race is present in every social configuration of our lives (Morrison, 1992). Perhaps for people of colour it is more obvious. However, to create this OIP, I had to recognize the impact that race has in the lives of Indigenous people of colour. CRT is a revolutionary approach that centres race in research analysis. Although there is no direct methodology, CRT began by identifying race through neutral ideas and equal protection by addressing structures of white supremacy and racism. Critical scholars have proposed ways to transform social structures toward racial emancipation (Parker, 2019).

CRT emerged on the heels of the civil rights and failures of the justice system to support African Americans in the United States (Ladson-Billings & Tate, 2016; Moodie, 2017). Further, between 1970 and 1989, CRT was highlighted by scholars as a call to action to bring racism to attention (Brayboy & Chin, 2018; Delgado & Stefancic, 2013; Mitchell, 2020). However, CRT has changed significantly from the merit-based approach that opposed segregation of people of colour, which asserted the problem could be solved if people of colour were given the same opportunities and seen as the same as white people. This approach, as Parker (2019) explained, was judging people of colour based on their merit rather than the colour of their skin. In the 1980s, the colour-blind visions of race-relations proved to be unsuccessful (Parker, 2019) and led to ignorance because people did not understand what made people of colour unique nor
could they grasp the impact of racism. Scholars argued equality, merits, and colour-blind ideology were in fact leading to racial disparities (Parker, 2019). Elites who held the power excluded people of colour (Parker, 2019), which in fact perpetuated racism and racist ideology. The foundation of CRT was focused on legal studies and evolved to look at issues from other perspectives including in education.

Multiple scholars brought CRT into education including Ladson-Billings and Tate’s (1995), whose seminal article, “Toward a Critical Race Theory of Education,” presented CRT as a framework for exploring race and racism in education. This was a shift in paradigm that allowed a wider use of the framework from other disciplines. CRT scholars have perceived the undertaking of using CRT framework in educational scholarship as complex and multi-layered (Dixson & Rousseau, 2005; Ladson-Billings, 2005; Ledesma & Calderón, 2015; Parker & Lynn, 2002). Applying CRT to Indigenous Canadians is complex and takes on new context when analyzing race and racism manifesting in legacies of colonialism. However, the Indigenous race has various frameworks for supporting the community, which this OIP has the opportunity to incorporate. The goal is to not overtheorize CRT (Ledesma & Calderón, 2015), but rather link the theory to practice.

Bell (1993) shares that racism is a fixture in society and the impact that has on racial power. As such, this framework is imperative to understand the PoP. CRT follows certain principles; some of these include the centrality of race and racism, challenge to dominant ideology, myth of meritocracy, commitment to social justice, and centrality of experiential knowledge (Decuir-Gunby et al., 2018). The centrality of experiential knowledge of Indigenous stakeholders is particularly important for this OIP because it “highlight[s] the importance of voice and focuses on the experiences of People of Color” (Decuir-Gunby et al., 2018, p. 5). CRT studies and transforms the relationship between race, racism, and power (Mitchell, 2020) as well as challenges oppression (Delgado & Stefancic, 2013). This approach aligns with TL, which focuses on social justice, as well as DL, which questions and shifts who holds power. Delgado
and Stefancic (2013) stated, “CRT believes the social world is not fixed and can be changed” (p. 4); therefore, by highlighting the impact of race on Indigenous youth and community, Organization X can find ways to tackle the concern and find meaningful ways to address the solution through CRT.

CRT will be incorporated throughout this OIP and the change implementation plan. Delgado and Stefancic (2013) and Mullins (2016) described CRT as the storytelling of a counter story and deconstructed the Western view. Centring the story of Indigenous youth and community through CRT complements the OIP by ensuring that change is culturally sensitive and through the lens of the community this OIP impacts. Change is possible, and telling RTR’s and the Indigenous youths’ stories will help break down barriers to success. This can be done by talking about racial disparities and cultural norms (Perry & Castro, 2020). Highlighting not only disparities but cultural attributes to support resilience will guide the change process and ensure culturally appropriate planning.

Through CRT, this OIP will ensure barriers of power are removed when suggesting organizational change. One way is to recognize that systemic racism exists in all organizations and is often displayed in unconscious bias or myths (Decuir-Gunby et al., 2018). A second way is recognizing that Indigenous youth have not been given the same opportunities and supports as their non-Indigenous counterparts. The last way is for the organization to understand the oppression of colonialism and the reality that Indigenous youth are placed into child welfare systems at disproportionate numbers due to race and racism. The organization has an obligation to reduce barriers caused by systemic racism within all levels of government, including Organization X. This can be done by providing the comparable services that all youth in BC receive. CRT argues that providing the services required by the Indigenous population, in alignment with Indigenous philosophy, must take priority to ensure complete client support and the reduction of racial barriers to care.
The main criticisms of CRT are that it is rooted in African American context and literature in the past has targeted predominantly this population (Hiraldo, 2010). There is a sentiment of some in Indigenous studies, rightly or wrongly, that CRT devolved to analyzing the Black-white binary (Russell, 2020). However, proponents of CRT argue that it is a valued framework to understand Indigenous context (Russell, 2020). Another concern expressed, as Darder and Torres (2004) explained, is the focus on race as the centre of analysis (Ledesma & Calderón, 2015). While I understand the criticism of CRT centring race, I believe my robust use of this framework within Organization X is required. This OIP examines how race manifests itself in Organization X, even in creating programming for youth. This will provide an opportunity for self-reflection, enabling me to actively engage in issues and change structures to fight oppression. By using CRT as a tool of analysis with Indigenous communities, stakeholders can identify bias and adjust Organization X’s plan accordingly.

Addressing the historical and current factors (Ledesma & Calderón, 2015; Lynn & Parker, 2006) impacting Indigenous youth in the child welfare system, as identified earlier, is the starting point. Further, the goal is to use CRT as a resource to provide space that empowers Indigenous youth, the department, and the community. While I know this is complex, I believe centring the community in this OIP will provide space for this process. The change implementation plan will allow for experiential knowledge (Ledesma & Calderón, 2015), rather than being caught in theory.

It is also important to allow for a counter story to be told that is not dominated by the Western view. This counter story includes how this OIP can be offered, who can help create and implement OIP, and who will assess its success. Further, it is important to allow space for supports to centre around the wishes of community and community leaders including the Indigenous department. Counter stories support social justice, which is my aim as a change leader. It is not enough to include Indigenous voices; stakeholders at Organization X will need to critically reflect and learn that the structure in which they work has contributed to the
oppression. Matias (2013) explained this can be done by understanding the impact of whiteness and actively dismantling the structures, which in this case includes those that have impacted the Indigenous youth at Organization X. This OIP uses the five tenets to guide research and inquiry on equity and racial justice (Solórzano & Bernal, 2001), a prominent guide for scholars of CRT, which I speak about in depth further.

**Critical Indigenous Research Methodologies**

The second theoretical approach I use is CIRM. When conducting qualitative research, CRIM asks questions like, “What are the kinds of things that are important for the conduct of social action in this local community of social practice?” (Brayboy et al., 2012, p. 6). In other words, what is important to this population? However, researchers cannot look at Indigenous people as a collective; rather, they must ask what makes each community unique. Indigenous methodologies were created because of a vacuum left by Western methods. Qualitative inquiries during the 1970s to 1980s explored new methods (Denzin & Lincoln, 2008), which led scholars to delve into Indigenous knowledge.

Studying an Indigenous worldview in writing was complex because it required a shift from oral traditions to the Western perspective of written research (Brown & Strega, 2015), which does not align with traditional methods. In her 1999 book *Decolonizing Methodologies*, Tuhíwai Smith founded Indigenous methodologies; however, the book did not focus on a specific research method (Walter & Suina, 2019). Two decades since Tuhíwai Smith’s work, Indigenous methodological scholarship has been primarily associated with qualitative research (Walter & Suina, 2019). Qualitative research and Indigenous methodology complement each other, thereby making it the dominant approach when conducting research impacting Indigenous people. Philosopher Dilthey (1989) explained, qualitative research can be used “to describe an individual’s first-person perspective on his or her own experience, culture, history, and society” (Brayboy et al., 2012, p. 6), pushing scholars to be more reflexive on the impact of their worldview in research.
Over time CIRM emerged, and it is now seen as vital in conducting research on Indigenous populations. Leading voices on CIRM include Tuhiwai Smith (1999), Brayboy (Brayboy & Chin, 2018; Brayboy et al., 2012), Kovach (2015), Wilson (2008), and Singer (2020). Through CIRM, these scholars reflect on how others recognize and actively diminish processes of power, including colonization, assimilation, whiteness, capitalism, and other oppressive forms of government systems, from health care to schools (Brayboy & Chin, 2018; Brayboy et al., 2012; Kovach, 2015; Singer, 2020; Tuhiwai Smith, 1999; Wilson, 2008). This approach to scholarly work actively addresses social injustice from an Indigenous lens. Indigenous researchers sought research methods that fought against colonialism and would not harm their community. Western scholars also searched for methods that were ethical and aligned with Indigenous approaches by considering factors such as cultural values (Kovach, 2015).

CIRM scholars all agree Western approaches to research continue to fail Indigenous communities. Brown and Strega (2015) correlated it with whiteness. Evans et al. (2009) explained, “Indigenous methodology can be summarized as research by and for Indigenous peoples, using techniques and methods drawn from the traditions of those peoples” (p. 4), which is the underpinning of this method. The CIRM method is a denunciation of Western research, which Brown and Strega (2015) explained as political. Scholars must be comfortable with the reality that research is political and with that will come criticism both favourable and unfavourable. Research organizations in Canada such as national research funding agencies understood the importance of including Indigenous communities in all aspects of research, including moving results into transformative action (Evans et al., 2009). One example of centring Indigenous communities in research by Aboriginal Capacity and Developmental Research Environments (ACADRE) and nationally funded centres across Canada. The ACADRE supports research by and for Indigenous populations while providing opportunities for Indigenous and non-Indigenous scholars to work in partnership when collaborating with Indigenous communities (Evans et al., 2009). ACADRE, along with other scholars, have
emphasized four Rs of research when engaging with Indigenous communities: respect, relevance, reciprocity, and responsibility (Evans et al., 2009), which I discuss further in Chapter 2. This approach to research fosters connections between researchers, communities, and the topic of inquiry.

When creating resources and support services for Indigenous youth in RTR it is essential that approaches are embedded in Indigenous knowledge. Deloria (1969) stated, “Indians are like the weather. Everyone knows all about the weather, but none can change it.... One of the finest things about being an Indian is that people are always interested in you and your ‘plight’” (p. 1). This powerful statement by Deloria began my journey as a researcher, leading me to ask how I could provide research that did not intentionally or unintentionally attempt to change Indigenous people and communities. Rather, I sought to provide research that centred Indigenous ways of being and knowing that would light that path of this research forward, which brought me to CIRM. While there are no straight definitions of what constitutes a CRIM, there is an appreciation of how and in what ways Indigenous scholars have initiated to critically address the need for Indigenous-based research and practices (Brayboy et al., 2012). For CIRM, the starting point is with Indigenous people (Lincoln, 2008), and that is the starting point of the PoP. As a change leader, I am committed to upholding the four Rs in supporting Organization X examine the problem as well as in creation of the change implementation plan.

I have to acknowledge that I had concerns about using CIRM, wondering if I have a right to use this method at all. I wondered if I knew enough about Indigenous culture to do justice by this methodology and the OIP in general. However, I came to understand that CIRM is used for various reasons. Singh and Major (2017) explained two kinds of people undertake Indigenous research: Indigenous researchers who have grown in Indigenous cultural knowledge and connections and non-Indigenous researchers conducting research in Indigenous communities. I am the latter, and rather than conducting research in community, Organization X along with my leadership will work with Indigenous communities. Organization X is dedicated to the welling
being of the youth in its care. While I recognize that I cannot fundamentally ground my research in Indigenous knowledge, I do present Indigenous ways of knowing through careful and respectful consideration of understanding the concerns impacting Indigenous youth in RTR through the use of the four Rs of the CIRM.

Indigenous issues and respecting community are important to me as a person of colour. Given that I am a person of colour who is also a product of colonialism, I also understand the impact when communities outside my own attempt to support, positively or negatively. I am not Indigenous and, therefore, I will need to ensure I centre Indigenous voices in my OIP. It is my hope that by working with the Indigenous department in Organization X, the youth, and the community through this OIP, these groups will be able to identify my shortcomings due to my worldview and adapt the OIP to safeguard the integrity of the community. While I have created the OIP, I will accept that changes will be made based on guidance from the community. Deloria (1969) spoke about Indigenous people reclaiming their intellectual lives, which will allow for development of practices that are guided by beliefs, actions, and experiences. I also acknowledge that this research is not looking at the envisioned state as the answer; rather, it is a starting point for more changes to be made. Further, Brayboy et al. (2012) explained, “[The] CIRM approach is driven by service and is tied to well-being, rather than an approach that views knowledge accumulation as the end goal” (p. 435).

This OIP should not be viewed as the end goal; RTR will continue to support Indigenous youth and continue to build on improving the program to meet community needs. Thus, CIRM requires researchers to conduct research rooted in transformative processes that support communities, which can continue to meet their requirements (Brayboy et al., 2012). Further, Indigenous knowledge is centred on a transformative lens (Denzin et al., 2008, p. 2), helping RTR move past the boundaries of Western ideology in the pursuit of support that aligns with Indigenous teachings. Organization X will take the lead from the Indigenous department and the community to determine what sections of the OIP to keep and what requires adaptation.
This OIP will be a living document that will adapt based on need. While that might be an uncomfortable place for research, it is required to protect ethical practice.

The limitation is not the theory itself; rather, it is me as the change leader not identifying as Indigenous to Canada. The literature is also clear on the idea that a community’s needs are best assessed by the community itself (Brayboy et al., 2012, p. 435). Incorporating Indigenous ways of being in a Western context is complex; the researcher must pay attention to the discomfort of creating work that fits into academic frames and provide work that aligns with Indigenous worldview (Brown & Strega, 2015).

While improving services is beneficial to Organization X, the purpose of the change implementation plan will centre on how the change benefits the youth and their community. This will be done by critical reflection of the change implementation plan, ensuring it meets the standards of CIRM (Singh & Major, 2017). I will ensure self-determination is safeguarded throughout the change implementation plan by drawing on the knowledge and experiences of the community.

**Critical Race Theory and Critical Indigenous Research Methodologies**

CRT and CIRM are two intersecting ways of ensuring research looks to those who have been marginalized or hurt due to race and colonialism (Brayboy et al., 2012; McKinley et al., 2019). It is my hope that this OIP will support and place at the forefront community relationships and interests. I merge the two approaches to deepen understanding of the complexity as well as best practice when working with Indigenous communities. I use the five tenets of CRT to guide research and inquiry on equity and racial justice (Solórzano & Bernal, 2001) and the four Rs of respect, relevance, reciprocity, and responsibility (Evans et al, 2009). Both these approaches will be explained further under frameworks for leading change in Chapter 2.

The CRT and CIRM are woven through the OIP to not only mitigate unconscious bias but also to support best practice when addressing the PoP and possible solutions. The next section
examines guiding questions that emerged through the PoP. The two leadership lenses I use to guide my OIP are TL and DL. These approaches are congruent with my transformative worldview, CRT and CIRM.

**Transformative Leadership**

Burns (1978) identified transformational leadership and later helped introduce TL into the world. This leadership approach is congruent with my paradigms as it is grounded in justice and democracy. This leadership style analyzes inequitable practices and offers the promise of a better life for all (Shields, 2010). I have worked for the RTR since its inception. While the organization is hierarchical in structure, this OIP will strive towards creating leadership that is open to new ways of functioning.

One of the most valuable internal and external voices are emergent leaders, with firsthand knowledge of what works. According to Montuori and Donnelly (2017), “Transformative leadership is, at its heart, a participatory process of creative collaboration and transformation for mutual benefit” (p. 3). TL allows emergent leaders, such as myself, the space to lead and, more importantly in the context of Indigenous matters, to collaborate. In my role as a case worker and supervisor, I have observed the inequitable treatment of Indigenous youth who often do not receive the support they require. I have personally seen youth being treated only for behaviour concerns when they required additional supports. As a supervisor and social worker with a depth of experience who has cared for the most vulnerable in various settings for more than 15 years, I have firsthand knowledge of the impact of both providing or not providing the required services. My vast experience has aided me in my own identity development (Bruce & McKee, 2020).

In my current role as supervisor, I assess youth, create specialized programs to address youths’ identified problem behaviours, advocate for youth in clinical meetings and with other stakeholders, recommend courses of action, and implement and adapt programs for youths’ 3-month stay and support overall operations of RTR, including overseeing staff. I also educate
and train community members in how to duplicate the program in community settings. In particular to Indigenous youth, my role includes building community connections and facilitating and joining in Indigenous programming, both with the Indigenous department as well as in community. TL is not hierarchical, allowing space for relationship building (Bruce & McKee, 2020) with Indigenous communities, which has allowed for relationships and connections to be created. I believe I have a trusting working relationship with Indigenous department and open communication is ongoing. Due to my experiences in client care and supervisory roles, I found the gap in youth supports to be apparent.

Later, I will deconstruct how providing proper support to youth could vastly reduce recidivism (Shields, 2010, 2012). While deconstruction is one portion of analyzing social and cultural knowledge that is the cause of inequity (Shields, 2010, 2012), reconstructing new knowledge will support resiliency and provide needed change. When working with Indigenous communities, it is important to enter spaces with openness to learn; I know change in mindset is a strength not weakness (J. Chapman, 2019). In line with TL, I am dedicated to continuing to learn while participating in allyship, advocacy, and activism (Bruce & McKee, 2020). TL fits my leadership philosophy; as a social worker, I determine success by removing barriers for youth, allowing space for youth to live a full and healthy life. The Indigenous paradigm has allowed for the right theoretical lenses, CRT and CIRM, to be implemented to support RTR to address PoP and find best outcomes to address the problem.

**Distributed Leadership**

In this OIP, distributed leadership (DL) is defined as expanding past formal leadership (Bush & Glover, 2012) to include internal (youth, staff, management, Indigenous department) and external (caregivers and Indigenous communities) stakeholders. According to Spillane (2005), “Distributed leadership is first and foremost about leadership practice rather than leaders or their roles, functions, routines, and structures” (p. 144). According to Spillane, “Leadership practice is [often] viewed as a product of the interactions of leaders, followers, and
their situation” (p. 144). This point is particularly important because it suggests knowledge is gained through interactions rather than expert voice. DL attempts to move away from conventional roles of hierarchy (Chatwani, 2018) in which one person holds power (Burke, 2010). DL sees leadership as a social construct; not something done to an individual, but rather a group that works through and within relationships (Chatwani, 2018). DL moves from an individual’s actions to group actions (Bolden, 2011), allowing for collaborative decision-making (Heck & Hallinger, 2009; Muijs & Harris, 2006). According to Chatwani (2018), DL “questions power and who makes decisions and how organizations are governed” (p. 28). DL sees leadership as a collective social process, a more holistic approach (Chatwani, 2018). Discussing, Spillane’s (2005) work, Tian et al. (2016) argued leadership is “generated from interactions” (p. 11). Rowland (2018) stated, within this approach, “diversity in perspectives is encouraged” (p. 170). Organization X has operated from the approach that management knows best.

My leadership approach moves away from roles of hierarchy in an attempt to utilize the extensive knowledge base and education within RTR and Indigenous community. During the process, stakeholders will collectively hone in on the plethora of experiences staff and management have and distribute leadership equally among the various stakeholders, which will mobilize the best outcomes in addressing the OIP, because DL contributes to organizational growth (Harris, 2011). As a change leader, I centre collaboration with all stakeholders. This includes senior management staff, caregivers, and in particular Indigenous communities and youth. This OIP will address concerns through cultural understanding and, therefore, will require a collaboration ethos that shuns separatist perspectives (C. M. Wilson, 2014); as such, this approach is also congruent with TL. DL properties, including interdependence, meaning reciprocal dependence of two or more people (Gronn, 2002) and coordination, encompass “the design, elaboration, allocation, oversight, and monitoring of the performance of an organization” (Gronn, 2002, p. 433). It is equally important to understand how interactions occur and how to reach goals through interactions. DL supports organizational improvement
With DL, both internal and external stakeholders can work in relationship to create and implement the OIP.

DL also aligns with Indigenous traditions of collective contribution in leadership. Mishibinijima (2007), the nation of the Ojibway people of Canada, gives an example of using DL in their community; they use what they call conductors. This group is responsible during their expeditions of hunting or fishing, because this group has the highest skill set in this area. All planning and decision-making was done on a collective council level, similar to DL (Mishibinijima, 2007). Collective investment in finding solutions to PoP, builds on the universal belief in Indigenous culture and gives the voice to an often silenced community. It is no longer acceptable practice to tell community members what is best. Self-determination means Indigenous communities are in every process of resolving problems and finding solutions. DL has multiple leaders depending on subject matter (Diamond & Spillane, 2016; Spillane, 2005); when addressing Indigenous youths’ needs, it is paramount that community members engage and take the lead. This OIP provides a blueprint; however, changes will likely be needed based on community recommendations. This Indigenous approach of togetherness will be for the betterment of the organization and adds a wealth of diverse ideas. More importantly, it shifts from a top-down approach to an equitable one that supports Indigenous people. It is important to recognize that damage can occur when Indigenous people are not part of and leading the change.

This section discussed my leadership position and lens statement, including the historical context of my personal position, the role I hold within the organization, and an exploration of TL. The next section discusses the leadership PoP.

**Leadership Problem of Practice**

The PoP I will address is the high level of recidivism amongst Indigenous youth in the RTR program. Currently Organization X’s treatment plan focuses on behavioural intervention strategies without addressing other factors, which are often the underlying cause of the
behaviour youth display. Organization X currently has no services available for Indigenous youth in the RTR program that target recidivism. Addressing recidivism is urgent because Indigenous youth in the organization are one of the most vulnerable groups in BC.

Unfortunately, there are little data on Indigenous youth in the child welfare system and their rates of recidivism. What is known, despite limited data, is “that trauma resulting from ongoing colonial distress has been passed down through generations to Indigenous children” (Carriere et al., 2019, p. 9). Giroux et al. (2017) noted, “Government policies and programs, including the Indian Act and the residential school system, contributed to increased prevalence of mental illness, intergenerational trauma, Indigenous overrepresentation in the child welfare system” (p. 5).

Organizations must take a transformative approach to the health of Indigenous people and prioritize a wellness strategy (First Nations Health Authority, 2018). There are a multitude of factors that have contributed to Indigenous youths’ rates of recidivism in Organization X. The question remains, what support is needed to reduce recidivism and increase Indigenous youths’ success after discharge? For Organization X, success will mean once Indigenous youth are discharged from the program they are not re-entering RTR for additional supports because the program will have met their complex needs. Success for the community will mean that Indigenous youth stay in their community and are supported by family and community. This goal is congruent with the calls to action in the Truth and Reconciliation Commission of Canada (2015) report to have fewer Indigenous youth have contact with the child welfare system.

**Relevant Gap Between Current Practices and Desirable State**

In the 7 years since RTR has been added as a pillar of support for youth in Organization X, concerns have remained regarding the number of Indigenous youth who revert back to treated behaviours after leaving the program. The Government of BC, MCFD’s (2018) goal “is to address the root cause of the over-representation of Indigenous children in care” (para. 3), as shown in Appendix C. The Truth and Reconciliation Commission of Canada (2015) has called on
the child welfare system to “provide adequate resources to enable Aboriginal communities and child-welfare organizations to keep Aboriginal families together where it is safe to do so, and to keep children in culturally appropriate environments, regardless of where they reside” (p. 1). Currently, the resources RTR provides are applied behaviour analysis (ABA) and positive behaviour support plans. O’Reilly et al. (2016) explained,

ABA studies the behaviour of children and (the) positive behaviour support plan is the assessment and treatment of difficult behaviours. The positive behaviour support plan does this by restructuring and changing the environment, increasing prosocial and adaptive behaviours that may improve quality of life.

(p. 241)

The RTR program has allocated time and resources to Indigenous youth wishing to spend time with an Indigenous cultural worker; however, this support is limited. During this time, the Indigenous youth learn about their history, practices, traditions and more. Shepherd et al. (2018) suggested, “Strong cultural identity has been found to promote resilience, improve self-esteem, foster pro-social coping styles and ... [is] a protective mechanism against mental health symptoms” (p. 2). However, the current allotment of 10 hours a week for all Indigenous youth is insufficient.

In the desired state, RTR youth would benefit from additional support that targets recidivism. RTR would benefit from providing youth an opportunity to spend time with clinicians who can provide holistic clinical support and address concerns that are not resolved through current practices. Clinicians would provide clinical support in consultation with Indigenous cultural workers, who are Indigenous and provide cultural teachings. This will reduce the prevalence of untreated mental health problems (Etter et al., 2019). Health Canada has stated that the high rates of adverse mental health and suicidal concerns in Indigenous communities is of grave concern and should be top priority (Etter et al., 2019). These supports should include individualized modalities targeting recidivism while providing culturally relevant
experience. Relevant means, depending on the youth, their lived experiences, the location of the youth’s band (which refers to where their ancestors originated) and their knowledge about their own cultural identity; the support plan would need to shift.

For individualized plans to be effective, staff would require cultural competency training specific to Indigenous youth. Providing these additional supports for Indigenous youth could be the missing piece needed to improve the youth’s chance of long-term success. Behavioural intervention is still required, however; due to the complex care needs of youth, adding support to address other factors including mental health will further improve supports and successful outcomes. Lastly, collaboration with the Indigenous department within the organization and the youth’s community will ensure the Indigenous lens and perspective is the driving force for healing. This section explored leadership PoP. The next section discusses how the PoP is framed.

**Framing the Problem of Practice**

To fully understand the problem I will review the historical context in relation to both the impact of colonization on Indigenous people, as well as an overview of the RTR historical context.

**Historical Overview of Colonization**

The Government of Canada (2017a) stated, “Indigenous peoples occupied North America for thousands of years before European explorers first arrived on the eastern shores of the continent in the 11th century” (Part 2, para. 2). Pre-contact describes a thriving community (First Nation Health Authority, n.d.). Pre-contact refers to a time before Europeans arrived. The First Nations of Canada enjoyed an active lifestyle and a healthy traditional diet which supported good health (First Nation Health Authority, n.d.). Traditional healing was understood and utilized by all, which supported their dense and diverse population (First Nation Health Authority, n.d.). The first people of Canada include the Aboriginal, Inuit, and, after contact, Métis. After contact, which refers to the earliest recorded contact between First Nations and non-Aboriginal people, occurred in the late 1700s (First Nation Health Authority, n.d.), the
impact of colonization cannot be understated. Appendix D provides an overview of historical factors impacting Indigenous communities. Colonialism through policies has impacted all areas of Indigenous peoples lives in Canada, including social-economic, equality, access to services including health care, education, employment and housing, traditions, culture, and customs (MacDonald & Steenbeek, 2015). European colonists who desired access to Indigenous land used treaties and reserves systems as policies and formal structures that have served to segregate and oppress Indigenous people.

For the purpose of this paper, I highlight three factors that impact youth in the child welfare system. First was the residential school system, the purpose of which was to assimilate Indigenous children and youth (Barker et al., 2019). Second was the 60s scoop, in which Indigenous children were apprehended by Canadian child welfare agencies and placed in non-Indigenous homes (Barker et al., 2019). Third was the millennial scoop, in which high numbers of Indigenous children were placed in foster care, refusing parents the right to raise their own children, again with the purpose of assimilation (Kwantlen University, n.d.). These histories are identified in Appendix D.

**Historical Overview of RTR**

RTR was created to address a demographic of youth not yet supported by Organization X. Before the creation of this program, communities were struggling to support the most vulnerable youth in BC, who were often Indigenous, due to complex behaviour concerns. These youth were ending up in the criminal justice system and institutional or hospital settings. Often their behaviours caused breakdowns in their homes, which resulted in a transfer to specialized non-profit residential homes. Despite moving to specialized residential homes, this demographic was still struggling, and residential organizations and staff were unable to manage the complex behaviours displayed. Youth were often transferred to multiple placements due to lack of knowledge and resources. This was the impetus for the creation of RTR, which was established to address the complex care requirements of youth whose differing needs were not
being addressed. Since the creation of the program, RTR has supported hundreds of youth, both in RTR and in the community.

The RTR is a six-bed treatment facility. While the RTR has had significant success with youth, they have found that they are unable to treat the full complement of six people at once. Therefore, the program has been functioning at a very limited capacity with a long wait list. Currently, the RTR is only able to take up to three youths at a time, with only one or two being complex cases. Complex cases include individuals with extreme behaviour needs, multiple diagnoses, medication requirements for mood stabilization, difficulty regulating emotions, and tendencies toward being physically violent. These complex cases require external regulation (in the form of a staff member) to support them throughout the day. What is difficult to explain to governmental officials, who are not satisfied with RTR serving only half of the anticipated number of youth, is how the complexity of each case and the level of clinical care and consideration that each youth requires impedes RTR’s ability to service six youth at once. Furthermore, RTR is fielding requests from the outside community to readmit previous youth for further support due to regression in behaviour.

**PESTE Analysis**

The PESTE analysis is useful for assessing the “relative importance of all of the factors and sub-factors” (Yüksel, 2012, p. 65) of a given project. In the subsections that follow, I discuss the political, economic, sociocultural, technological, and environmental contexts of the OIP.

**Economic Context**

Not addressing recidivism is a concern on many levels, including the economic consequences for society. When not sufficiently supported, youth are much more likely to end up in the criminal justice system, the hospital system or back in the child welfare system. The best way to avoid the first two interactions is to reduce the number of young people in the child welfare system by allowing Indigenous communities their right to self-determination (Bamblett & Lewis, 2007). This means supporting Indigenous youth in “reconnecting with homelands,
cultural practices, and communities, and ... reclaiming, restoring, and regenerating homeland relationships” (Corntassel & Bryce, 2011, p. 153), which is the foundation of CIRM.

However, because of the complex behaviours these youth can exhibit, they often spend significant time in government care, which is both costly and, more importantly, damaging to the well-being of the youth. Unfortunately, there are budget constraints being felt in the public sector due to the coronavirus disease 2019 (COVID-19) pandemic. RTR was under review in 2020, and many members of the organization were concerned that program auditors would not understand the challenges and costs of running the program or its importance. Fortunately, the review did determine that the program was exemplary; however, recommendations were also made to expand services and increase the number of youth served.

**Social Context**

Political factors have had a serious impact on the social reality of Indigenous youth throughout Canada, in particular the youth of Organization X. Due to the negative impacts of colonization, Indigenous youth’s quality of life has decreased (Ball, 2008). Colonization has caused adverse childhood experiences (ACE). The visual in Appendix E shows the impact of ACE (Felitti et al., 1998; Whitters, 2020). ACE refers to the negative factors in childhood that lead to negative health outcomes, including lack of basic needs, lack of proper housing, inadequate education, mental health concerns, abuse and neglect. When youth enter the RTR, they bring with them not only intergenerational trauma caused by residential schools but also current trauma. Hamburger (2018) found that different cultures experience social or cultural trauma specific to the community whether the person experienced the trauma firsthand or vicariously or as intergenerational trauma. Currently, RTR is failing to address the underlying trauma caused by living in an oppressive system. In order to break the cycle of recidivism, youth should be empowered to understand the underlying causes of their displayed behaviours and the impact of colonization in alignment with CRT and CIRM.
**Cultural Context**

Indigenous youth and particularly those in RTR are at greater risk of mental health concerns. Youth served by the organization differ; D. P. Chapman et al. (2004) explained, “A large population have faced physical, mental or sexual abuse which cause various health problems including depressive symptoms” (p. 218). Duppong Hurley et al. (2009) noted 43–93% of youth in residential programs like RTR have mental health concerns. If these issues are not addressed, youth who have had two or more adverse experiences in childhood will be at increased risk of homelessness, illness, and early death when they age out of the child welfare system (Rebbe et al., 2017). Alarmingly, Underwood (2011) emphasized, “Youth in care are 17% more likely to be hospitalized in BC than the general population” (p. 3). These statistics are a reality for RTR clients and impact youths’ well-being. This section discussed the framing of the PoP. The next section delves into key organizational theories.

**Guiding Questions Emerging from the Problem of Practice**

Organization X has seen high numbers of youth regress after discharge from the RTR program. Concern around Indigenous youths’ success rates after discharge has led to asking the following three guiding questions and lines of inquiry:

**What Services Should be Accessible to Indigenous Youth in RTR to Increase Desirable Behaviour?**

Preyde et al. (2011), who studied outcomes of youth in residential programs, found those with complex needs who received mental health supports were successful a year following discharge. Not all agree with this conclusion, as explained by Leichtman (2008), who said the reason RTR has not shown to have a long-term positive effect on youths’ adaptive skills is because of inadequate post-discharge planning and connection to the community. Preyde et al. (2011) disagreed and explained, “Longer term adaptive skills are possible and regressive behaviours of children do not have to be the outcome after discharge, with mental health supports” (p. 2). Research attained through standardized measures of psychosocial functioning
children in RTR found that mental health improved three years past discharge (Preyde et al., 2011). Providing mental health support in RTR is imperative; RTR “is unique and often the only multi-service program for youth with moderate to severe mental health problems that has capacity to provide this service” (Preyde et al., 2011, p. 2).

**Does Change Need to Occur Within the RTR to Provide an Environment Where Indigenous Youth are Successful After Being Discharged from the Program?**

Youth in RTR are found to display higher clinical needs (Knoverek et al., 2013). Indigenous youth in the RTR setting have experienced a great deal of trauma. The number of traumatic events youth in RTR are exposed to is significantly higher; 5.8 in contrast with 3.6 of youth not in RTR (Knoverek et al., 2013). Indigenous youth in RTR are particularly affected by trauma in connection to race. Trauma is impacted by a wide variety of cultural indices including social and cultural realities. Youth with minority backgrounds are at heightened risk of trauma exposure and post-traumatic stress disorder (Caldwell et al., 2020). While the need for support is apparent, few youth in RTR are assessed and fewer are referred for treatment (Knoverek et al., 2013). RTR is often too focused on the behaviours of youth, rather than looking at what is causing the behaviour in the first place.

Research indicates intervention should recognize the psychosocial development that has been impacted by trauma (Knoverek et al., 2013). Research indicated a need for diverse therapeutic treatments that are culture-infused and involve providing traditional methods of healing (Brady, 2015). RTR should aim to provide culturally sensitive mental health modalities to prevent the continued oppression of Indigenous peoples (Brady, 2015); however, this has yet to be added to the scope of support provided. Culturally relevant therapy has been shown to reduce oppression through addressing issues such as racism and injustice (Bowden et al., 2017). Indigenous clinicians should be hired, and Indigenous youth should take lead in counselling to empower Indigenous voices (Brady, 2015). It is also important to recognize that elders have knowledge to share which Indigenous youth can gain from.
Culturally Appropriate Strategies to Help Indigenous Youth in RTR Address Mental Health Concerns

Greenwood and de Leeuw (2012) stated,

Colonial legacies are, thus, determinants impacting Indigenous children’s lives and can only be accounted for by applying a social determinants \([\text{sic}]\) of health lens that is inclusive of multiple realities and considerate of Indigenous peoples’ distinct sociopolitical, historical and geographical contexts. (p. 382)

Social determinants look at a broad range of factors in Bronfenbrenner (1979) systems theory; including microsystem (immediate environment), mesosystem (connections), exosystem (indirect environment), and macrosystem (social and cultural values). Indigenous mental health practices provide a holistic framework, recognizing the well-being of mind, body, spirit, and emotions (Carriere & Richardson, 2012). Health and well-being for Indigenous youth entails a holistic approach to health. A holistic approach moves beyond biomedical realms and instead, addresses social determinants (Carriere & Richardson, 2012). Clinical techniques require flexibility, addressing historical and current determinants while including decolonizing strategies (Greenwood & de Leeuw, 2012). Social determinants of health must underpin mental health interventions with the goal of enhancing Indigenous youth’s health and well-being (Greenwood & de Leeuw, 2012). Lastly, Greenwood and de Leeuw (2012) explained, “Interventions should not target individual behavioural change or focus solely on proximal determinants of child health” (p. 383). Instead Greenwood and de Leeuw (2012) proposed employing strategies that are culturally appropriate in order for both clinicians and youth to understand the social and historical context Indigenous peoples find themselves in. Distinct knowledge exists within Indigenous communities, and engaging with those communities is necessary in order to provide appropriate support (Greenwood & de Leeuw, 2012). These may not be conventional mental health supports, as they rely on community knowledge and traditions.
Leadership-Focused Vision for Change

This section will discuss the present state and the OIP envisioned future state of the organization, identify priorities for change and lastly, identify change drivers within Organization X.

Present State

Indigenous youth often have promising outcomes during the start of their treatment program; unfortunately, during the end of their stay, and even more commonly after discharge, a high number of youth regress in behaviour. The regressive behaviour leads to further contact with the child welfare system. Child welfare systems continue to intervene in the lives of Indigenous families in Canada at a rate greater than any other population in the country. “Currently there are more Indigenous children in government care than there ever was in the residential schools era” (Greenwood & de Leeuw, 2012, p. 382). Connection to the child welfare system is often traumatic. Stewart and Marshall (2016) explained how “trauma has been shown to impair the health of Indigenous people” (p. 77). Mental wellness is fundamental to the overall health of Indigenous youth (Stewart & Marshall, 2016), yet it remains unfilled in current RTR practices.

What is apparent is that the current practice of providing behavioural intervention is not substantial enough to meet the complex care needs of youth in RTR and reduce recidivism amongst Indigenous youth. Behavioural intervention is one approach that focuses exclusively on the surface and this OIP aims to improve the present state of care and ensure the success of youth after leaving the RTR. Behavioural interventions have a place within organizations; however, Organization X will need to add on to the services to provide a holistic approach to care. Services don’t have to be one or the other. Organization X knows through its data and research that behavioural intervention has some success; however, Organization X cannot assume a one-size-fits-all approach to care. This OIP reveals, due to the various mental health concerns and needs of Indigenous youth, targeting mental wellness must be included within
overall support plans. The program’s culture is stuck on the assumption that “that’s the way things are done,” rather than recognizing there is a problem that needs to be addressed.

This OIP challenges the status quo and provides new and culturally appropriate ways to additionally support youth well-being and success after discharge through CRT and CIRM lenses. Providing behavioural support should not stop Organization X from providing mental health supports. Currently, a significant number of youth regress in behaviour and community breakdown is occurring 1 to 3 months after discharge. Community members are asking for youth to return to the program for additional support. However, youth going in and out of care multiple times is a sign that the program needs to evolve and adapt. Further, being moved has a traumatic impact on youth.

Leadership style also influences the care provided to Indigenous youth. The current organizational leadership style is traditional and hierarchical, with little opportunity for bottom-up ideas. However, there are weekly meetings where collaboration of ideas is discussed and staff can raise concerns and ideas. This is where the organization has the best results. Unfortunately, the organizational culture has become stagnant and opportunities for new approaches have not been as actively pursued as they had in the past. While Organization X welcomes including Indigenous community members in the process, programming in RTR has never been created in collaboration with Indigenous stakeholders; as a result, valuable stakeholder input is being overlooked.

**Future State**

The future state of Organization X explores where they should aim to be in the near future. In this future, Organization X will have a high success rate of Indigenous youth after they are discharged. Success looks like caregivers in communities being able to care for youth and desirable behaviour continuing to be shown three months post discharge. Staff have the training to provide adequate services, and information is shared in a horizontal approach where all voices are heard, including youth and Indigenous community members. Indigenous youths’
mental health needs will be addressed using culturally appropriate and client-centred planning in collaboration with the Indigenous department and community members using the guideline of the five tenets of CRT (Solórzano & Bernal, 2001) and the four Rs of CIRM (Evans et al., 2009). Clinicians supporting youths’ mental wellness will be of Indigenous descent. Further resources applied to support mental wellness will be found in collaboration with the Indigenous department and community stakeholders. RTR will continue to work with youth and community caregivers for up to 3 months past discharge to provide transitionary support and continuity of care. After youth are discharged, their community caregivers should indicate minimal negative behavioural regression and will have the ability to meet youths’ needs.

To ensure the right approach, youth engagement will be part of treatment. Caldwell et al. (2020) stated, “Youth engagement involves youth in their own future planning. This definition means that young people should be involved in all aspects of their treatment planning and that adults should support the development and utilization of their voice for advocacy” (p. 32). Youth engagement allows RTR to understand what support is best suited for the youth and build trusting relationships.

RTR will adopt a culturally competent framework. Organization X will provide training on therapeutic modalities that provide cultural agility. RTR will distance itself from Western approaches and move toward the Indigenous lens. Professionals and researchers have observed that “mainstream” (Gone, 2011, p. 188) psychosocial treatments offered by mainstream (non-Indigenous) providers are not well suited for Indigenous youth, resulting in failed rapport, botched diagnosis, noncompliant patients, and ineffective interventions. While Indigenous clinicians will work with youth, there will be time when non-Indigenous clinicians may work with this population. Therefore, non-Indigenous clinicians in RTR practice will need to be reflective of their own experiences and internalized bias, given that clinicians live in a country with a long history of inequality in relation to Aboriginal peoples (Bowden et al., 2017). This practice will reduce bias, as it will encourage “multidimensional thinking, tolerance for
ambiguity, and assigning equal importance to others’ cultural values, beliefs, and respect for the ways of being and traditions of others” (Bowden et al., 2017, p. 44). Clinicians will be familiar with Indigenous approaches to healing in practice (Bowden et al., 2017). Lastly, clinicians will understand and examine a youth’s culture and race, and go deeper by putting emphasis on the intersection of race, class, gender, socioeconomic status, sexual orientation, and physical ability and disability (Bowden et al., 2017).

Consultation and collaboration with the Indigenous department in Organization X and Indigenous communities will reduce systemic racism caused by colonialism. Greenwood and de Leeuw (2012) discussed how “effective programs are characterized by vision and leadership, holism, active community participation, strengths-based orientation, and reinvigoration and revitalization of Indigenous cultures aimed at realizing self-determination” (p. 383). Working collectively and in a relationship will ensure best practice is applied in providing individualized approaches to youths’ programs in connection with their heritage. Greenwood and de Leeuw (2012) explained, “Social determinants of health increasingly explains the most pressing global inequities. They are defined as the conditions in which people are born, grow, live, work and age, conditions that together provide the freedom people need to live lives they value” (p. 381). Organization X will commit to fostering social determinants of health for youth and facilitate healing.

**Change Driver**

The change driver looks at both the internal and external factors that shape change. A change driver is referred to by Whelan-Berry and Somerville (2010) as a “necessity for a change, which is whatever gave birth to the desire or need for change in the organization” (p. 177). The goal of this OIP is to create a change implementation plan that will address the recidivism of Indigenous youth within the RTR along with action steps required for change. Through oversight of the program and maintaining control of the finances, the provincial government broadly and Director of Organization X specifically are also change drivers.
**Internal Factors**

The three internal change drivers I discuss include programing, staff, and youth. While some Indigenous youth leave the RTR and successfully integrate back into the community, too often these youth are not receiving the programming required to be successful once discharged. There is urgency, for it is urgent that they get strong support services for these youth. Organization X’s standing will improve when the data indicates an increase in Indigenous youths’ success during and after discharge. The director and management of Organization X are looking at internal data and recognizing that despite the incredible work of executing the behavioural interventions and training, youths’ behaviour often regresses. The organization’s leadership is receptive to supporting youth and has adapted before. Management is motivated by improving data outcomes that favor the program’s credibility.

Staff are also imperative change drivers. These staff include (a) clinicians—their role is to create the care plans for youth and provide outreach support, (b) case workers—whose role it is to provide direct support, and (c) the Indigenous department—their role is to provide an Indigenous lens. Clinicians often work in isolation from the team and create plans individually without consultation from other team members. Staff often find the program that is developed does not meet the needs of a youth. The Indigenous department is largely asked to work with youth in isolation and is not often part of creating treatment plans. This organizational culture is isolating to staff and leads to un-holistic youth-treatment plans. The intent of the OIP is to transform organizational culture. Whelan-Berry and Somerville (2010) explained, “Change in organizational culture is considered a fundamental organizational transformation” (p. 176). This OIP will utilize DL to engage all staff in creating change in the organization. As a leader, I believe in empowering all voices through transformative leadership. TL will help explain the social justice concern authentically as well as detail why the change implementation plan requires a systems shift, which will include the Indigenous community in developing, implementing, and monitoring the program, as well as the importance of such an approach.
Lastly, Indigenous youth are change drivers. The organization has an obligation to provide service that supports and empowers youth. Indigenous youth have a voice and RTR must take responsibility for listening and honouring their voices. The organization has found that Indigenous youth have been successful and receptive to learning through traditional Indigenous approaches, even among youth who have had minimal interaction with traditional teachings. Providing culturally appropriate support is required to build youth confidence and empower youths’ voices. RTR leadership and staff will need to listen to what is working to ensure effective support.

**External Factors**

I discuss two external change drivers: first, caregivers in community and, second, the Truth and Reconciliation Commission of Canada (TRC, 2015). Organization X feels pressure from caregivers in the community to take in more complex youth and provide services that will support client success after discharge. Current data show that RTR has served approximately 48 youth between 2014 and 2020. RTR has a capacity of six youths at once. As it rarely functions at full capacity that number is far below the potential of serving 24 per year, which after 7 years, would be 168 youth. Effectively we missed the opportunity of serving 120 youth. Caregivers in the community recognize that once these youth are discharged there is a high possibility of community breakdown. While roughly half the youth are successful it is difficult for the organization to explain why such high numbers of youth continue to regress in the long term.

Providing the required supports to Indigenous youth within Organization X allows the organization to live up to the calls to action from the TRC (2015). TRC believes providing mental wellness support will help reduce the number of youth in the child welfare system (TRC, 2015). While mental health supports should be provided so fewer youth enter programs like RTR, this is beyond the OIP’s scope of influence. However, within youths’ 3-month stay, RTR has the capacity to provide mental health services, and the organization should capitalize on this unique opportunity. TRC expects organizations to have programming that will reduce health disparities
between Indigenous and non-Indigenous youth. Furthermore, cultural competency training will provide recognition on the impact of residential schools on Indigenous youth (TRC, 2015). Lastly, TRC would like ongoing consultation with Indigenous communities and child welfare systems and to provide services that recognize traditional healing practices (TRC, 2015). Adhering to these recommendations will support positive outcomes for youth in RTR. The organization already has the capacity, training capability, resources, and the Indigenous department that can support the organization’s transformation. Implementing the OIP will continue to improve relationships between the organization and Indigenous communities. A leadership-focused vision for change will provide a clear roadmap for RTR to follow to address the PoP. It is also important to recognize flexibility is required and adaptation may be necessary after consultation with internal and external stakeholders.

**Organizational Change Readiness**

In order to form the best course of action to address the OIP, understanding Organization X’s readiness for change must be examined (Deszca et al., 2020). Deszca et al.’s (2020) organization’s readiness for change questionnaire is the tool I employed for this purpose. I also delve into the organization’s culture.

**Rate Organization X Readiness for Change**

The readiness questionnaire, as described by Deszca et al. (2020) is “a method to help leaders assess where the organization is and how ready the organization is to change” (p. 113). Deszca et al. proposed, “This tool provides leaders with insight to what promotes and inhibits change readiness” (p. 113). The development of change readiness is imperative to the growth of an organization (Deszca et al., 2020). This tool has six readiness dimensions with various questions under each section. The six dimensions include previous change experiences, executive leadership support, credible leadership and change champions, organizational openness to change, reward system, change and accountability measures (see Table 1). The score ranges from -25 to +50 (Deszca et al., 2020). Deszca et al. declared, “The higher the score the
more ready for change, if the score is below 10 it is unlikely the organization is ready for change” (p. 115). Table 1 presents Organization X’s change readiness by listing readiness dimensions and scores, presenting a final score of + 30.

Table 1

*Organization X Change Readiness*

<table>
<thead>
<tr>
<th>Readiness Dimensions</th>
<th>Readiness Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous Change Experiences</td>
<td>2</td>
</tr>
<tr>
<td>Executive Leadership Support</td>
<td>3</td>
</tr>
<tr>
<td>Credible Leadership and Change Champions</td>
<td>7</td>
</tr>
<tr>
<td>Openness to Change</td>
<td>14</td>
</tr>
<tr>
<td>Reward System</td>
<td>0</td>
</tr>
<tr>
<td>Change and Accountability Measures</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>+ 30</strong></td>
</tr>
</tbody>
</table>

*Note.* The six dimensions of readiness by Deszca et al. (2020) indicate that Organization X’s readiness for change is +30 change. I will speak to all six aspects in relation to Organization X’s change readiness.


**Previous Change Experiences**

While Organization X has been operating for decades, the RTR opened 7 years ago. The original model of care program has evolved and shifted to meet the needs of the youth. Through data collection and staff we are able to target successes and recognize failures of service. RTR’s previous change implementations were positive and improved program outcomes. The organization remains committed to adapting the program to support youth achievement. However, having time to research and implement new ideas remains a barrier.

**Executive Leadership Support**

RTR has received praise for their innovation, creativity, and ability to support and keep youth with complex care needs safe. Half of the organizational members expressed shifts in youths’ behaviour since entering the RTR. However, the RTR also receives criticism regarding
the regression of behaviour after discharge. Senior management feels a sense of urgency to provide data that indicate continued stability once youth are discharged. Resolving and addressing this issue is increasingly important to preserve the validity of the program.

**Credible Leadership and Change Champions**

Senior leaders within the organization are unique in that they have all worked in the organization for decades, often starting as frontline staff and working their way to senior leadership roles. Senior management are competent and work well together. The goal of leadership is the success of the organization. Senior leaders are accessible and open to hearing new ideas. Lastly, senior management treat all staff with great respect and trust in staff’s ability to accomplish their roles independently and are readily available to support staff.

**Organizational Openness to Change**

Organization X operates from the perspective that change is always occurring. The RTR approach to change is to improve the program with evidence-based literature as it develops (CCU Staff, personal communication, March 13, 2015). The organization believes in continuing research to constantly improve the program.

**Reward System**

Reward systems motivate and improve job performance (Mehmood et al., 2013). Mehmood et al. (2013) declared that group-based rewards have been proven to be more effective than individual ones, while also creating opportunities for cooperative and efficient teamwork, which ultimately increases the performance of the organization. RTR’s goal is supporting youth and the greatest reward is when positive reports come in from caregivers in the community after a youth’s discharge. If youth are doing well it indicates that staff, as a group, are a significant reason behind success. Reward systems in Organization X are linked to performance reviews, promotions and recognition (Mehmood et al., 2013). During the performance appraisals, management will have indicated staff succeeded in their role. Senior management will recognize staff’s hard work during a debrief process that occurs after youth are discharged. Lastly,
Organization X is known for promoting in-house, which is a motivator for staff to provide the best service.

Change and Accountability Measures

Followers’ opinions of their opportunities to take on leadership roles in the OIP are important. Simply telling followers that “change is coming” is not an effective tool to motivate members toward action. Management in the organization must consider the groups, subgroups, and individuals that will be affected (Bernerth et al., 2007). Having members of the organization involved during change will improve followers’ commitment to the transition process (Bernerth et al., 2007). Encouraging inclusion and promoting a just working environment will shape followers’ responses to change (Arnéguy et al., 2018). This OIP will provide space for followers’ voices to be heard. These steps will reduce feelings of uncertainty, which will reduce concerns followers may have (Jacobs & Keegan, 2018). Followers may express the following potential anxieties: How will I or my colleagues be treated if there is change? Will our voices matter? Providing a safe place where diverse ideas are welcomed will reduce followers’ anxieties. Inclusion in the OIP will provide a cultural shift that ensures a supportive change process that will ease the overall transition. After careful evaluation, I have determined Organization X is ready for change.

Chapter Summary

The reader has been provided an overview of the organization and an explanation of the problem of practice. I have thoroughly discussed my leadership lens as well as the theoretical lens that will help analyze the problem. The guiding questions pointed to how change from the current state to the desired future state would address the problem. Lastly, as explained through the change readiness tool, the organization has willingness to change. Chapter 2 shares leadership approaches, offers a framework for leading the change process, provides critical organizational analysis of what to change, looks at possible solutions to address the PoP, and provides context regarding leadership ethics and organizational change.
Chapter Two: Planning and Development

Chapter 1 identified factors that impact Indigenous youths’ outcomes after discharge from RTR. The PoP indicates a need to provide additional supports beyond behavioural interventions to reduce recidivism. In this chapter, I explain how TL and DL address the PoP and direct this OIP. The five tenets of CRT and four Rs of CIRM are explained as frameworks for leading change. I also describe Deszca et al.’s (2020) Change Path Model, detail how it is suited to this OIP, and show how the five tenets of CRT and four Rs of CIRM are used to guide this model. Lastly, I critically analyze Organization X using Nadler and Tushman’s (1989) organizational congruence model. Possible solutions are discussed and the best solution is identified. TL and DL will be elaborated on to share how this can be used to support change. I review ethical considerations with a focus on TL as well as ethics in counselling.

Leadership Approaches to Change

The leadership theories that I integrate in this OIP are TL and DL. I chose these approaches as they are congruent with my Indigenous worldview and theoretical frameworks and are best suited to address the problem. CRT calls on leadership to recognize their ethical responsibility to both “interrogate systems, organizational frameworks, and leadership theories that privilege certain groups” (López, 2003, p. 70) and challenge oppression in all forms. In theory, TL and DL live up to the ideals of CRT. Further, CIRM ideology recognizes everything is culture-dependent and perception of reality varies (Ogawa, 1995). As such, the change leader will need to be inclusive to new ideas and open to varying perspectives.

Transformative Leadership

TL is “an ethically based leadership model that integrates a commitment to values and outcomes by optimizing the long-term interests of stakeholders and society and honouring the moral duties owed by organizations to their stakeholders” (Caldwell et al., 2012, p. 176). Addressing the problem of recidivism is a moral and social justice issue for RTR (Shields, 2018). Recidivism is a term used in the criminal justice system to refer to re-offenders (Maltz, 2001). In
the context of this OIP, recidivism means community breakdown after Indigenous youth are discharged from RTR. Through the TL, Organization X can reduce recidivism by improving the efficacy of services. Organization X strives to provide the best supports to the youth; however, the top-down leadership style cannot address the radical shift in paradigm required.

TL creates space for CRT’s questions regarding race and impact of Canadian history and its treatment of Indigenous people. TL pushes leaders toward higher consciousness by posing questions that other leadership styles may not. For example, a leader may ask, “If racism were merely isolated, unrelated, individual acts” (Ladson-Billings & Tate, 2016, p. 55), why are there a disproportionate number of Indigenous youth in the child welfare system? A common colour-blind ideology is, “I don’t see colour” as a reason for avoiding conversations about race and racism that are difficult. These individuals blindly “refuse to acknowledge that racism is salient and racial differences exist, and believe that the color of one’s skin has nothing to do with the opportunities available in society” (Diem & Carpenter, 2012, p. 102). Once stakeholders deconstruct knowledge, then new knowledge can be constructed using an Indigenous lens for resolution finding.

**Roots of Transformative Leadership**

TL is rooted in Burns’ (1978) seminal book, called Leadership. Other notable authors on Transformational leadership include Hernandez (2018), Montuori and Donnelly (2017), and Shields (2018). He covered topics such as moral leadership, social sources of leadership, political leadership, and reform leadership (Shields, 2010). Burns discussed transactional leadership, which focuses on exchange and benefit, whereas TL emphasizes the need for real change (Shields, 2018) of the norms, institutions, and behaviours that structure daily life (Shields, 2018). Moreover, real change requires a structural metamorphosis (Shields, 2018). Blackmore (2011) compared and contrasted transformational and TL, which are often misinterpreted as being the same. Transformational leadership and TL are distinct. While transformational leadership looks at an organization as a homogenous whole, TL acknowledges
different experiences within the organization (Shields, 2018). While Burns never used the term TL, his concepts of leadership are closely connected to the evolution of TL (Shields, 2012).

**Transformative Leadership Perspective**

I identify as a transformative change leader for two reasons: first because of my education and experience as a social worker and second because of my work in Organization X as a change leader. Within the organization, I proactively take on leadership roles both officially and unofficially whenever I see a way to improve youth care. I recognize that I already create and lead (Montuori & Donnelly, 2017) by supporting program development and staff growth in their positions. Currently, I am in a leadership position within Organization X, which gives me the opportunity to advance this change.

TL is based on morals (Hernandez, 2018). Moral leaders foster trust and increase follower’s commitment (Caldwell et al., 2012). A leader can demonstrate morality by identifying with specific traits. These traits include being “authentic (Evans, 1996); or as Palmer (1998) advocates, to know ones-self” (Shields, 2018, p. 23). Proponents of TL assert there is integrity that comes with knowing oneself (Shields, 2018), which causes a transformation (Caldwell et al., 2012). What is inspiring is the personal growth leaders commit to in the pursuit of self-awareness. TL refers to self-consciousness as encompassing (self-knowledge, self-discovery, critical reflection, and critical consciousness). This assists leaders to better understand the skills and abilities, strengths and weaknesses of their practice (Shields, 2018). Further, this includes understanding one’s values, culture, and connection to wider community while rejecting essentializing notions of self and others (Shields, 2018). TL helps leaders understand how a cultural belief in one setting might be a conflict of values and beliefs of people in another culture (Shields, 2018). Indigenous communities have their own culture.

This leadership style will ensure individuals do not impose their own values and beliefs on others. Leadership will be open to new ideas and ways of doing things. According to Shields (2018), “without such openness, it is virtually impossible to begin to challenge existing beliefs.
that may no longer be correct” (p. 23). Through self-awareness leaders can truly see the other (Shields, 2018). Additional attributes transformative leaders should possess include moral, ethical, and spiritual dimensions (Shields, 2018). Spiritual connection refers to being connected to one’s deeper self, which in turn helps to feed one’s soul and the souls of others (Montuori & Donnelly, 2017; Shields, 2018). Spiritual connection inspires leaders to have courage and spiritual discourse that calls out acts of inequality, fairness, justice, and ethical concerns (Shields, 2018). Lastly, transformative leaders advocate for equitable change.

**Transformative Leadership and its Relationship to this OIP**

TL allows for deep and equitable change (Shields, 2018), which is what is required within Organization X. Shields (2018) explained, “Transformative leadership is not normative; it broadly identifies a desired state towards which we strive” (p. 20). Further, this leadership commits people toward action (Caldwell et al., 2012). The desired result of this OIP is to address the problem by transforming the organization. The role of the transformative leader is to light the path forward. While the path to change can be noble, it may meet resistance. TL asks difficult questions and addresses dilemmas around change (Shields, 2012), which can cause resistance at various levels.

One significant dilemma that RTR faces is the organization’s ability to shift its approach to care. Leadership will move RTR toward change by promoting equality, inclusion, and social justice (Shields, 2018) for youth. The TL philosophy of social justice will be used to leverage untapped leaders, including those within the Indigenous community and the Indigenous department. TL is less concerned about who proposes change and more with how change can transform systems. TL allows space for all the leaders within Organization X and the community to be part of improving outcomes for RTR youth. Organization X, while hierarchical, welcomes partnership and new perspectives. Further, my relationships with upper management will provide space to share why this approach to leadership is of benefit for both the OIP and the overall organization.
TL will provide space to examine issues and possible solutions by looking at the issue through the lenses of CRT and CIRM. TL will change the organization’s structure by including the community, the Indigenous department, and me as equal stakeholders in the change implementation plan. Further, this leadership approach will create new policies that support Indigenous communities from frameworks that are accepted by the community. From looking at the problem, to pondering possible solutions, to creating the change implementation plan, TL will help push the boundaries of what Organization X thought was possible. This will be done through education; explaining why the change is needed, structures of hierarchy can be oppressive, having community involved is important, and what we have been providing thus far to youth can be improved on. It will be critical to explain why leadership needs to include various stakeholders as well as the value of TL.

**Distributed Leadership**

DL is the second approach that will be used in each stage of change. This approach complements and contrasts TL. TL and DL share the philosophy that collaboration and understanding others’ perspectives enable an organization to be more successful. As Young and Laible (2000) attested, if changes are not made, programs will continue to construct predominantly white, middle-class management with minimal understanding of or interest in the colonial system of white privilege, oppression, and racism. Further, leaders must enthusiastically and intentionally interact with a diverse array of stakeholders from different cultural backgrounds (López, 2003) within Organization X and externally, with Indigenous communities in particular.

**Roots of Distributed Leadership**

Leadership literature often focuses on formal leadership (Spillane et al., 2004). However, DL focuses on individuals and the behaviours required for the situation (Spillane et al., 2004). An early theorist who discussed this leadership style was Follett (1924). Follett’s law asserted leadership could stem from the individual with the most relevant skills. Others, such as
Benne and Sheats (1948), suggested leadership is not about the individual, but about functions, and that numerous individuals could take up separate roles (see also Fitzsimons et al., 2011). Gibb (1954, 1969) argued leadership is best distributed, while Stogdill (1950) reasoned that leadership should be based on role differentiation related to goal setting and goal achievement (see also Fitzsimons et al., 2011). Bowers and Seashore (1966) indicated leadership can come from peers who could favourably impact outcomes, while Katz and Kahn (1978) explained, “The potential competitive advantage that can accrue to an organization in which reciprocal influence is widely shared” (Fitzsimons et al., 2011, p. 315). These are some of the theorists who have contributed to developing this leadership style. In the next section, I discuss the distributed leadership perspective.

**Distributed Leadership Perspective**

DL is rooted in interpersonal dynamics (Chatwani, 2018). DL seeks to promote joint optimization of shared visions, values, and ideals among stakeholders rather than maximization of subset or individual interests (Chatwani, 2018). This approach aligns with my leadership approach and the philosophy of Organization X. DL is an approach recognized as valuable within RTR. Presently, although leadership opportunities at times are shared among stakeholders to address goals, power, and influence remain vertical (Bolden, 2011) within Organization X, the agency tends to follow a distributed and hierarchical approach to leadership. The vertical structure of Organization X is a reality; as such, conscious implementation of DL will fall with senior management and me, as a change leader.

This OIP will challenge leaders in a healthy way to be more progressive. Chatwani (2018) explained the need to “shift hierarchically structured command and control patterns that place authority in semi-autonomous local sub-units” (p. vi). Senior management has a unique opportunity to listen to the voices of internal and external stakeholders regarding factors impacting Indigenous youth as well as which approaches should be adopted to improve outcomes. Further, DL will empower and inspire organizational culture to mobilize untapped
expertise from the Indigenous department and the community for the betterment of the program. Stakeholders have expertise to contribute; they require opportunities to influence changes in the program. Bolden (2011) explained the need for availability of resources as a condition for successful change. The most significant resource for this OIP is the Indigenous community given their wealth of knowledge that can improve youth outcomes.

**Distributed Leadership and its Relationship to this OIP**

RTR can empower stakeholders by implementing DL in the following ways: moving toward inclusion and diversity (Lipman-Blumen & Jones, 2004), addressing communication issues between people and their solutions (Spillane et al., 2004), changing from hierarchical to broad base (Chreim et al., 2010), and allowing stakeholders to share in creating change (Chreim et al., 2010). Implementing the above DL approaches during the change process will encourage more diverse voices to support the desired outcome. DL will also embolden senior management to share power and reduce the burden caused by hierarchical and authoritative leadership. Both leaders and management will take on leadership roles based on the situation (Spillane et al., 2004). As a change leader, I will capitalize on DL traits and the benefits of sharing leadership. Utilizing community members, staff from the Indigenous department, and me as key allies will alleviate workload on upper management and provide wealth of knowledge that will improve outcomes for the Indigenous youth. This management approach is already used within Organization X and will be welcomed by leadership. DL will be used in every stage of the change implementation plan in Chapter 3. This OIP will have all stakeholders included in the change, including the director, senior management, team leader, Indigenous department, community members, and me.

DL does not necessarily mean everything will be harmonious. It recognizes that stakeholders are individuals, each with their own perspectives on change. However, when ideas are shared, the collective can determine which approach is warranted; this supports the ideals of shared vision. While human activity can be constrained by individual, material, cultural, and
social factors (Bolden, 2011), DL reduces these by working together on the problem, planning for a path forward, and honing in on the diverse knowledge and skill sets available among RTR stakeholders. By centring collaboration around Indigenous voices, recognizing community members as the experts, and facilitating the right to self-determination, Organization X will help break down systems of colonialism found in the structure. DL’s intentional approach to addressing the problem shares the spirit of CRT and CIRM.

Framework for Leading Change

TL will support this change. Stakeholders will deconstruct inequalities and reconstruct knowledge (Shields, 2018). Further, TL and DL will connect well to the five tenets of CRT (Solórzano & Bernal, 2001) and four Rs of CIRM (Evans et al., 2009). Organization X will examine and shift thinking toward the new goal (Shields, 2018). Reflexivity will be used to understand both the context of the problem and the solution. TL will facilitate discussions around oppression and race and how historical and present factors impact Indigenous youth. To rectify oppression and injustice, stakeholders will address power dynamics, which requires looking beyond the walls of the organization to the greater community’s needs and wishes (Shields, 2018) and redistributing power (Caldwell et al., 2012). Power will be shared both internally and externally. This approach is unique, as “transformative leadership does not have a privileged locus, like an organization (whether for profit or not for profit) with specific roles and lines of authority or a community” (Montuori & Donnelly, 2017, p. 5). Proponents of TL assert power is optimal when distributed. Further, all members within the group can be leaders (Caldwell et al., 2012; Hernandez, 2018; Montuori & Donnelly, 2017). Leadership will recognize the voice of the Indigenous department and community members. Resolution will centre on collaboration and building relationships with Indigenous stakeholders.

Changing organizational culture involves global awareness and impact (Shields, 2018). Global awareness means moving beyond the organization and recognizing that Indigenous communities are impacted by how Organization X supports Indigenous youth. Finally, TL and
DL will provide a path forward that focuses on equality, inclusion, and social justice. Concrete ways for Organization X to implement TL and DL incorporating the five tenets of CRT (Solórzano & Bernal, 2001) and four Rs of CIRM (Evans et al., 2009) as shown in Figure 1.

**Figure 1**

*Five Tenets of CRT and Four Rs of the CIRM Merged*

Figure 1 depicts the merging of two theoretical frameworks of the five tenets of CRT (Solórzano & Bernal, 2001) and four Rs of CIRM (Evans et al., 2009). The four R’s of CIRM are shown in the blue circle and the five tenets of CRT are found in the outer gray section (see Figure 1). In the section that follows, I explain how these two approaches will be used to support both creating this OIP as well as the implementation.

**Relevance, Centring Race, and Challenging Perspectives**

When considering the relevance of the topic (Peltier, 2018), the literature revealed there is disconnect between what Organization X wants to accomplish and the reality that Indigenous youth require to ensure success after discharge. As a change leader, I, along with the Organization X team will need to engage community members before proposing ideas (Peltier, 2018). What Organization X is proud about is its community engagement with Indigenous stakeholders, which is a high priority. Organization X invites community leaders to facilitate and
lead ceremonial events at Organization X. Further, all staff within the Indigenous department identify as Indigenous. Organization X has built relationships with Indigenous stakeholders, which will be beneficial when implementing the OIP. Lastly, this OIP presents a clearly defined PoP, which community members can understand and adapt as needed. Organization X having strong relationships with Indigenous stakeholders will help this OIP remain accountable to community members by involving them in all aspects of research (Peltier, 2018). This will fit nicely with the view of CRT, which centres race and racism to ensure bias does not take over (Solórzano & Delgado Bernal, 2001). I recognize the impact of colonialism and Western dominant voice in research. It will be important to highlight that for Organization X to challenge the dominant perspective. Organization X being under the Ministry of Children and Family Development (MCFD) has been a large contributor to policies that continue to impact Indigenous communities. As such, Organization X must address uncomfortable conversations directly in order to explain the direction they wish to go in to create better outcomes for Indigenous youth. CRT works to challenge dominant narratives and centres marginalized perspectives (Solórzano & Delgado Bernal, 2001). The centring of Indigenous communities will be the main objective in this OIP when implementing the change implementation plan.

**Reciprocity and Being Interdisciplinary**

Reciprocity for this OIP looks at the intention of the relationship, the reconciliatory nature, that I wish to show in my research when working with Indigenous communities. The OIP should be in relationship and be mutually beneficial. Organization X cannot ask community members to engage without requesting them to be part of the process. This process can happen by gathering stories (Peltier, 2018) or, as CRT describes it, inviting storytelling. Organization X will have the opportunity to explain the RTR program to the community, share their success rate, and inform people of the resources RTR provides Indigenous youth. Community members will then have an opportunity to share with Organization X stories that can support and improve outcomes for Indigenous youth. This reciprocity will strengthen the outcomes (Peltier, 2018) of
this OIP. As with CRIM, CRT scholars believe that the world is multidimensional, and research should reflect multiple perspectives (Solórzano & Delgado Bernal, 2001). Allowing space for the Indigenous department, community members, youth, and Organization X to be part of OIP and outcomes is in the best interest of youth and community (Peltier, 2018).

**Respect and Valuing Experiential Knowledge of Indigenous Communities**

Respect, in the context of this OIP and in partnership with Indigenous stakeholders, requires a focus on honouring of Indigenous knowledge (Pidgeon, 2019). This will be accomplished through ongoing consultations with the community stakeholders (Peltier, 2018). This will be done throughout the change implementation plan. Consultation will require Organization X to gather feedback from the community and implement changes when possible. This also aligns with the CRT approach, which values experiential knowledge of Indigenous communities and people of colour. This OIP will build on oral traditions of Indigenous communities and will centre the narratives of this population when attempting to understand social inequality (Solórzano & Delgado Bernal, 2001). Having direct and ongoing interactions with all Indigenous stakeholders will be a pillar of this OIP.

**Responsibility and Commitment to Social Justice**

In the context of this OIP, responsibility connects to the role of DL. Responsible relationships means both Indigenous and non-Indigenous stakeholders are engaged in institutional change as well as having higher accountability to feature cultural teachings in the change (Pidgeon, 2019). This perspective is important; Organization X cannot expect community members to implement a change unless they are active participants in developing the change implementation plan. Working in collaboration with the goal of supporting Indigenous youth will foster the relationship but responsibility must be at its centre. This philosophy of responsibility correlates to CRT commitment to social justice and the TL approach to change. CRT is motivated by a social justice agenda and this OIP will address the PoP and create the OIP from this lens.
Framework for Leading the Change Process

With the leadership approaches required for the evolution of PoP chosen and the framework for leading the change identified, I now discuss Deszca et al.’s (2020) Change Path Model, which will guide the organization through the change process. I also show how each section of the five tenets of CRT (Solórzano & Bernal, 2001) and the four Rs of CIRM (Evans et al., 2009) will be used in planning for the change implementation plan.

Change Path Model

The Change Path Model combines process and prescription (Deszca et al., 2020). The Change Path Model created by Deszca et al. (2020) has four steps: awakening, mobilization, acceleration, and institutionalization (Deszca et al., 2020). The Change Path Model is the best model for implementing change in Organization X, RTR because it has a clear path that is structured while allowing for flexibility in the process as well as being more comprehensive than Lewin’s (1951). The Change Path Model is an approach that Organization X will understand because it is clear and structured. At the same time this model allows of Indigenous perspectives and approaches to integrate seamlessly in every stage of change, which complements the CRT and CIRM. Further, this model provides opportunity for reflexivity required by CRT to ensure change is culturally appropriate in the Indigenous context. Opportunity for reflexivity will occur during weekly meetings with change teams and with the larger organization in planned training days. I am confident that this approach will also provide space for TL and DL to integrate appropriately because of the model’s openness to growth and development.

Awakening

The first stage of the Change Path Model is awakening (Deszca et al., 2020). In this stage the change agent is scanning for internal and external factors. This process helps organizations understand forces for and against organizational shift (Deszca et al., 2020). Leaders and followers will reflect on factors inside the organization that limit the ability to address the PoP. According to Deszca et al. (2020), in the awakening stage it is believed “the most powerful
drivers for change tend to originate outside (an) organization” (p. 52). There are internal change drivers for Organization X, which include the pressure from management to provide services that support Indigenous youth and internal data indicating the decline in Indigenous youths’ success both during their stay as well as after discharge. The OIP findings also indicate that an external driver for change is equally as powerful. External change drivers for Organization X include; youths’ communities expressing concern that, once they are discharged from RTR, youths’ behaviours regress causing community breakdown. The most poignant external change driver is the TRC (2015) report, which has recommended Indigenous youth in the child welfare system be provided the service they deserve and require to be successful. The hope is if youth receive adequate services it will reduce Indigenous contact with the child welfare system. However, the service provided continues to fail youth despite perceived best effort by the RTR. This OIP has identified a need for change as the current behaviour intervention is not sufficient given that Indigenous youths’ underlying emotional concerns are overlooked.

In the awakening stage, I will articulate the gap between present and envisioned future (Deszca et al., 2020). As a change leader in this OIP, I will provide a powerful vision for change that is in collaboration with internal stakeholders within the organization, including youth and the Indigenous department; as well as with external stakeholders such as Indigenous communities within BC. In this stage, changes to the plan should be expected after feedback from Indigenous department and community. Further, managing readiness for change must be a priority. I discussed internal stakeholders’ readiness for change in Chapter 1. However, Indigenous communities’ readiness for change is more complex. While supporting mental health will be important, trust that it will be done right and with good intentions may be a greater concern, given the history Indigenous communities have with MCFD. Relevance, centring race and challenging perspectives identified in Figure 1 will support mitigating these concerns. In order to understand the relevance of the PoP, holding meetings where internal stakeholders go to the community to share the organization’s plan, building relationships, and
asking for guidance will help reduce concerns and start to build a trusting relationship required for collaboration. Further, As a change leader I will both need to have meetings where we learn about the impact that race has played in both youths’ lives but Organization X systems as a whole and begin to have conversations on how we can challenge thinking and policies within Organization X power to mitigate impact. This will require opportunities for reflection and also hearing from the community and the Indigenous department on how race manifests in policies and practices in the workplaces and programming. Without representation from Indigenous community in program creation, programs may fall short of meeting the needs of the youth.

**Mobilization**

The second stage is mobilization, as explained by (Deszca et al., 2020). It is the “determination of what specifically needs to change and the vision for change is further developed and solidified by additional analysis” (Deszca et al., 2020, p. 52). Mobilization takes an in-depth look at the problem by observing change through formal systems of structure and leveraging systems to reach change (Deszca et al., 2020). Through a gap analysis, I have identified that Indigenous youth are regressing in behaviours and placements and some are unsuccessful shortly after discharge. Similar programs that I have researched indicated youth in programs like RTR experience high levels of social disadvantage after discharge, including negative health and risk-taking behaviours (Richardson & Lelliott, 2003). Deszca et al. (2020) pointed out, “The gap analysis allows change leaders to clearly address the question of why change is needed and what needs to change” (p. 53). Mobilization can promote a social justice lens, by assessing power and culture dynamics, various stakeholders and recipients of change will build associations that support change (Deszca et al., 2020). By paying close attention and assessing social justice, power, and culture, stakeholders within Organization X will be motivated to move toward a future that can better support Indigenous youth. The last goal of mobilization is to “understand how existing situations can be leveraged in order to increase the prospect of success” (Deszca et al., 2020, p. 53). Through DL, all stakeholders, including the
director, senior management, supervisors, clinicians, case workers, the Indigenous department, youth, and Indigenous communities, will have a role and a voice. This falls under the concepts of reciprocity and being interdisciplinary in Figure 1. Stakeholders must support each other to enact the desired change. Representation matters when supporting racialized groups. Reciprocity will require reconciliation, relationships, and working together. This is the stage at which drafting, developing, and beginning to implement the plan will occur. Close working relationships with internal and external stakeholders will be a primary focus as a change leader. The collaboration will be ongoing and in person when possible. Communication and monitoring tools will be developed. Interdisciplinary open dialogue, time, communication, and sharing of information will allow Indigenous communities to guide what is working and what may need to be reviewed and adapted. This will offer the organization an opportunity to hear from stakeholders and hold important conversations and share stories around race, Indigenous history, and why the change is necessary.

**Acceleration**

The third stage is acceleration. This phase “involves action planning and implementation” (Deszca et al., 2020, p. 53). This is done by using insight received at earlier stages and creating a detailed plan of action for change (Deszca et al., 2020). As a change leader, I will empower stakeholders and create an atmosphere where leadership is distributed equitably based on skills, knowledge, and abilities that will enhance and ensure successful change. This stage will include sharing of tools and resources that will create an environment of new knowledge sharing while building momentum through the transition process (Deszca et al., 2020). Change is a long process, and an important part of it is acknowledging the small wins (Deszca et al., 2020) along the way. According to Deszca et al. (2020), change requires “managing the transition, celebrating the small wins and achievement of milestones along the large, more difficult path to change” (p. 54). Small wins empower staff and management, recognizing that while change can be challenging, it is important not to lose sight of small
improvements in client care. That includes asking clients for the feedback on the change and explaining why their voices are important.

Lastly, it will be important to contact Indigenous community members in personal and meaningful ways to thank them for their time and knowledge. This falls under respect and valuing experiential knowledge of Indigenous communities in Figure 1. As a change leader, I will open up discussions with internal stakeholders with the support of Indigenous department and community around what respect looks like in practice when working with Indigenous communities. That includes honouring the knowledge within the community, which will be done with ongoing consultation with all stakeholders. Members of Organization X will need to actively listen and implement changes suggested by the community as the change implementation plan is in action. Further, this approach is congruent with CRT, which values experiential knowledge of Indigenous communities and people of colour. This will include Indigenous teachings in solving the PoP and implementing the change plan. These theoretical perspectives call for ongoing communication and collaboration with Indigenous communities throughout the change process.

**Institutionalization**

The last stage, institutionalization, is the successful conclusion to the desired new state (Deszca et al., 2020). Change takes time to be embedded into organizational practice. Tracking change is a familiar practice in the RTR program and will help guide progress toward the final goal, as well as identify when modifications are needed (Deszca et al., 2020). Tracking change will act as a buffer in reducing the likelihood of reverting back to problematic patterns. Leadership will “develop and deploy new structures, systems, processes and knowledge, skills and abilities, as needed, to bring life to the change and new stability to the transformed organization” (Deszca et al., 2020, p. 54). As a change leader, I am addressing the problem of recidivism from a social justice lens, which requires action. I also highlight why hierarchical and authoritative practice is ineffective in future states. What is required is to look at DL to provide
Organization X with the ability to utilize skills already present but underutilized. This falls under the domain of responsibility and commitment to social justice in Figure 1. Responsibility, for the purpose of this OIP, means tracking change and discussing what the findings indicate, updating policy with new programing, and determining how this will be facilitated long term.

Organization X will explain in policy the need to update the community on the progress of mental health supports annually for at least 2 years post implementation. Cultural teachings will be incorporated in mental health support for Indigenous communities based on collaboration with community members. Further, internal stakeholders, including Indigenous department staff, will receive support to share feedback to management in order to learn how mental health supports can continue to improve. This coincides with CRT’s social justice approach to addressing problems. By honouring and working closely with Indigenous stakeholders and centring their voices, while actively participating alongside community to address the PoP, this OIP will honour social justice perspectives to understand and address the problem. Lastly, these theoretical lenses will provide a robust policy that will continue to be adaptable as new perspectives emerge to support mental wellness and thereby reduce recidivism.

Implementing change is a challenging process and Deszca et al.’s (2020) Change Path Model has its limitations. This model is a linear process (Deszca et al., 2020). This OIP recognizes that change is complex and many factors can impact the direction change takes. Further, oversimplifying complex problems may lead to errors in judgment (Deszca et al., 2020). While change can seem straightforward, change is often happening at multiple levels at the same time (Deszca et al., 2020). Despite its limitations I have chosen this approach for two reasons. The first is because it asks, “what needs to change?” Having a clear vision of the problem that all stakeholders understand is necessary for change to be successful (Deszca et al, 2020). The second is that it gives a clear direction for how to manage and assess change by using data collection. The organization will know the change has been successful when the data
indicate recidivism has declined in the Indigenous youth population. Lastly, outcomes can be evaluated by asking if Indigenous community members find the implementation of the change to be valuable.

My two leadership approaches will complement and reduce any downfalls of this change model. TL will provide a critical analysis of the problem, while DL will offer an opportunity for a diverse collection of ideas to be shared to resolve the problem. Further, the CRT and CIRM can be appropriately used to raise awareness and provide the best way forward. While no one change model is without fault, I feel this model is superior in this case. What makes the leadership transformative is not the model chosen, because many can be used; rather, it is the leadership approach to addressing the OIP.

This section discussed the framework for leading the change process. The next section examines critical organizational analysis.

**Critical Organizational Analysis**

In order to successfully resolve the PoP, change leaders will need to modify the programs offered to address the organizational problem in support of the goal. Critical organizational analysis is a tool that can help determine what needs to change using a clear framework (Deszca et al., 2020). This is done by focusing on different organizational levels through an analytical lens and concluding how Organization X’s environment will shift over time (Deszca et al., 2020). This framework will help the organization understand how to best support Indigenous youths’ success after discharge and reduce recidivism. The Organizational Congruence Model by Nadler and Tushman (1989), shown in Figure 2, will be the tool I will use to analyze organization dynamics. The Organizational Congruence Model recognizes the organization is a complex system “that, in the context of an environment, an available set of resources, and a history, produce output” (Nadler & Tushman, 1989, p. 194). This model has two components: the first is strategy, which looks at patterns and decisions, and the second is organization, the instrument that develops strategies into output (Nadler & Tushman, 1989). Organizations consist of work,
people, formal and processes, and informal structures and processes (Nadler & Tushman, 1989). The flexibility of this model and the diversity of areas reviewed including historical and culture context demonstrates Organizational Congruence Model is applicable to the depth of self-awareness and critical perspective required in the CRT and CIRM.

**Figure 2**

*Organizational Congruence Model*


**Input**

In the input stage, as outlined in Figure 2, I will look at three areas: environment, resources, and history and culture (Nadler & Tushman, 1989). The history of the organization is twofold. First, the organization focuses on behaviour support for youth. This has led to narrow treatment options and limited success. Second, while Indigenous historical factors are recognized, steps to reduce barriers in support for this population are too often overlooked and Western narratives are instead employed. Recognizing the trauma of colonial history must not be overlooked. Indigenous youths' voices need to be at the centre of solving the problem and currently the way in which RTR is providing services puts the staff in the position of power,
youth have limited power in their treatment planning. The OIP recognizes “That the external environmental factors play an enormous role in influencing what organization chooses to do” (Deszca et al., 2020, p. 72). Indigenous people face barriers to mental wellness supports (Canadian Human Rights Commission, 2016), which this OIP recognizes as a factor to youth success. Organization X, under the provincial government, has a long history of oppressive practices towards Indigenous people and has an obligation to change. One way to reduce oppressive practices is to review and refine practices that impact Indigenous youth. Listening to the voices of Indigenous communities will strengthen programming and ensure the organization is providing services that support both youth and their community. The ultimate goal should be to improve relationships and move towards reconciliation.

Once youth are discharged from RTR, the feedback from community caregivers is that youths’ behaviour regresses. Caregivers are asking for additional support in the community. More importantly, caregivers in the community are often doubtful if interventions provided within RTR are meeting the needs of youth. In the future state RTR will have feedback that indicates youths’ mastery after discharge and negative behaviours have diminished.

Organization X has various resources which assist in resolving this problem. Organization X, with funding from the provincial government, has moved into a new building with additional space. The space can be used to support training of RTR staff as they learn, support and implement change. Organization X houses many stakeholders (senior management, clinicians, staff, and members of the Indigenous department) who are employed with the organization and will play a central role in the future. As external stakeholders, Indigenous community members will be contacted through the Indigenous department, who have a strong community connection. As a change leader, I will ensure that both senior management and I are engaging with community members in order to build trust.

The history and culture of the organization will also be supportive toward change. Organization X’s director, senior management, team leader, and followers have implemented
and supported the creation of the program, which allows for a depth of understanding regarding how change is implemented. In the future, senior management will become champions for change. However, members of the Indigenous community have a strained relationship with MCFD. Organization X has been building relationships with Indigenous communities, which has allowed for trust to be rebuilt. Utilizing the DL approach to change will continue to improve these connections and help facilitate discussion to address concerns.

**Strategy**

In the input area, I have discussed historical and environmental factors that can be both strengths and weaknesses. Strategies emerge due to environmental opportunities and threats (Nadler & Tushman, 1989). They examine the mechanisms that develop in order to turn strategies into output (Nadler & Tushman, 1989). Strategy will focus on vision and guidance of the leader (Deszca et al., 2020). There are several strategies to address. In the first place, change in programming will need to be addressed and a holistic approach that is more supportive of Indigenous youth must take precedence. Indigenous youth have a unique story and the examination of and resolution to the problem should be through CIRM. This OIP will discuss ways in which the RTR will move towards a solution that is guided by the Indigenous eye. Lastly, through CRT strategies, it will look at reducing the voice of Organization X as the expert and allowing Indigenous youth and community to be the prominent voice.

**The Transformation Process**

The next section of the model will look at components that produce output; these four areas are work, people, formal organization and informal organization (Deszca et al., 2020; Nadler & Tushman, 1989).

**Work**

Work looks at the basic tasks the organization will complete in order to implement the strategies (Deszca et al., 2020; Nadler & Tushman, 1989). Tasks examine the programming required, roles of various stakeholders, along with resources and training required to execute
strategies. In this stage, change leaders will share and collaborate with internal and external stakeholders about how roles and responsibilities will change so that everyone has a clear understanding of the ultimate goal.

**People**

The people within the organization and Indigenous communities play the greatest role in this OIP. The people are responsible for performing tasks that have evolved in this OIP and in organizational systems and structures already in existence (Deszca et al., 2020; Nadler & Tushman, 1989). This OIP will examine roles of youth, staff, senior leaders and directors, and Indigenous communities as well as how their roles will change. This OIP will also include change leaders that are often limited in their engagement with RTR. In alignment with transformative and DL, change leaders will highlight the voices of youth, the Indigenous department, and Indigenous communities, which pairs well with the CRT and CIRM.

**Formal Organization**

Deszca et al. (2020) explained, “The formal systems of an organization are the machines to help an organization accomplish its work and direct the efforts of its employees” (p. 74). This OIP will look at who needs to be recruited and what training is needed to improve services. The goal is to support the organizational culture while changing behaviour of staff to support a new vision. TL will help stakeholders reflect on the correlation between how formal systems operate and their direct impact on youth care—both positive and negative.

**Informal Organization**

Lastly, informal organization speaks to relationships among people and groups within an organization and the informal way things are accomplished, as well as social norms and the way culture is demonstrated (Deszca et al., 2020; Nadler & Tushman, 1989). This OIP will examine organizational processes and determine what is working and what needs to change. This includes recognizing informal leadership (Deszca et al., 2020; Nadler & Tushman, 1989). Staff within Organization X acknowledge there are gaps in youth care and take on roles, such as an
informal counsellor, when clients are expressing past trauma. However, Organization X must recognize that providing support to youth to address mental health concerns must be a priority because the impact of historical trauma on youth is a sensitive and delicate matter requiring the best care.

**Output**

Output looks at the organization as a whole (Deszca et al., 2020), with a focus on desired output of systems, units, and individuals (Nadler & Tushman, 1989). Output the services and products provided to meet mission-related goals (Deszca et al., 2020). The goal of this OIP is to reduce recidivism by further developing the program. The output will look at resolving the problem through growth and development. Through TL stakeholders will understand the need for change. DL will facilitate concrete steps to resolving the problem.

**Gap Analysis**

Through the use of The Congruence Model by Nadler and Tushman (1989), it is evident that Organization X has yet to live up to the promise of the mission, identified in Chapter 1, *CCU Policy and Procedure Manual* making RTR not congruent. It is not a just conclusion to assume failure is caused by a community’s inability to duplicate RTR service in the real world. The education level of Organization X staff is highly specialized while community resources often have a diploma or less in formal education; while families commonly have no formal training.

While managing complex change, I recognize what is and is not congruent. One area is the political climate of change (Nadler & Tushman, 1989). Despite being open to collaborating with the Indigenous department and communities, Organization X has room for improvement in this area. As a change leader, it will require focus to foster collaboration between internal and external stakeholders. As stated in Chapter 1, Organization X is ready for change, and collaborating with Indigenous stakeholders will lead to congruence in this area of change. However, I suspect Indigenous communities may have apprehension around the change. As a change leader with support of key members in Organization X, we will have open dialogue to
address concerns and revise the plan as needed. Lastly, it will be crucial for Organization X to actively manage transitions (Nadler & Tushman, 1989) and evaluate congruence.

**Possible Solutions to Addressing the Problem of Practice**

In this section, I delve into possible solutions for addressing the PoP. RTR treatment uses positive behaviour support plans to address and change youth behaviour; however, this OIP has concluded the current behavioural intervention strategies alone fail to meet the needs of Indigenous youth. Through research, this OIP will share four solutions that I believe will improve youth outcomes.

**Possible Solution 1: Mental Health Services**

Chapter 1 outlines historical factors of Indigenous youth that can lead to mental health concerns. Further, Indigenous youth in the child welfare system have one or more ACE and traumatic experiences which impact their mental wellness. Chapter 1 has further indicated that mental health support for youth in RTR with complex care needs has been proven effective at supporting youth with behavioural concerns (Preyde et al., 2011).

Currently RTR employs clinicians. The clinicians’ role in RTR is to create positive behaviour support plans. This OIP is proposing to reimagine the role of clinicians within the organization to provide direct clinical counselling to Indigenous youth identified as requiring mental health support. This requires either an amendment to the clinician’s job description to include providing direct clinical counselling, or creating a new position. Organization X will also provide and train clinicians in therapeutic modalities. As explained in Chapter 1, mental health clinical supports must be client centred, meaning no two people are the same and therefore service should adapt to the needs of the youth. Therapeutic modalities will recognize the complex care needs and special needs and adapt counselling supports to clients’ cognitive ability. However (Carr, 1998; Knoveryk et al., 2013) pointed to specific therapeutic modalities which have been shown to have the greatest benefit with youth residing in treatment facilities such as RTR. These modalities include emotional regulation treatment, cognitive behaviour
therapy, attachment regulation and competency, structured psychotherapy for adolescents responding to chronic stress, expressive therapy, play therapy, dyadic therapies, family therapy, and narrative therapy. Further, RTR should provide time to allow clinicians to review therapeutic modalities and provide refreshment training. Providing mental health services is a realistic possibility requiring minimal funding.

The primary shortcoming of this solution is the willingness of clinicians to want to take on additional duties. While I believe many will welcome this opportunity, others may be hesitant.

**Resources Needed**

Organization X will need to invest in extra resources to support the solution. Staff will need to be reviewed. RTR will need to fill one clinician position that will provide counselling. If management decides to hire rather than allocating this task, annual wages will need to be added to the budget. Support from the director, senior management, team leader, and I are resources needed to provide support in the change implementation plan. Funding will include paying for clinician wages and training opportunities. Wages for clinicians will be explained further in Chapter 3. Resources include counselling books and training opportunities. A lot of training opportunities can be done for free with Organization X because of the diversity of experiences the clinicians and management have. With its new state-of-the-art building and technology (monitors, screens, computers, whiteboards, etc.) in every space, the organization can host presentations using various applications. Time is an important resource. Staff who will participate in the change implementation plan will need to be allocated time from their other work to dedicate to the change implementation plan. Time required will be 4 hours per week.

**Benefits and Consequences**

The main benefit of this solution is that it will provide a safe space with experienced clinicians to work through trauma. The consequence to this solution is traditional Western counselling modalities may not be able to address the specific needs of Indigenous youth, as that imposes a Western perspective of mental health support.
Possible Solution 2: Culturally Sensitive Counselling Modalities

In Solution 1, I discussed a need for mental health counselling for Indigenous youth and various therapeutic modalities that have shown promise in supporting youth. Solution 2 goes a step further by ensuring culturally sensitive counselling modalities when providing mental health counselling to Indigenous youth. Chapter 1 has identified the unique experiences and traumas of Indigenous youth and recognizes the need for clinicians to be mindful of them (Oulanova & Moodley, 2010). Indigenous mental health support will take a holistic approach to treatment (Carriere & Richardson, 2012). While clinicians have qualifications to provide clinical counselling, it is important for RTR to invest in culturally sensitive education and training prior to working with this population. By providing services that are culturally sensitive, this OIP hopes to reduce barriers of unfamiliarity and possible distrust (Robertson et al., 2015). This is the responsibility of the clinician and the larger team, to have an understanding of the whole individual, including cultural context (Robertson et al., 2015). Indigenous youth vary, so clinicians must understand historical, political and social contexts while being open to an individual story (Bowden et al., 2017). Indigenous youth may internalize a mix of cultures both traditional and modern (Robertson et al., 2015). Remaining open to hearing an individual’s story will reduce stereotypes. One way to reduce stereotyping youth is to have the counselling process be collaborative. Counselling can be a collaborative process between two experts, the youth and the clinician (Robertson et al., 2015).

Training is also important in implementing a culturally sensitive practice. Organization X currently provides all staff with Indigenous cultural competency training. Further, during performance reviews employees are expected to be working towards the goal of cultural agility and Indigenous competency training. Training can be provided in house with the Indigenous department taking lead and sharing research or through traditional training provided by Organization X. Further in the output or change, the Indigenous department and community leaders will be sought out and encouraged to address topics related to historical and current
factors impacting Indigenous youths’ mental health and healing practices that can support clinical work. Topics to focus on during training will include social justice, culturally relevant therapy, bias and reflexivity training, as identified by (Oulanova & Moodley, 2010), as well as traditional healing.

A potential shortcoming is willingness to make space for educational engagement. In the past the organization has been reluctant to provide funding for professional development. However, to provide clinical support to Indigenous youth, professional development must be a priority. This process can be conducted in house with internal experts, including the Indigenous department and clinicians. One framework that can be used is a learning circle which aligns with the Indigenous way of sharing information. The purpose of the learning circle is to help understand the problem, foster critical thinking, and propose solutions through collaborative learning and set out designated times for members of the organization to get together (Kishchuk et al., 2013). This approach aligns with both TL and DL, which reframes traditional methods of organizational practice as well as CRT and CIRM. The learning circle will inform what program will be provided and will shape the direction of mental health support (Kishchuk et al., 2013).

**Resources Needed**

Resources needed for this solution are comparable to that of Solution 1. Clinicians will still need to be designated. Space, funding, and technology are required. However, the type of training offered and who is providing the training will differ. The Indigenous department and community will be asked to teach staff about history, detail the current context impacting youth, and share traditional methods as well as how, when, why, and who can use them. The Indigenous department is already part of Organization X’s payroll system and, therefore, no additional cost will be paid. However, the Indigenous department will need to be allocated 10 hours of their work week for 3 years to support the implementation of this OIP. Going forward, 10 hours a week will need to be allocated to support creating individual mental health programming for new youth and additional time to participate in traditional healing modalities.
with youth when required. RTR will allocate time required for the Indigenous department in youths’ positive behavioural support plans, which is the working document that guides the support provided to youth. When community leaders are identified and they agree to participate in the change implementation plan, time and compensation for work will need to be negotiated. It will be ideal for Organization X to have a contract with the community leaders identified for a minimum of 4 hours and maximum 10 hour per week. It will be important to identify two community leaders. Wages will need to be in alignment with community leaders’ current cost for their time and experience. This contract will be for the full 3 years required for the change implementation plan to be completed.

**Benefits and Consequences**

This OIP will take the counselling further by ensuring it is culturally appropriate. Traditional teachings will be almost always used to address mental wellness. Further, this solution aligns more with the CRT and CIRM and takes into consideration the unique needs of Indigenous youth requiring solutions to address mental health concerns from an Indigenous perspective. The consequences are that, while the lens in which the organization supports Indigenous communities is incorporated, there is still room for improvement. One of the reasons is because, while it is encouraged that Indigenous mental health supports be provided by Indigenous people, that is often not the case in practice. Other counselling services and positions regarding Indigenous issues are often filed by non-Indigenous people. The role of a change leader is to advocate for Indigenous counsellors.

**Possible Solution 3: Collaboration with Stakeholders**

The internal collaboration necessary to support clinicians is between case workers, team leaders, senior management, and the Indigenous department. This will ensure an appropriate collaborative process (Robertson et al., 2015), in supporting the mental health of youth. Supervisors, case workers, and the Indigenous department must be aware of how the counselling session is transpiring throughout the process. After a counselling session, it will be
important for stakeholders to discuss how RTR can best support a youth post counselling. Further, data collection of how youth are doing 1 month, 2 months, and 3 months after counselling will help all parties identify areas of success and areas requiring adjustment.

Clinicians, along with RTR staff, are change leaders who have a responsibility to ensure therapeutic modalities are not harmful to the youth and their community (Bowden et al., 2017). Collaboration with Indigenous departments within Organization X will be one way to guarantee proper mental health modalities are provided. Collaboration is an opportunity to receive feedback and make changes to treatments as needed in consultation with the Indigenous department.

Consultation and collaboration cannot be done without Organization X’s Indigenous department. The Indigenous department provides traditional forms of healing and is also a resource for youth to connect and learn about Indigenous culture specific to their traditional territories. Organization X is fortunate in that there is an Indigenous department composed of experts from the Indigenous community. RTR will need to increase this connection, providing clinicians and staff the opportunity to learn traditional healing practices such as talking circles, sharing circles, smudging and medicine wheel teachings (Oulanova & Moodley, 2010). These traditions improve the health of youth and their sense of connectedness to their Indigenous community (Oulanova & Moodley, 2010).

Collaboration with the community is an external factor. Counselling visibility within the Indigenous community is also a part of being credible in providing services (Robertson et al., 2015). How Organization X and clinicians stay connected with the Indigenous community is crucial. One way is to build relationships with Indigenous communities, which aligns with CRT and CIRM. Building relationships means joining in ceremonial traditions and connecting with the community throughout the creation of this OIP and onwards. Relationship building should be seen as a priority in work required in providing mental health support (Robertson et al., 2015). More importantly, leadership must ask for the community’s direction, input, and critique
throughout the change and adapt as required. This may even require significant change to OIP, which is part of the planning process.

The difficulty with collaboration is the act of finding time to communicate with all the members of a large organization. Recognizing workload difficulties, technology such as Microsoft Teams, a software program that contains video chat options, can make collaboration a smoother process for various stakeholders to meet. Stakeholders should remain flexible. It should be expected that new programs will have growing pains during the implementation process and adjustments to collaboration style is an important part of fine-tuning the change process. Organization X will need to lean into the knowledge of the Indigenous department and recognize this department as the first contact before implementing counselling treatment to ensure efficacy.

Additionally Indigenous communities may be skeptical of interacting with government agencies because of historical factors. Organization X will hold the responsibility of reaching out, being transparent with the services provided and humbly asking for community expertise.

**Resources Needed**

Resources required would be the same as Solution 2. Additional resources required include the Indigenous community. Indigenous department, senior management, and I would reach out to community leaders in the Province of BC, as this is the population of youth at RTR, and invite them to join the change implementation team as advisors. There will need to be some form of payment for the community stakeholders’ time and resources that will be negotiated with community and senior members of Organization X, as explained in Solution 2. There will also be a change team as detailed in Chapter 3, which will also be allocated 4 hours a week to support the implementation of this solution. While there will not be an additional cost, Organization X will need to allocate time for the team to meet and implement the plan weekly for 3 years.
Benefits and Consequences

Solution 3 takes into consideration the importance of gaining knowledge directly from the community. Further, this solution asks the Indigenous department to engage in the treatment by offering traditional mental health supports and to engage in the planning and implementation of counselling. This approach allows the Indigenous community to facilitate training opportunities for staff but also engage in supporting youth at varying levels. The consequences to this approach, being client centred means recognizing that not all youth identify with or want to practice traditional approaches. Collaborating with the Indigenous department, community members, and youth to tailor mental health supports to meet youths’ needs will be central to ensuring right support for the right client.

Solution 4: Combination

Solution four is a combination of 1, 2, and 3. It will provide mental health services that focus on youth with complex care needs and are tailored for youth in RTR. Further it will focus on Indigenous youth, and provide mental health support that is culturally sensitive. Lastly, this solution will reach out in the spirit of collaboration to the Indigenous department and Indigenous communities, throughout the change implementation plan, to ensure the right type of mental health support is provided.

There may be skepticism among stakeholders around the ability to involve all staff, management, the Indigenous department, and the community in the change process. As a change leader, it will be my role to connect all stakeholders. I will connect stakeholders with the senior manager and director so everyone understands the change implementation plan. I will encourage a senior manager in a position of power to be the change champion in this OIP. Senior management is open to the OIP. Further, the director is committed to working with Indigenous stakeholders and improving services in Organization X to reflect the needs of the community. I have been in communication about my OIP and the combination of support by senior management and rich resources and skills within Indigenous department and existing
connection to community stakeholders will be a great value. Through this OIP, the stakeholders will have an understanding of why change is occurring, roles that stakeholders hold and how change will be implemented, which will reduce any concerns that may arise.

**Resources Needed**

Resources needed for this solution will be a combination of all resources listed for Solutions 1, 2, and 3. The most important resources are the people. Connecting with the Indigenous department, community members, staff, and youth will ensure that different perspectives are heard and considered when making decisions.

**Chosen Solution**

I have chosen Solution 4 as the approach that is best suited to resolve the problem. The OIP cannot be fully solved by applying one solution alone; it requires a thoughtful complex look at the needs of Indigenous youth. To resolve those needs, the resolution requires a transformative and distributed approach to leadership. By bringing together all the elements of Solutions 1 to 3, the organization will be able to address the needs of youth and provide a program that works to increase successful outcomes. Solution 4 looks at the problem from CRT and CIRM by considering and understanding the layers to address the PoP. Providing regular mental health support without thinking about the implications through the lenses of race and racism and without considering historical factors and Indigenous methods of healing can cause harm. Further, the cultural framework will not work without youths’, the Indigenous department’s, and the community’s perspectives. Allowing space for community members to engage and to teach traditional healing aligns with the organization’s ethical obligations.

As a change leader, I recognize the complexity of this problem, and I am aware that I have blind spots. As such, it is critical to centre Indigenous people in the solution process to leave space to adjust approaches after consultation. As explained in Chapter 1, the organization is rich in resources and supports, both internally and externally. Senior management is open to change and, through my role as change leader and my strong relationships, I will share the plan
with senior management and offer support in its implementation. Using the theoretical frameworks of CRT and CIRM (see Figure 2), I will explain why collaboration, distribution, and representation are important when creating change impacting Indigenous populations. I will work with senior management to identify a change champion, which I discuss further in Chapter 3. This OIP has an opportunity to make significant contributions in this field of work. Due to these factors, Solution 4 is both attainable and the responsible solution to meet the needs of RTR Indigenous youth.

**Leadership Ethics and Organizational Change**

Ethics plays a crucial role in implementation of this OIP. The two areas I will focus on are TL and ethics as well as counselling of Indigenous youth, under which there are six ethical considerations discussed. Considering these are important to ensure the safeguarding and proper implementation of change and identification of challenges Organization X may encounter.

**Transformative Leadership and Ethics**

Leadership ethics contribute to a more caring and just society, provides system of principles that guide us in making decisions about what is right or wrong (Northouse, 2016). TL views ethics through a transformative paradigm (Baez, 2002; Butler, 2002; Liamputtong, 2007; Peled & Leichtentritt, 2002; Sanders & Munford, 2005; Shaw, 2003). TL, in the context of this OIP, means considering and aligning the focus around Indigenous youth and traditions. Shields (2014) explained, “Transformative leadership [is] addressing deep and equitable change” (p. 32), this aligns with Deszca et al.’s (2020) awakening step of the Change Path Model, which explains why change is required. Indigenous youth in the RTR program are often the voiceless in society as highlighted in Chapter 1, thus it is an ethical concern that leadership must be made aware of. Despite research showing that mental health is a proven resource in supporting youth, this therapeutic modality has yet to be provided. Leaders have a responsibility to address inequalities youth face in accessing services. By addressing ethics from a social justice lens,
leadership can distinguish and analyze inequalities faced by current practice and awaken (Deszca et al., 2020) to change. By recognizing and understanding the problem, change leaders can contribute to social justice by way of change (Mertens & Ginsberg, 2008), and move towards the acceleration stage of the Change Path Model, which focuses on planning and implementing the change (Deszca et al., 2020).

My personal role as a change leader in this OIP will depend on my ability to bring about change (Ciulla, 2020), but this requires internal analysis to conclude if change is for the betterment of the clients. In this OIP, I examined several ethical questions: Is this the right thing to do? Was it done in the right way? Was it done for the right reason? (Ciulla, 2020). Given my position as a middle manager within the organization, conducting this OIP has helped build trust with senior management. I am confident that allowing the voice of youth and Indigenous stakeholders to be centre displays great ethical consideration.

Counselling Indigenous youth is the second ethical consideration. Clinicians within the organization will be part of the development of how counselling will be provided, as well as, how clinicians remain ethical in their work. There are various counselling ethical bodies which counselling professionals must adhere to in their practice. These include British Columbia Association of Clinical Counselling (BCACC), British Columbia Association of Social Work (BCASW), British Columbia Psychological Association (BCPA) and Canadian Counselling Psychological Association (CCPA). Ethical consideration in counselling would fall under all four stages of the Change Path Model (Deszca et al., 2020), ensuring ethical practice throughout. CCPA is the largest regulatory body, therefore I will use their code of ethics to explain specific responsibilities when supporting Indigenous youth. A specific code of ethics was developed by CCPA (2020) and is “based on the premise that counsellors/therapists approach Indigenous Peoples, communities and contexts from a place of humility and not-knowing. It is based on being respectful of the unique history of the land now known as Canada” (p. 30).
There are five areas to consider in regards to providing counselling to Indigenous youth. First is to have an awareness of historical and contemporary contexts. This discusses “the impacts of the helping profession in contributing to the historical, political, and socio-cultural harms endured by Indigenous Peoples in Canada” (CCPA, 2020, p. 30). This requires leadership to facilitate training opportunities to ensure historical understanding is suitable in the Awakening stage (Deszca et al., 2020). The second area is reflection on self, personal, cultural, and identity. Clinicians should “reflect on and understand their own identity” (CCPA, 2020, p. 30), as well as reflect (Tomkins & Nicholds, 2017) on “internalized racism, unexamined privilege, questioning assumptions and previous learning” (CCPA, 2020, p. 30). This will lead to self-directed inquiry into one’s self-concept, self-esteem, motives, values, beliefs, and behaviours (Tomkins & Nicholds, 2017). Leaders will take action to support this process and appropriate acceleration of the change process (Deszca et al., 2020). The third area is recognition of Indigenous diversity. Although Indigenous Peoples within Canada may share values, beliefs, and cultural practices, it is crucial to acknowledge Indigenous diversity (CCPA, 2020). During implementation it is vital to shift to client-centred practice, placing youth as the expert in their treatment. The fourth area is honouring client self-identification. Meaning “consider Indigenous peoples in the context of their culture and history, dependent upon the youth’s wishes to identify with and participate in their own cultural practices” (CCPA, 2020, p. 32). Distributed practice in counselling supports social determinants and has been identified by this OIP as a necessary ethical approach for Indigenous youth. Distributed counselling means allowing youth an equal role and voice in their counselling (Zepke, 2007). This approach is justice based and assists to change systems and structural hierarchy by empowering youth self-determination (Zepke, 2007). The fifth area is respectful awareness of traditional practices. That includes being familiar with traditional teachings, values, beliefs, approaches, protocols, and practices and getting permission from Indigenous communities before incorporation of Indigenous teachings.
This can be done by seeking clarity through cultural leaders such as elders or healers (CCPA, 2020) and the Indigenous department.

**Chapter Summary**

This chapter identified TL and DL as the chosen approaches to guide the change process. I described Deszca et al.’s (2020) Change Path Model as frameworks for implementing change. I critically analyzed Organization X using Nadler and Tushman’s (1989) Organizational Congruence Model to understand the layered system in which Organization X operates and to understand what is congruent and what is not. I outlined four solutions and I chose Solution 4, as the best path forward. Lastly, I discussed leadership ethics and ethical counselling considerations in organizational change. The next chapter discusses the implementation, evaluation, and communication of the OIP.
Chapter Three: Implementation, Evaluation, and Communication

As shown in Chapter 2, organizational change is complex and requires a detailed analysis of the organization. It requires the right leadership approach, a well-thought-out framework for leading change, a thorough analysis of the organization, as well as a solution that is applicable and able to be implemented. I have identified what is required to achieve the desired state in Chapter 2. In this chapter, I cultivate the chosen solution to provide mental health counselling that is culturally sensitive and collaborative with key Indigenous voices. I incorporate the knowledge gleaned from previous chapters to create a change implementation plan, define the process of monitoring and evaluating change, outline the communication plan, discuss limitations, and, finally, discuss future considerations. The CRT and CIRM are central frameworks and considered in all aspects of planning the change implementation plan. TL and DL, despite being a departure from traditional leadership styles found in Organization X, are necessary for the change implementation plan to be successful.

Change Implementation Plan

The PoP addressed in the OIP is the recidivism that many (but not all) Indigenous youth experience after being discharged from the RTR program. I also use Deszca et al.’s (2020) Change Path Model of awakening, mobilization, acceleration, and institutionalization to guide the change process and provide action steps for this OIP while incorporating the five tenets of CRT (Solórzano & Bernal, 2001) and four Rs of CIRM (Evans et al., 2009).

The change implementation plan will provide Organization X with guidance and evaluate the ongoing process. One of my roles as a change leader is to identify a change champion (senior manager) who will have three responsibilities: (a) initiation—to learn and have a change mindset, (b) facilitation—organizing learning activities for self and others, and (c) implementation—planning and managing the change process (Warrick, 2009).

In Figure 3, I provide a snapshot of the current state of the organization and the proposed envisioned state that is the final goal. Currently, RTR provides behaviour supports
during a youth’s 3-month stay. As a change leader, I will present a new envisioned state that addresses the underlying mental health needs of Indigenous youth. In the envisioned state, mental health counselling will be provided by clinicians in collaboration with the Indigenous department and the community.

**Figure 3**

*Current State to Envisioned State*

The time required to complete proposed Solution 4 is 36 months. The OIP has allowed for more time to build key relationships with Indigenous communities and give community members the time required to provide thoughtful feedback to the change implementation plan. The proposed change addresses three areas: implementation of mental health services, provision of culturally sensitive modalities, and collaboration with stakeholders.

**Change Implementation Timeline**

In this section, I discuss the change implementation plan. I seek to anticipate stakeholder reactions to change, determine other supports and resources, identify potential implementation issues and how they will be addressed, as well as identify short, medium and long-term goals and, finally, acknowledge limitations.

In Chapter 2, I concluded that Deszca et al.’s (2020) Change Path Model will be the framework used for the change implementation plan. Momentum will be built and sustained in the long term by using five tenets of CRT (Solórzano & Bernal, 2001) and four Rs of CIRM (Evans et al., 2009). These will provide a framework for stakeholders to understand the problem, share experiences, and be part of a process in a way that supports Indigenous ideology, which will help mitigate resistance and malaise. See Appendix F for a change plan timeline using
the Change Path Model (i.e., awakening, mobilization, acceleration, and institutionalization).
The change implementation plan provides a detailed plan of the necessary supports and resources, which I explain further later in this section. The plan details supports and resources including time, human, technology, financial, and information.

In Figure 4, I present a timeline of 36 months to implement change. The timeline corresponds with the Change Path Model (Deszca et al., 2020). The optimal time to start the change implementation plan is January 1, 2022. The three subsequent years are as follows: Year 1 – Awakening, Mobilization; Year 2 – Acceleration; and Year 3 – Institutionalization.

**Figure 4**

*Change Implementation Timeline*

**Awakening Phase**

As a change leader, I need to ensure organizational members are aware of the need for change (Deszca et al., 2020). First, I recommend the organization review this OIP the December prior to January 1, 2022. There is a research review process senior management must follow in order to approve the use of a document. In the first 6 months of Year 1 (January–June, 2021), I
will meet with stakeholders face to face and explain the need for the change as well as share external and internal data collected by the organization. The director, senior management, Indigenous department and I will discuss internal and external stakeholders (Deszca et al., 2020) required and their perceptions of change.

In March 2022 of Year 1, RTR stakeholders will gather together and share the proposal for change through a gap analysis (Deszca et al., 2020) with internal stakeholders. During this time staff will complete a survey regarding their thoughts and concerns. The results of the survey will allow members of Organization X to directly provide input into the new vision. At the same time, along with the change champion and head of the Indigenous department, I will facilitate a meeting with various Indigenous leaders identified throughout BC who can contract with Organization X to support the change implementation plan.

With local representatives, we will go to their communities for discussions and, if the budget allows, take air transport to distant communities. I recognize the COVID-19 restrictions may limit in-person interactions, and in that case we will use technology to interact. We will not use surveys with Indigenous communities; rather, I wish to invite community members to share their feedback through oral discussions, which is more culturally appropriate. Further, they may have a preferred model of collaborating and providing feedback which we will adopt. Both internal and external feedback will be included in the new vision. This will also be the time when internal and external staff meet each other to create a collaborative working team. As detailed in Figure 1, relevance, centring race, and challenging perspectives are critical to improving the plan and to understanding how race and Indigenous history can impact but be a source of strength in this OIP. These discussions will occur with all stakeholders present and throughout the change implementation plan. I will help facilitate learning circles with a focus on historical and current factors impacting Indigenous youth and resilience. The Indigenous department and community members will take the lead. Further, stakeholders will be required to complete cultural
competency training offered by Organization X that is focused on supporting Indigenous communities at this stage.

_Mobilization Phase_

Reviewing and analyzing staff survey and discussion points from the awakening phase will impact the next phase: mobilization. From June to December 2022, the formal systems and structures will be leveraged (Deszca, 2020). There will be two internal change teams overseeing the operation, as shown in Appendix G. First, the steering team, which includes the director and senior management will oversee operations and provide support to the change implementation team. Second, the change implementation team includes two members, not including management of each internal position, as shown in Appendix B, which include one senior manager, one team leader, two Indigenous department, two clinicians, and two case workers. The roles of members of the change implementation will include providing recommendations to the steering committee. The external change team will include identified Indigenous community leaders and caregivers as needed.

However, Organization X will need to create a reward system for internal team members who will motivate stakeholders to join the change implementation team. Compensation for Indigenous community members’ time will be done in consultation with the community. Rewards for the internal team can be in the form of monetary supplementation or earned time off. The steering team will use DL to differentiate roles and responsibilities and integrate new roles with existing departments. DL provides opportunity for change teams to work together and offer feedback on areas of success and areas still needing augmentation. This correlates with Figure 1, with reciprocity aligning with being interdisciplinary. Following CRT and CIRM, the change implementation team and external team together will be responsible for assessing power and cultural dynamics using the stakeholder analysis template found in Appendix H. This will allow stakeholders to reflect on power dynamics, in particular with external stakeholders, to mitigate power imbalance. Emergent leaders will be utilized based on need and skill required
(Lichtenstein et al., 2006). The external team of Indigenous leaders will look to communities where youth live or part of their band for knowledge of cultural needs of the youth, which can aid in mental health supports. Caregivers will continue to track Indigenous youths’ behaviour using RTR data sheets after discharge. This will allow RTR to assess the effectiveness of mental health services long term. This is where therapeutic modalities identified and training opportunities will be planned and implemented.

My role as a change leader is to encourage a shift to a transformative lens of assessing power and influence (Deszca et al., 2020). Leadership within Organization X will allow for the building of greater trust and relationship between management, staff, youth, and community. Once the action plan draft has been approved (Deszca et al., 2020), the change champion and I will communicate the need for change to all stakeholders, recognizing individuals may initially react negatively to the idea of change “before, during and after the change” (Deszca et al., 2020, p. 243).

**Acceleration Phase**

With mobilization underway, the acceleration phase will take focus. This will occur in Year 2 (January–December, 2023) with planning and implementation (Deszca et al., 2020) of the change plan. The change implementation team, along with the steering committee and external team, will develop “new knowledge, skills, abilities, and ways of thinking that will support the change” (Deszca et al., 2020, p. 324). This aligns with Figure 1, with respect aligning with valuing experiential knowledge of Indigenous communities. The change teams will develop a framework for implementation using tools of action planning, which can identify issues and actions taken to solve the problem. The change implementation team and external team will together discuss when and how to provide counselling services, including what is involved in an assessment and intake process. During this time, the change implementation team and external team will meet together weekly for 2–4 hours or as needed.
Training will be provided to all stakeholders using the learning circle (identified in Chapter 2) on topics such as counselling therapeutic modalities, traditional Indigenous approaches to mental health, and cultural sensitivity training. Staff, the Indigenous department, and the Indigenous community will be invited to provide training associated with their expertise once a month. Training will be all day. Case workers, clinicians, and supervisors will create data-tracking sheets that highlight areas of concern during Indigenous youths’ admission to the program. The data will be analyzed throughout a youth’s stay in order to determine what change has occurred, either positive or negative (undesirable or desirable), as the result of mental health supports. This is referred to as behavioural markers. Undesirable markers youth may display include but are not limited to physical harm to self or others, property damage, negative language, not following directions, and an inability to self-regulate. When youth are not meeting in these areas, it impacts their ability to go to school, make friends, have stable homes, and maintain overall health. Desirable markers include, but are not limited to, being physically safe to self and others, listening to directions, following schedule, being a good friend, increasing distress tolerance, and being able to express needs in healthy ways.

The data will be tracked daily and specifically geared to areas that impact individual youth. RTR wants to see youths’ undesirable behaviours decrease and desirable behaviours increase. Community members will use the same data sheet to track behaviour. The goal would be to see recidivism decrease and success in community 3 month post-discharge. Clinicians will also chart counselling sessions to document clinician’s perspective if there has been improvement in mental well-being. The Indigenous department will be part of the decision-making process to ensure culturally appropriate practices are utilized in sessions with youth. During the mental health supports process, youth will have a voice regarding which approach and cultural modalities will be incorporated. Further data will be collected in the youth’s perception of well-being using the medicine wheel, as shown in Figure 5.
Figure 5

Medicine Wheel Assessment Tool

Note. Based on the works of Bamblett and Lewis (2007), Hiraldo (2010), and Mayes (2019).

Figure 5 is a medicine wheel adapted to fit target goals for RTR youth by looking at the whole person including (emotional, mental, physical, and spiritual). The youth and RTR will know if the youth is reaching balance in their life. Adaptations to the medicine wheel will be made based on developmental level. Some youth will draw feelings, and others will circle pictures that describe how they feel. Some may write, while others will share orally with clinicians to fill in necessary information. Adaptation of this assessment tool will be client centred.

Mental health support will be considered a pilot project and will need to be a fluid process in order to adjust to new information and circumstances. Lastly, Organization X will celebrate the small wins along the path of change (Deszca et al., 2020). Small wins will mean the organization has completed the three phases of Year 1—awakening, mobilization, Year 2—acceleration, and Year 3—institutionalization. At the end of each phase, the organization will
celebrate by paying for lunch and providing positive work appraisal. For external team and community members, we will send handwritten thank-you cards.

**Institutionalization Phase**

During the third year of the change implementation plan (January–December, 2024), the process will evolve as it moves towards the envisioned state. The RTR will track the ongoing change, guiding progress toward goals and modifying approaches as needed to mitigate any risk (Deszca et al., 2020) in collaboration with each change team. The organization will continue to “develop and deploy new structures, systems process(es), and knowledge, skills, and abilities as needed” (Deszca et al., 2020, p. 372). That means ensuring the teams and collaboration between internal and external stakeholders is successful. Further, as time passes, new ways of improving counselling for youth will be identified and implemented. This supports CRT and CIRM in Figure 1, with responsibility aligning with commitment to social justice, which requires the teams to act and improve the program together at the same time centring justice. Ultimately, by implementing the Change Path Model, Indigenous youth will receive mental health supports, which will improve their quality of care and their chances of moving forward after discharge.

Indigenous communities will be involved at each stage of change. During the acceleration phase, when the mental health support is provided, the change implementation team and external team will meet bi-weekly. In the final phase, institutionalization meetings will be monthly; these will be used to update internal and external stakeholders on the change and what the data are showing, again face to face when possible. External team members will be able to provide feedback at all times. Further, community leaders will be invited to provide training or to join in training offered by Organization X, thereby addressing the PoP. Training will be ongoing until change implementation is completed. Meetings will be arranged in collaboration with input from all teams. Agendas and meeting minutes will be shared with all teams, taking into consideration privacy when sharing information with external team members. Data on program success will be shared with all stakeholders. More information on individual youth
success will be shared with all teams and caregivers on a monthly basis in a report and face to face by the change implementation team and external team. The change implementation plan will be intentional and thoughtful when opening up the team to include Indigenous communities with the hopes to repair relationships with community members, recognizing the best approach to health requires an Indigenous approach to health and healing, which pairs with CRT and CIRM. Policies will be updated to include mental health supports. This section examined the change implementation plan in detail. The next section explores stakeholders’ reactions to change.

**Understanding Stakeholders’ Reactions to Change**

The importance of how change recipients, in this case stakeholders of Organization X, perceive and respond to change cannot be underestimated. Reaction to change has both cognitive and behavioural components (Stensaker & Meyer, 2012). Further, leadership’s ability to predict and handle different responses to change among employees are key management challenges (Stensaker & Meyer, 2012). According to Ceptureanu (2015), resistance to change can occur for a variety of reasons. The change champion, along with the change implementation team, should monitor this through face-to-face communication and surveys to understand various perspectives. Leadership plays a role in facilitating and supporting stakeholders change capabilities (Ceptureanu, 2015). Experience with previous change within the organization and the degree of experience individuals have with change (Stensaker & Meyer, 2012) can also impact stakeholders’ reaction to change. According to Stensaker and Meyer (2012), “Employees with limited change experience exhibit strong behavioral and emotional reactions, while employees with extensive change experience use less effort to resist change and show more loyal reactions to change” (p. 107). Stakeholders within Organization X have varying experiences with change. Employees who have been around a long time will more likely have a favourable view of change, because they have seen successful change outcomes. New staff may be more hesitant
because they may not understand how change improves quality of care and how it may impact them.

Youths’ and external stakeholders’ experiences with change should also be understood. Youth are also stakeholders in this change. Leadership will need to recognize that if clients have experienced negative impacts from past trauma, they may resist change. External stakeholders’, specifically caregivers’ and Indigenous communities’ reactions to the change will also impact the change plan. Caregivers will have a favourable view of additional resources that can improve youth stability once discharged. However, Indigenous communities may be more hesitant due to the historical and present relationship with MCFD and impact of policy changes on this population.

Adjusting plans to support individuals who are hesitant and sceptical about change will be accomplished by tracking perceptions of change, including all stakeholders in the change process, and addressing stakeholders’ concerns and listening to their recommendations when possible, which is in the change implementation plan. When stakeholders feel that change is in their control and they are part of the process, they are more likely to have favourable views of the change and participate willingly.

**Individually Who Empower Others**

TL will empower stakeholders in Organization X to address the problem by activating a social justice and activism perspective. TL inspires individuals to look at issues from a global perspective (Shields, 2018) and calls on individuals to provide greater service, while it addresses equality and justice for all. Furthermore, staff in Organization X are in the helping profession and often share this philosophy. Leadership will be shared. TL will centre the Indigenous voice and experience, in particular the Indigenous department and communities. Indigenous community leaders will be invited to speak with internal stakeholders about Indigenous perspective and how the organization has and can further improve the change implementation plan. Indigenous communities will be directly part of the change implementation team. Further,
DL will provide opportunities for internal and external stakeholders to contribute in their areas of expertise and take on leadership opportunities on the change implementation team throughout the change process. This fluid and balanced approach toward leadership will empower others to step up. DL is relational in approach. Relational leadership often leads to collaborative partnerships among leaders who aim to change the environment to improve outcomes (Grin et al., 2018). Indigenous communities centre themselves in relationship with others. In particular external Indigenous communities will understand this approach to change and collaboration. Nurturing relationships will help alleviate issues of trust (Grin et al., 2018) for Indigenous youth and communities. This approach of focusing on relationships is both a TL and DL approach. Further, it will change the top-down approach to leadership to one that sees everyone as equal and in fact views Indigenous communities as the experts, coinciding with the CRT and CIRM.

While empowering employees is important, it is critical that Indigenous youth feel empowered during the process of receiving mental health counselling too. Indigenous youth will feel empowered when clinicians provide space for hope, belonging, meaning, and purpose, which are measurable indicators of wellness. As such, the clinician and client relationship will be imperative. The clinical process should be a safe and trusting environment that builds resilience (McGuire–Kishebakabaykwe, 2010) in Indigenous youth. During the clinical process, youth should be involved in determining the type of mental health support used, including the Indigenous approaches incorporated. Youth will be asked to share their feedback with the Indigenous department on the counselling process and whether they found it helpful. This information will inform processes and impact the program moving forward.

**Supports and Resources**

In this section, I identify and explain the support and resources required to effectively exercise the change implementation plan by focusing on human, technology, financial, and informational. See Appendix F for the impact of these supports and resources on the change
implementation plan in chronological order. The steering committee, change implementation team, and external team will meet regularly throughout the process as identified earlier in this chapter. Management may choose to hire new clinicians to provide counselling or allocate this to current clinicians as a new duty. Office space, computers, and basic administrative supplies including a library of counselling books are needed. Resources and costs should be minimal.

**Potential Implementation Issues and How They Will Be Addressed**

Members of Organization X will need to understand potential implementation issues and how to address them. In this OIP, I have identified three potential implementation issues that could occur: (a) individuals or leaders not supporting change, (b) people not understanding reasons for change, and (c) increased workload overwhelming current staff. These issues will be addressed by (a) creation of a sense of urgency, (b) education about the need for mental health supports, and (c) distribution of work to make change manageable.

**Create a Sense of Urgency**

As a change leader, I have found that providing mental health counselling, which traditionally offers a centred approach (Gone, 2013), is effective. I will clearly communicate this to the director, the change champion (senior manager), steering committee, the change implementation team, and the external team. The change champion, the Indigenous department, and I will also talk Indigenous communities. This must be done by explaining the serious problem identified in Chapters 1 and 2, and management will need to create new systems that centre Indigenous voices (Hindle & Moroz, 2010). As identified in Chapter 2, the internal data showed that Organization X is not serving the number of youth originally expected by the government. Factors including complex care needs and historical and current impact facing Indigenous youth has led to recidivism. That indicated a strong need for review of RTR practice and services. An external factor that cannot be ignored is the concern of community caregivers regarding youths’ behaviour regression after discharge. Management will need to move out of its current comfort zone (Kotter, 1995), which includes creating new systems. A
change champion can create urgency for change by inspiring other stakeholders. The change champion will need to rebalance schedules to remove low priority items and dedicate time toward the change implementation plan and be a visible symbol in the change (Kotter, 2009). Leaders will need to be aware of individuals that will find reasons why change is not important. Bringing these individuals into the process is vital, assuming they are skeptical but willing to examine the data (Kotter, 2009). However, if they cannot be brought on board it could cause serious damage to any efforts towards change. Skeptical reactions from Indigenous stakeholders need to be taken seriously and adjustments must be made based on recommendations. Change urgency must be kept up to improve results (Kotter, 2009) throughout the creation of the new vision.

**Education about the Need for Mental Health Supports**

The change champion and my role as a change leader is to facilitate conversations with stakeholders about the process of change and why it is necessary (Fernandez & Rainey, 2006). To convince stakeholders, the change champion and change leader will explain the new vision in a way that is clear and enticing for stakeholders (Fernandez & Rainey, 2006). This will occur during the awakening phase, in the second half of Year 1. First, the steering committee and I will meet with the Indigenous department face to face. The plan will be shared and documents will be made available for staff to review. We will have a follow-up meeting to discuss the plan, answer questions, and hear concerns and recommendations. We will continue to meet once a week, or as required. The Indigenous department and change leader will schedule a meeting with leaders in their community and share the adapted plan after incorporating the Indigenous department’s feedback. Community members will also be given 2 weeks to review documents and then invited to attend an in-person sharing session. We will meet frequently over a month until the community is satisfied with the plan. At the same time, we will hold learning circles at the office to share information with staff face to face and to receive feedback. How information is shared is important as well (Oreg, 2006). The steering committee will allot training and
educational opportunities to individuals to help them understand why mental health support is needed and how providing this service will improve RTR. During this process, there will be space to ask questions and give feedback. We will hold a large meeting with staff and will be able to answer follow-up questions one on one or in small groups from each department.

**Buy-in From Youth and the Community**

The MCFD has a strained relationship with Indigenous communities because of laws like the Indian Act (1985) that have impacted all aspects of Indigenous life. Further, MCFD as an organization has been part of the system that removes Indigenous youth from communities, historically with the goal of assimilation. As explained in Chapter 1, there are more youth in the child welfare system now than ever before, and this can lead to distrust. Clients’ experiences with adults and systems like RTR have not always been safe and reliable. What that explains to me is resistances to change is an expected and necessary mechanism to protect one’s self and community. Five tenets of CRT (Solórzano & Bernal, 2001) and four Rs of CIRM (Evans et al., 2009) will help leaders anticipate and honour hesitancy. Knowing that hesitancy is accepted and welcomed, TL and DL approach to leading can midgait these appropriate concerns that may arise. Leadership will also need to include the youth and Indigenous community in the change implementation plan (Cunningham et al., 2002), which will bolster willingness to change.

**Identifying Short-, Medium-, and Long-Term Goals**

Using the phases of the Change Path Model, I identify short-, medium-, and long-term goals and indicate milestones of the change implementation plan, as shown in Appendix I. Short-, medium-, and long-term goals provide a path to achieving the desired future state. Short-term goals are about understanding, approving, and creating a team. This includes identifying a change champion, director approving plan, creating change teams, sharing info, and collecting feedback. The medium-term goal is the heart of the change process, involving understanding and communicating the need for change, eliciting feedback, training staff, and implementing the change. This phase includes the following: analyzing feedback including
surveys, holding meetings with stakeholders to communicate need for change, training for staff, assigning clinicians, and providing counselling. Lastly, the long-term goal involves tracking change, improving service as needed, and updating policy to include the new solutions. Behaviour data and the medicine wheel will be used to track data in Year 2. Further, policy will be updated and improvement to solution will be ongoing.

**Limitations**

Creating change within any system is not without its limitations and Organization X is no different. Implementation of this OIP is entirely possible and within the scope of the RTR and its coalition members. I discuss the three limitations that could be the greatest challenges. First is the perception and bias around Indigenous youths’ ability to succeed with mental health supports. As identified in Chapter 1, this population has complex diagnoses and with those come stigma about their ability to benefit from counselling (Preyde et al., 2011) or mental health supports. Equally of concern is an organizational culture that may be stuck in its pattern of providing only behavioural support, rather than focusing on services that can empower the voice of the youth.

The second concern is collaboration with the Indigenous department and how that will function. Currently, the contract with the Indigenous department staff is limited to 10 hours a week; this is not sufficient and would require a renegotiated contract with increased hours to collaborate in a meaningful and productive manner. This OIP requires an additional 10 hours a week from Indigenous department to support this change. Organization X is looking to hire two full-time staff for the Indigenous department, which would meet the need for this OIP change implementation plan. Shift in perception and frequent collaboration with the Indigenous department would be required in this change implementation plan.

Lastly, as discussed earlier in this chapter, clients’ and the Indigenous community’s buy-in are essential due to historical factors with the Government of Canada, including 60s scoop and millennium scoop. The organization will need to understand issues through a CRT lens and
incorporate collaboration with the community through an CIRM lens. TL and DL will support easing limitations discussed.

In summary, the Change Path Model (Deszca et al., 2020) was used to outline the 36-month change implementation plan. This OIP assessed the resources required and organized goals into categories of short, medium, and long term. Identifying and addressing potential issues will assist Organization X in understanding how to support stakeholders during the change process. Lastly, I discussed limitations associated with perception and operational matters. The next section explains how to monitor and evaluate the change implementation plan. This section discussed stakeholders’ reactions to change. The next section explores change process monitoring and evaluation.

**Change Process Monitoring and Evaluation**

In this section I address the approach to monitoring and evaluating this OIP along with the overall leadership approach. Evaluation team will also follow Deszca et al.’s (2020) Change Path Model timeline in the system change evaluation. Two important tools for monitoring and evaluation are identified: Patton’s (1994) developmental evaluation and Latham’s (2014) the systems change evaluation. Developmental evaluation is used to address questions, develop resolutions, and give timely feedback. Systems change evaluation holds accountable the organization to move toward “co-creating new relationships with First Nations people, including how organizations work with each other” (Restoule et al., 2015, p. 93). Further, developmental evaluation allows for face-to-face interactions that create belonging, trust, and relationships that highlight Indigenous ideology. Systems change evaluation allows leaders to look at the change implementation plan from a CRT perspective of what needs to change and how these systems have impacted Indigenous youth. Further, developmental evaluation aligns with a CRIM in that it is about relationship building and connecting in the moment to resolve issues that arise.
Leadership Approach to Change

In Chapters 1 and 2, TL and DL were identified as the approaches grounding this OIP. These leadership approaches will also be used throughout the change implementation plan identified in this chapter. The evaluation team will use DL to monitor and evaluate change, allowing the right voices to be heard and concerns to be addressed. The evaluation team will include two community leaders, one team leader, two Indigenous department staff, one clinician, one case worker. The need for TL will be apparent in the awakening and mobilization phases, supporting the urgency and enthusiasm needed to enact change. The bulk of DL will occur in the mobilization and acceleration phases, where the program is gaining momentum. As a change leader, I will support the evaluation team, change implementation plans and evaluation process. Lastly, both leadership approaches will be used in the acceleration and institutionalization phases, where the majority of the evaluating of the change implementation plan occurs.

Evaluation Frameworks

I will use two evaluation frameworks: developmental evaluation (Patton, 1994) and the system’s change evaluation (Latham, 2014) for evaluating Organization X’s change implementation plan. These two approaches will complement one another and be deployed alongside the change implementation plan, using Deszca et al.’s (2020) Change Path Model. I have chosen these frameworks because the distinct evaluation processes analyze areas not addressed by the other.

Developmental Evaluation

Developmental evaluation fills the gap that system evaluation leaves and will help Organization X evaluate the program. This evaluation approach is suitable because it focuses on the cultural and local context of the organization (Patton, 1994, 2016), which centres on employee development and support. Further, “developmental evaluation is not method-based which allows it to sit comfortably within Indigenous perspective” (Patton et al., 2016, p. 30).
One of the strengths of developmental evaluation is its adaptive development, which informs and supports innovation (Patton, 1994). This framework asks stakeholders to be reflective and practical and to consider ethical consequences (Patton, 2016) when providing support to Indigenous youth. This will be an ongoing practice, recognizing in the past the government did not practice reflective practice when caring for this population. Patton (1994) also asserted, “[It] brings to innovation and adaptation the processes of asking evaluative questions, applying evaluation logic, and gathering and reporting evaluative data to support project, program, product, and/or organizational development with timely feedback” (p. 31). Evaluation provides rapid feedback and is collaborative. It invests in social involvement with stakeholders and tests approaches long term with the goal of intentional change and development (Patton, 1994). This evaluation support will be provided to various internal stakeholders during the change implementation plan and completed by the evaluation team. Further, the evaluation team will seek a “critical friend,” which in this case includes Indigenous leaders or community members who will engage in ongoing evaluation discussions with staff and organizational leadership (Fagen et al., 2011). This process will begin at the end of the awakening phase (May to June, 2022).

In the mobilization phase (July–December, 2022), acceleration phase (January–December, 2023), and institutionalization phase (January–December, 2024), questions will arise from the evaluation team or various stakeholders. Within this framework group discussions will occur, and the evaluation team will review relevant information and give timely feedback to support change face-to-face. According to Patton (1994), “Development evaluation then becomes part of the intervention” (p. 33). The organization’s culture will shift as a result of the learning that occurs during the evaluation process, both among the evaluation team (Patton, 1994) and the stakeholders. Developmental evaluation focuses on evaluation of change throughout the change process and centres on the individuals within the organization. Developmental evaluation will be conducted face-to-face to see how change is taking place and
resolving issues that arise. This will be done during daily shift changes between outgoing and incoming staff. The evaluation team will use templates to ask questions and listen to questions staff have. Further, the evaluation team will meet with clinicians weekly to evaluate progress face to face or by email. Evaluation team will update the community bi-weekly or monthly and ask for the feedback. This process aligns with both CRT and CIRM and with DL and TL. It will be important to celebrate the small wins at the end of every phase of change with internal and external stakeholders through positive praise from management.

**System’s Change Evaluation**

The second model discussed is the system’s change evaluation. The goal of this model is to evaluate systems and system change (Latham, 2014). This model consists of a set of tools that Organization X can tailor to its own evolutionary needs. Using the *Systems Change Evaluation framework* (Latham, 2014), this OIP will focus on (a) evaluation planning, (b) collecting baseline data and follow up, (c) describing the change between baseline and the follow up, and (d) analyzing how the proposed solution contributed to change (Latham, 2014). This will facilitate the change implementation plan and ensure systems change is aligning with Indigenous community’s needs.

**Evaluation Planning.** Evaluation planning has three-steps: (a) deciding where to focus the evaluation, (b) identifying your research questions, and (c) developing a data collection plan (Latham, 2014). Leadership in Organization X must engage various teams in identifying evaluation priorities by means of creating learning teams (Latham, 2014), which in the context of this OIP are called learning circles, a method that is often used in Indigenous communities and aligns with the Indigenous lens. Through these learning opportunities, reflection on various topics will result in answers that will support decision making (Latham, 2014). Organization X will monitor clients through two forms of data collection: the behavioural data collection sheet and the medicine wheel. The first form of data collection, the behavioural data collection sheet. This behavioural data sheet looks at overall behaviour of youth daily. The
areas of focus are aggression, property damage, compliance to programming, harm to self or others, and emotional regulation. Data will be collected daily and charts created monthly to see if there is an increase or decrease in undesirable behaviour. The second form of data collection is a medicine wheel. This sheet will be used at the start of counselling in collaboration with youth. The focus will be on the spiritual, mental, emotional, and physical well-being of youth as explained in Figure 5. The medicine wheel will be used minimum three times within counselling sessions to see how youth are progressing in these areas using their own perspectives. Both data collection tools will be reviewed by the evaluation team. The behavioural data will be collected and analyzed bi-weekly and the medicine wheel once a month a total of three times. Clinicians will chart after each session on what modalities have been used. Through the collection of data, the organization will understand the impact of the change implementation plan on youth and make changes as required. The steering committee will facilitate face-to-face bi-weekly meetings to discuss the change implementation plan with change teams. The evaluation team will take notes and support brainstorming of resolution to problems that arise collectively. Finally, through collection of data, the organization will ask the following questions:

- Has providing mental health support addressed recidivism?
- Are Indigenous youth benefiting from this service?
- Has the provision of this service improved community caregiver’s review of the program?
- What is the Indigenous department and community’s perception regarding this service?

These questions will need to be answered during the final phase of the change implementation plan; however, it is important for the evaluation team to be asking these questions in the acceleration phase as well. All surveys throughout will be administered by the evaluation team, provided to all stakeholders, reviewed by management and results shared through email and face-to-face learning circle meetings. TL will support critical thinking while
DL spirit will focus on collaborative practice. Leadership’s role will be to provide an environment where staff feel safe to share the strength and failures of the system without repercussion. Collaboration with Indigenous communities will break down racial factors identified in the CRT and foster relationships, as explained in the CIRM section.

**Collecting Data at Baseline and Follow-Up.** Data collection will correlate with questions identified in the evaluation plan (Latham, 2014). The evaluation team will identify means of collecting data to resolve the questions. This group will provide a confidential survey to staff. The survey should be a mix of yes and no, scaling (1–10 points), and short answers. The focus should be on the impact of the change on programming, along with how the system operated during the change. Collection of client data will be conducted in the acceleration to institutionalization phases in Year 2 (January–December, 2023) and Year 3 (January–December, 2024). Collection of staff data through surveys and face-to-face discussions will be conducted in all phases of Deszca et al.’s (2020) Change Path Model (January, 2022–December, 2024).

**Gauge Progress and Assess Long-Term System Changes.** The survey provided to stakeholders will be used to evaluate progress. Another analysis will be conducted to understand what long-term system change looks like in Organization X. See Table 2 for a pragmatic compare-and-contrast exercise that will allow Organization X to analyze change (Latham, 2014); this table offers a framework for Organization X to review data over an extended period of time. The proposed change is to provide counselling to Indigenous youth. In the baseline summary, RTR will look at how youth are doing by using the medicine wheel (Graham & Stamler, 2010). During and after providing counselling, the medicine wheel would be reviewed to see if changes have occurred, providing greater balance in the youth’s life. This will include asking for feedback from youth, clinicians, case workers, and caregivers. The addition of the summary of change will expand the ability of RTR to recognize and record if long-term positive effects have been the result of program changes.
Table 2

The Long-term System Changes Summary Table

<table>
<thead>
<tr>
<th>Aspect of Proposed Change</th>
<th>Baseline Summary</th>
<th>Follow-up Summary</th>
<th>Summary of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counselling for Indigenous youth of RTR requiring and agreeing to this service.</td>
<td>Data collected on Indigenous youths’ overall health (physical, emotional, spiritual and mental). During youths’ stay and 1, 3, and 6 months after discharge.</td>
<td>Data collected on Indigenous youths’ overall health (physical, emotional, spiritual and mental) after counselling services. During youths’ stay and 1, 3, and 6 months after discharge.</td>
<td>This service is new. It is expected that Indigenous youth would receive this support if required to support their overall health. Further this support would improve outcomes.</td>
</tr>
<tr>
<td>Collaboration with stakeholders. Including staff, Indigenous department, clinicians and caregivers in community.</td>
<td>Review collaboration process currently in place.</td>
<td>Review collaboration process after implementation.</td>
<td>Collaboration should improve services provided to Indigenous youth.</td>
</tr>
</tbody>
</table>

Analyzing How the Proposed Solution Contributed to Change. Organization X will have looked at the data over an extended period of time. The final section takes “analysis a step further and explore(s) the ways that the initiative’s strategies have contributed to the changes ... identified” (Latham, 2014, p. 81).

Using DL requires analyzing the effects that collaborative functioning has had on the success of the systems change initiative (Latham, 2014). This can be done by creating a chart with various stakeholders’ roles and the outcomes of actions taken on the proposed solution. While detailing the successes of change is important, an evaluation cannot overlook the failures; it should reflect on these as a means of learning.

Evaluation Plan Timeline

Aligning with the five tenets of CRT (Solórzano & Bernal, 2001) and four Rs of CIRM (Evans et al., 2009), the evaluation team will be activated in the acceleration and institutionalization phases of the change path. After a thorough evaluation, all teams will
reconvene and make final changes to the proposed solution, as necessary. Policy will be drafted and the changes will be actualized.

In Appendix J, I outline the evaluating plan timeline system change, which spans 3 years. In the awakening phase, the evaluation team will meet bi-weekly for 4 hours and formulate evaluation templates, including how they will analyze behaviour data and medicine wheel data. In the mobilization phase, the evaluation team will meet bi-weekly for 4 hours and relevant data will be collected. The evaluation team will collect feedback from staff and community members and then share findings and provide recommendations. In the acceleration phase, the evaluation team will meet bi-weekly for 4 hours and analyze and make sense of data collected. Behavioural data will be collected daily and made into a chart monthly. The evaluation team will share data with internal and external stakeholders. Finally, during the institutionalization phase, the evaluation team will determine the proposed solution outcome. Data will be tracked 1, 3, and 6 months after discharge into the community using a behaviour data sheet to see if desirable behaviours remain after discharge. Evaluation team will collect and review community data. Caregivers will be asked to complete assessments weekly looking at target behaviours identified for the youth. Community clinicians will provide monthly updates on youth through home visit assignments. This section examined change process monitoring and evaluation. The next section discusses the plan to communicate the need for change and the change process.

**Plan to Communicate the Need for Change and Change Process**

In this section, I outline how communication will take place. Well-planned communication is important at every level to ensure stakeholders are enthusiastic and productive during the change implementation plan. Effective communication will be central in supporting Organization X as it prepares various stakeholders for change. Clearly communicating the need for change throughout the change process reduces resistance to change. “When resistance to change levels is low within an organization, the change-effort turns
out to be more productive” (Husain, 2013, p. 43), which is the purpose of developing a clear and inclusive communication plan. Without effective communication by leaders, misinformation runs rampant throughout the organization (Deszca et al., 2020). The communication plan also examines the interpersonal context between the deliverer of information and receiver within the larger social/organizational/cultural context (Baker, 2007).

As noted earlier, TL and DL will be integrated throughout the communication plan. As explained in Chapter 2, TL focuses on explaining and communicating the need for change with an emphasis on social justice and creating equality. Further, DL focuses on amplifying the voices of formerly underrepresented stakeholders during Deszca et al.’s (2020) Change Path Model. These two leadership approaches will support Organization X throughout the communication plan.

**Communication Plan**

Communication channels are vital to the change implementation plan. The communication plan centres around the following goals: (a) to infuse the need for change throughout; (b) to enable individuals to understand the impact of change and how it will influence organizational processes; and (c) to keep people informed about progress along the way (Deszca et al., 2020). The communication plan will remain fluid to allow for fine-tuning throughout the change process. This OIP will ensure internal stakeholders and Indigenous community members understand and believe in the objective (Restoule et al., 2015). Organization X’s communication plan will take a four-phase approach: (a) pre-change approval, (b) developing the need for change, (c) midstream change and milestone communication, and (d) acknowledging and celebrating the small successes along the way (Deszca et al., 2020). The communication plan will focus on various stakeholders throughout the change implementation process to ensure everyone understands what is happening and to allow for ample opportunities to answer questions and ask for feedback. These stakeholders include internal and external individuals and groups. Internal stakeholders include the director, senior management (change
champion), the team leader, the Indigenous department, clinicians and other staff. External stakeholders include the Indigenous communities, caregivers — parents, staff and resources— as well as the homes in which Indigenous youth reside.

**Channels of Communication**

The channels of communication are a vital aspect of the change implementation plan. Some channels of communication are more effective than others. Face-to-face interactions or door-to-door interactions, as they call it in Indigenous communities, are the most effective (Klein, 1996; Restoule et al., 2015). See Figure 6 for the channels of communication from least to most effective communication strategies in change implementation planning. While all forms of communication will be used, Organization X will focus particular attention on the most effective channels. When face-to-face is not possible, video conference, phone, and emails may be required to share information. Furthermore, documentation in the form of written reports will be required of the organization. Figure 6 explains the channels of communication.

**Figure 6**

*Channels of Communication*

![Channels of Communication Diagram]


Organization X will aim to use face-to-face interactions as the prominent channel of communication. However, general and personal email reports will at times be required to share information.
**Pre-Change Phase**

My role as a change leader in this phase is to convince the director, senior management, and team leader, Indigenous communities that change is needed (Deszca et al., 2020). This will be done by creating knowledge (Lewis, 2019). This requires linking change to organizational goals. As a change leader, I will explain what a change champion is and why a particular individual from senior management is best suited for this role. Steering committees will also share the change implementation plan points with family heads, Elders, youth, community groups, band administration, Chief, and Council (Vosters, 2016) and seek their input again using the five tenets CRT and the four Rs of CIRM (Evans et al., 2009; Solórzano & Bernal, 2001), understanding relevance, centring race, and challenging dominate perspectives. Once the necessity of an overall vision is understood and adopted by the senior management, the change leader and change champion, Indigenous department, Indigenous community will create the communication plan for the next phase.

The communication plan will occur in the awakening phase of Deszca et al.’s (2020) Change Path Model. The first channel of communication used in this phase will be personalized emails, which I will send out to the director, senior management, and the team leader to request a meeting with all the internal stakeholders and share supporting documents regarding the reason for meeting and presenting the whole change implementation plan agenda. The second channel of communication in this phase will be face-to-face interactions. As identified in Figure 6, this approach is the most effective. It is important that senior management, community and staff understand how the change implementation plan will be executed. Face-to-face conversations provide an opportunity to clarify information and allow for open dialogue. While TL will be central to this phase, DL will be discussed as an important aspect of the subsequent phases. The steering committee will share the same documents with Indigenous communities and ask for feedback and make changes based on that. Further, a schedule will be made in collaboration so they can be part of internal meetings. This phase will occur in Year 1, from
January to June, 2022. Face-to-face meetings will take place weekly. This will give senior management, the change implementation team, and Indigenous communities an opportunity to engage in multiple face-to-face meetings to build a concrete plan that can be presented to stakeholders throughout the change implementation plan. At this time, the steering committee will ask the Indigenous department to solicit input from Indigenous communities using upward communication (Lewis, 2019) to empower their voice and feedback in the creation of the change implementation plan.

**Developing the Need for Change**

The second phase of the communication plan is to create awareness of the need for change (Deszca et al., 2020). The change implementation team and external team will create a communication plan to “explain the issue and provide a clear, compelling rationale for change” (Deszca et al., 2020, p. 350), and the change leader will paint a clear picture of what the future state will look like. When stakeholders are informed and understand the incoming change and their role in it, change has a much greater chance of success (Johansson & Heide, 2008). Reciprocity, being the interdisciplinary section of CRT and CIRM, will be used in communication. Stakeholders will discuss the efficacy and appropriateness of the change (Armenakis & Harris, 2002) and in collaboration will review, plan, and make changes based on feedback to ensure any concerns are addressed and plan is revised.

Recognizing various learning styles, Organization X will share information through written, oral, and visual means. Mass emails will disseminate information regarding the proposed change and the implementation plan ahead of group meetings. Dates for face-to-face meetings will be sent out 2 weeks before, and work schedules will be shifted to ensure all staff are able to attend. The first face-to-face staff meeting will run for half a day. Slideshow presentations will be provided. The presenters will include the change champion, the change leader, the change implementation team. They will address the need for change, the change implementation plan, the proposed future state, and what a change team actually is. There will
be an opportunity to ask questions and give feedback and surveys will be given out at the end of the day. Space will be created for all stakeholders to provide meaningful opportunities to engage in issues related to the change initiative with serious engagement in decision makers (Lewis, 2019).

This same presentation will be shared with the Indigenous community because external stakeholders’ voices will be vital for this change process (Lewis, 2019). Presentations will be brought to communities when possible. They will be able to give feedback face to face or to the Indigenous department alone. The second face-to-face meeting provided to internal staff will follow the same format as the first. It will, however, be focused on therapeutic modalities, the Indigenous department’s role, as well as on how the Indigenous lens can be better used in counselling. The Indigenous department will take the lead on traditional mental wellness perspectives and approaches through a sense of balance of body, mind, emotion, and spirit (Vosters, 2016), while clinicians will present other therapeutic modalities. In these meetings, talking or sharing circles will be utilized, which aligns with the Indigenous lens. These face-to-face interactions will help build trust, which will reduce resistance (Husain, 2013). The Indigenous department and clinicians are part of the implementation team and will be allocated 4 hours a week to develop their approach. This will be an ongoing process.

This phase corresponds with the mobilization phase of Deszca et al.’s (2020) Change Path Model. All of the ground work will have been completed and minor adaptation may then occur as a result of this group feedback. Two face-to-face meetings in large groups will take place in the 7th and 10th month of the first year. In this section, TL and DL will be utilized to create excitement about advocating for social justice. Staff members will also be provided with leadership opportunities, which are not often presented at this time. This phase will occur in Year 1, between July and December, 2022.
Midstream Phase

This is the third phase of the communication plan. At this point all stakeholders, both internal and external, will have all information “communicated to them about future plans and how things will operate” (Deszca et al., 2020, p. 351). In this section, the plan will have been created, the policy and procedure draft completed, and clinicians secured through internal movement or external hiring. Principal support will be provided by the steering committee so that all the teams are adequately resourced (Armenakis & Harris, 2002). Having clear direct conversations about the steps required will help stakeholders understand both the plan and their roles. This will be done by implementing respect and valuing experiential knowledge of Indigenous communities using CRT and CIRM in all aspects of the plan and by gaining approval before moving ahead.

Staff and external stakeholders (caregivers) will be updated by clinicians bi-weekly by phone or email with updates on youths’ progress in counselling. Further, external stakeholders, in particular the external team, will have face-to-face meetings with the change implementation team in their community, at Organization X or by video conference, to review how they collect client data and what the data reveal. This will also allow time for the external team to ask questions and provide feedback. Updating members of the community will build trust and allow them to provide feedback (Vosters, 2016). This is the action phase, the heart of the change. Communication will provide internal stakeholders the support required. During the change implementation plan, clear communication will provide employees with the feedback and reinforcement they need as well as strengthen stakeholders’ ability to make better decisions and prepare them to understand the advantages and disadvantages of change (Gilley et al., 2009). In this phase, distributing leadership among members of the change implementation team and external team will build an atmosphere of creativity and generate enthusiasm for change.
The road to change is bumpy and requires the investment of all stakeholders; therefore, leadership will celebrate the small wins throughout the process by recognizing the teams and staff through thank-you cards and small gifts that youth can make with staff members’ help.

In this phase, counselling will be provided to Indigenous youth who require it using traditional healing methods and using the medicine wheel. Incorporating traditional culture specific to youth examples include smudging, medicine, storytelling, music and arts incorporated in culturally sensitive counselling modalities identified in the solution in Chapter 2. Change implementation teams will provide counsellors with resources and documents which are a form of communication that allow information to be shared without face-to-face interactions. A policy and procedure manual will be shared via email and discussions will be held in small team meetings, specific to each department to clarify changes.

Indigenous youth will have the opportunity to share their feedback with Indigenous department about what they liked and did not like about the counselling sessions. Youths’ feedback will be important in improving the change implementation plan. The Indigenous department and clinicians will check in with youth about how they are feeling about the counselling they are receiving throughout the process. At the end of their counselling sessions, youth will be given a survey in which they can provide feedback. Counselling is optional and youth have a choice not to engage in this service.

This phase corresponds with the acceleration phase of Deszca et al.’s (2020) Change Path Model. DL will be the dominant leadership approach and many stakeholders will be taking on leadership roles with the goal of initiating transformative change. Creating enthusiasm and momentum while celebrating small wins will be central to the approach of the communication plan. This will be throughout Year 2, from January to December, 2023.

**Confirmation Phase**

The final phase of the communication plan will be to communicate and celebrate the success (Deszca et al., 2020) of the change implementation plan. Celebrating success is often
overlooked, yet is imperative. According to Deszca et al. (2020), “Celebrations are needed along the way to make progress, reinforce commitment, and reduce stress” (p. 352). In this phase, the change implementation plan is approaching its conclusion. Therefore, the change experiences, as a whole, should be discussed with stakeholders (Deszca et al., 2020). Leaders will engage the Indigenous department, clinicians, staff, Indigenous youth, external caregivers, and Indigenous communities in order to obtain various perspectives; the evaluation team will document what was learned.

In this final phase, Organization X will hold ongoing face-to-face meetings. Prior to youth being discharged, clinicians will present data at staff meetings using slideshow presentations developed throughout youths’ process to determine if behaviour has improved during their 3-month stay. This same data will be shared with caregivers and Indigenous communities. Organization X’s data on youth will examine their aggression toward others, tendency for self-harm, habit of property destruction, their compliance to the program, and their emotional regulation. The Indigenous department and clinicians as above will share a second data report using the medicine wheel to view a youth’s progress. The final objective will determine if Indigenous youth have positive behaviour outcomes in RTR after being provided counselling.

Nearing the 36-month mark there will be a large, whole-day, final presentation for all stakeholders, both internal and external utilizing the learning circle, at which point the Indigenous department will take the lead. The teams will compile all data from each Indigenous youth who participated in counselling over their 3-month stay and share data findings. During the learning circle, clinicians will also share data collected during the Indigenous youth’s stay as well as data from the community, based on the same parameters as the data used by Organization X, to see if Indigenous youths’ positive behaviour changes continue once they are in their community.
All data will be in both hard copy and digital format. Data will include a digital graph of youths’ behaviour during their counselling at RTR, as well as tracking 3–6 months after youth return to caregivers. All data collected will be analyzed and reported in these group meetings with all stakeholders. Information provided will be in slideshow presentations, and a final report will be distributed to all stakeholders via email. The external team will also be invited to share their findings and reflect on the process and give final recommendations.

Policies and procedures will be updated and shared with all stakeholders via email and a hard copy will be presented to all departments. A final survey will be provided to internal and external stakeholders to share how they view the change implementation plan, the service provided, pros and cons, and any additional information they want to share. One-on-one performance evaluations will take place that align with Organization X’s yearly performance evaluation timeline. This will provide staff with the opportunity to receive feedback from management and celebrate individual successes.

External stakeholders (caregivers) and the external team will be given a face-to-face oral presentation individually by clinicians connected to the individual youth of the findings. External stakeholders will be able to express their feelings about the change in a short survey and directly with Indigenous department and clinician. The final report will also be shared with Indigenous community leaders approved by the Indigenous department. Relationship building that will occur with the Indigenous community will hopefully lead to increased trust with Organization X and MCFD in general. Personal valence (Armenakis & Harris, 2002), or “what is in it” for stakeholders, will be apparent. Indigenous community members will be recognized for their services to improve programming that will support their community. It will give the community the opportunity to transform government structures toward a culturally competent approach.

Communicating the success and the impact that stakeholders have made will empower and validate the hard work and success of the change implementation plan. This ties in with
responsibility and commitment to the social justice section of CRT and CIRM, which all stakeholders are invested in. Lastly, there will be an internal celebratory team day, to go out and have fun after the implementation plan is completed. The external team will be invited to the Team Day celebration too. This will help wrap up the process and show internal stakeholders that their hard work is appreciated. Organization X will now be ready for the next change (Deszca et al., 2020).

This phase corresponds with the institutionalization phase of Deszca et al.’s (2020) Change Path Model. In this phase, Organization X will analyze and evaluate measures and procedures in place to ensure that the solutions realized remain effective and in place (Donnelly & Kirk, 2015). Further, Organization X will examine what modifications are needed (Donnelly & Kirk, 2015). Lastly, Organization X will assess their state of readiness to make another change (Donnelly & Kirk, 2015). TL and DL will be used in this phase. The communication plan centres the Indigenous experience and lens while actively fighting against oppressive systems to include Indigenous voice which is the framework of CRT and CIRM. This phase will take place in Year 3, from January to December, 2024. The next section will provide a visual representation of the timeline for the change implementation plan and the communication plan.

**Timing and Communication Plan**

Effective communication will be carried out throughout the change implementation plan by the steering committee and the change implementation team. All stakeholders will be contacted in order to ensure understanding of both the plan and proposed change. The communication styles will align with Deszca et al.’s (2020) Change Path Model. See Appendix K for the timing and focus of the communication plan for Organization X. The communication plan works together with the change implementation plan. The communication plan can impact the outcome (Klein, 1996) of the change implementation plan. The communication plan will need to adapt based on assessments discovered and recommendations made by the evaluation team throughout the process. This section examined the need for change and the change
process. The next section discusses the next steps in the OIP process as well as future considerations.

**Next Steps and Future Considerations**

The change implementation plan provides the framework so that youth mental health needs can be addressed through a change in practice. This approach to care looks at the youth from a socioemotional perspective. The new plan will provide counselling services to youth. This counselling will be client centred and culturally sensitive. Indigenous approaches will be implemented in various ways based on need after the intake assessment is complete and cultural needs are assessed. Once change is implemented, the process should not end but rather continue to build on the service already provided. Organization X may wish to examine providing counselling support in the community and by opening counselling to other youth.

**Counselling Support in Community**

Providing counselling service while at RTR is a great first step. Counselling will likely be short term, around eight sessions. While it is expected that patients receiving short-term counselling will recover faster from both depressive and anxiety symptoms in the first year, there may be a limit to its effectiveness. Long-term counselling, of 3 or more years, has been shown to be more beneficial than short term (Knekt et al., 2008; Lindfors et al., 2015; Maljanen et al., 2016). Organization X may wish to consider if clinicians assigned to a youth can follow-up in the community to see how a youth is doing and perhaps also provide solution-focused, short-term counselling for youth who are maintaining and doing well. Solution-focused, short-term counselling objectives mean looking at the problem and finding a solution (Sklare, 2005). This can be done in one or two sessions. However, with youth with more complex needs, long-term counselling in the community may be required. Organization X should consider playing a more active role in ensuring counselling is available to Indigenous youth. This counselling service should be provided by the community and use an Indigenous approach to counselling (Restoule
et al., 2015). Further, collaboration with the Indigenous community should be ongoing to support Indigenous youth care.

**Counselling Service for all Youth**

The final consideration is branching off and providing counselling services to all clients within Organization X that are identified by RTR as benefiting from counselling services. In this OIP, I focused on Indigenous youth because the Indigenous population is at greatest risk and is more likely to be in contact with the child welfare system, as explained in earlier chapters. Therefore, the urgency of providing counselling services to reduce recidivism for this population was the priority for this OIP. Support for all youth requiring these services should be strongly considered and implemented. This will support all youth in a manner which behaviour intervention alone cannot accomplish.

**Chapter Summary**

In this chapter, I shared the change implementation plan and timeline. I detailed the phases of implementation. I also discussed stakeholders’ reactions to change and the need for change process monitoring and evaluation. I described the plan to communicate the change process, which concluded with a discussion of short-term counselling. In the next section, I provide the OIP conclusion.

**OIP Conclusion**

The experience of writing this OIP has changed my outlook on the importance of leadership in organizations and, more importantly, on the importance of using the right type of leadership to support organizational development. I have always struggled with the services Organization X has provided and always felt that more could be done to support Indigenous youth. This OIP highlights that Indigenous youth have a unique history that impacts various areas of their life and that can cause an imbalance in their overall health. Indigenous communities speak extensively about the medicine wheel and the value of a community’s vision of Indigenous people attaining balance in their lives (spiritual, physical, mental and emotional).
It is apparent that focusing on behavioural interventions alone cannot meet the needs that Indigenous communities have indicated are required in order to reach overall health for Indigenous youth. Providing culturally appropriate counselling support will be one additional resource that will help Organization X address more of the needs of Indigenous youth.

I am confident that providing counselling to Indigenous youth is what is missing in Organization X. This solution is the right approach to addressing recidivism after discharge. All stakeholders, both internal and external, will be engaged in the change implementation plan. On a broader scale, Organization X will be at the forefront of client-care, once again providing services to Indigenous youth that are holistic and take into account all the needs of an individual, including mental health. I suspect this project will be followed closely by not just the BC provincial government but by other organizations that have similar objectives. Providing mental health services in the form of counselling, currently focuses on Indigenous youth in Organization X, however this should be considered the starting point. Organization X’s next steps would include expanding this service to all youth requiring this service in RTR as well as extending counselling into the community for long-term support.

Finally, COVID-19 has highlighted the seriousness of providing mental health supports. The global community understands that if someone is struggling, they need to be provided with mental health support. The sudden traumatic event of COVID-19 has impacted individuals that would otherwise not suffer with mental health concerns. Indigenous youths’ life experiences and contact with the child welfare systems have caused long-term trauma and mental health concerns. This only further solidifies my call to implement this OIP and support the Indigenous youth in the RTR program of Organization X.
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Appendix A: Program Structure

This is a visual representation of Organization X vertical program structure that targets Residential Treatment program, Clinical Outreach program, and Indigenous Department.
Appendix B: Specialized Team Matrix Structure

This organizational chart depicts the staff who work in direct contact with youth and will be most affected by change in the OIP. Director and Senior Management oversee the organization.
Appendix C: Provincial Rate of Children and Youth in Care per 1,000 Population

<table>
<thead>
<tr>
<th>Year</th>
<th>All</th>
<th>Indigenous</th>
<th>Non-Indigenous</th>
<th>Rates of CYIC per 1,000 Population (0-18 Years) All</th>
<th>Rates of CYIC per 1,000 Population (0-18 Years) Indigenous</th>
<th>Rates of CYIC per 1,000 Population (0-18 Years) Non-Indigenous</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>8,832</td>
<td>4,491</td>
<td>4,202</td>
<td>10.0</td>
<td>60.6</td>
<td>5.1</td>
</tr>
<tr>
<td>2010</td>
<td>8,394</td>
<td>4,663</td>
<td>3,818</td>
<td>9.7</td>
<td>58.7</td>
<td>4.6</td>
</tr>
<tr>
<td>2011</td>
<td>8,264</td>
<td>4,729</td>
<td>3,697</td>
<td>9.2</td>
<td>57.5</td>
<td>4.5</td>
</tr>
<tr>
<td>2012</td>
<td>7,952</td>
<td>4,630</td>
<td>3,469</td>
<td>9.1</td>
<td>55.1</td>
<td>4.2</td>
</tr>
<tr>
<td>2013</td>
<td>7,925</td>
<td>4,567</td>
<td>3,754</td>
<td>8.8</td>
<td>50.1</td>
<td>4.6</td>
</tr>
<tr>
<td>2014</td>
<td>7,934</td>
<td>4,483</td>
<td>3,795</td>
<td>8.9</td>
<td>48.7</td>
<td>4.7</td>
</tr>
<tr>
<td>2015</td>
<td>7,736</td>
<td>4,417</td>
<td>3,319</td>
<td>8.6</td>
<td>50.8</td>
<td>4.1</td>
</tr>
<tr>
<td>2016</td>
<td>7,217</td>
<td>4,420</td>
<td>2,797</td>
<td>8.0</td>
<td>49.8</td>
<td>3.4</td>
</tr>
<tr>
<td>2017</td>
<td>6,951</td>
<td>4,364</td>
<td>2,587</td>
<td>7.7</td>
<td>48.1</td>
<td>3.2</td>
</tr>
<tr>
<td>2018</td>
<td>6,698</td>
<td>4,253</td>
<td>2,446</td>
<td>7.4</td>
<td>46.0</td>
<td>3.0</td>
</tr>
</tbody>
</table>

*Note.* CYIC = Children and Youth in Care.

This is a graph of redacted data that shows the difference between Indigenous children and Non-Indigenous children and youth in care. RTR is a program that supports children in care. This graph demonstrates that Indigenous children are overrepresented. Definition of care is children who have a legal order that states the government will support them by having contact with an individual and is legally responsible for the child.

### Appendix D: Historical Overview After Contact

<table>
<thead>
<tr>
<th>Contact</th>
<th>The earliest recorded contact between First Nations and non-Aboriginal people occurred in the late 1700s, with Russian, French, Spanish and British traders and explorers visiting the coast during this time (First Nation Health Authority, 2020)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population Collapse</td>
<td>Along the coast, there were widespread smallpox outbreaks in the 1770s. Epidemics spread through First Nations communities in advance of explorers (First Nation Health Authority, 2020). In reporting events, entire villages were destroyed by a single disease. Mortality rates in these communities ranged from 50 per cent to 90 per cent of the population. (First Nation Health Authority, 2020).</td>
</tr>
<tr>
<td>Colonial Period</td>
<td>First Nation Health Authority (2020) “Following the population collapse, governments and churches sought to actively colonize and control First Nations” (p. 13). First Nation Health Authority (2020) “Colonial authorities were expanded to facilitate land and resource extraction and to limit First Nations rights” (p. 13). Indigenous spirituality, political authority, education, health care systems, land and resource access, and cultural practices were all repressed (First Nation Health Authority, 2020).</td>
</tr>
<tr>
<td>Impact of Church and State</td>
<td>Indigenous communities lost control of their traditional health systems, which included cultural practices and herbal healing (First Nation Health Authority, 2020). Western doctors, churches and governments held power over First Nations health during this period (First Nation Health Authority, 2020). Health services were limited or low-quality, and sometimes Western health services were denied to First Nations people entirely (First Nation Health Authority, 2020).</td>
</tr>
<tr>
<td>Residential Schools</td>
<td>Residential schools began in 1800; the last school closed in Saskatchewan in 1996 (Barker, 2019). Residential schools were established throughout Canada as a church and state partnership; by 1930-1940, it was legally mandated that all school-age Indigenous children attend, with the goal to assimilate by eliminating the “Indian problem” (Barker, 2019). Indigenous children were prohibited from speaking their language, practising spiritual beliefs, maintaining cultural traditions and were often deliberately taken away from their community (Barker, 2019). Children were physically and sexually abused or neglected; some children never made it home (Barker, 2019).</td>
</tr>
<tr>
<td>60s Scoop</td>
<td>Canadian government policies that followed the closing of the residential school era continued to cause harm to both Indigenous families and communities (Barker, 2019). One of these policies was the “Sixties Scoop,” where Indigenous children were apprehended by Canadian child welfare agencies and placed in non-Indigenous homes. Children were often sold to affluent white families outside of Canada (Barker, 2019).</td>
</tr>
<tr>
<td>Millennial Scoop</td>
<td>The Canadian government began a program where they flagged children pre-birth who they deemed to belong to “at risk families”; oftentimes, these were Indigenous families. High numbers of Indigenous children were placed in foster care, refusing the right of parents to raise their own children for the purpose of assimilating Indigenous children (Kwantlen University, n.d.).</td>
</tr>
</tbody>
</table>

*Note.* Historical overview showing the negative impact of colonialism on Indigenous peoples.
Appendix E: Relationship Between Early Childhood Trauma and Health and Well-Being Program Later in Life

This image was developed Kaiser Permanente by ACE; it explains that increased adverse childhood experiences lead to poor health outcomes in adulthood and even early death.

## Appendix F: Supports and Resources Needed for Change Implementation Plan

<table>
<thead>
<tr>
<th>Supports &amp; Resources</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Time</strong></td>
<td>- 36 months is the approximate time required to complete the change implementation plan.</td>
</tr>
<tr>
<td></td>
<td>- I will need 2 months prior to implementation to have the OIP reviewed by the organization's research and approval body.</td>
</tr>
<tr>
<td></td>
<td>- I will meet with the Director and senior management for 1 to 2 hours to explain the OIP and share role of change champion (during awakening phase).</td>
</tr>
<tr>
<td></td>
<td>- The steering team and change implementation team will meet weekly for 2 to 4 hours to facilitate the change implementation plan throughout all phases of The Change Path Model.</td>
</tr>
<tr>
<td></td>
<td>- Steering and change implementation team will be given time to review surveys from staff.</td>
</tr>
<tr>
<td></td>
<td>- Change implementation team will meet for 2 to 4 hours weekly.</td>
</tr>
<tr>
<td></td>
<td>- Group training will be ongoing, beginning with mobilization phase with focus on modalities and cultural training. Each training session should be 1 to 2 hours.</td>
</tr>
<tr>
<td></td>
<td>- Mental health counselling will be provided in acceleration phase, approximately in the 14th month. Time and length of counselling will be individualised.</td>
</tr>
<tr>
<td><strong>Human</strong></td>
<td>- Steering and change implementation teams will be allocated time during their work week to support the process of change.</td>
</tr>
<tr>
<td></td>
<td>- Steering committee: Director, Senior Management and Team Leader</td>
</tr>
<tr>
<td></td>
<td>- change implementation team: (2) Indigenous department (2) clinicians, (2) case worker, steering committee. Human resources, administration, and financial departments as needed.</td>
</tr>
<tr>
<td></td>
<td>- Interview may be required if a lot of interest is shown to join these teams-teams will need to officially take one short-term assignment and sign for this opportunity following union rules.</td>
</tr>
<tr>
<td><strong>Technology</strong></td>
<td>- Computers, office space, charting systems, record filing systems, and a secure location to share information on an office computer hard drive. Traditional mental health items.</td>
</tr>
</tbody>
</table>
| **Financial**        | - Creating new positions (clinicians) or allocating new jobs to existing clinicians. New clinician position annual wage starts at $68,500.
<table>
<thead>
<tr>
<th>Supports &amp; Resources</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>- 46.51 and goes up to $78, 183.63 after 5 years.</td>
<td></td>
</tr>
<tr>
<td>- Adding more work to the Indigenous department requires increasing contract time allocation. However Indigenous department is in the process of hiring 2 full-time staff therefore would not have cost associated.</td>
<td></td>
</tr>
<tr>
<td>- Technology costs (may be applicable).</td>
<td></td>
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</tbody>
</table>

**Information Resources (books, journal articles on counselling).**

- Explain change implementation plan with stakeholders through change implementation plan.
- Group training on counselling modalities for clinicians and cultural training for all stakeholders involved in client care.
### Appendix G: Change Implementation Teams

<table>
<thead>
<tr>
<th>Change Implementation Team</th>
<th>Steering Committee</th>
<th>External Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior Management (1)</td>
<td>Director (1)</td>
<td>Caregivers (as needed)</td>
</tr>
<tr>
<td>Team Leader (1)</td>
<td>Senior Management (1)</td>
<td>Indigenous communities connected to client</td>
</tr>
<tr>
<td>Indigenous Department (2)</td>
<td>Team Leader (1)</td>
<td></td>
</tr>
<tr>
<td>Clinicians (2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case Workers (2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administration (as needed)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human Resources (as needed)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial Department (as needed)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This table shows the various change implementation teams, both internal and external.
## Appendix H: Stakeholder Analysis Template

<table>
<thead>
<tr>
<th>Stakeholders</th>
<th>Predispositions towards change</th>
<th>Power and influence</th>
<th>Who influences them</th>
<th>Who is influenced by them</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

This table is an example of an assessment tool to look at power and influence patterns, both informal and formal. This document is confidential and should be updated regularly.

*Note.* Adapted from Deszca (2020). Organizational Change Management. The change-path model for ensuring organizational sustainability.
## Appendix I: Short-, Medium-, and Long-Term Goals Corresponding with Change Implementation Plan

<table>
<thead>
<tr>
<th>Timeline</th>
<th>Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Short Term:</strong></td>
<td><strong>Awakening Phase</strong></td>
</tr>
<tr>
<td></td>
<td>- I will identify the change champion in the first week.</td>
</tr>
<tr>
<td></td>
<td>- Director will approve the change implementation plan in the first to second month.</td>
</tr>
<tr>
<td></td>
<td>- Change champion and I will create the steering committee and change implementation team, external team (Indigenous community, caregivers).</td>
</tr>
<tr>
<td></td>
<td>- The steering committee will disperse the survey to stakeholders on the fifth month.</td>
</tr>
<tr>
<td><strong>Medium Term:</strong></td>
<td><strong>Mobilization and Acceleration Phase</strong></td>
</tr>
<tr>
<td></td>
<td>- Analyze employee survey will be completed by the sixth month by the change implementation team. Changes will be made to the plan as needed.</td>
</tr>
<tr>
<td></td>
<td>- Steering committee will communicate the need for change to stakeholders on the sixth month.</td>
</tr>
<tr>
<td></td>
<td>- Group training for various stakeholders to support change will start on the seventh month and will be ongoing.</td>
</tr>
<tr>
<td></td>
<td>- Implement the change and allocated clinician(s) that will provide mental health counselling to Indigenous youth identified as needing this support will start on the 12th month.</td>
</tr>
<tr>
<td><strong>Long Term:</strong></td>
<td><strong>Institutionalization Phase</strong></td>
</tr>
<tr>
<td></td>
<td>- Track clients progress through two data collection (behaviour data sheets and medicine wheel). This will start year two and will be ongoing.</td>
</tr>
<tr>
<td></td>
<td>- Update policy on thirty-fourth month to reflect implementation of the solution and adjust, on an ongoing basis, as an organizational mandate.</td>
</tr>
</tbody>
</table>
## Appendix J: Evaluation Plan Timeline (System Change)

<table>
<thead>
<tr>
<th>The Change Path</th>
<th>System Change</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Five Tenets and 4 R</td>
<td>System Change</td>
<td></td>
</tr>
<tr>
<td><strong>Awakening</strong></td>
<td>Evaluation Planning</td>
<td>Year 1 (January–June, 2022) should be when evaluation plan templates are created. How evaluation will take place in the acceleration phase.</td>
</tr>
<tr>
<td>Relevance, centering race and challenging perspectives</td>
<td>- Two forms of data collection (behavioural data collection sheet and Medicine wheel).&lt;br&gt;- Staff surveys (multiple choice and short answers).&lt;br&gt;- Evaluation team will meet bi-weekly for 4 hours.&lt;br&gt;- Deployed by the evaluation team.</td>
<td></td>
</tr>
<tr>
<td><strong>Mobilization</strong></td>
<td>Collecting data at baseline and follow-up</td>
<td>Year 1 (July–December, 2022) Data collection should be on-going in perpetration for evaluation. Further it’s important that data is being tracked correctly.</td>
</tr>
<tr>
<td>Reciprocity, Being Interdisciplinary</td>
<td>- Staff surveys (multiple choice and short answers).&lt;br&gt;- Staff surveys reviewed.&lt;br&gt;- Staff survey dispersed during workplace organized learning circles.&lt;br&gt;- Staff survey determination will be concluded, analyzed, implemented and shared.&lt;br&gt;- Client pre-change implementation plan data gathered.&lt;br&gt;- Two forms for client data collection include (behavioural data collection sheet and Medicine wheel).&lt;br&gt;- Clinicians will collect client data for both behaviour data and medicine wheel (pre-admission).&lt;br&gt;- Evaluation team will meet bi-weekly for 4 hours.&lt;br&gt;- Deployed by the evaluation team.</td>
<td></td>
</tr>
<tr>
<td><strong>Acceleration</strong></td>
<td>Long-term system change</td>
<td>Year 2 (January–December, 2023) Data will be</td>
</tr>
<tr>
<td>Respect, Valuing experiential</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Change Path Phase</td>
<td>Five Tenets and 4 R System Change</td>
<td>Timeline</td>
</tr>
<tr>
<td>-----------------------</td>
<td>----------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>knowledge of Indigenous communities</td>
<td>- Behavioural data collection sheet- collected daily and charts are created monthly by case workers.</td>
<td>reviewed and analyzed.</td>
</tr>
<tr>
<td></td>
<td>- Medicine wheel data will be provided to clients by clinician bi-weekly. Data collected by clinicians.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Medicine wheel analyzed bi-weekly as needed.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Deployed and analyzed by the evaluation team.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Behavioural data collection sheet and Medicine wheel will be tracked 1, 3 and 6 months after discharge.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Caregivers will track data. Evaluation team will review data.</td>
<td></td>
</tr>
<tr>
<td>Institutionalization Responsibility, Commitment to Social Justice</td>
<td>Analyzing how the proposed solution contributes to change</td>
<td>Year 3 (January-December, 2024). Members from each team will determine how the proposed solution contributed to change. Ongoing refinement will occur and the program will continue to be offered to Indigenous youth.</td>
</tr>
<tr>
<td></td>
<td>- Behavioural data collection sheet and Medicine wheel will be tracked 1, 3 and 6 months after discharge.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Caregivers will track data. Evaluation team will review data.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- All data will be collected, reviewed and concluded.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Evaluation team will meet weekly.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Data will be shared with stakeholders face-to-face (learning circle) on the final all day event.</td>
<td></td>
</tr>
</tbody>
</table>
## Appendix K: Timing and Communication Plan

<table>
<thead>
<tr>
<th>Date</th>
<th>Communication Need for Different Phases</th>
<th>Phase &amp; Plan</th>
<th>Strategy and communication</th>
<th>Stakeholder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year 1: 1-6 Months</strong></td>
<td><strong>Pre-change Approval Phase</strong></td>
<td><strong>Awakening Phase</strong></td>
<td>- Personalized Correspondence (email) informing stakeholders of dates for face-to-face meetings</td>
<td>- Director, senior management, team leader &amp; community.</td>
</tr>
<tr>
<td>(January to June)</td>
<td>- Communicate plan to convince top management and community (Deszca et al., 2020).</td>
<td>- Share plan with management &amp; community (vision, Plan &amp; proposed change). Communicate with change implementatio n teams.</td>
<td>- Face-to-face meetings.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Meetings will be weekly</td>
<td></td>
</tr>
<tr>
<td><strong>Year 1: 7-12 Months</strong></td>
<td><strong>Developing the need for Change Phase</strong></td>
<td><strong>Mobilization Phase</strong></td>
<td>- Email all relevant internal stakeholders.</td>
<td>- Senior manager (change champion), Indigenous department, team leader, community and staff.</td>
</tr>
<tr>
<td>(July to December)</td>
<td>- Explain the need for change, reassure internal and external stakeholders, clarify the steps in the change process and gather enthusiasm and sense of urgency (Deszca et al., 2020).</td>
<td>- Invite internal and external stakeholders to group discussions about the change, inform them of where they can complete surveys and give feedback.</td>
<td>- Face-to-face meetings in large groups, a minimum of 2 times in the 7th and 10th months.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Communication weekly or bi-weekly.</td>
<td></td>
</tr>
<tr>
<td><strong>Year 2: 12-24 Months</strong></td>
<td><strong>Midstream Change and Milestone</strong></td>
<td><strong>Acceleration Phase</strong></td>
<td>- Email will be provided with one month advanced notice).</td>
<td>- Senior management, team leader, Indigenous department.</td>
</tr>
<tr>
<td>(January to December)</td>
<td>- Framework for change is created and</td>
<td></td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td>Communication Need for Different Phases</td>
<td>Phase &amp; Plan</td>
<td>Strategy and communication</td>
<td>Stakeholder(s)</td>
</tr>
<tr>
<td>------</td>
<td>---------------------------------------</td>
<td>-------------</td>
<td>----------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Respect, Valuing experiential knowledge of Indigenous communities</td>
<td>Communication Phase.</td>
<td>implemented. Information and resources will be provided to implement change. Change teams and evaluation teams will answer questions as they come up.</td>
<td>Face-to-face meetings both large (all staff) and small (relating to a particular job description)</td>
<td>internal staff, external stakeholders (caregivers and Indigenous members)/</td>
</tr>
<tr>
<td>Year 3: 24-36 Months (January to December). Responsibility, Commitment to Social Justice</td>
<td><strong>Confirming and Celebrating the Change Phase</strong></td>
<td>- Inform internal and external stakeholders of success, celebrate change and things learned through change, and prepare organization for the next change (Deszca et al., 2020).</td>
<td>- Email will be provided with one month advanced notice).</td>
<td>Senior management, team leader, Indigenous department internal staff.</td>
</tr>
<tr>
<td></td>
<td><strong>Institutionalization Phase</strong></td>
<td>- Feedback, evaluation of change success will be shared with all stakeholders.</td>
<td>- Face-to-face presentation from Clinicians on data showing positive behavioural change, type of counselling used, and Indigenous approaches unitized, PowerPoint of evaluation including graphs.</td>
<td>Document will be shared with relevant external stakeholders.</td>
</tr>
</tbody>
</table>