



Holding Hope in Our Hearts: Relational Practice and Ethical Engagement in Mental Health and Addictions

FINAL REPORT

**Submitted by:
Cultural Safety Working Group, First Nation, Inuit and
Métis Advisory Committee of the Mental Health
Commission of Canada**

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Executive Summary

Background

As part of their “Building Bridges” initiative, the Mood Disorders Society of Canada (MDSC) and the Native Mental Health Association of Canada (NMHAC) collaborated with the First Nations, Inuit and Métis Advisory Committee (FNIM AC) to the Mental Health Commission of Canada (MHCC) in a joint research project to understand best and promising practices that constitute cultural safety and relational practice in the Canadian context. In 2009, they commissioned a total of forty-one focus groups in Western and Eastern Canada, a national symposium in Ottawa in 2010, and two research papers, one on social inclusion, the other on cultural safety. The purpose of this report is to provide an overview of findings from the Western focus group consultations, augmented by themes identified in the proceedings of the symposium. The Executive Summary of the Eastern focus groups can be found in Appendix D.

Research Question

The central question underpinning this project was “What will improve practice in mental health and addiction services for all Canadians?” We sought insight into this question by conducting 27 focus groups in five Western Canadian cities with people who have experienced mental health and/or addictions services, including practitioners and recipients of services, approximately two-thirds aboriginal, one-third non-aboriginal, the majority working in aboriginal-led organizations serving aboriginal people. The focus on mainly aboriginal agencies, their staff and clients, was an intentional decision given that aboriginal “voices” have seldom been privileged.

Findings

Six overlapping categories were developed to capture the emerging themes and organize research findings: direct care; interpersonal relations; professional development; ways of knowing; organizational context; and, policy.

1. *Direct care* refers to the qualities of the care provider/care recipient relationship. As viewed by participants, the relationship needs to be accessible, inclusive of the disabled, respectful and responsive to the uniqueness of each individual, strengths focused, flexible, trauma-informed, acknowledging of grief, and making use of human connection in healing.
2. *Interpersonal relations* refers to the range of relational networks and formal and informal supports in which both the care provider and recipient are embedded, including relationships with families, community members, colleagues, peers, mentors, supervisors, other service providers and agencies. Participants emphasized the importance of reciprocity and dialogue, support for self-care, self-awareness and conscious growth, and the necessity for circles of support for both care provider and care recipient.
3. *Professional development* refers to the informal, non-formal, and formal knowledge and skill development received by professionals in the course of their training to become a mental health practitioner, as well as the multiple life experiences and cultural practices that care providers draw upon in their work. On this topic, participants shared insights about informal, non-formal and formal

education/training, mentoring, lived experience, balance and harmony, and wisdom teachings.

4. *Ways of knowing* refers to the approaches taken to understand, document and make sense of the social world. “All my relations”, cultural continuity, the power of story, and tensions between Western and Indigenous ways are themes that emerged in the focus groups.
5. *Organizational context* refers to workplace norms, policies, resources, agency mandates and professional routines. Participants spoke about organizational norms, centralization vs. decentralization, integration of services, family and community context, and healthy effective organizations.
6. *Policy challenges* refer to government legislation, policies, and funding. Significant challenges identified in the focus groups include the tension between individual and collective rights, between biomedical and complementary approaches, and concerns about the capacity for response to ethical dilemmas.

Domains for Consideration

Five topical areas emerged from the findings as well as the process through which the project evolved; they are ‘group process and leadership’, ‘guiding principles and practices’, ‘metaphors and liberating concepts’ as summarized below.

1. *Group process and leadership* – the research model chosen was based on inclusion, participatory methods and indigenous ways of sharing knowledge both within the focus groups and within the working group. Dialogue with the data and between researchers led to a new way of understanding mental health and addictions as a human experience.
2. *Guiding principles and practices*-- a series of principles and associated practices are identified in the report: honouring humanity and human experience; centrality of connectedness and relationships; valuing and learning from diversity; well-funded and flexible programming; fundamentals first and “do no further harm”; patience and deep listening; radical acceptance; reconnection; respect; collective healing; community of practice; strengths based; relational attunement; honouring boundaries; recovery model; nature as healer; culture as healer; prayers and ceremony.
3. *Metaphors and liberating concepts* – metaphors and liberating concepts arise from the findings. Metaphors include: spiral as connected completed circles, two-way street and walking together. Liberating concepts include: many choices and freedom to choose; return to the large human tribe; all life matters; humanized and humanizing relationships; knowing self, knowing other in context; know what you stand for and change self; circles within circles; ripple effect; speak the truth in love to people; intentional disruption is good; healing and recovery as learning and growth; intuition, wholeness and change.

Way Forward

The findings presented in this report represent practices that can be summarized as safe, ethical, respectful, critically conscious, “culturally good” and socio-politically aware. When these ideas are used as perceptual lenses they can guide practice, inform the education of practitioners, and provide a foundation for program and policy development

1.0 Introduction

As part of their “Building Bridges” initiative, the Mood Disorders Society of Canada (MDSOC) and the Native Mental Health Association of Canada (NMHAC) collaborated with the First Nations Inuit and Métis Advisory Committee (FNIM AC) to the Mental Health Commission of Canada (MHCC) in a joint research project to understand best and promising practices that constitute cultural safety and relational practice in the Canadian context. In 2009, they commissioned a total of 41 focus groups in Western and Eastern Canada, a national symposium in Ottawa in 2010, and two research papers, one on social inclusion, the other on cultural safety. An Abstract of the Cultural Safety Lit Review can be found in Appendix B, and the Executive Summary of the Eastern focus groups can be found in Appendix D. The themes arising from the Ottawa symposium are captured in the “Domains for Consideration” section of this report.

The question central to the project was: “What will improve practice in mental health and addiction services for all Canadians?” To find answers to this question we conducted 27 focus groups in five Western Canadian cities with people who have experienced mental health and/or addictions services, including practitioners and recipients of services, approximately two thirds of them aboriginal, one third non-aboriginal, the majority working in aboriginal-led organizations serving indigenous people. The inclusion of ‘aboriginal’ and non- aboriginal people takes into account our understanding that ‘race’ is a social construction; we do not dichotomize ‘aboriginal/non-aboriginal’; rather we seek to include a range of perspectives that take into account different experiences. We see aboriginal and non-aboriginal people as heterogeneous groups of people whose lives are shaped by class, living situations, age, etc. The focus on mainly aboriginal agencies, their staff and clients, was a deliberate decision based on the need to privilege a “voice” that has often been marginalized. It is generally accepted knowledge that historically, health care in Canada has been dominated by the illness and health belief systems of the dominant culture and has subsumed those of indigenous people (Smye and Brown, 2002). The outcomes for indigenous health have been poor. By listening to people rarely consulted, situated in contexts seldom researched, the authors attempted to document some of the interests, values, beliefs, and principles that may hold promise for improving the health and well-being of indigenous and non-indigenous people, as a contribution to transforming the mental health system in ways beneficial to all Canadians.

This report describes our methodology and approach to analysis, offers a synthesis of key concepts based on a literature review undertaken as part of the project, and presents the findings emerging from this work. It invites discussion regarding the implications and opportunities for a transformed mental health system in Canada.

2.0 Methods

The Western focus groups were held in Saskatoon, Winnipeg, Iqaluit, Yellowknife, and Whitehorse in October and November 2009. A total of 147 people participated. Of these, 97 identified themselves as indigenous (22 Inuit and 75 First Nations or Métis). One hundred and

eight participants were practitioners/service providers. Thirty nine were individuals with lived experience of mental illness. A significant number of providers (25) reported having gone through their own healing journey, with or without formal assistance, to evolve into service providers themselves. Participants working for or receiving assistance from indigenous based organizations constituted 56% of the total, those working for non-governmental organizations made up approximately 29%, with 15% working for a government agency. A detailed demographic of Western focus group participants can be found in Appendix A.

The facilitators' longstanding relationships with key stakeholders in the communities enabled them to draw upon existing community networks to recruit participants for the focus groups. Participants' investment of time and energy was motivated by their interest in the purpose of the project and its potential outcomes.

Discussions began with an overview of the project context. Focus group facilitators explained that the initiative is intended to contribute to the joint efforts of the FNIMAC within the MHCC, the NMHAC, and the MDSC to address the question, "What will improve practice in mental health and addiction services for all Canadians?" The intention was to further the understanding of culturally safe practice in mental health and addictions.

Through a combined process of circle dialogue and storytelling, participants were invited to reflect on their experiences with mental health and addictions services. They were asked to consider what was working, what was not working, and what could be improved. Participant experiences were centered and the dialogue was generative and emergent. Participants recounted stories of success and they also spoke of challenges and limitations and ways of addressing these. All focus groups were audio recorded and transcribed verbatim.

To augment the focus group consultations, a two-day symposium was held in Ottawa in March 2010, attended by 60 mental health practitioners, consumers, advocates and policy makers. Participants met in large and small groups to discuss the questions:

1. What constitutes culturally safe practice and what are the conditions in which such practice could take root/thrive/be supported?
2. Do cultural and social institutions need to be restored or reformed in any way in order to accommodate cultural safety? If so, what changes need to be made and what is the best way to approach this?

Proceedings were audio recorded, transcribed verbatim and key ideas incorporated into this report.

3.0 Literature Review

A literature review entitled "Cultural Safety; An Overview" was carried out for this project by an academic team. What follows is a synthesis of highlights from this paper and additional sources.

Two key terms used in the literature review are cultural safety and cultural competence. An overview of the many contributions made by academics and practitioners to the understanding of these terms is beyond the scope of this paper. For our purposes here, we will rely on recent work by the Canadian Nurses Association (CNA). In a recent position statement (2010) culture is defined as “the processes that happen between individuals and groups within organizations and society that confer meaning and significance” (CNA citing Varcoe & Rodney, 2009). Cultural competence “is the application of knowledge, skills, attitudes or personal attributes required by nurses [or other providers] to maximize respectful relationships with diverse populations of clients and co-workers.” Further, the underlying values for cultural competence are inclusivity, respect, valuing differences, equity and commitment.” (CNA referencing Aboriginal Nurses of Canada (ANAC), Canadian Association of Schools of Nursing (CASN) & Canadian Nurses Association (CNA), 2009; CNA, 2010a, Registered Nurses Association of Ontario (RNAO), 2007 and World Health Organization (WHO)).

CNA states further that cultural issues are intertwined with socio-economic and political issues and as an organization expresses commitment to social justice as central to the social mandate of nursing. Related to the concept of social equity, CNA defines cultural safety as both a process and an outcome whose goal is to promote greater equity. It focuses on root causes of “power imbalances and inequitable social relationships in health care” (ANAC, CASN & CAN, 2009; Kirkham & Browne, 2006, as cited in Browne et al., 2009).

While cultural competence is an important concept, it can sometimes overlook systemic barriers, which makes it inadequate to fully address health-care inequities. Cultural safety, however, “promotes greater equity in health and health care ... [as it addresses the] root causes of health inequities” (CNA, 2010b). As quoted by CNA: “Cultural safety is a relatively new concept that has emerged in the New Zealand nursing context. It is based on understanding power differentials inherent in health service delivery and redressing these inequities through educational processes” (CNA, 2010).

CNA believes that the responsibility of supporting cultural competence is shared among individual nurses [providers], employers, educators, professional associations, regulatory bodies, unions, accrediting organizations, government and the public. The view of the authors of this final report is that cultural safety is most likely to be achieved as an outcome by recipients of care if investments in cultural competence occur throughout the care system from the service interface to system wide policy levels.

CNA, with ANAC and CASN, has also provided an excellent review of the literature as it relates to nursing education in the document “Cultural Competence and Cultural Safety in First Nations, Inuit and Métis Nursing Education: An Integrated Review of the Literature” (2009). The paper provides an overview of the context within which cultural competency must be developed with a look at colonization, health disparities, health inequities, diversity of First Nation, Inuit and Métis Peoples and historic trauma transmission. A full discussion of the complex context within which cultural safety and cultural competency must be developed throughout the health care system is a task beyond the scope of this paper.

This project included a literature review of selected publications entitled “Supporting Mental Wellness of First Nations, Inuit and Métis Peoples in Canada: Cultural Safety” (Smye, Browne and Josewski, 2010). The authors note that the hope related to the work on cultural safety is that it will enhance the ability of healthcare providers and others to deal more effectively with major structural and relational issues and barriers facing indigenous and non-indigenous communities. The authors see the research and analysis related to cultural safety and cultural competence as tools to deal with identified inequities in health, education and social services.

Smye et al., (2010) provide an overview of another key idea, that of “relational” approaches. This concept “recognizes that peoples’ experiences, including health and illness experiences are shaped by the contextual features of their lives – social, historical, political, cultural and geographic as well as other factors such as age, gender, class, ability, biology and so on” (Hartrick Doane & Varcoe, 2005, 2007, 2008). Relational approaches refer to more than respectful, supportive, caring and compassionate relationships. Although interpersonal connections are a central feature of excellent relational practice, this view takes into account “how capacities and socio-environmental limitations” influence health and wellbeing, the illness experience, decision-making and the ways people manage their experiences” (Browne, Hartrick Doane, Reimer, Macleod & McLellan, 2010).

One of the sections of the literature review focuses on the historical and present context of colonization and additional impacts affecting First Nation, Inuit and Métis mental health. The section is summarized in this way: “the mental health inequities of Aboriginal peoples cannot be glossed over as lifestyle, behavioral or cultural issues; rather, they are manifestations of the historical, social, political, and economic determinants” (Smye et al., 2010, p. 15). The cumulative losses in population, land and economic resources, language and cultural teachings, self-government and self-sufficiency “mortally threatened holistic health while disrupting the ways and means through which health was taught, maintained, and restored” (Mussell, Nicholls & Adler, 1993 as cited in Smye et al., 2010).

Smye et al., (2010) identify that an important historical and contemporary tension contributes to sustaining mental health inequities: A tension exists between Indigenous ways of understanding and responding to mental health and illness and the current mental health system, a system dominated by biomedical understandings. The findings were summarized in the statement that: “[m]ental health service delivery models that are designed in keeping with the dominant biomedical views of mental health and illness, create barriers to access and often only inadequately recognize the health care needs of Aboriginal peoples” (Smye et al., 2010, p. 18), a perspective in keeping with many other authors (e.g., Adelson, 2005; British Columbia Provincial Health Officer, 2002; Canadian Institute for Health Information, 2004; Dion Stout, Kipling & Stout, 2001; NAHO, 2002, 2003; Smye & Mussell, 2001). Mental health services often are not effectual, underused and not accessed by Aboriginal peoples (Smye & Mussell, 2001). In addition, research continues to show that tacit and sometimes overt discriminatory practices and policies continue to marginalize many Aboriginal people in the mainstream health care system (Browne, 2005, 2007; Brown & Fiske, 2001; Culhane, 2003; Dion Stout & Kipling, 1998; Dion Stout et al, 2001; RCAP, 1996; Smith et al. 2009a, as cited in Smye et al., 2010).

Control over health services delivery has been a priority for First Nation communities for more than two decades. As summarized by O’Neil et al, (1999) “true community healing and well-being can be found only through self government and self determination” (as cited in Smye et al., 2010, p.18). The Kirby report set the stage for the current work of the MHCC by supporting a formal commitment to improving Aboriginal health; recognition of the issues; support for self-determination and control; fostering greater participation in design, delivery and governance of programs; improving social determinants of health and promotion of culturally appropriate, holistic approaches to health (Kirby, 2002, as cited in Smye et al., 2010, p.19).

Connected to the issue of Indigenous control is the issue of cultural continuity and its relationship to individual and collective identity. Cultural discontinuity has been strongly linked to the disproportionate problems of Aboriginal communities with depression, suicide and family violence. (Chandler and Lalonde, 1998; RCAP, 1995, as cited in Smye et al., 2010). In contrast, studies have found that the degree of control that First Nations communities have over civic life, such as education, health care, child and family services, and fire and police services, was negatively correlated with rates of suicide (Lalonde, 2005, as cited in Smye et al., 2010)

Under the conditions of colonization, Aboriginal systems of medicine were disrupted and challenged by new forms of understanding health and illness. “Traditionally, Aboriginal peoples understand health as a holistic concept, which results from a harmonious balance or equilibrium between different spheres of life, such as the physical, mental, spiritual and social dimensions” (Mussell et al, 1991; Smye & Mussell, 2001; Waldram, 2004, as cited in Smye et al., 2010, p. 21).

The literature review describes the findings of a review of Aboriginal best practices in mental health. The working group that led the best practices review found that community based initiatives and a balanced approach to mental health including treatment, prevention and health promotion strategies have proven more effective than treatment-oriented mainstream services under non-Aboriginal authority (Smye & Mussell, 2001). In addition, findings from the Aboriginal Healing Foundation (AHF) projects suggest that the necessary elements of promising healing practices related to historical trauma (e.g. residential school abuse) include: programs that reflect Aboriginal values; ensuring personal and cultural safety as a prerequisite to healing from trauma; capacity to heal, i.e., the presence of skilled healers, therapists, elders and volunteers; and, reclaiming history. Also, included in this framework are the ‘three pillars of healing’: i) cultural interventions, ii) therapeutic healing, i.e. a combination of a broad range of traditional and Western therapies and iii) an environment that meets the conditions that influence both the need for healing and the success of the healing process” (AHF, 2010, as cited in Smye et al. 2010, p. 21).

The literature review also introduces the concept of “ethical space.” The notion of ethical space represents a space of engagement that facilitates the development of cross-cultural approaches that are ethically sustainable and aim to redress inequities (Ermine, 2005, 2007; Tait, 2008, as cited in Smye et al., 2010, p. 25). In the context of ethical space, and in consideration of the moral questions that cultural safety prompts, mental health and addictions services have the potential to be transformed in ways that “acknowledge the pain, suffering and intergenerational realities and experiences of Aboriginal peoples resulting from colonial assaults and the resilience and

resistance of Aboriginal peoples to historic and contemporary adversity” (Tait, 2008, as cited in Smye et al., 2010, p.25). Finally, Smye et al., (2010) support a call for integrated services meaning services that “include interdisciplinary teams of skilled Elders, community outreach workers, trauma counselors, specialists in chronic pain, residential school healing circles, psychological services, social workers, housing services etc” (p. 26).

4.0 Analysis

Analysis was undertaken by the five members of the FNIM AC cultural safety working group (which included the two focus group facilitators). Transcripts were closely read multiple times and emerging themes and potential framing metaphors were identified. Over the course of several meetings, a number of high-level themes began to be generated by the team. This led to a framework for analysis depicted in Figure 1. Specifically, six interrelated categories were identified to capture the themes emerging from the focus group transcripts: direct care, interpersonal relations, professional development, ways of knowing, organizational context and policy. Each of these categories was conceptualized as existing within a defined space and as embedded within a larger sociopolitical and historical context.

Next, each team member read a set of transcripts from one of the five cities using the framework as a point of reference. Members then met in-person to discuss their emerging understandings and perspectives. The group continued to meet, either in person or through teleconference, to deepen their analysis and comprehension of the multiplicities and complexities of the data. Our findings emerged through a process of iterative cycles of analyses, ongoing discussion and negotiations, consultations with colleagues, collective reflection on our goals, and a return to the literature.

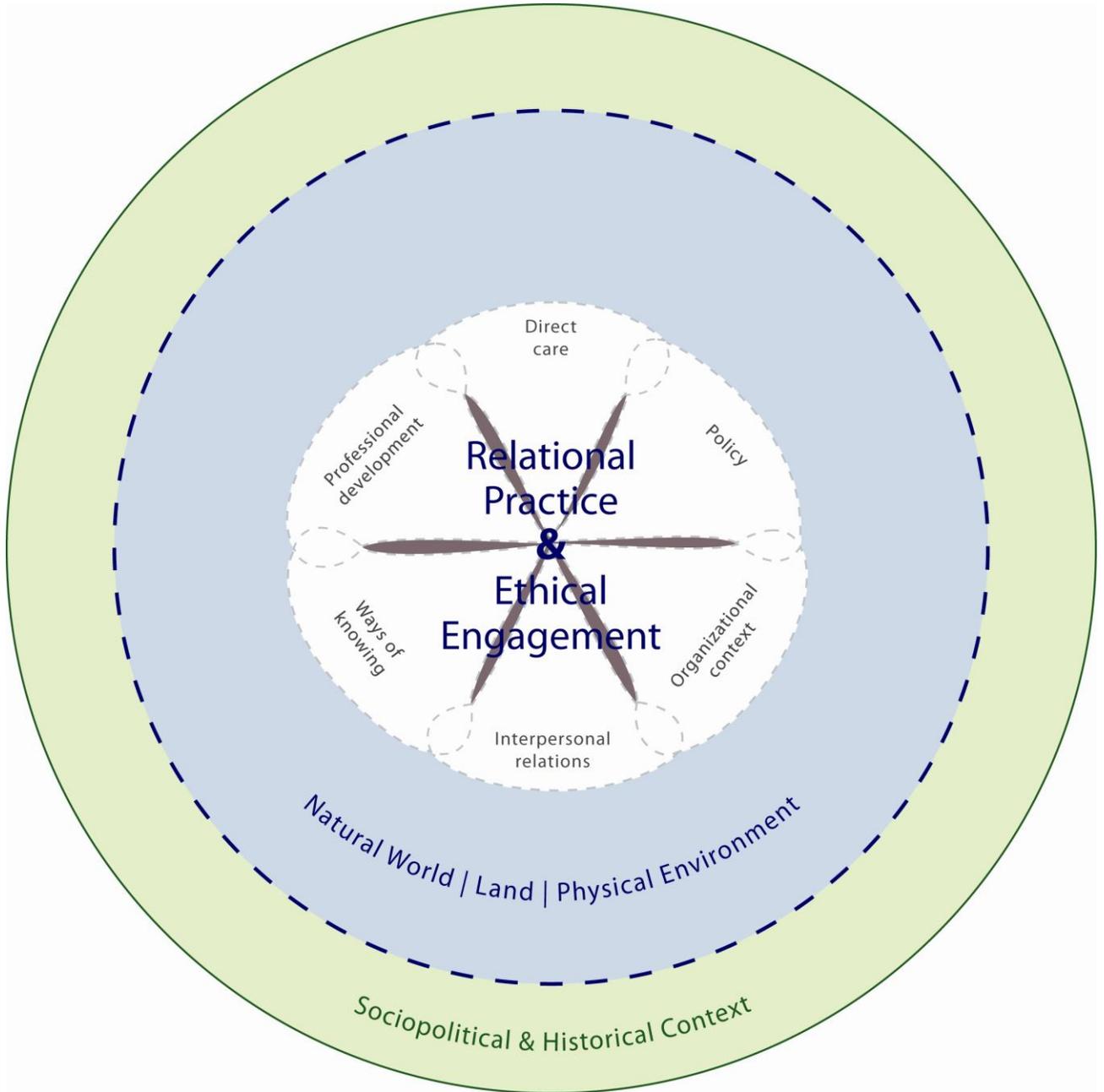
While participants spoke about the tensions and constraints within the field of mental health and addictions, they also described innovative, strengths-based practices in the face of these considerable challenges. We decided that the best way to honour the persistence, creativity and resilience of focus group participants would be to emphasize their hopeful actions and ideas about “good cultural practices.” These are described in sections 5.2 to 5.7 of the Report.

The work of our team was supported by secondary thematic analysis of the focus group data completed by research assistants from the University of Saskatchewan. The methodology included the use of ATLAS-TI software which was used to manually code and organize the data. Their analysis uncovered barriers and challenges that are described in section 5.1 of the Report.

Figure 1 graphically provides one example of how the larger context that includes socio-political and historical factors works with the natural world, land and physical environment (including human constructed things and systems) to influence our relational and ethical engagements. The six aspects that will be used to organize findings are captured in the over lapping segments– these are interrelated and contribute to the forces that both enable and constrain relational practice and ethical engagement which rest in the centre of the model.

Some of these categories have been drawn from White (2007).

Figure 1



5.0 Findings

5.1 Barriers and Challenges

Participants identified specific barriers and challenges that must be addressed to improve the mental health system, including service, institutional and funding barriers.

Barriers to services include general access due to geography including but not limited to rural, remote or reserve experiences, sometimes due to a lack of transportation and/or affordable and safe housing or shelter.

Institutional barriers are those created by the structures and processes through which mental health and related services are delivered. Barriers and challenges identified in this category include:

- the structure of mental health and addictions services often separated from and delivered in isolation from other health services and silo funding;
- classism, racism, sexism, ableism and other forms of social and structural discrimination;
- isolation – personal perception and experiences, geographic distance to services, lack of reliable transportation and social isolation including experiences of multiple stigmas related to cultural identity, poverty, mental health and addictions;
- lack of continuity of care in rural and remote communities due to staff turnover and lack of aboriginal care providers in small communities with multiple personal and professional relationships with clients and the need for boundaries and time away from community responsibilities;
- lack of organizational supports for self-care and healthy living on the part of service providers;
- periods of incarceration interrupting care;
- overall lack of resources in communities;
- lack of support for rebuilding individual, family and community cultural identities and connectedness;
- lack of respect for aboriginal healing approaches and methods;
- onerous monitoring, reporting and program evaluation requirements by funding agencies;
- lack of responsiveness by agencies to history of residential schools, disruption to families of child welfare-related interventions, cultural disconnects due to impacts on land, language, traditional economies etc.;
- unmet high needs related to intergenerational trauma and programs of insufficient length and scope that fail to provide treatment of both mental health and addictions

Funding barriers are related to insufficiency of financial resources to support programming. Barriers and challenges in this category include:

- lack of resources to meet basic needs or to fund comprehensive and culturally appropriate mental health and addictions services;
- lack of community capacity for volunteerism;
- unstable, short term funding arrangements;
- very demanding reporting requirements linked to eligibility for funding;
- erosion or absence of social safety net increases vulnerabilities for some clients;
- silo funding of services;
- no core funding – all project based and short term – not able to build organizational capacity;
- overall cuts to front-line services.

The remaining findings have been organized using the six aspects depicted in the model above – direct care; interpersonal relations; professional development; ways of knowing; organizational context and policy. The categories are interrelated; many of the stories and findings arising from the stories could have been captured in several different ways in more than one category.

5.2 Direct Care

Direct care in the context of this project refers to the qualities of the care provider/care recipient relationship. Focus group participants expressed that direct care needs to be: accessible (physically, emotionally, mentally, and spiritually), inclusive of the disabled, respectful of and responsive to the uniqueness of each individual, strengths-focused, flexible, trauma-informed, acknowledging of grief, and making use of human connection in healing. They emphasized the interconnectedness of the physical, emotional, mental and spiritual needs and the necessity of addressing these in their wholeness, since in the person of the recipient of care they are always interrelated, not fragmented.

Access

Direct care should be physically accessible in terms of its location, eligibility criteria, environment, and provision of handicapped access; emotionally accessible through assurance of confidentiality and welcoming staff who encourage and support movement beyond fear, stigma and discrimination; mentally by providing materials in different languages (appropriate to the geographic area), through reading and literacy levels that match the readiness of potential clients; and spiritually, validating of personhood, soul, and culture.

“A person can walk in here and say I have this problem, could I see someone, and that person would be accepted and told we would call them back or be seen face to face right away if that was possible. Someone always goes to talk to them right then.” (Service Provider [SP] Whitehorse)

An accessible service is one that is well-located and designed, properly staffed by compassionate and appropriately skilled people who are non-judgmental, have strengths-based respectful approaches, and invest in building social supports. Staff is well networked with complementary services and agencies (one door, many resources) with the capacity to respond to basic needs in practical ways including provisions for food, clothing, shelter, safety.

“You can talk all you want, but after the talk is done and the session is over, they’re back on the street... so you know housing is a necessity, a major issue...and if they need to have psychological help, get them that help, and if they need detoxification, then get them into a treatment program, and if they need further education, you know, go for it, but if they’re willing to take on a job, well then, get them one...” (Service Recipient [SR], Yellowknife)

The desired service philosophy is decolonizing and humanizing, and addresses root causes, rather than offering only a superficial “fix”.

“We specialize in core issue therapy, rather than deal with things piece meal. We have a program of healing that ...shows you where all this is coming from and gives you the tools for living today.” (SP, Saskatoon)

Inclusiveness and disability

Inclusiveness is an important feature of an accessible service. Inclusiveness means designing and delivering services that are specific for individuals with special gifts, Fetal Alcohol Spectrum Disorder (FASD), brain injury, and other abilities and disabilities to adequately meet their unique needs. The price of inappropriate access for people with disabilities is underscored by the following comment by a participant in Yellowknife.

“Because of my disability background, I recognize that many of the people I’ve worked with in the correctional custody or on the streets are horribly disabled. These are people who, if they had escaped brain damage before they were born from whatever toxic substances they were exposed to, continue to sustain head injury from falls, blows to the head, substance abuse or addictions issues. We take those people and put them into correctional custody where even the guards say ‘they don’t belong here-they’re mental.’ And correctional guards are not trained to work with people with disabilities; they are trained in security work. We have got mentally ill people who have been using substances to deal with their disabilities in expensive government-run facilities called jails. It is not an effective way of dealing with homeless, addicted, mentally ill people.” (SP, Yellowknife)

Respectful and responsive

In the direct care process, each individual needs to be met where they are and as they are ready to “find a place and make a space”. The relationship must be reciprocal, a collaborative partnership, with the needs and readiness of the care recipient guiding the unfolding agenda. A menu of choices needs to be offered and options provided with unconditional acceptance as a vital prerequisite.

“I think another reason our constituents come to us is because we give darn good, comprehensive service in whatever will meet the constituents’ needs, so it’s informed by constituents’ choice, constituents’ strength.” (SP, Winnipeg)

Strengths-focused

Helpers need to believe in the ability of people to change while honouring their diversity and finding strengths-based approaches that work for them. A strengths-based approach is more positive and effective than a deficiency focus because it focuses on what the recipient of care brings, including their culture. It looks truthfully at problems while patiently building on the capacity and potential of the individual for positive change.

“What we do works because we are building on strengths. We’re building on a positive foundation, and that makes all the difference in the world.” (SP, Saskatoon)

Flexible

Non-Government Organizations (NGOs) often are able to provide more individual, group and community-based creative responses that are also cost effective. Government agencies have more constraints around which they must manage in order to innovate and respond to community needs and challenges.

“What we do have as NGO’s is a kind of freedom of thought; we don’t have the government culture coming down on us, having to tow the party line.” (SP, Whitehorse)

Flexibility in shaping a care plan according to individual needs and circumstances is a major determinant of successful outcomes. Underlying this is the principle that “the answers are within us”; the expert is the person who is living the life.

“I don’t know what these individuals have been through, so the client centered approach allows me to let them heal at their own rate with the means they know best rather than me imposing as an expert and telling them to “do this”.” (SP, Whitehorse)

Trauma-informed

Any effective service needs to incorporate a knowledgeable and skillful approach to individual and collective trauma and racism while at the same time, recognizing and believing in peoples’ capacity to “embrace life” in their own unique ways. While trauma is a reality in the lives of many Canadians, for aboriginal people, individual and intergenerational trauma is too often a consequence of colonial processes and practices. Historically and currently, aboriginal people experience trauma related to the undermining of safe family and community connections, loss of land, culture and language. Systemic racism, covert and overt, erodes a positive sense of personal and cultural identity and wellbeing.

“With our FN people, there are all those experiences of abuse added to the effects of colonization on our people as a whole.” (SP, Saskatoon)

Grief as universal

Unacknowledged losses are experienced by many Canadians. Indigenous people have a backlog of grief connected to colonization and high rates of loss of all kinds that create a somewhat unique context. To be effective, care providers need to understand how the burden of unresolved personal and historical losses carried by many recipients of care may shape present behaviour.

“They suffered, and because their children suffered, their grandchildren suffered. Now I am saying each of these three generations needs counseling.” (Community Member [CM] Yellowknife)

Use human connection

Many aboriginal people have been deprived of human connection as a consequence of colonial policies and practices such as the residential schools – a foundational loss. To enhance and augment the value of individual therapy, many care providers use small groups and other collectives for re-creation through play, social and practical activities that support relearning the healing nature of “fun” while building positive relationships and developing life skills. Some services are activity based, rather than just “talk therapy”; for example, hunting on the land, going fishing, making a meal, crafting an implement or camping. Participating in cultural activities helps people re-build connections, not only to culture, but also to each other.

“We do cultural skills training...cabinet making, small tools, and repairing snowmobile engines.” (SP, Iqaluit)

5.3 Interpersonal Relations

Interpersonal relations refers to the range of relational networks and formal and informal supports in which both the care provider and recipient of care are embedded, including relationships with families, community members, colleagues, peers, mentors, supervisors, other service providers and agencies. Focus group participants emphasized the importance of reciprocity and dialogue, support for self-care, self-awareness, conscious growth, spirituality and the necessity for circles of support for both care provider and recipient of care.

Reciprocity and dialogue

The care provider’s work is characterized by a quality of reciprocity and dialogue based on a perception of the recipient of care as equal in value to themselves, as being a teacher as well as a learner in the relationship, and as capable of becoming proactive in building and maintaining their wellbeing.

“I learn something new every day from clients, who have a lot to teach us.” (SP Saskatoon)

Care for care providers

Self-care and personal growth are priorities for both care provider and the recipient of care. In order to help others, practitioners must continually deepen the way they honour and nurture themselves and role model a commitment to self-awareness, spiritual development and conscious growth that supports their capacity to “show up” relationally. An outcome of the commitment to nourish ones’ developing self awareness and personal capacity is a growing personal presence, “walking your talk” and/or “finding of voice” for both provider and recipient of care.

“...if you are going to get into this field, in order to be of help to anyone you need to be coming from a place of strength; that means I need to take care of myself first. You need to deal with your own stuff first, so you don’t put your stuff on to anyone else.” (SP, Whitehorse)

“We have a ‘heal the healer’ first situation because we have students dealing with abusive relationships, PTSD, substance abuse. We had to intensely work on getting the potential healer to be healthy first so...there was a lot of work, academic and counseling at the College. We hired a counselor specifically to work with the mental health students because of the fact that we have such difficult issues to face. So it is a continual work; it is not something that is going to happen in two years.” (SP, Iqaluit)

When renewal and healing is as much part of the human journey for care providers as recipients of care, it contributes to a loving and intentional presence that is one of the most powerful gifts one can bring to the other. Healing must be multi-faceted, realistic and a life-long process. We each have our own ways to heal, grow and develop our gifts and full potential. Practitioners who “walk the talk” are most effective in guiding people living with the challenges of mental health issues through their own unique process.

“Until you have something traumatic happen to you, it’s really hard to open yourself to understand what other people are going through. I had some traumatic things happen, so it just created something inside of me that I wanted to help. I felt that my experiences made me a more caring, open, patient, understanding person, and I find this job requires so much of that. And I think that I am good because I am not very judging. I tend to just see people as people. You are not this illness or that illness; you are just a human being. I try to be a good listener and try not to say, you need to do this or you need to do that, and just let them talk and solve their own problems by kind of guiding them through. Because I don’t have all the answers, and I believe that they do.” (SP, Yellowknife)

Circles of support

By definition, circles are inclusive. Care providers see one of their most important roles as “bringing people into the circle”, building social connections and peer support through healing and recreational approaches as well as group therapy.

“We do our Healthy Living Program; they make soup, socialize, and work in activities. We always work in new ideas with input from the people that come. Outreach does a lot of excursions in the summer...like going to have picnics and barbeques and to just get folks out of town to see the wilderness and nature.” (SP, Whitehorse)

Care providers also recognize that there is a special quality in learning from peers and group dynamics that allows them to work through family and group related traumas and find new versions of “family” and “community” with the recipient of care. Importantly, providers see that this applies to themselves as much as to recipients of care. They affirm the necessity for supportive environments that promote their own personal and professional growth and development, without which there is stagnation and burnout. Such supports sustain relational practice, which thrives in a nurturing collegial community.

“It is a difficult job to do on your own because clients are very complex. I do a lot of networking. Networking is essential to me.” (SP, Saskatoon)

5.4 Professional Development

Professional development refers to the informal, non-formal and formal knowledge and skill development received by professionals in the course of their training to become a mental health practitioner, as well as the multiple life experiences and cultural practices that care providers draw upon in their practice. Participants contributed the following about professional development; insights about informal, non-formal and formal education/training, mentoring, lived experience, balance and harmony, and wisdom teachings.

Education/Training

In every culture, education begins in our families and communities, where many of our most important values, attitudes and beliefs are first nurtured. The institutions of the formal education system are more successful when they build on the foundations laid in the early years. For many aboriginal learners, there is a significant “disconnect” between the cultural orientation of home and that of school, making it very challenging for them to reconcile and apply school learning to the realities of their personal and professional lives.

“When I took my social work training it was all westernized, there was nothing aboriginal about it. Later training was all changed and I was able to really incorporate a lot of what I had learnt there, because it was good, focused on Northern remote aboriginal communities, and because I had already learned a lot about my own culture and my own identity.” (SP, Yellowknife)

For non-aboriginal service providers in mental health and addictions to be well prepared to serve aboriginal people in culturally meaningful ways, their professional training must be congruent with indigenous understandings of health, illness, healing and history.

” We have people coming into social work who have very good intentions, they want to be helpers. They are learning that the impact of colonization is still going on, and instead of an approach to healing that ‘medicalizes’, they learn about social suffering and the power of acknowledging where people are and that their responses to atrocious things that have happened are pretty normal.” (SP, Yellowknife)

When formal education and training incorporates informal and non-formal strategies that allow people to experience relational practice marked by ethical engagement, this can support and foster human development, knowledge and skills acquisition. Methods for incorporating meaningful teaching of relational practice and ethical engagement remain under construction. The following strategies emerging in current mental health and addictions practice provide promising strategic directions.

Mentoring

When done in a good way, the development of mentoring relationships across generations, across disciplines, across agencies and across cultural divides can promote very significant learning and support new capacity development related to relational practice and ethical engagement. Mentoring and role modeling are powerful ways of teaching and learning.

“People with more advanced training need to go to the smaller communities more often to help support and train people working in the community.” (SP, Whitehorse) “The nurses that are in a consulting role are using the resources in

the communities to consult, to teach, to assist, all of that, so you are building up your communities.” (SP, Whitehorse)

“Our team members have gone out to several of the communities and done micro-skills and counseling education so it builds capacity for them. We respond; we don’t impose.” (SP, Whitehorse)

Valuing woundedness and healing through lived experience

We are all wounded and must honour our own woundedness. With our woundedness and our commitment to healing comes an obligation to be fully engaged in our own lived experience. That lived experience as it unfolds moment by moment is the crucible of relationship that we bring to each engagement. This dynamic either affects our relational space within our awareness or out of our awareness – the effect is there either way. Deeply reflective practice involves seeing life as a spiritual journey and opens the helper to be helped. To act out of unawareness increases the potential to harm another. As we gain further awareness and proficiency in our own process, we can help others. Many care providers and consumer advocates testified that their on-going learning from self-reflection based on lived experience serves as their most valuable resource in working with others.

” If someone hasn’t worked on their own stuff, they are of no help at all.” (SP, Saskatoon)

“The significant difference between our organization and other organizations is people on our board and people that work there have had problems. We have no difficulty saying that we needed help and we had problems, and we helped each other.” (SP, Yellowknife)

Balance and harmony

“Bringing people into the circle” means providing a range of teaching and learning methods and content options to people at the individual, family, group and community levels. Rural and remote communities need relevant and accessible options and resources for building internal capacity. Needs, strengths and resources must be balanced to support equitable access to professional development opportunities that further support equity in health status for all Canadians whatever their culture, geographical location, or socioeconomic status.

“You need the diversity; you need the people on the ground who can be the generalists, who can do the care, provide some problem solving and support, and you need the people with the training who can guide the people on the ground or assist when you have people who are suicidal.” (SP, Whitehorse)

Wisdom teachings

Wisdom can be gained through experience and through spending time with people whose knowledge is physically, mentally, emotionally and spiritually integrated. To find ways of accessing wisdom from a spiritual tradition or traditions that are in alignment with one’s path and making time and space to learn is one of the best investments possible in human growth and development. When practitioners have opportunities for interpersonal learning of wise teachings from multiple perspectives without the privileging of one over others, they can build on the strengths of all.

“We don’t need to teach the elders, they are already taught, and they are already professors and experts in their domain. It’s the people that we are training right

now in schools that we have to help them to think about the strengths, and alternative forms of healing for our people.” (SP, Yellowknife)

5.5 Ways of Knowing

Ways of knowing refers to the approaches taken to understand, document and make sense of the personal and social world. “All my relations”, cultural continuity, the power of story, and tensions between Western and Indigenous ways are themes that emerged in the focus groups.

All my relations

This phrase embodies the value and importance of relationships to generations that have “gone before” (ancestors), the generations that will come after (yet unborn), land (a place that remembers you), community, cultural and traditional paths, language and all elements of the natural world. All of these are of central importance to most aboriginal care providers and recipients of care, and become significant to non-aboriginal care providers working with aboriginal people.

Cultural continuity

Some of the focus group participants spoke about the importance of Elders. Elders have enduring lessons to teach with respect to rebuilding and maintaining health and wellness, generation to generation. For many, Elders are the keepers of cultural continuity. They hold oral tradition; they keep the stories and the songs. They do the ceremonies and teach others how to do the ceremonies. Without relationships with Elders and their generosity of spirit in sharing what they know, the rich wisdom that they carry will be lost. All of us need to be committed to learning and sharing as cultural continuity is a collective effort with responsibilities for all.

“I have been a survivor of suicide, I have been a survivor of mental health issues, and the reason I was able to get back on my path was the culture. Without the cultural teachings and without elders’ help I do not know where I would be today.” (SP, Winnipeg)

The power of story, re-storying and restoration

The power of stories was a strong thread in the focus groups. Indigenous people and client groups are often the objects of stereotyping and social exclusion or victims of a single story that simplifies and essentializes the diversity of human realities and in that process, dismisses much that is true about the group about which the story is being told (http://www.ted.com/talks/chimamanda_adiche_the_danger_of_a_single_story.html). Part of therapy and healing is to understand how our stories are the outcome of our lives and contribute to perpetuating patterns in our lives. We do not always tell ourselves a truthful or complete story. The potential for restoration through re-storying our lives is powerful. The re-storying must take place on both personal and societal levels, so both the care recipient, care provider, and the socio-political contexts in which they live are freed from the shackles of the dehumanizing single story.

” Every person has his or her own story. You can’t label because each person is unique.” (SP, Saskatoon)

“One night I was sitting with three co-workers and started talking about treaties and colonization. I was thanked by one co-worker who said she learned more from me in 15 minutes than from all the hours of equity training, aboriginal awareness. So, if that is going to be my role on the floor, I will educate them, I will try to

ignore their ignorance and their discrimination to hopefully help them see a little more from my perspective, not the narrow view they have.” (SP, Saskatoon)

Tensions between Western and Indigenous ways

Indigenous people with limited experience in highly complex government organizations often need assistance in developing the organizational literacy to be able to see and deal with tensions between what they may view as right and good and the organizational culture in which they find themselves. Non-indigenous members of the organization also need help to make explicit and change organizational values and practices that block effective service delivery.

” When you end up working for government, it ends up being another level of challenges because of the hours you’re constricted to, or the office. It’s just not conducive to the cultural way of helping that was the reason they wanted to be helpers, to help their community, and they end up having to use a government process that is very foreign to them.” (CM, Iqaluit)

Underlying these tensions is a fundamental difference in the ways in which mental health and mental illness are conceptualized from western and aboriginal perspectives that has implications for all aspects of a mental health system.

“The frames of reference in FNs compared with the western world in terms of what wellness means are radically different.” (SP, Whitehorse)

” Mental health is a very Eurocentric word...our government is thinking about this as an individualized personal problem inside our minds... and needs to think about these concepts differently.” (SP, Whitehorse)

“For mental health, you have to know who you are, your history and where you are going because it is the root of who you are. Mental health has to recognize the treaty relations because that is the basis of who we are within Canada and that’s what cultural safety is. It’s us running our own organizations, our partnering, but we are real partners; we are not just at the table.” (SP, Yellowknife)

5.6 Organizational Context

Organizational context refers to workplace norms, policies, resources, agency mandates and professional routines. Focus group participants spoke about organizational norms, centralization vs. decentralization, integration of services, family and community context, and healthy effective organizations.

Organizational norms

Positive norms support good practice. In organizations, there may be tensions experienced between indigenous and non-indigenous ways of knowing being and becoming when culturally different groups work together. The indigenous imperative to be respectful and responsive to people, sometimes at the expense of policy is not always supported in organizations. Concerns about budgets and efficiency may well trump client-centered concerns. Indigenous ways of knowing are relationally led and informed. From an indigenous perspective, the needs of the recipient of care ought to guide the helping process, and policies and procedures that block or circumvent effective practice need to be identified and addressed.

“We are status blind; we serve anyone who is aboriginal, Inuit or Métis.” (SP, Winnipeg) “The two systems (First Nations and non) are so different. One is about appointments and procedures; these did not work in the small communities.” (SP, Whitehorse)

“With the amalgamation of services, the manager role is more worried about admin and financial management (not paying overtime or sick time) than developing teamwork. There is no teamwork on our floor. Five years ago, the focus was on the best patient care. The team leader was accountable, looked after the staff so they could be well rested and provide the best patient care. The new manager came in with different values. His approach is all about the budget and time management. If he meets the budget he gets a nice bonus at the end of the year.” (SP, Saskatoon)

“Your system reflects your approach. When I was hired, my boss said here we aren’t hierarchical; we are all equal whether your work is to answer the phone and greet people or you are a clinician. We are on one page, every opinion matters, everybody is deserving of equal respect. So that whole kind of we are one, we are equal philosophy passes down to clients.” (SP, Whitehorse)

Centralization versus decentralization

Many participants noted the importance of aboriginal self-determination. Autonomy and self-direction at the community level ensures the best fit of service to need. A balance of centralized and decentralized services needs to be achieved and maintained dynamically in order to maximize the effect of resources invested and to get the services as close to the people as possible. For example, organizations that provide services to rural and remote populations need to have the authority and capacity to design and deliver appropriate programs and services to diverse and dispersed people.

“The biggest need is for a proper community-driven mental health facility because people here are still skeptical about the people who caused the problem now being the solution to it.” (SP, Iqaluit)

Integration or linking of services

Innovation is needed in some cases to find new ways of integrating, bringing together or linking services. Focus group participants talked about people “getting lost in the cracks” due to lack of good linkages that work for people. Many participants spoke about the need for health services to link with housing and educational and employment opportunities.

“Like for me it’s hard to find a decent job because I’ve got no education. I can’t really get anywhere unless I try,”

“It would be good to have small-income loans and low-rental places for people that need a place to stay.” (Service Recipients [SRs], Yellowknife)

“Housing is a huge challenge for a lot of people, especially for women.” (SP, Saskatoon)

Partnering between agencies or individual helpers is one way to increase capacity and ability to serve.

“We try to address as many of the determinants of health as we can, so in terms of facilitating movement out of poverty, we will focus our attention on securing the educational supports...social supports...all of those linkages, where we take them and pick them up and bring them back...the transportation to do their grocery shopping or go to their medical appointments so that they can consistently attend to their health needs.” (SP, Winnipeg)

Another major challenge is to link mental health with addictions services.

“Most indigenous people that have mental health issues have addictions issues, but we have no way of accessing the mental health issues because we have no way of accessing the addictions issues. We need to provide stabilizing services to people, connect with those people, so they can then access mental health services, which we still have to develop.” (SP, Whitehorse)

Family and community context

Many participants noted the importance of the interconnectedness between the individual, family and community. They recognized that the individual needs a healthy family and community context to build and maintain their own wellbeing. The capacity to serve “community as client” through community development, capacity building and other growth oriented pathways needs to be greatly enhanced throughout the system. The continual repetitive use of individually focused interventions disrupts the integrity of family and community systems.

“The answer is the community having resources and having time. I think it is important somehow that we get out of the way to allow the community to connect with processes that are connected with elders and ancestors.” (SP, Whitehorse)

Healthy effective organizations

Just as organizations need a cycle of renewal, so does a priority need to be placed on investing in, supporting and rewarding staff growth and development – both personally and professionally. Healthy organizations that are effective need to invest in planning, implementation, harmonization and evaluation in a balanced way. Often organizations fail to fully invest in planning and evaluation or learning from clients and front line workers so as to inform and reform those processes. With the focus on implementation, the capacity to harmonize with sister agencies, volunteers, family and clients is often compromised.

5.7 Policy Challenges

Policy challenges refer to government legislation, policies, and funding. Significant challenges identified in the focus groups include the need for policy supports for sustainable funding, tension between individual and collective rights, between biomedical and complementary approaches, and concerns about the capacity for response to ethical dilemmas.

Policy supports for program funding

Program funding that truly serves people is adequate, equitably distributed, multi-year (up to five years) and begins to flow at the beginning of year one. In addition, the funding should continue uninterrupted for the full term, and if renewed, continue for the renewal period uninterrupted. The multi-year stability provides a real opportunity to demonstrate results. Monitoring, evaluation and reporting processes are strategic and should be easy to use and take a minimum amount of time and energy away from providing care. Policy and government implementation processes need to

align with each other in order to maximize the ability of government and non-government community agencies to serve people. Ensuring sustainability for programs and services of proven effectiveness is also a challenge.

“Temporary funding is not the way to meet the health needs of the North.” (SP, Whitehorse)

“There’s a lot of catches to this funding money. We operate, from quarter to quarter and uncertainty is the biggest problem we face because people are fed up, rightly fed up, after many years of programs being started and they start to improve their lives and all of a sudden your funding disappears and the program’s gone. That’s the biggest problem is the sustainability. We are looking to having to close the doors on March 31st after six full years thanks to the Aboriginal Healing Foundation (AHF). And this year, we are \$8500 short because the feds haven’t come through with the money though we signed the papers. I say live up to your commitments because if you don’t, you kill the program.” (SP, Iqaluit)

Individual rights and collective responsibilities

The mainstream system is focused on individual rights as a primary concern that supports a policy response to individual needs. From an indigenous perspective, collective responsibilities are seen as primary and therefore the most important response focuses on the nexus between individual and collective responsibilities. Rights, in the indigenous view are earned through carrying out responsibilities in ways that benefit present and future generations.

“What would it look like to create a truly family friendly service that engages the family and community? We don’t think the language of diagnosis is friendly and office hours are unfriendly; there are a lot of things that are unfriendly.” (SP, Whitehorse)

Biomedical model, indigenous and complementary approaches

The biomedical model often stands in opposition both to indigenous and complementary approaches that are more holistic, whereas the biomedical tends to be an individualistic, curative perspective. Indigenous and complementary philosophies and methods are usually congruent. The predominance of the biomedical model is problematic as it leaves little room for these other models. Sometimes, for individuals struggling with indigenous identity, complementary approaches offer a pathway more acceptable to them. Participants called for building approaches that respond to multiple ways of knowing and multiple pathways to healing and recovery.

“Our program activities are holistic; a blend of contemporary and traditional services to meet the complex needs of our urban aboriginal population in order to move them to a healthier lifestyle. We like to say we take the best out of both worlds.” (SP, Winnipeg)

Capacity for response to ethical dilemmas

Both individuals and organizations often find themselves faced with ethical dilemmas, some of which have cultural and professional dimensions. As one person said,

“Who is it we go to when something happens that we cannot tell anyone about?” (Symposium Participant [S], Ottawa)

Organizations need to have capacity to assist in these situations to prevent ethical blindness, burnout or moral residue as a consequence of unresolved ethical tensions that may compromise relational capacity at the service interface. Truth telling and speaking truth to power must be supported in order to build and keep trust. A recurrent example of a major ethical dilemma is the lack of program sustainability.

“Programs actually come and go so frequently that they put people into a worse situation than they were to start with.” (SP, Iqaluit)

6.0 Discussion

The discussion is founded on the results of the literature review, a synthesis of views from participants, the analysis of the experience of the focus group facilitators, and the dialectic created in the relational space between the two. In this section, the voice of the report intentionally moves to “we” in order to speak collectively about what we have drawn as conclusions from the findings and the learning that emerged from our collective intent as a working group to “walk the talk”. The discussion blends the shared learning from the focus groups with personal and working group insights developed through dialogue with the data and each other. We chose to model inclusion, participatory methods and indigenous ways of sensing and sharing knowledge and wisdom in choosing our methods with the focus groups and within the working group. In both groups, we honoured the principle of allowing the participants to direct the process as it emerged organically from one stage to the next.

6.1 Group process and leadership

The wise and responsive leadership expressed by Bill Mussell was fundamental to our collective learning. As a result of his lifelong learning, Bill was able to design an open process for the focus groups that was both inviting and generative. He and Terry Adler created a space together of loving interest and inclusion that promoted significant contributions and deep sharing among participants. Focus group meetings were planned to optimize the comfort level of participants by being held “close to home” in familiar surroundings with participants who either knew one another or had much in common.

The talking circle as a method worked well, due to the way in which it was introduced at the sessions. The facilitators intentionally remained open and responsive to whatever emerged from the group. The perspectives of all participants were valued and the circle was kept and held until it was finished – time was provided to allow for consensus or a natural conclusion. Bill Mussell, as the primary circle keeper, demonstrated the loving presence, non-judgmental acceptance and openness that invited people to feel safe and contribute to the level that they felt comfortable. As facilitators, he and Terry were able to help participants find ways of safely “being on the bridge” – the bridge between aboriginal and non-aboriginal worlds; between care providers and those receiving care; and between community and institutional ways of caring. Learning and discovery was encouraged and mediated under their leadership. Each group was seen as a microcosm of the whole and an opportunity to experiment with “walking the talk” together. The process was co-created by all the participants, and the responsibility for the outcome jointly taken.

The working group came together under the leadership of Mussell and Adler to work with the information and knowledge that they had collected and generated throughout the data collection phase. There was a commitment within the group to affirm and reaffirm a collective belief in a

hopeful future. We were invited to hold “hope in our hearts” and to focus on strengths and possibilities while facing the current reality with unflinching courage. As we discovered, in order to hold the findings we had to be willing to let the information and growing awareness transform us. Through the emergent process, we were challenged to embody the current reality in order to hold the possibility for change in our conscious awareness – individually and collectively. The work both in person and through technology took on a loving, emergent quality and together we created the perspective needed to ensure we honoured the voices of those that took part and the many individuals with lived experience that were not able to participate. A profound valuing of the opportunity to connect with one another and make a hopeful difference became the wellspring that fed the work. The work was alive with generative cross-pollination of ideas and divergent perspectives.

Intentionality became an operative word as we visited and revisited our intentions. Meetings always began with a check-in circle to honour the fact that we bring all that we are and the connections that define us, including family and friends to the circle. In the circle, we were invited to “show our whole face”. Even our pain and distraction were welcome as signs of where we were, in our personal “process of becoming” on that day. The embracing energy of acceptance and allowing permeated the circle. We intended to make a contribution to positive change while honouring the voices of all who participated. We intentionally used space and time as a precious resource and valued reciprocity and mutuality in our relationships. The process was more of a spiral than a linear progression as we used indigenous ways of being together in dialogue and taking collective ownership of our work.

The view was a long term and patient one; the collective stance humble. Collectively, we hold an unfailing belief in individuals’ willingness and ability to change themselves, sometimes with the assistance of a “hand up” which is offered with high regard for their experience in that moment. We intend to do what we can. There was a distinct absence of ego driven competitiveness or a need for recognition and ownership. The work was truly spirit-led and spirit-assisted. A sense of hospitality and generosity prevailed as we cared for one another through the process. We invited each other over to our “home” perspectives with the enthusiasm of the best host or hostess. We trusted each other and the process enough to sit and visit with it until the next important realization bubbled to the surface and the next step became clear. Each individual and his or her sense of a need to protect “home territory” was honoured.

6.2 Principles and Practices

From this project emerges a new way of understanding and responding to mental health and addictions as a human experience, best expressed as principles and practices that apply to related programs, services and the systems supporting policy and program development and service delivery.

Honouring humanity and human experience in the process of becoming

Honouring humanity and the common ground of human experience entails recognizing pain in all of its human dimensions, supporting the voice of those who often do not have opportunities for expression, and affirming the health and resiliency of individuals, families and communities. In the practice of asking people, being helped ‘how they are becoming’ and honouring their evolving process, the care provider offers stewardship in the care recipient’s process of healing, growing and re-creating self.

Centrality of connectedness and relationships

The centrality to healing of connectedness and relationships comes from traditional Aboriginal ways of knowing that view illness as a result of disconnection. Disconnection from self, family, community, the natural world and Creator at a spiritual level is the most fundamental problem. What is needed is a “*soul to soul handshake*” (S, Ottawa) as a foundation for relationships intended to help a person rebuild connections that serve as a bridge back into a connected way of living.

Valuing and learning from diversity

Rebuilding and nurturing mutual respect between all cultural groups and peoples is fundamental for a just and healthy society and for creating an effective mental health system that honors and integrates the best of the knowledge systems of each culture so they contribute to the whole.

” I realize that what happens in a culturally safe place is that you are open to new ways of thinking. With each person, I am making new meaning, Myself, I feel cultural safety when I am being treated with dignity, and I know its absence: when I am being treated as an object.” (S, Ottawa)

Well-funded, flexible programming

Providing options that are community driven, flexible, responsive, and delivered within the context of multi-year stable funding provide for the most effective programs; otherwise, enormous energy is consumed by continual fund raising.

“I would say that 90% of the work I do for this center is keeping funds moving.” (SP, Iqaluit)

Fundamentals first and “do no further harm”

Food, clothing, shelter (housing), safety are important and foundational for healing as they meet the basic needs of human life. To “do no further harm” is to honor that each person involved in relational engagement has vulnerabilities and past woundedness and as a fundamental principle, the intention is to not add to the burden of pain or trauma through negative relational experiences.

Patience and deep listening

To have and express patience provides a quality to relationship that communicates that people are important and human connection takes time to unfold. Presence is not possible without patience to be with the other and wait for the next opportunity for deeper engagement to emerge.

“Time is love. The most important quality one can give is time.” (SP, Saskatoon)

Healing from the cumulative effects of intergenerational trauma and other major disruptions to wellbeing takes time.

“Twenty-eight days after two centuries of trauma is not enough intervention for most people.” (SP, Whitehorse)

“You don’t just go for a month somewhere and all of a sudden expect everything to be ‘fixed’. It doesn’t work that way. Your history is a factor of who you are. You come from somewhere and need to figure that out.” (SP, Saskatoon)

Following from patience is the ability to listen deeply to the other and hold space for their dignity to be protected and expressed.

“It makes a lot of difference when somebody actually listens to people.” (SR, Yellowknife)

Radical acceptance

Valuing each person and accepting the way they are provides a place for meeting them there and moving from that point together. Valuing and acceptance is at the heart of non-judgment. This is not to say that all behaviour can or should be accepted and allowed in all circumstances. Unconditional love and acceptance and deep valuing can co-exist with setting limits to behaviour if needed.

“In my work with people because I’ve been judged a lot in my own lifetime, is just to practice acceptance and see that person as a human being, not with all the garbage that is in the way, but underneath that. Because that is who they are is what’s underneath there, not all this other stuff they’ve been clouded up with, through a lot of times, no fault of their own.” (SP, Yellowknife)

Reconnection with self, others and the natural world

Illness is the result of disconnection and imbalance and therefore healing and recovery is founded on supporting reconnection with self, other, family, community and the natural world.

“Disconnection is from culture, from selfhood, from your own sense of agency; disconnect on a community level. It is pervasive. These are communities characterized by disconnection [within the community] and disconnection between the services and the population they are supposed to serve.” (SP, Whitehorse)

The balance of connections and the personal balance of mind, body, spirit and heart further the capacity for connection.

“So when they sent me back to my own people, they taught me how to take care of myself properly, they brought me back to praying, back to spiritual ceremonies and stuff like that. And they talked to me; they taught me how to be clean, how to survive, how to believe in myself, and how to feel more compete as a person.” (SP, Yellowknife)

The practices of “being with” in silence acknowledge the therapeutic value of “being” not “doing”. Land based healing allows for periods of quietude on the land in connection with nature, and time to be with one another in small groups or around a fire where people may companion each other in silence, with little talking or activity. Taking time alone to connect with self, reflect on one’s inner dialogue and experience as part of healing is a well supported indigenous practice.

Respect

Respecting the lived experience of care recipients, their family, friends and care providers is essential to honouring them and their process of becoming and healing in the world. A person can never know the full extent of another’s inner world but relational practice and ethical engagement can provide a safe bridge into a deeper and more authentic understanding of the other.

“Most of the family support work we do is trying to get from them how they see their world, how do they perceive it. It is all about hearing from them.” (SP, Yellowknife)

“People come because they feel safe...others have told them it is okay to come... they are not going to be judged or pathologized or labeled with the problem...they just need somebody to talk to and to know that they are actually present. To me if you can't be present, go drive a truck. It is about balancing out the pain with the hopes, and to be able to hold both.” (SP, Whitehorse)

Collective healing

Building from existing family and community capacities strengthens natural social networks, rather than setting them aside. We need to honour peoples' existing social networks and those they identify as family. Many one-to-one services disrupt family and community cohesion and fracture community connectedness. While we understand that not all relationships are always helpful or positive, we know that people are embedded in their social systems and healing needs to be supported at the collective as well as the individual level.

“We are dealing with a traumatized community. It's not just where the individual is at; it is where the community is at. Government has made huge errors going in with guns blazing saying here is what we will give you, when the community didn't invite them and hasn't been consulted.” (SP, Whitehorse)

Inclusive communities of practice

The idea of community of practice or community of care is important in supporting the ongoing growth and development of care providers – both paid and unpaid. Collaborative relationships within and between agencies provide for a spirit of working together creating attunement and synergy that better serves the people. Communities of practice need to embrace a diversity of helpers. When one person is the “expert”, there may be little room for learning.

“They (women in a federal prison) reminded me that I was just the same as them. Just because I am a Doctor doesn't mean I know it all and I would refer them to others who knew more than me. You are there more as a guide. Being humble, not acting as an expert is part of cultural safety.” (S, Ottawa)

Strengths-based approaches

Working from a focus on the strengths and capacities of a person or group is to affirm the positive and build from what is known to be strong. In Appreciative Inquiry this is known as seeking out the life giving forces, seeing them clearly and investing in them as a source of positive growth.

“What we do is development with them, capacity building. We get them to realize that they do have the solutions and that they are the ones who are the experts.” (SP, Iqaluit)

Relational attunement and shared living

Love and loving presence contribute to resonance between people. This is a deep and restorative form of connection. It is being in tune with the other and is a powerful antidote to fear, shame, and toxicity. Resonance signals the engagement of the heart and spirit, as well as the head.

Showing people how to live and how to live together by doing it reinforces that “*you embrace life by living it*” (S, Ottawa). Some people have forgotten how, so we need to live with them through life experience and help them relearn how to embrace life again.

It is important to identify and manage fear due to individual vulnerability or the emergence of relationship challenges, either as expressed by the recipient of care or the care provider. It is working with our “soft spots” that promotes change.

Honouring boundaries

Honouring personal and collective territory is important as individuals learn and relearn boundaries and boundary setting. Part of defending boundaries is strengthening the ability to resist influences that are harmful. At a community level boundary setting is about protecting and preserving land as a steward.

Recovery model

The recovery model has many helpful principles and practices including the use of peers and community agencies. It recognizes that recovery in addictions and mental health includes relapse, and often, movement onto further stages of recovery. Individual recovery needs to be supported by family and community level recovery. Policies and practices that govern the provision of programs and services should support recovery as a process at all levels. The recovery model used must be reflective of indigenous ways of knowing, culture, values and healing methods.

“I have been working in recovery for years with people on mental health on an individual level, but there is recovery at a bigger level as well. There needs to be a sharing of power and resources, and the respect for where people come from. For the aboriginal communities, they need to be the drivers.” (SP, Yellowknife)

Nature as healer

Relating to and learning from nature is helpful in rebuilding connections.

“On the land is where everybody is connected together, in every aspect of our life; our physical, our mental, our emotional, our spiritual and socially too, because it’s all there together.” (SP, Yellowknife)

Working with the seasons can put a person in touch with the ebb and flow of life and assist in learning how to let go and move on with a new season, in harmony with the cyclical nature of life. Activities in the natural world can reawaken peoples’ stored cultural knowledge, sense of spiritual connectedness, and hope.

“I had a women’s mobile on the land program years ago that went from one region to the next. By the third week, the change in the women was just amazing. The results would not have happened within an institution in three weeks. No way. No way. This sort of thing with the land is more spiritual and grounding and there is more support for your emotional disarray that nature will provide for you. You don’t need words.” (SP, Yellowknife)

“If I had the funding, I would do an on the land type of treatment program. Once they go out on the land, our people are totally different people. When you are out on the land there are so many different aspects of the life that touches peoples’ lives. One of the findings of the evaluation of the program was how those women really felt more empowered when they were on the land...it made a huge difference in the dynamic.” (SP, Yellowknife)

Culture as healer and therapy

Culture and cultural continuity is fundamental to positive identity.

“The bottom line is to regain our culture. When we started this project, our own Board who are all Inuit gave it the title “rising up through your own culture.” (SP, Iqaluit)

Part of using culture to support healing involves exploration of music, art and creative expression as therapy. One’s Mother Tongue is a powerful vehicle for connecting with culture.

” On the land is where I regained my language...and learned all the knowledge about the traditional roles of men and women and children.....” (SP, Yellowknife)

Well-proven cultural therapeutic practices have been showcased in the community-based projects funded by the Aboriginal Healing Foundation (AHF) www.ahf.ca, which was an outcome of the Royal Commission on Aboriginal People (RCAP) www.ainc-inac.gc.ca/ap/trc-eng.asp.

“In terms of the RCAP, all the answers were already there...on how to do more culturally appropriate treatment, how to work cross culturally. The answers are all there; the blue print is there. It really boggles my mind, you know, what more needs to be done?” (SP, Yellowknife)

“I have always said that aboriginal people have to take ownership of their own people. And through the AHF we have had tremendous support from them recognizing alternatives to mainstream technologies so to speak, and to able to more key into the cultural part of our people.” (SP, Saskatoon)

Prayers and ceremony

Prayers and ceremony are very important well-proven practices for healing within a cultural or spiritual context.

“One of the determinants of health we don’t see, is what I see as the driving or integral force for change inside the individual...your spiritual self...it is a vital component in change.” (SP, Yellowknife)

6.3 Metaphors

Metaphors are powerful ways of supporting human beings in understanding their experiences and the world around them. Shared metaphors help to create bridges of shared meaning and shared understanding.

Spiral as connected completed circles

Spiral is the metaphor for growth and human learning and change. Where each circle comes back around to join the next, there is a linking and an opportunity for connection, deeper understanding and insight. This set of ideas, arguably, is a more helpful model than the linear model in describing the process of change and healing.

Two way street

Relationship building and sharing time between people and within groups is a two way street with each person making an important contribution.

“This (building cultural safety) is a process, a learning opportunity, to build cultural competence that is a two way street. The people who hold onto the information are the FN, Inuit and Métis, and we have to be willing to share. The opposite is also true; the level of secrecy in government prohibits sharing. How do we build the intentional space in which people are safe to ask the questions?” (S, Ottawa)

“We have to negotiate a shared understanding of the problems that confront us.” (SP, Winnipeg)

“Aboriginal people can do a lot for all people if we are listening to their wisdom. We need to respect each other, have partnerships.” (SP, Saskatoon)

Walking together

When people walk together, the best way to relate and see each other is to walk side by side with neither leading nor following.

“A phrase shared by a presenter at the Native Mental Health conference in 2009 was that our people would call this ‘walking together.’ It is the closest, simplest way to approach talking about cultural safety. What are the barriers to doing this? They have a lot to do with power, and being self-reflective about power relationships. In my case, I am a white psychiatrist, working with the Feds, and I need to be self-reflective about that.” (S, Ottawa)

“How can we grow it to a point where we can have a common ground, to be able to develop something that can be a complement to the rest of the Nation, from the aboriginal perspective? This is the struggling part of aboriginal healing...to be legitimately involved within the process. Where is that common ground? Where is the respect for one another?” (SP, Saskatoon)

6.4 Liberating concepts

Liberating concepts are ideas that provide a foundation for redesigning our systems of care. Concepts that emerged from the analysis of information provided by focus groups and the Ottawa symposium include:

Many choices and freedom to choose

Choice requires access to options and exercising choice can be a powerful process of defining personal preferences that fit with an individual’s healing path.

“The opening up of spaces for many choices for people is critical.” (S, Ottawa)

Return to the large human tribe

Our connections, as human beings are founded in our shared humanity and characteristics which support much common ground.

“With a focus on technology over empathy we are sub-dividing ourselves into smaller and smaller tribes, none of whom will be able to speak to each other. Rather than a technical approach, adopting a more holistic one characterized by compassion and empathy has the power to reconnect us.” (S, Ottawa)

All life matters

Foundational to respect is the honouring of all life, from the most humble plant, insect, fish bird or animal to the most dominant of species, human beings. By honouring all life, we honour our own lives and find compassion for each other.

“I was standing with an Elder and he was teaching me some things – all of a sudden his gaze went to the floor. I followed his eyes and saw this little ant walking into the circle. Alex says: “See the ant?” and I say “yeah”. He said “He is my brother. He is no better than I and I am not better than him. When we as humans can think that way, we will have the peace we seek.” That has transformed my relationship with all people and all of creation. ... I don’t believe we can help people on their journeys of healing if we are one up and one down.” (S, Ottawa)

Humanized and humanizing relationships

Healing is about creating opportunities for each human being to become all they can be which requires approaches that are humanized and whole, not fragmented and mechanical.

“It takes confidence to speak from your heart, comfort with who and what you are, to show your face. It is important to build on Aboriginal perspectives of a ‘good way’ and Friere’s thoughts about being “fully human” in order to participate in humanized societies that counteract dehumanizing forces.” (S, Ottawa)

“The more we work, the more we understand; it is about building a relationship with another human being.” (SP, Saskatoon)

Knowing self – knowing other in context

To learn to know another, we must know ourselves and much of what we know and understand grows out of the context of our lives. The Elders tell us that we need to know who we are and where we come from in order to move on in life.

“‘You don’t know me and how can you work with me if you don’t know me?’ and ‘You don’t know me but you get to define me and by defining me you get to decide what happens in our relationship’ are quotes from an Aboriginal man that point the way for a human relationship of shared ‘knowing’ that is fundamental to ‘working with’ someone to assist in recovery. Power inequities are fundamental to any human relationship and the systemic and relational power dynamics must be consciously managed.” (S, Ottawa)

Know what you stand for and change self

In order to know “your side” and differentiate it from the “oppressor”, self-discovery and awareness is necessary. To hold on to where you stand and what you stand for as you continue to change yourself is a very powerful way to catalyze change. The Elders also point us to the idea that it is people who change, not systems. People do not relate to systems, they relate to the people representing the systems.

“The Elders that guide me tell me to not side with the oppressors, to change them. We need to do what we need to do to change ourselves and they will come around.” (S, Ottawa)

Circles within circles

Inner circles of intentional relational creativity and generativity provide the foundation to take ideas out to a broader circle in which there may be less intentional awareness and more diversity of ways of knowing, relating and working.

Ripple effect

Listening to and understanding each other will help guide where and how we throw the stone and what size and shape we should use to create intentionally corrective ripples.

“The image that comes to mind is the circles from a stone being thrown into water and gradually widening those circles. In terms of knowing where to go and how to get there, we need to listen careful and make sure we understand. Listening and acting on what we hear based on where we are at in the process are important.”
(S, Ottawa)

Speak the truth in love to people

Human history has shown us many times over that more positive change comes from love than from fear and anger. Love generates openness/expansion and fear/anger generates resistance/contraction. Fundamental to any positive change is finding the many truths that we all bring and speaking them to each other with loving presence and within a mutually created ethical space.

“We need to speak the truth in love to people. And there is no solo advocacy; it’s about collective advocacy.” (S, Ottawa.)

Intentional disruption is good

Complexity theory tells us that a complex system will not change unless there is an intentional disruption in the patterns that hold the system in current ways of operating. Cultural safety and relational practice may provide the foundation for a set of intentional interventions to modify the complex mental health and addictions system.

“It (cultural safety) is a practice that at some level disrupts. Culturally safe practice would disrupt the status quo; there would be a broader effect, some action-ability. One thing that is different about it is that it is meant to disrupt the system.” (S, Ottawa)

“When do I get to say, it’s wrong? Where do you ethically, spiritually and morally draw the line and say I can’t go past that line?” (SP, Yellowknife)

Healing and recovery as learning and growth

Healing and recovery is a human process that requires acquiring new insights, new knowledge and skills that support us in moving on to the next stage of becoming. An experience of safety is fundamental to being open to new learning.

“When you enter a circle and it is safe, it permits whatever in you that is related to what others are saying to surface, and new understandings to emerge. Safe circles are where we continue our journey of learning.” (S, Ottawa)

Intuition, wholeness and change

Intuition is a source of connection to inner guidance of many forms. Our spiritual selves know what our wholeness looks like and guidance from that centre helps us to return to the wholeness that is unique to each person. Healing often requires change and reintegration, reconnection with all four aspects of being – mind, body spirit and heart. That inner wholeness provides the base from which relationships with family, community, culture and land can be strengthened. Each individual in sharing stories of healing and change inspires and guides others.

“I think of my relationships and I realize that another part is speaking from the heart. The spiritual, the intuitive part is such an important part of us. Spirit is important in the healing journey. We talk about human relationships that are culturally safe, trusting, equal, respectful; all possible when we engage each other on all those levels of heart, mind spirit and the physical. In my exchanges with people, I can identify moments of change for me as well as them because I am engaged on all those levels because we have had that full engagement. Often I will share my stories when the person triggers that for me, regardless of so called professional boundaries. We need to start with our own sphere of influence.” (S, Ottawa)

7.0 Way Forward

The findings from the Western focus groups point to practices that can contribute to transformational change of the current mental health and addictions systems if they take place across multiple sites, including: individual, community, organizational and social structural contexts (Prilleltensky & Prilleltensky, 2006). Such practices, as described by focus group participants, can be summarized as safe, ethical, respectful, critically conscious, “culturally good” and socio-politically aware. The authors of this report explicitly recognize that an over reliance on micro-level practices or individual change efforts will not produce a transformed mental health system. We invite readers to think deeply about how to bring such practices into their own domain, whether that be individual practitioner/client interface, groups within organizations or agencies, the full organizational level, or the system-wide level, which includes practice, program design and policy.

The ideas shared in this report can act as a filter or perceptual lens. The use of this particular stance or approach when entering discourses can influence the quality of questioning and thinking to guide you into the next level of learning. This information can inform the evolution of your practice and affect the quality of your relationships, particularly inter-cultural relationships. It can also provide a foundation for program development and policy work.

We hope that the thoughts collected in this paper will serve to guide the work of the MHCC in developing and implementing strategies for transformational change. The results from this project have already been used by the project team for curriculum development. Through the use of cultural methods and experiential learning, the curriculum will be a valuable tool to translate the knowledge from this project.

The authors invite feedback on the ideas presented so that we may collectively further our understanding and engage collaborative planning and action. Please direct your feedback and ideas to the Project Lead Bill Mussell by email nmha@telus.net or mail to Native Mental Health Association of Canada, Box 242, Chilliwack, BC, V2P 6J1.

Appendix A

Demographics: Western Canada Focus Groups

Demographic information	Number of participants (N=147)	% of Sample
Gender		
Male	42	28%
Female	105	78%
Ethnicity		
Aboriginal	97	66%
Non-Aboriginal	50	34%
Relationship with Services		
Consumers	39	26%
Service Providers*	108	74%
Location		
Saskatoon (5 groups)	12	8%
Winnipeg (5 groups)	28	19%
Iqaluit (4 groups)	28	19%
Yellowknife (7 groups)	60	40%
Whitehorse (6 groups)	19	13%

* Individuals were identified as per the primary role each took in the discussions. At least 25% of Service Providers indicated they had lived experience of mental illness, though they may or may not have accessed conventional services in their healing process. At least half the Service Providers made reference to their supportive roles with family and/or community members who were experiencing or had experienced mental health challenges.

Appendix B

Abstract: Cultural Safety Literature Review

This report provides a critical exploration of the notion of “cultural safety” as it pertains to health care and Indigenous health. The notion of “cultural safety” is a relatively new concept that has its origins within the Maori nursing education context of New Zealand. Over the last decade, this concept has transcended national boundaries and increasingly gained international influence across a variety of professional and political organizations and associations concerned with redressing health inequities and achieving social justice. Firmly positioned within the paradigm of critical theory, the concept of cultural safety is used here as an interpretive lens to focus attention on social, structural and power inequities that underpin health inequalities/disparities – it prompts a moral and political discourse/dialogue. Cultural safety is, therefore, not about ethno-cultural practices, rather it highlights the need for the development of critical consciousness toward the power differentials inherent in the health care system as well as the broader socio-historical and political factors that shape health care and Indigenous health. Guided by the lessons learned from the New Zealand experience in implementing cultural safety into nursing education and critical-oriented knowledge derived from recent research on cultural safety outside its original context, this report critically discusses how to bring this agenda into relief in all areas of practice – clinical, education, research and policy.

Appendix C

Demographics: Eastern Canada Focus Groups

Demographic information	Number of participants (N=99)	% of Sample
Gender		
Male	32	32%
Female	67	67%
Ethnicity		
Aboriginal	45	45%
Non-Aboriginal	54	54%
Relationship with Services ⁱⁱ		
Consumers	47	47%
Family Members	5	5%
Service Providers	47	47%
Location		
Halifax (4 groups)	24	24%
Moncton (2 groups)	16	16%
St. Johns (2 groups)	13	13%
Montreal (2 groups)	16	16%
North Bay (2 groups)	14	14%
Sudbury (2 groups)	16	16%

Some individuals fit into more than one category; each person was identified as per the primary role he or she took in the discussions.

Appendix D

Cultural Safety Project: Eastern Canada Focus Group Report February 18, 2010

Executive Summary

Introduction

In 2009, the Native Mental Health Association of Canada and the Mood Disorders Society of Canada partnered to commission a series of focus groups across Canada as part of their “Building Bridges” initiative. The report reviews the findings from 14 focus groups held in Eastern Canada between November 2009 and January 2010. Participants included Aboriginal and non-Aboriginal consumers, family members/caregivers and service providers. The purpose of the discussions was to further knowledge and understanding of what happens when people attempt to access mental health and/or addictions services, what happens when they succeed in accessing services, what makes them feel safe and comfortable or not with the services, and what actions they take to protect and promote their own mental health.

What brings people to mental health or addictions services?

There are many reasons why people seek mental health or addiction services. Help-seeking is frequently precipitated by a crisis. Approximately half of the consumer participants shared the issue that initially caused them to seek help, and the most common responses were: serious depression, which often included suicidal thoughts, impulses or attempts; substance abuse; or substance abuse combined with a mental health problem. Close to one-third of consumers reported a history of physical and/or sexual abuse, including a majority of the Aboriginal consumers, many of whom endured abuse that was systemic, severe, and institutional in nature, i.e. it occurred over long periods of time in foster care, group homes and residential schools.

When service providers talked about why people present for services, they gave different reasons, depending on the mandate of the organization; although the person seeking help was often experiencing some type of life crisis. Service providers also noted that some people will not seek help no matter how desperate their circumstances, because of shame, stigma or fear of consequences such as a job loss. This is more of an issue in small communities and within certain ethnic communities. Some Aboriginal people have an ingrained mistrust of mainstream service providers due to their history of colonization and systemic abuse, which makes it difficult for them to use these services.

What challenges do people face when trying to access services?

*“The easiest place to access services so far for me has been jail.”
(Aboriginal Consumer, Halifax, Nova Scotia)*

“The only way to get in [to mental health services] is if you threaten to kill yourself. And even then, you will have to wait.” (Consumers, North Bay, Ontario)

With the exception of a small minority of consumers, all of the focus participants experienced some difficulties accessing mental health or addictions services. The main challenges people face when seeking services are listed below.

1. Lack of awareness of what services are available and how to access them, reported by seven groups.
2. Unavailability or limited availability of services, reported by 14 groups.

This includes accessing family physicians, community-based psychiatrists, non-medical interventions such as psycho-therapy, treatment for concurrent disorders and culturally safe and sensitive services for Aboriginal people and newcomers. Services are especially limited in rural and remote areas.

3. Long wait times for services, reported by 12 groups.

“I think consumers who have the courage to keep trying when there is a six month wait list - we don't say that if someone has a broken leg - they are incredibly strong and patient people.” (Service Provider, Halifax, Nova Scotia)

4. Having to push hard and advocate for themselves to get the care they need, reported by four groups.

“It's a brutal task to try and get services, especially on your own. Especially when you're not well.” (Consumers, St John's, Newfoundland)

What happens once people access services?

What happens when people succeed in accessing services depends on what services they access, where they access them and who is providing them. To some extent, their experiences are also influenced by personal characteristics such as race/ethnicity, socioeconomic status, and the nature of the problem. The following represents the themes that emerged in terms of experiences accessing mental health and addictions services.

1. Negative experiences at service entry points, reported by nine groups.

“They are shown a lot of disrespect and people will not go to the hospital, even if they are very ill, because of the way they are treated.” (Family Member, Montreal, Quebec)

It is not uncommon for people to have unpleasant experiences when entering the system of services, even when they are the ones reaching out for help. The entry points where people most frequently report experiencing poor treatment are crisis services and hospital emergency rooms.

Their concerns pertain primarily to unnecessarily long wait times, over-use of police and security guards who are not properly trained, and disrespectful treatment by service providers.

2. Concerns about assessments and diagnoses, reported by 13 groups.

“I know diagnosis is important but are we going to get the right one, or get one just because of how we look?” (Aboriginal Consumer, Halifax, Nova)Scotia

Concerns revolve around the timeliness and accuracy of diagnoses, including the criteria used to make diagnoses and the fact that diagnoses rarely involve a consideration of the consumer’s life experience and cultural context. This is a concern for Aboriginal people in particular, many of whom are living with the effects of inter-generational trauma from colonization.

3. Experiences of disrespect, condescension, stigma, racism or discrimination from service providers, reported by 14 groups.

*“We need professionals who treat you like a human being.”
Consumer, (North Bay, Ontario)*

Participants from all of the focus groups related incidents where consumers were treated disrespectfully and with a distinct lack of compassion by service providers. This has happened with a broad range of service providers including mental health care providers, health care providers and others (e.g. welfare workers). Many consumers talked about being treated like a label or a number, rather than a person. Many also spoke of feeling unheard, judged and looked down on, as if they were inferior in some way to the service providers. Those who had tried to complain found that their complaints were ignored or dismissed. People who have addictions, are poor or are Aboriginal are especially likely to feel judged and stigmatized and to experience discrimination from mental health service providers

4. Biomedical, rather than holistic and recovery-focused services, reported by 14 groups.

“Everything can’t be fixed with a pill.” (Consumer, North Bay, Ontario)

Concerns here are based on a heavy emphasis on medication as the main treatment modality, the lack of attention by providers to the context within which mental health or addictions problems arise and the tendency to treat consumers as diagnostic labels rather than whole persons.

5. Fragmented and uncoordinated services, reported by 12 groups.

Because organizations tend to operate as “silos”, services are limited, not linked with each other, and difficult to access. Consumers with multiple needs are often bounced around from one service to another. As a result, they have to tell their stories again and again and there is no continuity of care. This is especially frustrating for people when moving to one service system to another, i.e. from children’s mental health to adult services. Consumers and family members find it very challenging to have to navigate these service systems on their own and coordinate

their own care. The disconnection between mental health and addictions services is especially troubling, as participants see a strong linkage between the two. One of the largest gaps seems to be between the health system and the community organizations that offer self-help and peer support programs. People often stumble upon these supports on their own, having failed to receive any information about them from health care providers.

What makes people feel safe?

Consumers and family members were asked what makes them feel safe and comfortable when they are receiving services. The key themes that emerged from these discussions and the number of focus groups within which they emerged are listed below.

1. Accessible, compassionate and respectful service providers, reported by ten groups.

“I just want to be treated with respect.” (Consumer, North Bay, Ontario)

Many of the focus group participants spoke about feeling safe when they accessed a service provider who was kind, compassionate, accepting and respectful. These providers value the consumer’s lived experience. They do not judge, condescend or talk down to them. They are authentic and real and willing to share information about their own experiences. They try hard to eliminate inherent power imbalances and work with the consumer, using a team approach. They are available when needed or they provide back-up. This creates a sense of trust. Consumers feel cared for and cared about. These service providers could be working within the formal health care system or not; what matters is how they interact with the consumer.

2. Coordinated services and continuity of care, reported by six groups. Support from people who understand what they are going through, reported by six groups

For many consumers, support from people who understand their experiences is critical in helping them to feel safe and to begin to recover. A few have received this kind of support within the formal system of services. Many suggested however that it is unlikely that mainstream service providers could relate to their experiences, and they are altogether more apt to get this kind of support from community organizations especially those that offer peer support and self-help groups.

3. Respect for confidentiality, reported by three groups.

What makes people feel unsafe?

*“The mental health system and safety don’t really go together.”
(Consumer, Halifax, Nova Scotia)*

Consumers and family members shared what makes them feel unsafe or uncomfortable when accessing services. Key themes that emerged related to feeling unsafe or uncomfortable are listed below.

1. Feeling alone, uncared for, unheard, judged or disempowered, reported by eight groups

“Feeling safe with mental health people is frustrating because you can’t feel safe; there is no one looking after you.” (Consumer, Halifax, Nova Scotia)

When people feel that no one cares about them or listens to them, or that they are being judged and found wanting, this makes them feel uncomfortable and unsafe. The power imbalance between consumers and service providers can make consumers feel unsafe, especially if they have emigrated from a country where abuse from the military or police was common. This is also true for consumers who are mandated to take treatment.

2. Models of service that do not meet their needs, including their cultural or linguistic needs, reported by eight groups.

Consumers and family members may feel unsafe when models of service do not meet their specific needs. For example some feel safe only when they are at home, often because of a history of abuse, and they would prefer to be able to access services at home through telephone lines or outreach visits. Many consumers, family members and service providers also noted that services are not sensitive to the unique cultural and linguistic needs of newcomers and Aboriginal people.

3. Experiencing racism, stigma and/or discrimination, reported by seven focus groups.

“It’s really frustrating. I’m trying my best but I fear that people will always see me as a junkie and a thief.” (Consumers, North Bay, Ontario)

What needs to be improved?

All of the focus groups were asked what they would recommend to improve the system of services. The key themes are listed below, along with the number of groups endorsing each theme.

1. Provide holistic and culturally safe services, using a recovery model, reported by 13 groups.

“Everyone is a unique individual and they need to be treated as a whole person.” (Consumer, St John’s, Newfoundland)

An overwhelming majority of focus groups emphasized the need for a more holistic approach to service provision. This means moving beyond a narrow biomedical perspective and viewing each individual as a whole person with a unique history, current life circumstances and strengths as well as challenges. It also involves a focus on recovery and on all of the things that support this, so that people with mental health and addictions issues can live meaningful and productive lives. This would necessarily involve significant changes to organizational cultures and practices and to service provider training. It was noted however that such changes could be more cost-effective over the long-term.

Integral to a holistic approach to service provision is an understanding of cultural differences and unique cultural needs, and tailoring services to meet these needs. This is especially important for Aboriginal people, many of whom would like to develop and deliver their own services, using their own approaches. Others spoke of the need to have more Aboriginal people as decision makers, for mainstream organizations to train existing staff to provide culturally safe services and examine their hiring practices to ensure that they have representative numbers of Aboriginal staff.

“We need to start delivering our own services, and not just using the orthodox way but using a medicine wheel approach with our own ways of doing things. Otherwise, it just becomes the regular psychiatric/mental health system with a brown face. The white man’s way is to separate things into categories and we see things as part of a whole.”
(Aboriginal Consumer/Service Provider, Halifax, Nova Scotia)

2. Build capacity for a continuum of coordinated services, reported by 13 groups.

Almost all of the focus groups identified a need for a continuum of coordinated mental health and addictions services. Many suggested that service providers should receive training about the full range of available services and supports, so they are able to refer people as needed. This includes educating health care providers about community based resources such as self-help, peer support and traditional Aboriginal healing programs.

3. Make mental health and addictions a funding priority and direct funding to have the most impact, reported by 12 groups.

Almost all of the focus groups indicated that mental health and addictions services need more resources in order to function effectively. Inadequate funding limits the amount and quality of care that can be provided. Several participants commented that mental health is like the poor relative within the larger health care system. Some attribute this to the stigma that is still associated with mental health and, especially, addictions issues.

Simply allocating more resources to the existing system of services would not be sufficient for many participants, however. They would like to see a review of funding models and a redirection of dollars to areas where they would have more impact. Some suggested that there might be enough money to provide good services, if it was shared more equitably and duplication of services was reduced.

“Someone needs to look at the “big picture” and how the money is being spent.”
(Consumer, St John’s, Newfoundland)

With regard to where funding should be allocated, a number of participants would like more money dedicated to prevention and early intervention services. Many participants would like to see more resources dedicated to community-based services and organizations, particularly organizations that provide family and peer support services. A number of people said that these organizations are doing excellent work, with woefully inadequate funding.

4. Improve public awareness to reduce stigma and discrimination, reported by 12 groups.

*“We all need a little bit more understanding and public awareness.”
(Consumer, North Bay, Ontario)*

Most of the groups talked about the need to improve public awareness to reduce and ideally eliminate the stigma of mental health and addictions consumers. Initiatives aimed at improving public knowledge and awareness should focus on breaking down barriers, so that people do not view those with a mental health or addictions problems as different or “other” from themselves. Awareness training should begin early, in schools, and should involve direct contact with consumers. Public education about the history and unique challenges of Aboriginal people could help to eliminate the combined racism and stigma that many face.

5. Make it easier and faster to get services, reported by 11 groups.

The majority of focus groups emphasized the need to improve access to services by making it easier for people to get the services they need, when and where they need them. This includes access to family doctors, to psychiatrists and to other mental health and addictions services. Several focus groups also talked about the need for services that are more flexible, in terms of hours of operation and/or outreach capacity.

6. Make services more client-centered, reported by eight groups.

*“We’ve been hearing about client-centered services for more than ten years. We’ve gone from black and white Power Point presentations about it to coloured Power Point presentations, but not so much progress on the ground.”
(Service Provider, North Bay, Ontario)*

More than half of the participant groups talked about the need for more client-centered models of care. Client-centered service providers treat consumers as equal partners. They offer genuine caring, compassion and respect, value the lived experience of consumers and work with them using a team approach. This engenders trust, which promotes healing and recovery. Client-centered services support consumers in gaining knowledge for self-management of mental health or addictions problems.

7. Address the multiple determinants of mental illness and addiction, reported by eight groups.

*“The service providers should take into account the socio-economic factors that contribute to mental illness - poor, unsanitary living conditions, no job, no friends. People lose hope to get better, they give up. If you don’t take those factors into account, then you’re not looking at the person, just the diagnosis.”
(Consumer, Montreal, Quebec)*

Eight of the fourteen focus groups emphasized the importance of addressing the multiple determinants of mental illness and addictions. When people do not have a safe and healthy physical environment, sufficient food, decent housing, access to meaningful work and social

support, mental health and addictions problems are more likely and recovery becomes extremely challenging.

8. Engage and support family members and caregivers, reported by four groups.

While recognizing issues of privacy and consent, family members and caregivers would like to be more engaged in the care of their loved ones. If they had more information and were more engaged, they could be more helpful in the recovery process. Family members and caregivers also need recognition for the important role they are playing, along with support for themselves. It can be stressful and exhausting caring for a loved one with a mental health or addiction problem and this can affect the well-being of the caregiver. Some have found family member/caregiver peer support to be particularly beneficial.

How do people take care of their own mental health?

The seven consumer groups were asked what they do to protect and promote their mental health. The following represents their responses and the number of groups providing each response.

1. Practicing spirituality and hope, reported by six groups.
2. Helping other, reported by six groups.
3. Social and peer support, reported by six groups.
4. Being open/sharing your experience, reported by five groups.
5. Good health habits, reported by five groups.
6. Self-education and knowledge, reported by three groups.
7. Other: Comedy/humour; arts and crafts, reported by three groups.

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ⁱ In this report, we use this terminology as consistent with the terminology used by the Royal Commission on Aboriginal Peoples (1996a). The term Aboriginal peoples refers generally to the Indigenous inhabitants of Canada, including First Nations, Métis and Inuit peoples without regard to their separate origins and identities. When distinctions between Aboriginal groups are needed, specific nomenclature is used. We use the terms Aboriginal and Indigenous interchangeably in this report.