



Indigenous Mental Health & Substance Use Leadership Research Planning Initiative

FINAL REPORT

Elizabeth Hartney, Ph.D., R.Psych.
Centre for Health Leadership & Research
March 2019



Canadian Institutes
of Health Research

Instituts de recherche
en santé du Canada



Royal Roads
UNIVERSITY



Royal Roads
UNIVERSITY

Indigenous Mental Health & Substance Use Leadership Research Planning Initiative

Final Report

Elizabeth Hartney, Ph.D., R.Psych.

Centre for Health Leadership & Research

March 2019

© 2019 Elizabeth Hartney

Open Access Link: <http://dx.doi.org/10.25316/IR-4419>

Suggested citation

Hartney, E. (2019). Indigenous mental health & substance use leadership research planning initiative: Final report. Victoria, Canada: Centre for Health Leadership and Research, Royal Roads University.
DOI: <http://dx.doi.org/10.25316/IR-4419>

Sponsors

Canadian Institutes of Health Research (CIHR)

Competition - Planning and Dissemination Grant - Institute Community Support - 2016-08-16

Funding Reference Number (FRN) 150486

Application Number – Funded 373089

Grant Title: Indigenous Health Leadership Research Planning Initiative

Royal Roads University

Skidegate Health Centre

Interior Health Authority

PHS Community Services Society

Design Credits

Cover photographs by Elizabeth Hartney

Cover design by Kelly Poirier, White Raven Consulting

Map on page 10 by Patricia Bluemel and Alan Cundal, photographed and modified with permission by Dan Anthon

Contributors

Principal Investigator

Elizabeth Hartney, Ph.D., R.Psych,
Royal Roads University (RRU)

Indigenous Consultants

Asma-na-hi Antoine, MA, Toquaht Nation, RRU
Nadine Charles, Scia'new (Ceanuh) First Nation

Elders

Betty Richardson, Haida Gwaii Nation
David G. Archie, Secwépemc Nation
Diane Brown, Haida Gwaii Nation
Don Waldams, Kwakwaka'wakw
Ethel Thomas, Secwépemc Nation
Eydie Pelkey, Tsawout Nation
Ida Pranteau, Misipawistik Cree Nation
Isabel Brillon, Haida Gwaii Nation
James August, Secwépemc Nation
Kay Watson, Haida Gwaii Nation
Leona Thomas, Secwépemc Nation
Linda August, Secwépemc Nation
Marge Eugene, Secwépemc Nation
Minnie Phillips, Secwépemc Nation
Pete Thompson, Haida Gwaii Nation
Ralph Phillips, Secwépemc Nation
Robert Williams, Kwakwaka'wakw
Rod Tomma, Secwépemc Nation
Tahnyea Robbins, Secwépemc Nation
Virginia Peters, Sts'ailes Nation
Xavier Eugene, Secwépemc Nation

Indigenous Community Members

Chief Andy Phillips, Scowlitz First Nation
Art Andrew, Seabird Island Band
Bernadine Mawson, Tsawout Nation
Cindy Boyko, Haida Gwaii Nation
Cindy Williams, Haida Gwaii Nation
Daidri Marr, Adams Lake Indian Band
David Archie Jr., Secwépemc Nation
Harley Prosper, Vancouver Downtown East Side
Jon Rabenek, Snuneymuxw First Nation
Laura Commodore, Stó:lō Nation
Marina White, Coast Salish
Michelle McDonald, Haida Gwaii Nation
Pauline Arnouse, Secwépemc Nation
Rhona Bowe, Secwépemc Nation
Shawn Billie, Secwépemc Nation

Students & Trainees

Aaron Fredborg, Thompson Rivers University (TRU)
Anne-Marie Bump, RRU, Fraser Health Authority (FHA)
Eunice Joe, Tseshaht Nation, RRU, First Nations Health Authority (FNHA)
Heather Hastings, Tsartlip Nation, RRU
Jenny Morgan, Gitxan, University of Western Ontario, Provincial Health Services Authority (PHSA)
Lauren Brown, Haida Gwaii Nation, RRU
Lolly Andrew, RRU, Seabird Island Band
Michelle Buchholz, Wet'suwet'en, Simon Fraser University (SFU), PHSA
Michelle Maxey, RRU, Ministry of Children & Family Development
Kristina Hedlund, University of York
Sereana Patterson, TRU
Sydney Paul, University of British Columbia (UBC)
Terri-Lee Seeley, University of Victoria (UVic)
Tahnyea Robbins, TRU

Health System Research Partners

Alycia Fridkin, (PHSA)
Carrie Tamblyn, Northern Health Authority (NHA)
Cheryl Ward, Kwakwaka'wakw, PHSA
Celeta Cook, First Nations Health Authority (FNHA)
Christian Schütz MD, PHSA, UBC
Cindy Trytten, Vancouver Island Health Authority (VIHA)
Cody Caruso, Heiltsuk, FNHA
Denise Armstrong, FHA
Denise Bradshaw, PHSA
Mary Kellie, Skidegate Health Centre
Mary-Anna Ennis, FHA
Michelle DeGroot, Secwépemc Nation, FNHA
Michelle Loucks, NHA
Michelle Wishart, PHS Community Services Society
Heather Fulton, Ph.D., R.Psych., PHSA
Jehannine Austin, Ph.D., PHSA, UBC
Jennifer Cartwright, Academic Health Sciences Network (AHSN), VIHA
Jon Rabenek, Snuneymuxw First Nation, FNHA
Judy Sturm, Whispering Pines Indian Band, IHA
Kathryn Embacher, PHSA
Lara Miramontes, Ministry of Health
Lee Erickson, FHA
Leslie Bryant, AHSN, Interior Health Authority (IHA)

Indigenous Community Members

Tilkotmes Tomma, Secwépemc Nation
Tracey Richardson, Haida Gwaii Nation
Tyler BigChild, Sunchild First Nation

Indigenous Organizations

Bigheart Bannock Catering
Cowichan Trading
Eagle Transit Ltd
Joni Olsen
Potluck Café and Catering
Roberta Olson
Rose's Catering Service
Seabird Elders
SeaBird Youth Soccer
White Raven Consulting

Health System Research Partners

Lupin Battersby, AHSN, FHA
Lynn Ned, FHA
Mary Kellie, Skidegate Health Centre
Megan Misovic, FNHA
Nicolette McGuire, Ph.D., Ministry of Health
Rableen Nagra, AHSN, FHA
Renée Monchalin, Algonquin, Metis, Huron, AHSN, VIHA
Rae Sampson, IHA
Rod McCormick, Ph.D., Kanienkehaka (Mohawk), TRU
Russell Maynard, PHS Community Services Society
Ruth Kenny, Anishinaabe, PHSA
Savannah McKenzie, Metis, PHSA
Tania Andrews, AHSN, (Provincial Hub)
Taylor Hainstock, AHSN, VIHA
Tonia Nicholls, Ph.D., PHSA, UBC
Waneeta Richardson, FNHA
Willow Hunt-Scott, FNHA
Yvette Ringham-Cowan, Kwakwaka'wakw, VIHA

Acknowledgements

We would like to thank the Heron People of Royal Roads University Elders Circle, and the Research Office staff, in particular, Gwen Hill and Deborah Zornes, for supporting this initiative from its outset. We would also like to thank many others who supported the project, including Kevin Barlow and Colter Long of the Metro Vancouver Aboriginal Executive Council, Dr Lawrence Mróz of the BC SUPPORT Unit, Dr Shannon McDonald, Deputy Chief Medical Officer, and Dr Amanda Ward, Namaste Marsden, Patricia Vickers, Jenn Smith, and Jodie Millward, of the First Nations Health Authority, Stanley Kuperis and Denyse Houde of Fraser Health Authority, Kacey Dalzell of Vancouver Coastal Health Authority, and Dr Connie Coniglio, R.Psych., of the Provincial Health Services Authority, Dr Jim Campbell of Northern Health Authority, Londea Riffel of Secwépemc Nation for their support of the project. We also acknowledge connections with Shawna Duncan, Dion Thevarge, Donna Love, Jennifer-Lee Koble and Shaunene Smyth of the Vancouver Coastal Health Authority, Tara Nault of the Indigenous Sport, Physical Activity and Recreation Council, and Dr Theo de Gagne, R.Psych., of Providence Health Authority.

The map on page 10 is a 11' x' 5' original artwork on canvas, which was made by Patricia Bluemel and Alan Cundall, based on a map by Stuart Daniel/Starship Maps & Cheryl Coull in *A Traveller's Guide to Aboriginal B.C.*, by Cheryl Coull (published by Whitecap Books in 1996). It was created for the award-winning 2013 immersive theatre production, *From the Heart: Enter into the journey of reconciliation*, and then gifted to First Peoples House at the University of Victoria. We would like to thank the staff at First Peoples House at the University of Victoria for generously loaning the artwork, Dan Anthon for photographing the artwork and modifying it to include all of the First Nations involved in the project, and Will Weigler for providing access to the artwork and facilitating permission to modify and use it in this report.

Contents

Acknowledgements..... 4

Executive Summary..... 7

Introduction 11

 Objectives 12

 Outcomes..... 12

 Engagement Process..... 13

Haida Gwaii Nation & Northern Health Authority..... 15

 Research Priorities 15

 Leadership through Elders’ Council and Collaboration with Northern Health Authority..... 15

 Developing Informed Consent 16

 Addressing Stigma around Mental Health 16

 Medical Responses to Mental Illness and Suicide 17

 Increasing Knowledge of Approaches to Mental Health and Substance Use Treatment..... 17

 Research Planning..... 18

Stó:lō Tribal Council & Fraser Health Authority..... 19

 Research Priorities 19

 Community-Based Mental Health and Substance Use Services 19

 Systemic Challenges 20

 Prevention of Mental Health and Substance Use Problems..... 20

 Cultural Issues 21

 Research Planning..... 21

Secwépemc (Shuswap) First Nation & Interior Health Authority 22

 Research Priorities 22

 Role Models for Young Men 22

 Traditional Approaches to Mentoring Youth 22

 Harvesting Traditional Medicines 22

 Methodological and Ethical Considerations 23

 Research Planning..... 23

Tsawout First Nation & Vancouver Island Health Authority..... 24

 Research Priorities 24

The Impact of Poverty.....	24
Trauma and Suicide.....	24
The Role of Elders and Culture.....	25
Research Planning.....	25
Vancouver Downtown East Side, PHS Community Services Society & Vancouver Coastal Health Authority	
.....	26
Research Priorities	26
The Impact of Poverty.....	26
Trauma, Fatalities, Grief and Loss.....	26
Centre and Outreach Service Provision	26
The Role of Culture and the Arts in Healing.....	27
Research Planning.....	28
Provincial Health Services Authority.....	29
Research Priorities	29
Racism in the BC Healthcare System	29
Indigenous Peoples Working within the Healthcare System.....	29
Access to Specialized Services among Indigenous Peoples	30
Therapeutic Approaches to Treating Indigenous Clients with Severe Mental Health Problems	30
Research Planning.....	30
Overarching Messages.....	31
Access to Mental Health & Substance Use Treatment Services.....	31
Trauma.....	31
The Importance of Culture in Healing.....	32
Conclusion.....	33
Recommendations	33
Ministry of Health & Ministry of Mental Health and Addictions.....	33
British Columbia Health Authorities	33
Funders	34
Next Steps	35
References	36

Executive Summary

There is a need for effective, evidence-based yet appropriate and culturally safe mental wellness and substance use services for Indigenous peoples in British Columbia. Provision of such services is part of the mandate of the five regional health authorities, the Provincial Health Services Authority, and the First Nations Health Authority. This project was undertaken to conduct initial planning and dissemination for the Centre for Health Leadership and Research to lay the necessary groundwork for developing culturally appropriate health leadership research focused on mental wellness and substance use with Indigenous partners at Royal Roads University. The objectives of the project were firstly, engagement with Indigenous and First Nations leaders and communities in British Columbia to build collaborative relationships for the development of culturally appropriate health leadership research, empowerment of Indigenous peoples to fully participate in the research process – from inception through to dissemination – and engagement with multiple health system partners, such as the First Nations Health Authority, the five regional Health Authorities in British Columbia, and the Provincial Health Services Authority, the Ministry of Health and other ministries, and community partners supporting people with mental health and substance use problems. Secondly, the intent was to co-develop a plan for Indigenous health leadership research, which addresses important yet complex parameters such as research scope, research priorities, and inclusive approaches to knowledge translation.

The engagement process was supported by the Indigenous consultants embedded at Royal Roads University, specifically, Asma-na-hi Antoine, Manager of Indigenous Education and Student Services, and Nadine Charles, member of the Heron People Circle. It was also facilitated by Indigenous Royal Roads University graduate students, Lauren Brown, Lolly Andrew, and Eunice Joe, who took the lead on organizing meetings within reserve communities. Elders participated in meetings within every community visited. The Principal Investigator also engaged with Health Authority leads in mental health and substance use, and with the First Nations Health Authority. The process of engaging with health authorities was more challenging, often reflecting lack of clarity about roles and protocols, and systemic anxiety and apathy emerging as barriers to engagement.

The project unfolded through two phases. The first phase (2017-2018) involved the Principal Investigator visiting First Nations communities and holding dialogue sessions with Elders, community members, and health authority staff. The second phase (2018-2019) involved the Principal Investigator returning to the communities and presenting a preliminary report in sessions which were open to the public as well as invited contributors, with further dialogue and, in some cases, collaborative work on grant writing.

The Northern region engagement focused on the Skidegate community in Haida Gwaii Nation and Northern Health Authority. A key research priority identified was leadership through reinstatement and expansion of an Elders' Council and to promote reconciliation and collaboration with Northern Health Authority; this was the basis for a successful reconciliation grant application to the Social Sciences and Humanities Research Council (SSHRC).

The Fraser region engagement focused on the Seabird Island Band in the Stó:lō Tribal Council and Fraser Health Authority. Research priorities identified were firstly, to co-develop a culturally appropriate evaluation process for the new on-reserve recovery homes, which could be applied to future on-reserve services, such as an on-reserve withdrawal management (detoxification) facility. Secondly, a survey of youth within the community, should be conducted to identify recreational and cultural activities, which could provide a prevention function to reduce mental health and substance use problems.

The Interior region engagement focused on the Secwépemc (Shuswap) First Nation and Interior Health Authority. Research priorities focused on land-based approaches to prevention and healing. One project idea builds on previous work by Secwépemc Elders and community members, to provide male role modelling to youth, providing culturally appropriate rites of passage through learning traditional hunting methods and practices. Another project idea builds on previous work by Secwépemc Elders and traditional healers to provide experiential, land-based teachings of the identification, harvesting, and use of traditional medicines. Misalignment between community protocols and the culturally inappropriate demands of the grant submission process has impeded the funding process; at the follow up presentation, the Haida Gwaii reconciliation project kindled an interest in the Secwépemc Elders taking a similar approach.

The Vancouver Island region engagement process took place in the Tsawout First Nation and Vancouver Island Health Authority, with representation from the Ministry of Health and the Ministry of Mental Health and Addictions. Discussion focused on the co-development of culturally sensitive research within the Tsawout and Cowichan communities with parent-child dyads at risk of child apprehension due to parental mental health and substance use issues, to explore and identify specific parent and child support needs. The goal was, thus, to identify long term outcomes for parents and children. Follow up planning for funding took place between the Principal Investigator and the Ministry of Health, but funding has not yet been secured. Concurrently, collaboration that was already underway between the health authority and the Nuu-chah-nulth peoples of the Port Alberni area of Vancouver Island progressed to a successful CIHR Project Grant for the *Developing Elders Support for Trauma-Informed Emergency Departments* (DESTINED) project.

The Vancouver Coastal region engagement was the most challenging, due to the overwhelming needs of the urban Indigenous community. Engagement focused on urban Indigenous people in the Vancouver Downtown East Side, and engagement with the contracted PHS Services Society. Several research ideas were proposed, including development of alternatives to the disease model of addiction; how to recognize external impacts, such as poverty, abuse and trauma, racism and discrimination; development of a better understanding of lived experience as a form of expertise; and development of innovative harm reduction approaches, such as the fortification of beverages produced in the Managed Alcohol Program micro-brewery with essential nutrients. A plan for research funding has begun, which focuses on developing mentoring capacity for Indigenous peer leaders, with the guidance of training and support through an Elder, an Indigenous therapist, and Culture Saves Lives. The peers have been involved in an educational performance called “Illicit,” which details the experiences of people in the Downtown East Side, which could be filmed, developed into a virtual educational tool, and which could form part of our knowledge translation strategy. Further development is on hold due to leadership changes, and additional resources will be required to bring the project to fruition.

The Provincial Health Services Authority (PHSA) engagement focused on Indigenous and non-Indigenous staff who are working in mental health and substance use specialized services, and related areas. Priorities for research identified included an analysis of the reported incidents of anti-Indigenous racism submitted to the San’yas training run by the PHSA, with follow up action through the health authorities and/or regulating bodies. Internal quality assurance projects were suggested, which address issues related to Indigenous staff and clients, including an Indigenous complaints process, and appropriate decision-making specific to Indigenous issues by Indigenous people. The development of these projects could potentially be supported by Indigenous students or allies in the MA Leadership (Health Specialization) program at Royal Roads University. An exploratory study was also recommended, which would explore referral pathways and the experiences of Indigenous people with mental health problems who have been incarcerated, to better understand how to facilitate access to specialized mental health services. Finally, an in-depth study is needed to develop culturally appropriate approaches to treatment

for severe mental illness in Indigenous clients, including those with significant cognitive deficits. Academic colleagues holding dual appointments with the University of British Columbia and PHSA were supportive of future collaborations.

There were three overarching messages that came up in all discussions. Firstly, Indigenous people in British Columbia do not have access to adequate treatment for mental health or substance use treatment services, either on or off reserve. This urgently needs to be reviewed and addressed, particularly in the context of the high mortality rate through overdose and suicide. Secondly, trauma is central to the experience of Indigenous peoples in British Columbia. Often described as historical, trauma remains a current issue, impacting Indigenous peoples in BC in epidemic proportions. Trauma-specific services for Indigenous peoples, and for those who experience vicarious traumatization through providing their care, are urgently needed. Finally, the importance of culture in healing from historical trauma, and in treating mental health and substance use problems, was continuously emphasized. In conclusion, research planning is challenging in an environment where mental health and substance use treatment services are so significantly under-resourced, and systemic apathy is evident. Given the urgency of the issue, simultaneous advocacy for improved mental health and substance use services, research planning, and ongoing relationship building between First Nations and Indigenous communities, health authorities, and ministries are essential.

Recommendations to the Ministry of Health and Ministry of Mental Health & Addictions are firstly, to ensure that every First Nations community has access to primary care, specialized psychiatric and psychological services, and the full continuum of substance use and addictions treatment services, both on and off reserve. These services should be funded directly to communities, with supportive consultation from the health authorities. Secondly, financial support and oversight should be provided to the health authorities in implementing the recommendations contained in this report, and developing research plans to ensure services are effectively meeting the needs of Indigenous peoples. Finally, trauma-specific services (in addition to trauma-informed care), should be put in place, both for people who have experienced trauma and those providing professional services.

Recommendations to the British Columbia Health Authorities are firstly, to work collaboratively to ensure that First Nations communities and urban Indigenous people within their regions have access to the full continuum of mental health and substance use services, and that the process for accessing services is simplified, shortened, and communicated clearly and appropriately. Secondly, we recommend that each health authority should establish protocols to ensure respectful engagement with both Indigenous communities and researchers, making these available to researchers early in the engagement process, with accountability for follow through. Thirdly, we recommend that the systemic racism and apathy that is clearly prevalent in the health system today should be addressed through co-developing a coordinated provincial plan to eliminate racism towards Indigenous peoples in the BC mental health and substance use system, and to oversee its implementation.

Recommendations to funders are firstly, to advocate for increased research funding to support the development of culturally appropriate services for Indigenous peoples, both on and off reserve, particularly using participatory action and Indigenous research modalities. Secondly, to develop alternative, non-competitive models of funding for Indigenous communities. Thirdly, to recognize the importance of researchers and health authorities building relationships and trust with First Nations communities by visiting on a regular basis and to therefore include travel expenses in their funding models. Finally, to develop more flexible timelines for funding applications and for research to be conducted in recognition of First Nations protocols, seasonal impacts, and crises such as the impact of deaths and grieving on the community.



Introduction

The development and implementation of effective Indigenous healthcare leadership in BC and across Canada, as well as in other jurisdictions with Indigenous people, is a recognized need, which is yet to be met, as reflected in the Report of the Truth and Reconciliation Commission of Canada (2015), and the mandate letters of the federal Ministers of Health (Trudeau, 2015, 2017). Areas of particular concern include providing effective, appropriate, culturally safe mental wellness and substance use services. In British Columbia, this remains part of the mandate of the mainstream health system, as well as that of the newly formed First Nations Health Authority (2013). Central to accomplishing this is the building of trust within respectful, collaborative relationships, which honour Indigenous peoples, traditions, and practices, and provide opportunities for leadership and full participation in the research process. This project was undertaken to conduct initial planning and dissemination for the Centre for Health Leadership and Research to lay the necessary groundwork for developing culturally appropriate health leadership research focused on mental wellness and substance use with Indigenous partners at Royal Roads University.

Elevated rates of mental health and substance use problems among Indigenous peoples have been well documented since the 1990s (Noe, Fleming, & Manson, 2004), and more recent research has confirmed these health disparities are still a major issue (Callaghan, Cull, Vettese, & Taylor, 2006; Ryan, Cooke, & Leatherdale, 2016), particularly among Indigenous women (de Leeuw, Greenwood, & Cameron, 2010). The phenomenon of historical trauma, defined as “the cumulative emotional and psychological wounding, over the lifespan and across generations, emanating from massive group trauma experiences” (Brave Heart, 2003, p. 7), has emerged from decades of clinical practice and observations, as well as preliminary research, and is closely connected to substance use problems among Indigenous peoples. Although many Indigenous groups did not traditionally use psychoactive substances, and those that did, typically limited their use to ceremonies or certain prescribed times, colonial discourses have portrayed Indigenous peoples as deviant, and framed mental health and substance use problems in relation to this (de Leeuw, Greenwood, & Cameron, 2010).

While the development and implementation of effective Indigenous healthcare leadership, particularly in the areas of mental wellness and substance use, in BC and across Canada, as well as in other jurisdictions, has long been a recognized need (Culhane, 2009; Gone, 2009), only recently has this recognition moved towards action. This current shift is reflected in the formation of the First Nations Health Authority in British Columbia, through the release of their ten year mental wellness and substance use plan (First Nations Health Authority, 2013), the Report of the Truth and Reconciliation Commission of Canada (2015), and the Prime Minister’s first mandate letter to the federal Minister of Health, which stated: “No relationship is more important to me and to Canada than the one with Indigenous Peoples. It is time for a renewed, nation-to-nation relationship with Indigenous Peoples, based on recognition of rights, respect, co-operation, and partnership” (Trudeau, 2015), a message which is echoed in the mandate letter to the current federal Minister of Health (Trudeau, 2017).

The need for stronger Indigenous health leadership is well recognized, and has been mandated through both federal and provincial direction. However, engagement with and empowerment of Indigenous peoples to develop culturally appropriate healthcare requires time to build trusting relationships, and to ensure cultural appropriateness and cultural safety at all stages of the research process, as well as in

research dissemination and implementation in the health system. To this end, this planning and dissemination process engaged the Ministry of Health, the Ministry of Mental Health & Addictions, and the Ministry of Children & Family Development, and the seven British Columbia Health Authorities, to develop a shared, collaborative plan for Indigenous Health Leadership Research.

The initiative was intended to create conditions for the Centre for Health Leadership and Research at Royal Roads University to effectively engage Indigenous peoples in developing leadership to address the mental wellness and substance use needs of Indigenous people, both within the mainstream healthcare system, and within Indigenous communities. With an emphasis on cultural appropriateness and cultural safety, this was crucial in laying the groundwork for research with considerable magnitude and potential to change the healthcare system in ways that have evaded previous attempts to meet the mental wellness and substance use needs of Indigenous people.

The initial stages of the initiative involved building collaborative relationships with Indigenous leaders within the First Nations communities neighbouring Royal Roads University, and then more broadly across British Columbia. Concurrently, engagement activities were initiated across the British Columbia healthcare system, including the First Nations Health Authority, Vancouver Island Health Authority, Vancouver Coastal Health Authority, Northern Health Authority, Interior Health Authority, and Fraser Health Authority, as well as the Provincial Health Services Authority, the Ministry of Health, and the Ministry of Mental Health & Addictions. Engagement also included not-for-profit organizations, in recognition of the significant role they play in providing both direct treatment services and additional supports to people with mental health and substance use problems in British Columbia.

Objectives

The key objectives of the planning and dissemination process were:

- Engagement with Indigenous and First Nations leaders and communities in British Columbia to build collaborative relationships for the development of culturally appropriate health leadership research.
- Empowerment of Indigenous peoples to fully participate in the research process, from inception through to dissemination.
- Engagement with multiple health system partners, e.g. First Nations Health Authority, the five regional Health Authorities in British Columbia, and the Provincial Health Services Authority and Ministry of Health, as well as community partners supporting people with mental health and substance use problems, such as not-for-profit organizations, to develop a plan for Indigenous health leadership research, including research scope, research priorities, and inclusive approaches to knowledge translation.

Outcomes

The anticipated outcomes of the planning process were:

- Collaborative research plan(s) with full involvement and demonstrated leadership of Indigenous peoples, and involvement of health system partners, including the First Nations Health Authority, the five regional Health Authorities in British Columbia, and the Provincial Health

Services Authority and Ministry of Health, as well as community partners supporting people with mental health and substance use problems, such as not-for-profit organizations.

- Consensus building regarding the respective roles of Indigenous communities, Health Authorities, including the First Nations Health Authority, and not-for-profit community-based services in providing mental wellness and substance use services for Indigenous peoples.
- Development of an ongoing program of research within the Centre for Health Leadership and Research, led by and with full participation of Indigenous students at Royal Roads University, including opportunities for Indigenous students to lead and participate in projects for which they would be recognized.

The anticipated outcomes of the knowledge exchange and dissemination activities were:

- Knowledge exchange events, as required, to convey the outcomes of the planning process to Indigenous peoples, Health Authorities, and not-for-profit community partners.
- Development of curricula to enhance cultural safety for Indigenous people requiring mental wellness and substance use services throughout the healthcare system.
- Cultural competency curricula to enhance the existing MA Leadership (Health Specialization) program at Royal Roads University.
- Input into healthcare policy, for example, development of standards and guidelines for the healthcare system on culturally appropriate language and non-verbal communication, operating practices, and behaviours of healthcare professionals in relation to Indigenous patients and their families requiring mental wellness and substance use services.

Engagement Process

The engagement process took place continuously throughout the project. We began by engaging with the Heron People Circle at Royal Roads University, specifically, Nadine Charles with the support of other members, to provide consultation on this project. The Principal Investigator then reached out to Mental Health and Substance Use leaders within each health authority, to the First Nations Health Authority, and to First Nations communities through graduate students living and working in health services in these communities.

Engagement with the health authorities was often challenging in this project. Some health authority staff considered a project involving Indigenous peoples to be out of scope for them, or deferred taking action due to expressed concerns that correct protocols for engagement with the communities should be clearly understood and followed, and the right relationships in place first; yet protocols were not clearly communicated or followed, or steps taken to bring the right people to the table. In some cases, there was hesitancy to act in an environment where these protocols and relationships may not have already been established, even though the project was intended to help facilitate this process. In addition, clear internal processes for connecting the right people to engage at the events differed between organizations. Delays were also caused by staff reorganizations, staff transfers, and lack of communication or transfer of responsibility for the project during or after the person responsible took periods of leave without coverage, or retired from or left the organization, sometimes requiring the process of engagement to start again from the beginning.

Conversely, health authority staff with responsibilities for Indigenous health were often overwhelmed with other demands. Although large numbers of staff within the health authorities were consulted, meetings were sometimes agreed to and scheduled, then cancelled without follow up. While some individuals working within the health authorities expressed a commitment to addressing Indigenous mental health and substance use research, the constraints of their roles made it difficult to follow through. Overall, as well as anxiety leading to passivity or resistance to moving the work forward, there were many indications of the systemic apathy that underlies many of the indignities and disadvantages faced by Indigenous peoples, coupled with the low recognition of the importance of participating in the process of research to promote health system change.

However, the engagement process was greatly facilitated by graduate students within First Nations communities, or health authority staff working closely with Indigenous peoples. The staff of the BC Support Unit, part of the British Columbia Academic Health Sciences Network, and the First Nations Health Authority, were particularly helpful. These individuals took responsibility for organizing the consultation meetings on which this report is based, in their communities, inviting Elders and community members, and liaising with the Principal Investigator. When delays occurred in meeting with First Nations communities, it was the result of crises within the community, often caused by the deaths of community members, requiring periods of mourning and grief for the community. Delays were also caused by environmental issues impacting communities, such as storms and wildfires, requiring Elders and community members to be evacuated.

Most of the meetings were held on reserves, with the exception of the Vancouver Downtown East Side meeting, which was focused on urban Indigenous people, and the Provincial Health Services Authority, which has responsibility for the entire province. The meetings were conducted with the highest respect for all participants, with gratitude consistently being expressed by Indigenous Elders and community members for the opportunity to have input. When the Principal Investigator travelled to a First Nations community, it was openly acknowledged and appreciated by members of that community, and an invitation to return to the community was extended.

Initial consultation meetings were held in 2017-2018, and follow up presentations and open community presentations and dialogue sessions were held in 2018-2019. The meetings were held in Skidegate, Haida Gwaii in collaboration with Northern Health Authority; Seabird Island, Stó:lō Tribal Council in collaboration with Fraser Health Authority; Secwépemc (Shuswap) First Nation in collaboration with Interior Health Authority; Tsawout First Nation in collaboration with Vancouver Island Health Authority; the Downtown East Side of Vancouver with urban Indigenous community members, in collaboration with PHS Community Services Society, a non-profit organization providing many housing and health services in the area; and the Provincial Health Services Authority head office in downtown Vancouver, with Indigenous staff in collaboration with health authority staff responsible for mental health and substance use services and research, with the follow up presentation and open community dialogue held at the Burnaby Centre for Mental Health and Addictions. Initial draft reports were circulated back to participants for feedback and revisions prior to the presentations and completion of the final report.

Haida Gwaii Nation & Northern Health Authority

A community consultation and planning meeting was held at the Xaaynangaa Naay Skidegate Health Centre in Haida Gwaii on August 10th, 2017, which was opened with a welcome and prayer in the Haida language, led by Elder Diane Brown. It was particularly well attended by Elders, and community members were also present, including Susan Gladstone, a mental wellness counsellor and Knowledge Keeper within the community. One First Nations Health Authority employee participated, and two Northern Health Authority employees attended, although neither was in a position of leadership within the health authority. Elder Isabel Brillon opened the follow up presentation and open meeting with a welcome and prayer in the Haida language. This was held at the same location on August 8th, 2018.

The discussion was framed around the four Haida laws:

- Yahguudang: All acts must be done with respect
- Ad Kyaanang: All acts must be done with consent
- Tllyahda: If an act is not done with consent, or is witnessed, you must make it right
- Gina 'waadluuxan gud ad kwaagid: Everything depends on everything else

Research Priorities

The key priorities for the Skidegate community in developing mental health and substance use research focused on re-establishing leadership through Elders' Council and improving relationships with Northern Health Authority, addressing stigma around mental health, appropriate medical responses to mental illness and suicide, developing informed consent, increasing knowledge of approaches to mental health and substance use treatment, and reconciliation.

Leadership through Elders' Council and Collaboration with Northern Health Authority

"Meeting together as a people, writing about it and doing what the people want is very powerful. Sharing a meal and sharing knowledge."

The need for improved engagement with Northern Health Authority that was evident at the consultation meeting mirrored the perceptions of community members, who described how, historically, communications were distant and minimal, leaving the community with the overall impression that the health authority was not motivated to connect with them; for example, health authority staff have not responded to numerous invitations to visit, leaving the community feeling shut out of decisions. The Haida Gwaii community continue to extend an open invitation to Northern Health Authority to engage and work together on mental wellness and substance use initiatives.

The Haida Gwaii community has already worked to develop a shared understanding of wellness, through the development of an Elders' Council, which met during a series of Elders' dinners, facilitated by Susan Gladstone. These monthly dinners served a variety of functions, in particular, culturally appropriate leadership, but were discontinued, due to lack of funding. The reinstatement of the Elders' Council was proposed, as an opportunity to bring together Elders from Skidegate and Queen Charlotte, and for leadership from Northern Health Authority to engage with the community through an open invitation. Questions would be asked and answered, and as relationships were built, an Elder could join the Northern Health rounds. It was also noted that there were success stories of Haida people using the mainstream health services, and that this would provide an opportunity to thank Northern Health, as

well as to talk about services and issues they deal with. This idea demonstrated a move towards reconciliation.

Developing Informed Consent

Informed consent is a central principal of modern healthcare, yet there was a strong message that informed consent was not a consistent part of the experience of the Haida Gwaii community in mental health treatment. An example of this was an individual being put on strong psychiatric medication for 20 years, which impacted her quality of life and ability to engage with family members throughout that time. She later discovered that the medication should have only been taken for 3 months. She was saddened that nothing could bring back those years lost to the medication impacting her relationships. This was a reflection of how a whole family could be impacted by a health system approach that did not practice informed consent.

The issue of informed consent to participate in research was discussed. It was acknowledged that Indigenous peoples have a history of abusive research, without informed consent, especially through the Indian hospitals. This legacy makes it difficult to trust the health system in giving informed consent, particularly when knowledge is limited. There was only one research project that participants were aware of having taken place in the community, which had been focused on food. The researchers hired local people to conduct the research, but the community was never informed of what happened with the data, and after they left, the Haida Gwaii community never heard from the researchers again.

The consensus among those involved in the consultation was that developing culturally appropriate ways of giving informed consent was a task to be led by the Elders of the community. Processes could be established by which people need not be burdened by Western models of giving informed consent, such as reading and signing repetitive consent forms. Through an “evolution of research,” Elders could establish a process whereby information provided through the Elders’ Council could be used for more than one purpose. What was considered most important was for discussion to take place, and for permission to be requested before discussing experiences with others. Future consent forms should include a commitment that the research would never be used against the interests of the community, and when consent forms were to be used, they should include the Haida language.

Addressing Stigma around Mental Health

“We need to teach people what we are talking about and the direction we are going. How we present around mental health is really important.”

Participants felt that the stigma and fear that exist around mental health undermined respect for people with mental health problems and their families. The identification of mental illness was a key concern that would need to be addressed for the mental health and substance use system to treat Haida Gwaii people with respect. Several personal stories were shared, which illustrated the fear that continued to exist within the community about mental health challenges, sometimes perceived as “craziness” or “insanity.” This fear was thought to discourage people from talking openly about mental health.

One suggestion for how to address stigma was to change the language that was used, and get away from the existing language of “mental health,” replacing it with education and a more holistic model of wellness. The concept of “strong minds” as a reflection of the survival of Indigenous peoples had already been explored through Susan Gladstone’s work, and it was suggested that this could be the basis of future work in this area.

Medical Responses to Mental Illness and Suicide

“If I walked into the hospital and said I had chest pains I would get service right away. If I said I was going to commit suicide, there is a long wait. We need to get working right away. You’re just as sick as a person with chest pains.”

Suicide was a reality for the Haida Gwaii community, yet it was felt that the response to suicide from the medical system was inadequate and inappropriate. There was a need identified for the medical community to recognize that a person thinking of suicide is just as sick, and as much in need of urgent care as a person with chest pains. Similarly, the comparison was made between a broken leg, which can be seen, and therefore believed, and depression, which is an internal process that is difficult to communicate to others, and is therefore more frightening to many people when talked about.

Increasing Knowledge of Approaches to Mental Health and Substance Use Treatment

“How do we know what the right kind of care is around mental health? Therapy is such a personal thing. As individuals we don’t even know how to articulate what isn’t working.”

It was acknowledged that there was not yet enough awareness in the Haida Gwaii community of the different approaches that have been developed to treat mental health problems and restore wellness, for the community to be able to determine and advocate for appropriate care. Increased knowledge was needed, so that people in the community could understand what was being discussed in terms of mental health and the direction being taken. With increased knowledge, people could make decisions about their own care and that of their family members.

Knowledge of psychotherapeutic approaches to mental health treatment was limited to knowledge shared by Elizabeth Hartney, the Principal Investigator, and Susan Gladstone, the Mental Wellness and Addiction Specialist. Three approaches to therapy were discussed: narrative therapy, cognitive-behavioural therapy, and somatic regulation therapy. Narrative therapy was considered somewhat helpful, but the risk of re-traumatization was considered a risk, given the very high levels of direct experiences of trauma among members of the Haida Gwaii community, and the intergenerational trauma which has resulted from cultural injuries, such as residential schools, the smallpox epidemic, and systemic racism in the health system. Cognitive-behavioural therapy was considered even more problematic, for several reasons. Burdening the patient with homework and documentation of their thoughts, feelings and behaviours, which does not fit with cultural concepts of wellness, and may be particularly difficult for those with low levels of literacy, who may be further shamed by finding the process challenging. Somatic regulation therapy was described as having considerable potential in that it addresses the nervous system responses to trauma, and helps the individual to self-regulate, with the re-telling of stories not being required. However, it was noted that only one service provider was available to provide this service and, in addition, more education is needed for many people before deciding whether the therapy would be right for them. Research was required to identify which therapies would be most effective for treating mental health and substance use problems in Indigenous peoples; such research has not been conducted on Haida Gwaii.

Concerns about over-medication, and the prescribing of medications that interact with each other in negative ways, were expressed. Individuals also expressed concern around the prescribing of methadone and suboxone as treatments for substance use disorders, with the perception that this would simply replace one addiction with another. There was little awareness of medical resources available, such as whether there was a methadone program on Haida Gwaii (one of the hospital staff who attended the meeting confirmed that one physician was available to prescribe methadone and/or suboxone). It was also acknowledged that the lack of a proper withdrawal management facility on Haida Gwaii increased the risk for people who use substances; they may receive medical withdrawal services

within the hospital, but if they were discharged without a plan or any follow up support, they were at increased risk of death by overdose.

“The first thing is to gain trust. We had a man come who showed up a film about the disease of smallpox, but we never really talked about it as a community. It is still in our DNA. We still have the residential schools in our history. It is hard for us to talk about our pain. Until we have trust from the institutions, then we will open up.”

The trauma of colonization was ongoing for the people of Haida Gwaii. Historically, many still carry the wounds of residential schools, abuse, racism, and trauma. For some, re-living these experiences in order to support the research process would be too much, and even talking about research was distressing for some. Others provided support within the meeting when this occurred, and the meeting did not proceed without all present expressing their willingness to engage in the process and ability to cope through the presence of supportive Elders. It was recognized that it would be helpful during the research process for a healer, Elder, psychologist, or other support person to be present during an interview with a researcher. There was some discussion about whether family members would be appropriate supporters, and it was acknowledged that this might not always be ideal. Although family involvement is consistent with Haida culture, it may increase stress on the family, or increase the risk of traumatizing the family as a whole.

The role of family centred care was discussed. It was noted that a provincial initiative led by the Ministry of Children and Family Development and the Ministry of Health, Families at the Centre, has not included Northern Health Authority, although all the other regional health authorities were represented. This was reflected in a lack of awareness of this initiative in Skidgate. This initiative has resulted in a completed document, which identifies the need for specific work to be done with Indigenous families.

Lauren Brown presented her MA Leadership project on *implementing a Haida healthcare model of practice reflective of a Haida health governance model*. The role of Haida Gwaii culture was also discussed in relation to healing, and the need for support during the research process. Cultural activities such as singing, listening to traditional music, and dancing was considered to help to move the energy and ground people, bringing people back to their centre.

Research Planning

Several research ideas were proposed:

- A key research priority identified was leadership through reinstatement of the Elders’ Council, with monthly dinners as an opportunity for reconciliation and relationship building with Northern Health Authority, and to address issues related to informed consent, ethics, and cultural safety. This was the basis for a successful reconciliation grant application to the Social Sciences and Humanities Research Council (SSHRC), and the project is underway.
- A project focused on educating the community on reducing stigma and increasing knowledge about mental illness including treatments. Use of the Haida language, music, and dance should be included as central to developing culturally appropriate approaches to mental wellness research with the Haida people.
- Introduction of more therapists and therapies to the Haida Gwaii community, and consultation with the community on their effectiveness. Any research with Indigenous peoples should include the presence of a healer, Elder, psychologist, or other support person, who is compensated by the researcher for their role in supporting the research participant.

Stó:lō Tribal Council & Fraser Health Authority

A community consultation and planning meeting was held at Seabird Island on August 14th, 2017, which was opened with a welcome, and a prayer and blessing in the Sts'ailes language, led by Elder Virginia Peters. The meeting was particularly well attended by community members, Fraser Health Authority, and First Nations Health Authority. The discussion reflected a positive relationship between the health authority and the Seabird Island Band. The follow up presentation and open meeting was held at the same location on August 20th, 2018, where we were joined by more members of the community.

Research Priorities

The key priorities for the Seabird Island community in developing mental health and substance use research focused on community-based mental health and substance use services, prevention of mental health and substance use problems, cultural issues, and challenges within the current system.

Community-Based Mental Health and Substance Use Services

"We can be creative and innovative, but the modern world is not making this possible."

Seabird Island has recently opened two new on-reserve recovery homes, one for men and one for women, the first of their kind. Lolly Andrew presented her MA Leadership project on how *Culture supports clients in a First Nations recovery home*, detailing her action research process which was based on the culturally centred training Lolly received at Round Lake Treatment Centre, in which the medicine wheel concept was embedded into how the recovery homes were being run. This has been found to be helpful in restoring balance in the emotional, spiritual, and physical domains. Client feedback on the wraparound services in the Seabird Island community has been positive, although these services had not yet been formally evaluated. Participants in the initial meeting were taken on a tour of the men's recovery home (with clients' permission). At the follow-up meeting, Lolly reported that a third recovery home was being built for families. She also presented her educational orientation for staff who are coming to work in the recovery homes.

In spite of the new recovery homes, and other successful initiatives at Seabird Island, it was recognized that many community-based resources are needed to support people with mental health and substance use problems in the Seabird Island community. Additional resources were needed to provide staff with expertise to address the concerns of clients. Many do not feel equipped to deal with severe mental illness, or sexual abuse and resulting trauma. There had been a shift in substance use preference in the community from alcohol to drugs in recent years. The women being treated have predominantly suffered extreme sexual abuse, some as early as the age of two. In addition, they were suffering from the problems of colonization, suppression, oppression, racism, discrimination, and violence. It was also noted that these women would need support following discharge, to prevent relapse.

In addition, it was noted that there was a gap in services provided to youth. Previously, there had been a treatment centre for Indigenous girls in Abbotsford, but funding had been withdrawn. The only option available was in Williams Lake, where there was a long waitlist. Previously, Seabird Island Band had submitted a proposal for services to Fraser Health Authority, which blended Western and traditional models of care, called the "Circle of Care," but it had received no response. It was noted that a service

provider, Dr Benning, had worked with a cultural counsellor to integrate Western and traditional approaches, which was very effective; however, funding had been discontinued.

Withdrawal management (detoxification) services were off reserve, and waitlisted. When people from Seabird Island access these services, they experience racism, and a lack of support afterwards. There was discussion about the need for detoxification services within the community, so that there could be a quick response when people needed help. It should be tied in with the other mental health and substance use services being developed. It was noted that the “Wilderness detox” model is effective, and could be successful in an area like Seabird Island.

Elder Virginia Peters worked part time at a women’s prison, and noted that the lack of mental health services was very evident. Some participants thought the Provincial Health Services Authority would start covering the cost of mental health and substance use services in corrections.

Systemic Challenges

“You can blame the federal government in the 1990s for making us into Nations. We aren’t Nations, we are villages within tribes, and many of us are related. We need to look at which languages define our tribes... Each community had its own strengths and relied on each other. Indian Affairs separated us and made us fight.”

It was noted that there was an unhealthy focus on competition for funding between Nations. As a result, those who secured funding benefited, while other communities were “left behind.” There were 24 communities in Stó:lō, as a result of colonization. Competition in the context of a profound lack of resources results in further negative cycles within Indigenous communities.

Prevention of Mental Health and Substance Use Problems

“The reality is that kids [in the Seabird Island community] are exposed to families that are not even close to healing.”

It was acknowledged that in spite of individual differences, all the children and youth in the Seabird Island community were “at risk” due to the history of their people, and exposure to ongoing situations of substance use, violence, and racism. While the community has done a great deal to provide opportunities for youth to thrive, they are still at greater risk of developing mental health and substance use problems, and of suicide than non-Indigenous youth.

Andy Phillips and Lolly Andrew have both volunteered as soccer coaches. The focus was on soccer as a sport in the community, but it also served primary and secondary prevention functions. It provided youth with a healthy, socially appropriate activity in which to engage, as an alternative to unhealthy activities which take place in the community, such as substance use. It also gave them experience of discipline through learning the sport. In addition, the coaches built supportive relationships with the youth, and provided them with additional guidance concerning healthy lifestyles, promoting education and high school completion, healthy parenting, and healthy drinking limits.

However, it was acknowledged that although many of the participants of the soccer program have completed high school and some have gone on to university, sports are not an area of interest or ability for all youth. One negative aspect of the soccer program that was identified was that it promoted

competition between youth. While this was a positive experience for those who did well, it was not for those who were not skilled or interested in competition or sports.

Cultural Issues

“There is a lot of education that needs to happen with caregivers in hospitals and clinics. They need to have a better idea of who we are and what we have endured.”

It was acknowledged that there is a long history of abuse of Indigenous peoples – going back through seven generations of residential schools, the 60s scoop, and the related sexual abuse and addictions – that needed support through mental health and substance use services. However, it was difficult for communities to advocate, and overcome the poor education and incarceration rates among Indigenous peoples, when they do not have capacity.

The role of family, ceremony, and traditional language were all acknowledged as important elements in promoting the spiritual health of the community. Along with connection to the land, language was seen as an important source of Indigenous identity, which helps to provide meaning and worth in the face of the negative labels that have been put on Indigenous peoples historically. It was also noted that fishing, drying fish, gathering berries, and hunting were an important part of the cultural heritage of Seabird Island that connect people; yet, many younger people did not engage in these activities. A family-based wellness centre, which included opportunities for parents to get healthy, while youth engaged in cultural activities such as fishing, hunting, language, and sports, would be a positive addition to the community. This would create a sense of belonging among struggling families, nurture children who are not necessarily intellectually, socially, or sports inclined, and promote healthy relationships.

Research Planning

Several research ideas were proposed:

- Lolly Andrew and the Principal Investigator presented, “Developing strong cultural support in on-reserve recovery homes,” at the Public Health Association of British Columbia in Vancouver, BC, in November 2018.
- Lolly Andrew, Lauren Brown (Haida Gwaii), and the Principal Investigator have collaborated on a chapter, “Development of culturally-based community-health centres through Indigenous leadership and collaborative allyship,” which will be published in *Community Health Centres in Canada*, by Canadian Scholars.
- Seabird Island Band and Fraser Health Authority could co-develop a culturally appropriate evaluation framework for mental health and substance use services for Indigenous peoples, that includes lived experience of culture as an aspect of healing. The evaluation framework is developed and piloted in the new Recovery Homes on Seabird Island.
- The Riverstone team in Fraser Health Authority could work with Seabird Island Band to develop and evaluate a culturally appropriate, on-reserve withdrawal management (detoxification) facility, which could be integrated into the continuum of care in the community.
- A survey of youth could be conducted within the community, to identify other activities which could provide a prevention function. This could lead to expansion of the soccer program as a prevention initiative, and enhance and explore the role of language revitalization, and traditional activities, such as hunting, fishing, drying fish, and gathering and canning berries, in promoting mental wellness and educational outcomes for youth.

Secwépemc (Shuswap) First Nation & Interior Health Authority

A community consultation and planning meeting was held at the Shuswap Nation Tribal Council on May 2nd, 2018, which was opened with a welcome, prayer and blessing in the Secwépemc language, led by Elder David Archie. The meeting was particularly well attended by Elders and academic partners, including students from the Secwépemc community. One Interior Health Authority employee was present, and her role was specific to Indigenous research and knowledge translation in the BC Support Unit. The discussion focused on land-based approaches to preventing and healing mental health and substance use problems. The follow up presentation and open meeting was held on February 6th, 2019, at the Qwemstin Health Society, which was attended by additional Elders and health authority staff. This meeting opened with a welcome and prayer in the Secwépemc language, led by Elder Ethel Thomas.

Research Priorities

The key priorities for the Shuswap community to develop mental health and substance use research focused on role models for young men, traditional mentoring for youth, and traditional plant medicines.

Role Models for Young Men

The problems experienced by young men in the community was identified as an issue, and particularly the absence of positive role models and father figures for many, particularly those being raised by single mothers. The question of how to bridge this gap was discussed, particularly in traditional ways which teach young men about emotional and spiritual wellness. Elders stated that when young men do not have positive male role models, something is missing that they will try and fill with drugs, which has led to increased opioid addiction among young men and young fathers.

Traditional Approaches to Mentoring Youth

Traditional approaches to mentoring have been maintained by Secwepemc Elders and community members. This includes teaching youth traditional hunting methods and practices, which might provide youth with opportunities to provide food for their families and communities. The long-term goal is that this kind of program would eventually become financially self-sustaining.

Hunting is a traditional practice that meets physical, mental, emotional, and spiritual needs in young men, and allows recognition of their manhood by themselves and their communities. It was recognized by Secwépemc Elders that the lack of such as rite of passage has been harmful to Secwépemc young men, leaving them devoid of positive male role models, instead seeking out negative role models, and behaviour through the substitute of substance use. The cultural identity of Secwépemc young men was also strengthened through the traditional practice of hunting.

Harvesting Traditional Medicines

The connection to the land involved in seeking, finding, harvesting, preparing, and using traditional medicines meets the physical, mental, emotional, and spiritual needs of both the traditional medicine people, and their learners, who received the medicine. Traditional medicine people were role models and mentors in culturally appropriate activities (i.e. harvesting traditional plant medicines), which developed a positive cultural identity and positive role modelling and behavioural modelling of spiritually fulfilling activities for Secwépemc learners. This type of project would develop expertise in traditional medicine among Secwépemc community members. By developing cultural awareness of traditional medicines among Secwépemc people, this may provide a safe alternate drug supply through

Indigenous medicines. The project would provide access to traditional medicines for the healing of conditions that predispose individuals to developing problematic substance use issues, including trauma and pain. The long-term goal is that eventually, knowledge keepers will be employed in this expert capacity, providing health services alongside mainstream medical service providers.

Methodological and Ethical Considerations

All research would be conducted in ways that ensure protection of sacred knowledge. Ceremonies would form part of the process, but would be only shared with non-Indigenous peoples by invitation, and as agreed by Secwépemc communities. Non-Indigenous team members were recognized as allies and supporters. All members of the team would be committed to the leadership and cultural knowledge of the Secwépemc peoples. All research and evaluation materials would be owned and held by the Secwépemc Health Caucus; research partners would support and provide guidance but commit to protecting the ownership and sacred knowledge of the Secwépemc peoples. The Secwépemc community would lead all decision-making. Projects should provide paid opportunities for Secwépemc Elders, Knowledge Keepers and community members.

Research Planning

Two main research ideas were initially proposed:

- The first project built on previous work by Secwépemc Elders and community members, to provide male role modelling, by mature Secwépemc men, to Secwépemc male youth. This would provide youth with culturally appropriate rites of passage through learning traditional hunting methods and practices.
- The second project built on previous work by Secwépemc Elders and community members to provide experiential, land-based teachings of the identification, harvesting, and use of traditional medicines. Horticultural therapists at Royal Roads University have expressed interest, which was well-received at the follow-up meeting as a possible future direction.

During the time between the initial meeting and the follow-up presentation, several grant applications were drafted but not submitted. Misalignment between community protocols and the culturally inappropriate demands of the grant submission process has impeded the process of obtaining research funding within the community. At the follow up presentation, the Haida Gwaii reconciliation project kindled an interest in a similar approach.

Tsawout First Nation & Vancouver Island Health Authority

A community consultation and planning meeting was held in Tsawout First Nation on July 6, 2018, which was opened with a welcome, prayer and blessing, led by Elder Eydie Pelkey in the SENĆOŦEN language. The meeting was also attended by Nadine Charles, Asma-na-hi Antoine, several members of the Tsawout community and members from surrounding First Nations communities, two employees of Vancouver Island Health Authority whose roles were specific to patient-oriented research, an employee of the First Nations Health Authority, representatives from the Ministry of Health and the Ministry of Mental Health & Addictions, and several Royal Roads University students. The discussion focused on issues related to systemic challenges to Indigenous people and the intersection with mental health within families. The follow up presentation and open meeting was held at the same location, on February 25th, 2019, and was attended by additional health authority staff and Indigenous community members from Tsawout and Tsartlip First Nations. Knowledge Keeper Bernadine Mawson opened the meeting with a welcome, prayer and blessing in the SENĆOŦEN language. The Principal Investigator acknowledged the passing on February 19th, 2019, of Nadine Charles from Scia'new Nation, also a member of the Heron People Circle at Royal Roads University. Nadine was an important contributor in the previous meeting at Tsawout First Nation.

Research Priorities

The key priorities for the Tsawout community in developing mental health and substance use research focused on the impacts of mental health and substance use on families, and challenges within the current system which perpetuate mental illness and other harms, such as suicide.

The Impact of Poverty

"I have diabetes. The doctor said I should have five to seven vegetables a day. I can only afford one. I feed my children before myself because I have to. Mental and physical health is related to food and what we can afford."

Poverty was highlighted in the discussion as one of the biggest challenges facing many Indigenous peoples. Their income may not be adequate to properly feed and clothe themselves and their children, which can be interpreted as neglect, particularly by the child welfare system. Grandparents may be caring for numerous grandchildren, to avoid apprehension and loss of children; yet, may not be eligible for foster care funding to support them, and may not receive the same level of housing as non-Indigenous people living off reserve. When basic needs such as food, clothing, and housing were not readily available, it was difficult to prioritize mental health. It was also difficult to advocate because of the fear of authority instilled in residential school survivors, and the ongoing racism within the system. Parents may not have felt they could reach out for help or admit that they were struggling because of the deeply engrained and legitimate fear that they would be judged, and would be at risk of losing their children.

Trauma and Suicide

"When you look at mental health there needs to be healing and treatment. I went to a treatment centre and it felt like residential school."

The issue of suicide was discussed several times; particularly in relation to traumas such as sexual abuse and other horrific events experienced in residential schools and Indian hospitals, and in relation to child

apprehension. It was also noted that those left behind struggle with grief and loss on a continuous basis, with no time to recover – it was described as “trauma on top of trauma.” Children who were separated from their families suffered trauma as a result. The ways that children were separated from their families could add to the trauma; for example, one family was instructed to lead a four year old with autism into a play room at the ministry office and abandon her there; they were threatened with RCMP intervention if they did not comply. This was deeply distressing to the family. The system also perpetuated racism through judgemental attitudes, and parents avoided seeking help for mental health problems, for fear of child apprehension. Processes such as the home study process for fostering relatives was very invasive, yet it was noted that cases of neglect and abuse of Indigenous children within non-Indigenous foster care were often not investigated. It was also acknowledged that there was emerging evidence to support the understanding that trauma is intergenerational, both through experiences and through physiology.

The Role of Elders and Culture

It was acknowledged that Elders play a key role in wellness, and that culture is integral to healing for Indigenous peoples. This included traditional food and language revitalization programs.

It was recognized that it is taking time for Indigenous peoples to heal from the trauma of residential schools and other historical abuse, as well as the ongoing issues that were raised during the dialogue. The long wait lists impeded access to treatment services, and the care received may not have been appropriate. However, much could be done from a preventative perspective, particularly to support families staying together and receiving adequate support to ensure child safety.

Research Planning

Research planning focused on the central idea of co-developing culturally sensitive research within the Tsawout and Cowichan communities with parent-child dyads at risk of child apprehension due to parental mental health and substance use issues, to explore and identify specific parent and child support needs. Therapy would be available for participants, researchers, and Elders affected by the emotional nature of the project. A two-year extension of the project was discussed, during which families would be supported in maintaining custody of their children. The long term outcomes for parents and children would be assessed.

Follow up planning for funding took place with the Principal Investigator and the Ministry of Health, although project funding has not yet been secured.

Concurrently, collaboration that was already underway between the Vancouver Island Health Authority and the Nuu-chah-nulth peoples of the Port Alberni area of Vancouver Island progressed to a successful CIHR Project Grant for the *Developing Elders Support for Trauma-Informed Emergency Departments* (DESTINED) project. This project is focused on exploring ways to improve emergency services for Elders in Port Alberni and Victoria hospitals. Eunice Joe from Tseshah Nation, a Royal Roads University student and First Nations Health Authority Director from the Tseshah Nation, is also leading the Port Alberni branch of this project, while Heather Hastings from Tsartlip Nation, also a Royal Roads University student, has contributed to the planning of the Victoria branch of the project. Along with Asma-na-hi Antoine, these two students and the Principal Investigator presented this research at the *Healing Our Spirit Worldwide Eighth Gathering* in Sydney, Australia, in November, 2018.

Vancouver Downtown East Side, PHS Community Services Society & Vancouver Coastal Health Authority

A community consultation and planning meeting was held at the Alexander Street Community in the Downtown East Side of Vancouver on July 20th, 2018, which was opened with a welcoming song and drumming by Robert Williams of Culture Saves Lives, and a prayer and blessing, led by Elder Ida Pranteau. The meeting was also attended by Indigenous community members, two employees of the PHS Community Services Society (contracted by Vancouver Coastal Health Authority), and an internship student from the University of York. The discussion focused on issues related to the mental health and substance use challenges faced by urban Indigenous people in the Downtown East Side community. The follow up presentation and open meeting was held in the same location on August 16th, 2018. The welcoming song and drumming was performed by Don Waldams, and Elder Ida Pranteau led the prayer and blessing.

Research Priorities

The key priorities for the Downtown East Side community in developing mental health and substance use research focused on the poverty and powerlessness of urban Indigenous people, and challenges within the current system which perpetuate mental illness and substance use and other harms, such as suicide.

The Impact of Poverty

Poverty among urban Indigenous people in the Downtown East Side is extreme. Some individuals have not easily obtained the ID cards necessary to be eligible for welfare, and may have had to resort to panhandling or bottle collecting for survival.

Trauma, Fatalities, Grief and Loss

"We [peers] are unofficial counsellors."

The population of the Downtown East Side was described as highly traumatized, and the rates of complex post-traumatic stress disorder and fatalities were extremely high in the community. As a result, survivors were constantly grieving multiple losses of friends, in the context of their own active trauma symptoms. A grief and loss group was held at the centre, but clients frequently asked for counselling, which was not currently funded. Illicit alcohol (non-beverage alcohol, such as mouthwash or rubbing alcohol) and other drugs were used to numb the pain that many were feeling on an ongoing basis.

The depth of emotional pain and dislocation experienced in this group was so extreme that it would be difficult to find a counsellor who could demonstrate adequate empathy. Therefore, providing peer support group opportunities was considered the best approach to providing emotional support and a first step towards recovery and stability for this population. Group leaders would be survivors experiencing greater stability, who would be urban Indigenous themselves. This would help progress to these people feeling a sense of belonging.

Centre and Outreach Service Provision

"This is the first step off the street – we need the next step to support people who are [becoming sober], to get people involved in other things."

Centres such as the recently closed Drug Users Resource Centre, and the Alexander Street Community Centre where the meeting was held, were considered essential for a sense of safety among this highly marginalized population. Although the need for more centres, and improved services within centres, was discussed, it was also recognized that outreach is essential to reach the many people who are even more isolated, living in single room occupancy (SRO) housing, using substances alone and therefore at high risk of death.

The managed alcohol program provided people with the opportunity to engage in a peer-run micro-brewery, and to exchange illicit alcohol for brewed alcohol at low or no cost. Although this may seem counter-intuitive, for people with extreme addiction to alcohol, continued consumption may be necessary to avoid severe withdrawal symptoms, including seizures, psychosis, and death. In the absence of appropriate treatment and supportive housing options, this was a harm reduction approach that prevented higher rates of mortality. Yet, the notion that these clients have rejected or failed evidence-based treatments is clearly a fallacy; many of them would have welcomed supportive treatment, but it was either unavailable or they found themselves excluded.

The centre, therefore, provided a first step towards a more sober lifestyle, where some people have been observed to experience spontaneous recovery and raised self-esteem. They could connect with others in a safe social setting, and could get access to a few healthcare services. This needs to be expanded, so that people have one place where they can get access to ID, housing, and the full continuum of healthcare and treatment services.

The Role of Culture and the Arts in Healing

“Creating [the play] Illicit keeps the spirit alive.”

Culture Saves Lives is a non-profit organization, set up to support Indigenous people in the Downtown East Side of Vancouver, in recognition of the profound pain and isolation felt by many inhabitants. They perform traditional drumming, prayers, songs, and ceremonies, such as smudging, to facilitate normal human processes, such as celebration and mourning. While every culture is different, Culture Saves Lives has an apprenticeship approach, whereby drumming is taught by a master or brother. There are important spiritual and identity aspects to these cultural practices for Indigenous peoples. Unlike some other cultural groups, which have excluded people who are under the influence of alcohol or drugs, Culture Saves Lives includes everyone, thereby providing important spiritual support to people most in need of it.

The recently closed Drug Users Resource Centre gave people access to a variety of arts, including art, music, and writing, and its closure was a great loss to the community. Part of the community’s response to the closure was the creation of the play, “Illicit.” This play was written, produced, and performed by people from the Downtown East Side community, and expressed the challenges that individuals within the community are going through, and was a great source of pride and motivation to those involved. The play has been performed in Vancouver, Victoria, and Kamloops. The play would provide an opportunity for knowledge translation, and would support the learning of healthcare professionals to better understand people who use substances. If filmed, it could improve healthcare if it was part of mandatory training for professionals working with this population.

Research Planning

Several research ideas were proposed:

- Development of alternatives to the disease model of addiction, for people whose condition is rooted in external impacts, such as poverty, abuse and trauma, racism and discrimination.
- Development of a better understanding of lived experience as a form of expertise, particularly in relation to health conditions.
- Development of innovative harm reduction approaches, such as the fortification of beverages produced in the Managed Alcohol Program micro-brewery with essential nutrients.

A research funding proposal was discussed, which focused on developing capacity for peers, who were already providing leadership within the program, to provide mentoring and peer support, with the guidance of training and support through an Elder, an Indigenous therapist, and Culture Saves Lives. The peers have been involved in an educational performance called “Illicit,” which details the experiences of people in the Downtown East Side. There is a possibility this could be filmed and developed into a virtual educational tool, and could form part of our knowledge translation strategy.

Provincial Health Services Authority

A community consultation and planning meeting was held at the Provincial Health Services Authority Headquarters on July 23, 2018. The meeting was attended by Indigenous and non-Indigenous employees of the Provincial Health Service Authority from Indigenous Health, Mental Health and Substance Use Services, the BC Women's and Children's Hospital, the Burnaby Centre for Mental Health and Addictions, and Heartwood. Dr Jehannine Austin, Executive Director of the MHSU Research Institute and University of British Columbia Department of Psychiatry, participated in the meeting. Additional consultations were conducted individually with Dr Tonia Nicolls, at the Colony Farm Forensic Hospital in 2017, Dr Christian Schütz, Psychiatrist, and Dr Heather Fulton, Registered Psychologist, at the Burnaby Centre for Mental Health and Addictions in 2018, and Cheryl Ward on July 19th, 2018. The discussions focused on issues related to experiences of racism in the BC healthcare system, as reported in the San'yas Indigenous Cultural Safety Training, systemic challenges to Indigenous peoples working in the health system, the accessibility of specialized services to Indigenous peoples, and appropriate therapeutic approaches to treating Indigenous clients with severe mental health problems. As the discussions took place at different times with different contributors, some comments included were made during the review period. Further discussion took place during the follow up presentation and open meeting, which was held at the Burnaby Centre for Mental Health & Addiction in Burnaby.

Research Priorities

The key priorities for the Provincial Health Services Authority to develop mental health and substance use research focused on utilizing the available data on racism in the healthcare system to promote system change, exploring reasons for the lack of access to Indigenous culturally safe care within specialized mental health and substance use services among Indigenous peoples, and quality assurance issues involving systemic challenges to Indigenous peoples working within the healthcare system. A recurring theme that emerged is that Indigenous people need to be involved right from the beginning in order to foster true reconciliation.

Racism in the BC Healthcare System

The San'yas Indigenous Cultural Safety Training has been a portal for participants to disclose experiences of anti-Indigenous racism in the BC healthcare system. Hundreds of accounts have been gathered over the years, and some of the harms arising have been analyzed in a Simon Fraser University student report. A more detailed analysis could potentially be conducted, to provide the BC health system with recommendations of how to address this systemic problem. The issue of resistance to the label of racism from employees in the health system was discussed, and it is anticipated that with this evidence, the denial that is evident in reactions of non-Indigenous employees could be countered. The idea of unconscious bias was also explored as a possibility for people to raise their awareness of their own implicit bias. However, explicit bias, as evidenced by accounts of racism, is clearly a priority that needs to be addressed. This could be linked to mandated training for physicians and other professionals requiring continuing Indigenous cultural safety training, and policies to ensure safe care for to Indigenous clients. An Indigenous-specific complaint process was proposed, which could be developed and piloted.

Indigenous Peoples Working within the Healthcare System

Several challenges were identified for Indigenous people working in the healthcare system, which is lived experience for several participants. Indigenous staff can feel isolated and/or feel that they are

"token" if they are the only Indigenous person on a team and feel like they are being asked to represent the voice of all Indigenous people. Indigenous staff can find themselves as the only Indigenous person on a committee deciding on issues that are specific to Indigenous patients/clients. It is challenging for Indigenous employees to carry the burden of informing/educating non-Indigenous employees.

Access to Specialized Services among Indigenous Peoples

The issue arose of whether specialized services, such as those offered at the Burnaby Centre for Mental Health and Addictions, and Colony Farm Forensic Hospital, are being underutilized by Indigenous clients in the community. It was speculated that, given the proportion of the population that is Indigenous, and the over-representation of Indigenous peoples in the criminal justice system, individuals who could be deemed not criminally responsible on account of a mental disorder might be disproportionately sent to jail, and should have a higher number/representation in these supportive PHSA services.

Therapeutic Approaches to Treating Indigenous Clients with Severe Mental Health Problems

We are limited by Western data which has historically and currently informed practices in deciding what is most culturally appropriate and effective treatment for Indigenous people with severe mental health challenges. The Burnaby Centre for Mental Health and Addictions modified the standard evidence-based treatment such as cognitive behavioural therapy, for example, by integrating the medicine wheel concept. Indigenous peoples' input is required to review the appropriateness of the medicine wheel concept and to ensure all programming is relevant, acceptable and effective for Indigenous clients/patients. It was noted that therapies such as cognitive behavioural therapy which requires a high level of cognitive functioning, may not be helpful to clients who have suffered from traumatic brain injury or been impacted by damaging substance use patterns including repeated overdose.

Research Planning

Several research ideas were proposed:

- An analysis of the reported incidents of anti-Indigenous racism submitted to the San'yas training, with follow up action through the health authorities and/or regulating bodies.
- An exploratory study looking at referral pathways and the experiences of Indigenous people with mental health problems who have been incarcerated, to better understand how access to specialized mental health services is done in an Indigenous culturally safe way.
- An in-depth study to develop culturally safe approaches to treatment for severe mental illness in Indigenous clients, including those with significant cognitive deficits.

Overarching Messages

Access to Mental Health & Substance Use Treatment Services

Stated simply, Indigenous people in BC do not have access to adequate treatment for mental health or substance use treatment services, either on or off reserve. While access to these services affects all British Columbians, the problem of access is compounded for Indigenous peoples by geography, often requiring them to travel long distances to access care. Past and current experiences of racism and disrespectful treatment within the mainstream healthcare system discouraged Indigenous people from seeking help. The advocacy and self-advocacy required to adequately address a mental health or substance use problem, during a time of emotional vulnerability, is extremely challenging and often impossible in this context.

More mental health and substance use services are needed within First Nations communities. While geography plays a part, the desire for on-reserve and Indigenous-specific services appears to be grounded, at least in part, in the avoidance of negative experiences in the mainstream healthcare system. This urgently needs to be addressed, particularly given the large numbers of Indigenous people living off reserve, who have no choice but to seek help within the mainstream healthcare system.

A review of the current mental health and substance use services available to Indigenous peoples in BC is urgently needed, before an evaluation of their effectiveness is conducted. This should include access to culturally appropriate, affordable, and supportive assessment and diagnosis, counselling and psychotherapy, psychiatric medications where appropriate, the full continuum of substance use and addictions treatment (withdrawal management, inpatient and live-in treatment programs, outpatient treatment, and long term recovery housing).

Trauma

Trauma is central to the experience of Indigenous peoples in BC, and was raised as an issue in every discussion. While often described as historical, trauma is a current as well as a historical issue, and it is impacting Indigenous peoples in BC in epidemic proportions. Whole families as well as many generations within families are being affected by trauma today, through impacts such as exposure to racism, poverty, child apprehension, the ongoing consequences of untreated mental health and substance use problems, and the repeated losses of community members through devastating causes such as suicide, drug overdose, injuries, and disease.

In visiting First Nations communities and urban Indigenous people, it is clear that trauma is a socially created and socially perpetuated issue for Indigenous peoples in BC. While Indigenous peoples are carrying the burden of these traumas, the causes are social, and are grounded in the perpetuation of a colonial system that puts Indigenous peoples at a disadvantage. The majority of these traumas are preventable, and could be reduced or eliminated by systemic change. Although culturally appropriate treatment is essential, and it is clearly important to conduct research to establish the most effective modes of trauma treatment for Indigenous people, the more urgent need is to address the current causes of trauma: poverty, which is perpetuated by lack of resources, and racism towards Indigenous peoples, which manifests in every aspect of life, and most notably, in Indigenous people's treatment within the healthcare system.

Trauma extends to those providing care. Professionals and peers providing support are overwhelmed by the extent and depth of trauma that has and continues to be experienced by Indigenous peoples. It is essential that self-care and support for vicarious traumatization and burnout is provided to carers and professional supporting Indigenous peoples, throughout the health and social care systems.

The Importance of Culture in Healing

In every community, the importance of culture in the process of healing from historical trauma, and from current mental health and substance use problems was emphasized. This ranged from the role of language revitalization programs within communities and use of Indigenous languages in the healthcare system, to traditional medicine and food harvesting and hunting, to ceremonies and traditional practices, such as drumming, dance, art, and ceremonies such as smudging. Colonization and modern life has interfered with these expressions of culture, which play an important role in giving Indigenous peoples a positive identity and a sense of belonging, and bringing the community together in positive ways. As many cultural practices are sacred, it is important for health leaders to recognize their importance, to support and create space for culture to be explored and expressed by Indigenous peoples within the healthcare system, and to welcome and compensate traditional healers and Elders to lead this process, without interfering or dictating how cultural practices can take place.

This issue is of great importance to the support of the mental health, wellness, and recovery of Indigenous peoples with mental health and substance use problems, yet non-Indigenous health leaders often misunderstand culture in healing, leading to mismanagement of services.

Conclusion

It is challenging to plan research into mental health and substance use treatment when the services in question are so significantly under-resourced, and systemic apathy is evident. Given the urgency of the issue, advocacy for improved mental health and substance use services, research planning, and ongoing relationship building between First Nations and Indigenous communities, health authorities, and ministries are all essential, and will need to continue simultaneously. There is considerable motivation from all partners who engaged in this project to collaborate and move this vital work forward.

Recommendations

Ministry of Health & Ministry of Mental Health and Addictions

Increased access to mental health services for Indigenous peoples is urgently needed in BC. However, much of this need is the result of lack of basic resources and opportunities to support other aspects of life. It is recommended that:

- The Ministry of Health and the Ministry of Mental Health and Addictions ensure that every First Nations community has access to primary care, specialized psychiatric and psychological services, and the full continuum of substance use and addictions treatment services, both on and off reserve. These services should be funded directly to communities, and communities should be provided with designated supportive consultation from the health authorities.
- The Ministries should also provide financial support and oversight to the health authorities in implementing the recommendations contained in this report, and developing research plans to ensure services are effectively meeting the needs of Indigenous peoples.
- Expand access to trauma-specific services (in addition to trauma-informed care), both for people who have experienced trauma, and to support those providing professional services, to prevent and treat vicarious traumatization and burnout.

British Columbia Health Authorities

It is recommended that each regional health authority, in consultation with local First Nations and Indigenous peoples:

- Ensure that First Nations communities and urban Indigenous people within their regions have access to the full continuum of mental health and substance use services, and that the process for accessing services is simplified and shortened, and communicated clearly and appropriately.
- Ensure that there is at least one named point of contact for Indigenous research within each health authority, and that protocols to ensure respectful engagement with both Indigenous communities and researchers are made available to researchers early in the engagement process, and that health authorities are accountable for follow through.
- Provide staff with orientation and mandated training regarding the historical and current issues impacting Indigenous peoples, and include working collaboratively with Indigenous peoples within the scope of all employees' job descriptions.
- Develop and implement policies and processes for the prevention of racism within the mental health and substance use system to eliminate disrespectful and inequitable treatment of

Indigenous peoples, with straightforward, transparent processes for receiving and addressing complaints from Indigenous people, with Indigenous people involved in the response to each complaint.

- The Provincial Health Services Authority may be best positioned to develop a coordinated provincial plan to eliminate racism towards Indigenous peoples in the BC mental health and substance use system, and to oversee its implementation. As this is a hidden problem, the outcome of this process should be made publicly available through an annual report, demonstrating accountability and system improvements.

Funders

The level of need for mental health and substance use resources and services for Indigenous peoples, and culturally appropriate research, far outstrips the funding available in the current system. It is recommended that funders:

- Advocate for increased research funding to support the development of culturally appropriate services for Indigenous peoples, both on and off reserve, particularly using participatory action research modalities. This will allow services to be put in place without causing delays by the time taken to conduct and disseminate research.
- Develop alternative, non-competitive models of funding, to avoid harm to communities through reinforcing a message of inadequacy to Indigenous peoples who do not wish to compete or are not successful in competitions for funding.
- Enable health authorities to connect to learn from one another to share evolving understanding and best practices to support engagement with Indigenous communities and researchers through networking and collaboration funding; and enable this learning to be shared more broadly, including with funding agencies, with the overall goal of increasing the agility and capacity for the system to engage.
- Include travel expenses in their funding models, in recognition of the importance of researchers and health authorities building relationships and trust with First Nations communities by visiting on a regular basis.
- Develop more flexible timelines for funding applications and for research to be conducted, in recognition of First Nations protocols, seasonal impacts, and crises such as the impact of deaths and grieving on the community.

Next Steps

Improving mental health and substance use care for First Nations and Indigenous peoples is a shared responsibility, and we will continue to engage with the health authorities to support this important issue.

Every community that participated in this project has identified priorities for mental wellness and substance use research. Some communities have moved forward with grant applications, publications, and conference presentations. We will continue to work collaboratively with all communities to move this research forward, ideally, with the full involvement and leadership of Indigenous peoples at every stage of the research process. Relationships will be maintained through key contacts in each community, and we are open to working with additional communities.

We will also continue to engage with health authorities and other health system partners and academic partners to increase opportunities for collaboration, particularly with a view to developing leadership skills and opportunities for Indigenous students and Indigenous professionals working in the health system.

References

- Battiste, M. & Youngblood Henderson, J. (2000). *Protecting Indigenous knowledge and heritage: A global challenge*. Saskatoon: Purich Publishing.
- Brave Heart, M. (2003). The historical trauma response among Natives and its relationship with substance abuse: A Lakota illustration. *Journal of Psychoactive Drugs*, 35(1), 7.
- Callaghan, R. C., Cull, R., Callaghan, R. C., Cull, R., Vettese, L. C., & Taylor, L. (2006). A gendered analysis of Canadian Aboriginal individuals admitted to inpatient substance abuse detoxification: A three-year medical chart review. *American Journal on Addictions*, 15(5), 380–386.
doi:10.1080/10550490600860270/full
- Culhane, D. (2009). Narratives of hope and despair in Downtown Eastside Vancouver. In L. J. Kirmayer & G. Guthrie Valaskakis (Eds.), *Healing traditions: The mental health of Aboriginal Peoples in Canada* (pp. 160-177). Vancouver: UBC Press.
- de Leeuw, S., Greenwood, M., & Cameron, E. (2010). Deviant constructions: How governments preserve colonial narratives of addictions and poor mental health to intervene into the lives of Indigenous children and families in Canada. *International Journal of Mental Health and Addiction*, 8(2), 282–295.
doi:10.1007%2Fs11469-009-9225-1
- Gone, J. (2009). Encountering professional psychology: Re-envisioning mental health services for Native North America. In L. J. Kirmayer & G. Guthrie Valaskakis (Eds.), *Healing traditions: The mental health of Aboriginal Peoples in Canada* (pp. 419-439). Vancouver: UBC Press.
- Noe, T., Fleming, C., & Manson, S. (2004). Reducing substance abuse in American Indian and Alaska Native communities: The Healthy Nations Initiative. In E. Nebelkopf, M. Phillips, E. Nebelkopf, M. Phillips (Eds.), *Healing and mental health for Native Americans: Speaking in red* (pp. 19-31). Walnut Creek, CA, US: AltaMira Press.
- Ryan, C. J., Cooke, M., & Leatherdale, S. T. (2016). Factors associated with heavy drinking among off-reserve First Nations and Métis youth and adults: Evidence from the 2012 Canadian Aboriginal Peoples Survey. *Preventive Medicine*, 87, 95–102. doi:10.1016/j.ypmed.2016.02.008
- Trudeau, J. (2017). Minister of Health Mandate Letter. Ottawa: Office of the Prime Minister. Retrieved from <https://pm.gc.ca/eng/minister-health-mandate-letter>
- Trudeau, J. (2015). Minister of Health Mandate Letter. Ottawa: Office of the Prime Minister. Retrieved from https://pm.gc.ca/eng/minister-health-mandate-letter_2015
- Truth and Reconciliation Commission of Canada (2015). *Honouring the truth, reconciling for the future: Summary of the final report of the Truth and Reconciliation Commission of Canada*. Retrieved from http://www.myrobust.com/websites/trcinstitution/File/Reports/Executive_Summary_English_Web.pdf



Royal Roads
UNIVERSITY

LIFE.CHANGING