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BRIEFING NOTE

TO: PUBLIC HEALTH AGENCY OF CANADA

FROM: FIRST PEOPLES WELLNESS CIRCLE

DATE: November 14, 2019

Rationale:

The Federal Framework on PTSD Act

The Public Health Agency of Canada is leading the implementation of the Federal Framework on PTSD Act. The development of the federal framework is intended to address the challenges of recognizing the symptoms and providing timely diagnosis and treatment of PTSD. Specifically, the framework is to be developed in relation to the following priority area:

- improved tracking of the incidence rate and associated economic and social costs of PTSD;
- the promotion of the establishment of guidelines regarding o the diagnosis, treatment and management of PTSD
- the sharing of best practices related to the treatment and management of PTSD; and,
- the creation and distribution of standardized educational materials related to PTSD, for use by public health care providers, that are designed to increase national awareness about the disorder and enhance its diagnosis, treatment and management.

The Federal Framework on PTSD will primarily focus on workplace-related PTSD. It will also acknowledge and highlight, where appropriate applicability to other non-workplace related trauma, and recognize related mental health conditions sustained as a result of exposure to trauma.

This policy brief is intended to inform the Federal Framework on PTSD and serve as a foundation to ensure that First Nation and Métis perspectives are accurately reflected in the framework.

Background:

Post-Traumatic Stress Disorder

Post-traumatic stress disorder (PTSD) is a chronic, often debilitating mental health condition, which results from exposure to a traumatic event or discrete set of events.[1] The event or events may comprise actual or threatened death or serious injury, or alternative threats to an individual's well-being, as well as learning about the unexpected or violent death, serious harm, or threat of death or injury of a close associate or family member.[2] PTSD is construed as a fear-based disorder and symptoms are consistent with fear reactions and consequent avoidance and hyper-vigilance.

Post-traumatic stress disorder is a global health issue with a prevalence as high as 37%, and three-quarters of Canadians are exposed to a traumatic event sufficient to cause psychological trauma in their lifetime. Within the general population of Canadians, researchers have found the prevalence rate of lifetime PTSD in Canada estimated to be 9.2%, with a rate of current (1-month) PTSD of 2.4%.

Complex PTSD

Complex posttraumatic stress disorder (CPTSD) has been proposed as a distinct clinical entity in the forthcoming WHO International Classification of Diseases (ICD), 11th version.[3] It shares some of the clinical features of PTSD with three additional clusters of symptoms: emotional dysregulation, negative self-cognitions, and dysfunctional relationships with others resulting in interpersonal problems.

Prolonged and persistent exposure to trauma appears to be the key distinguishing causal factor between CPTSD and PTSD, with the latter being caused by an exposure to a discrete traumatic incident or set of events as opposed to ongoing exposure, particularly in childhood. Studies indicate that CPTSD is in fact a discrete entity from PTSD, that it is valid and useful to conceptualize PTSD and CPTSD as different mental disorders[4], and that different treatment approaches are needed for the two disorders.

Secondary Trauma

It has been recognized that a person, typically a health care provider, first responder or caregiver, who is exposed to the traumatic experiences of another may experience secondary trauma. Symptoms of secondary trauma may include depression, anxiety, intrusive imagery, numbing and avoidance phenomena, cognitive shifts, and social and relational problems. These reduce the capacity of the care provider to be empathetic.

Secondary trauma can present symptoms similar to those of PTSD and poses many mental, physical, and emotional problems for care providers, including burnout, decreased self-worth

[1] Van Amerigen et al, 2008
[2] American Psychiatric Association (2013). DSM-5, Criteria for Post Traumatic Stress Disorder
[3] Girorou et al, 2018
[4] Böttche et al, 2018

and low morale, which can lead to higher staff turnover, as well as decreased productivity, negative attitudes towards patients/clients, lack of communication, and clinical errors.

Risk factors for secondary trauma include a personal history of trauma, pre-trauma mental health issues, external locus of control, negative coping styles, current life stress, lower education and socioeconomic status, female gender, age, empathic engagement with the victim, relationship with the direct victim, feelings of helplessness, severity of the trauma, degree of exposure, and perceived threat and appraisal of the stressor[5]. Other risk factors identified include the quantity of exposure to different patients/clients and their traumatic experiences; the amount of time spent with patients or clients who have experienced trauma; the proportion of trauma cases treated; and caseload size.[6] Regarding personal trauma history, risk is especially significant for adults who have experienced childhood trauma and abuse. Gender is also a significant risk factor, with a preponderance of studies indicating that women are more at risk than men.[7] Younger age and having had less experience in the (helping) field have been cited as risk factors as well. [8]

Secondary trauma has been identified as an issue for various groups of service providers, including mental health professionals such as therapists and social workers; firefighters, ambulance workers, police and other first responders[9]; and health care professionals such as nurses, with between 4% and 29% of service providers experiencing secondary traumatization as a result of their work.

The understanding of trauma in First Nation and Métis communities must include a thorough understanding of the effects of colonization, including the residential school experience, and the consequent intergenerational trauma suffered by multiple generations in these communities in Canada. These historical and ongoing colonial forms of trauma compound the risk factors and impacts of secondary trauma for First Nation and Métis people. In any discussion of trauma, it is important to consider the effects and potential interventions in First Nations and Métis communities, including among service providers, must occur in the context of First Nation or Métis worldviews. The consideration of First Nation or Métis worldviews is critical to ensure any guidelines that are established are based on best practices grounded in First Nation or Métis knowledge and evidence.

Effects of Colonization

Before the arrival of Europeans, First Nations people in North America were independent and self-governing, determining their own philosophies and approaches to cultural, economic, religious, familial, and educational matters based on their own worldviews and knowledge systems.[10] Post-European contact, the advent of the fur trade gave rise to a new group of First

[5] Lerias & Byrne, 2003
[6] Guitar and Molinaro, 2017; Finkelstein et al, 2015
[7] Greinacher et al, Lerias & Byrne 2003
[8] Girirou et al, 2018; Rosenfield et al, 2018; Karatziasa et al, 2018 Böttche et al, 2018
[9] Benedict et al, 2007; Cohen & Collins, 2013; Finkelstein et al, 2015; Centrano et al, 2017; Greinacher et al, 2019
[10] RCAP, 1996; Bombay et al, 2009

Nation and Métis people, the offspring of First Nation women and European fur traders – the Métis.[11] This population established distinct communities and married among themselves, and developed a distinct society with its own culture, social and economic orientation, with extensive kinship networks that supported political and economic alliances.[12] Years of colonization and attempts at forced assimilation wreaked havoc on initially, First Nations communities and cultures, and then with the emergence of Métis people, on Métis communities, who were shunned, marginalized and actively discriminated against.[13] The Métis have often been called the forgotten people, with both their Europeanness and their Indigeneity called into question by the settler population, partly because few Canadians know who they are and also because both federal and provincial governments denied responsibility for ensuring Métis access to basic services.[14] It was not until 2016 that the Supreme Court affirmed that the term "Indian" included Métis people, correcting a historical error.

The North-West Resistance marked the ongoing conflict between the Métis people and the newly formed government of Canada over the settlement and expansion of western Canada. The Battle of Batouche in 1885 and the consequent hanging of Louis Riel, the leader of Métis people, has left an indelible mark for Métis as many dispersed across Canada and the US fleeing the possibility of annihilation. The results have embedded the Métis as a 'forgotten people' with weakened cultural, political, social and linguistic structures that has further exacerbated the ongoing and persistent stressors for Métis.

The Indian Residential School (IRS) experience is particularly relevant here, as it involves generations of First Nation and Métis people being subjected to persistent, ongoing and severe stressors. From the 1880s until the last IRS closed in the mid-1990s, it is estimated that more than 150,000 First Nation and Métis children in Canada attended IRSs.[15] The IRS system was a key mechanism by which the Canadian government, by its own admission, attempted to achieve the goal of assimilating First Nation and Métis children and eliminating the "Indian problem".[16] By 1930, roughly 75% of all First Nations children between the ages of 7 and 15 attended residential schools, as did significant numbers of Métis and Inuit children.[17] For the majority of First Nations people in Canada, the IRS experience extends through four or five generations.[18]

As Indian Residential Schools began to close, education of First Nation and Métis children was transferred to Indian Day Schools. These schools were established, funded, and operated by the federal Department of Indian Affairs where First Nations and Métis children were forced to

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[11] Métis Nation of Canada https://www.metisnation.ca/index.php/who-are-the-metis
[12] MacDougall, 2017
[13] Ibid
[14] Ibid
[15] Barkan, 2003 in Bombay et al, 2014
[16] RCAP, 1996
[17] Fournier & Cray, 1997 in Bombay et al, 2014
[18] Aguiar & Halseth, 2015

attend by law, under the Indian Act. In most cases, Indian Day Schools were operated and maintained by the very same religious organizations administering Indian Residential Schools. Many of the children who attended these schools also suffered the same types of abuses that were incurred in the Indian Residential Schools including abuse, damage to family and systemic harm to First Nations culture and language. Although numbers of children who attended and were impacted by their experiences in these schools are not clear it is known that these schools began operating as early as 1920 until the 1980s where it is believed that more than 150,000 children attended these schools.

Other colonial acts of violence include the Indian tuberculosis hospitals (1920-1980) that quarantined First Nation and Métis people suspected of carrying the TB virus. Legally, First Nation and Métis people were segregated and quarantined in hospitals where they often received substandard health care, were subjected to medical and nutritional experiments and kept from their family, language and culture. The effects for those who attended these TB hospitals have been described as similar to the IRS experience.

In addition to the IRS experience and persisting until the present, First Nation and Métis children have been much more likely to have been separated from their parents compared to non-Indigenous children. Beginning in the late 1950s large-scale apprehensions of First Nation and Métis children by child protection authorities (known as the 60s scoop) were undertaken, often removing them from their families and communities permanently, placing them with non-Indigenous families across the world and effectively eliminating their First Nation and Métis identity. This was true for Métis children as well as First Nations children. Today, First Nation and Métis children continue to be highly over-represented in the child welfare system and more likely to be placed in foster care, termed the millennium scoop, furthering the dislocation of First Nation and Métis families.

The 2019 report of the National Inquiry for Murdered and Missing Indigenous women and girls highlights the multiple sources of violence incurred by First Nation and Métis women and girls that has led to devastating impacts across families and communities. The report recognizes the acts of a settler colonial country; imposed laws, institutions, culture and policies of assimilation meant to eliminate First Nation and Métis people in Canada brought on by racist colonial attitudes has led to everyday common occurrences of colonial violence and racism directed toward First Nation and Métis women, girls and 2SLGBTQQIA people. Colonial violence is witnessed in interpersonal violence and through Canadian institutional systems, laws, policies and structures has resulted in First Nation and Métis people being "…normalized to violence, while Canadian society shows an appalling apathy to addressing the issue *(of genocide)*" (www.mmiwg-ffada.ca, 2019).

An often undescribed and forgotten consequence of colonialism has been the trauma First Nation and Métis people have incurred due to the dislocation and desecration of their home lands. Colonial worldviews about land and its resource being a commodity to be owned (and exploited for personal gain) is in direct contradiction to First Nation and Métis worldviews of land and its resources as a part of the larger family and community system of First Nation and

Métis people. The language used by First Nation and Métis signifies the important relationship with the land referring to land as Mother Earth and recognizing all things associated with the land or Creation as their relatives. Although not well examined there is a lot of informal evidence that supports destruction of land and water, as well as dislocation from traditional territories, has left devastating impacts on the social, emotional, mental, physical and spiritual wellbeing of First Nation and Métis people.

Current Status

PTSD, CPTSD and Historic Intergenerational Trauma in First Nation and Métis Communities
There is little research available on the prevalence of PTSD in First Nation and Métis communities. One study investigating the prevalence of PTSD in Indian Residential School (IRS) survivors found that 64% met the diagnostic criteria for PTSD, which is extremely high compared to the Canadian population at large, however, the sample size was quite small. As a comparator, international research shows a high prevalence of PTSD among both Native Americans and Aboriginal Australians which would suggest a high prevalence of PTSD for First Nation and Métis people in Canada as well.

Many scholars consider the PTSD diagnosis to be inadequate for the type of trauma experienced by First Nation and Métis communities as it ignores the role of culture, the context and the impact of the complex, collective and massive accumulated trauma across generations. What PTSD typically fails to capture is the complex, collective, cumulative, and intergenerational qualities of these experienced traumas. Given the prolonged and profound history of multiple traumas in First Nation and Métis peoples in Canada, including traumas inflicted to the lands of First Nation and Métis people, some scholars have proposed that *intergenerational trauma* is a more meaningful and valid concept than PTSD for understanding trauma as it presents at the individual, family and community level in First Nation and Métis communities. Intergenerational trauma is similar to Complex Post Traumatic Stress Disorder (CPTSD) in that it is a result of complex, layered and prolonged trauma; it differs in that it is a collective rather than an individual experience. Intergenerational trauma has been defined as *a collective complex trauma inflicted on a group of people who share a specific group identity or affiliation . . .. It is the legacy of numerous traumatic events a community experiences over generations and encompasses the psychological and social responses to such events*. A case may also be made for viewing the effects of the residential school experience as a culture-specific subtype of CPTSD.

There is an absence of any research specific to prevalence rates of CPTSD in First Nation and Métis communities, although there appears to be significant similarities between CPTSD and Intergenerational Trauma.

Considering the significant role that trauma plays in the lives of First Nation and Métis peoples, it is important to identify the mechanisms by which the cycle of trauma and stress repeats itself across generations, in order to intervene and stop the intergenerational cycle. The IRS

experience is particularly pertinent in this regard. The literature has shown consistent relationships between a history of familial IRS attendance and various types of psychological distress including depression. By extension, it is reasonable to expect that similar types and levels of psychological distress also occurs for survivors of the Indian Day Schools, the Indian TB hospitals and children apprehended through the child welfare system. Impacts of child welfare have also had collective consequences to families and communities who've experienced devastating effect on the social structure of Firs Nation and Métis communities. The deteriorating social structure when added to a host of negative coping behaviors further entrench First Nation and Métis people in the child welfare system.

In addition, there is growing evidence supporting the idea that offspring are affected by parental trauma exposures occurring before their birth, and possibly even before their conception. Poor parenting styles, for instance, have significant effects on early development, and chronic child neglect or abuse manifests in a multitude of psychological, physical and behavioral problems, including difficulties with emotional regulation, emotional reactivity, hyper-vigilance, and developmental delays, all of which can persist into adulthood. Moreover, a more recent claim supported by a growing body of literature is that the effects of the experience of trauma may also be passed along through biological mechanisms. For example, being exposed to stressful events may result in epigenetic changes that suppress certain genes, which changes can potentially be transmitted from one generation to the next.

There is a dearth of literature regarding prevalence rates of secondary trauma among First Nation and Métis service providers as well as an absence of any evidence of formal mechanisms in place to track secondary trauma among these providers. However, given the ongoing impact of historical trauma, the fact that PTSD rates are higher in First Nation and Métis communities than among non-Indigenous people, and that mainstream service providers (mental health professionals, health professionals, and first responders) show secondary trauma rates of between 4% to 29%, it is entirely reasonable to assume that First Nation and Métis providers would be at greater risk for secondary trauma.

Effects of Persistent, Severe Stressors

Stressors such as those described above generate what is known as the "stress response", involving the activation of various physiological responses, including neurochemical changes in several brain regions. Although the stress response can be adaptive in the short-term, if the stressor is particularly severe or persistent, the relevant biological systems may become overly taxed, resulting in increased vulnerability to physical and psychological pathology, and contributing to heart disease, high blood pressure, stroke, diabetes, and the exacerbation of immunologically related illnesses and neurodegenerative disorders, as well as mental disorders such as depression, PTSD and substance abuse.

Health and Social Issues of First Nation and Métis Peoples

Overall, First Nation and Métis peoples in Canada suffer from more health problems than non-Indigenous Canadians. These include chronic physical health problems such as diabetes, arthritis/rheumatism, high blood pressure, and heart disease, as well as lower life expectancies.

Mental health problems such as depression, anxiety and substance abuse disorders are also more common among First Nation and Métis people compared to the general population. Generally, literature acknowledges the poor health and social conditions for First Nation and Métis people is a direct result of the trauma experienced through colonial acts.

Compared to non-Indigenous Canadians, First Nations and Métis people have significantly higher rates of social health challenges such as lower educational attainment levels, lower employment levels, and living in poverty. More domestic violence is reported by First Nations and Métis people compared to non-Indigenous people. Incidences of childhood sexual and physical abuses are much higher in First Nation and Métis communities compared to all other ethnic groups. First Nation and Métis people are also much more likely to experience stressful experiences in adulthood compared to the population at large, including violence to self and others, homicide, assault, and witnessing traumatic events. Many of these social challenges are observable in the decrease in community social structures such as decrease in volunteerism, less community accountability and trust, lateral violence and increases in negative or unhealthy community behaviors such as gossiping or internal family conflicts.

Manmade or natural disasters have devastating impacts on multiple generations to the health and wellbeing of First Nation and Métis communities. Some disasters require community members to be evacuated from their land and their homes where they are susceptible to culturally unsafe decisions and practices. In many cases, decisions about the implications of a potential manmade disaster or the response to disasters does not involve First Nation or Métis leaders which violates their self-determination. When decisions and practices that do not value and recognize First Nation or Métis worldview, cultural practices, language and/or personal experiences as critical to their wellness these individuals are at greater risk of experiencing trauma. Impacts can be found in the physical, mental, emotional, spiritual and social health including loss of language, loss of healthy family structures such as parenting, loss of traditional harvesting and cultural practices, increased chronic diseases, food security and increased fear, anxiety and depression. In some cases, the disaster and its consequences lasts decades, across generations, which perpetuates the complexity of the trauma paving the way for further intergenerational trauma.

Experiences of racism and discrimination are common, in interpersonal interactions as well as in the systems where they access services, which serve as daily stressors in the lives of First Nation and Métis people. The current systems are created from a non-Indigenous worldview and are often experienced as alienating and unwelcoming for First Nation and Métis people. Feelings of mistrust in service providers and systems of care are commonly reported and are biproducts of culturally unsafe care. There are numerous reports of how culturally unsafe care has been traumatic, and in some cases lethal, and has multiple generations of First Nations and Métis people questioning if their lives matter. Systemic racism and discrimination can be encountered in many different systems. Systemic racism from the education system has damaging effects to the personal and cultural identity of young people who feel a need or obligation to conform to the mainstream values and norms at a critical developmental stage when they should be developing/building healthy sense of self and identity. For First Nation and

Métis people who have experienced generations of culturally unsafe systems of care from a predominantly oriented mainstream approach often trigger historical memories and prolongs intergenerational trauma at an individual and collective level.

Emerging Issues

There is greater awareness of colonial influences on the health and wellbeing of First Nations and Métis people, particularly colonial systems and its impacts. Recent exposure of trauma experienced by Indian Day School survivors and family members of Murdered and Missing Indigenous Women and Girls are two emerging situations where we expect significant reports of PTSD and CPTSD. The Millennium Scoop is another emerging situation that will highlight traumatic experiences and PTSD of the survivors. Similar to the Sixties Scoop it is anticipated that loss of culture, language, and identity will be central tenets to the trauma impacts of the Millennium Scoop survivors. It is reasonable to expect that all of these traumatic experiences are more likely to be defined as CPTSD and/or intergenerational trauma for First Nation and Métis people.

Key Considerations

First Nation and Métis World Views and Knowledge Systems

The worldviews and knowledge systems of First Nations and Métis people vary – there is no pan-Indigenous worldview or knowledge system. At the same time, the various First Nation or Métis worldviews and knowledge systems share some core commonalities, including the conception of all things as living spiritual entities who are interrelated. There is also a profound sense of place within First Nation knowledge systems, which gives rise to distinctive tribal cultures, as defined by the peoples' relationship to their particular physical geography, its landmarks, and the stories that relate to them, as well as to all living things that inhabit those spaces. In First Nation worldviews, relationships *are* reality. The world is a web of connections and relationships, and nothing can exist without being in relationship, including knowledge systems and ways of knowing. Métis people can be considered to exist within a third space, a space that overlaps with Western and First Nations spaces while at the same time remaining separate and distinct. This Third Space is an "existential and epistemological meeting place where Western and Indigenous knowledge and perspectives collide, mix and mingle to form new cultural expressions and understandings".

First Nation and Métis Views on Health and Trauma

A major paradigm within the cultures of First Nation and Métis peoples is the medicine wheel, which encompasses a wide conceptual understanding of life and the interrelatedness of all its functions. Although there are differences in concepts and emphases among First Nation and Métis peoples with regard to the medicine wheel, there is enough similarity among First Nation and Métis philosophies to apply these concepts generally. Based on the concept of the medicine wheel, First Nations views of health and wellness focus on the concept of balance, with wellness being understood from a whole person perspective wherein there is a balance of a person's spirit, heart/emotions, mind and physical being. Persons who experience wellness

have hope, know where they belong in this world, and understand that their life has meaning and that they have a unique and specific purpose in life. Métis concepts of wellness are similar, in that holistic health includes the physical, mental, emotional, spiritual and cultural aspects of life.

In addition, one cannot speak of First Nation and Métis worldviews and knowledge systems without acknowledging the critical importance of the land and natural world to First Nation and Métis peoples. Many knowledge traditions and cultural practices are strongly linked to the land and waters. Therefore, the health and wellbeing of First Nation and Métis people is intricately tied to the health of the land and waters, and damage to or disruption of the natural environment could be construed as a form of trauma at the individual, family and community level, affecting as it does the capacity for First Nation and Métis people to live a balanced life and to pass on their traditional cultural teachings. It must also be noted that it is connection to land that can also help First Nation and Métis people to heal. The resurgence in land-based healing initiatives has gained popularity within the last decade and have been used with people of all ages to both prevent, as well as treat, the impacts of trauma experienced by First Nation and Métis people.

Using this conceptualization of wellness, one can envision trauma as an injury to a person, community and/or natural environment, which throws this balance out of alignment, thus affecting overall wellness and depriving people of a sense of hope, belonging, meaning and purpose.

Workplace Factors Influencing Secondary Trauma

A key issue regarding the risk of developing secondary trauma among service providers in First Nation communities is that most of these staff are members of the communities in which they work. Thus, work life and personal life are not always easily separable. In some cases, a worker may be the only person in their role in the community, meaning they may have to intervene in a professional capacity to traumas and critical incidents involving family members. Workers often also face very high expectations from community members and leaders in their roles which can cause difficulties in maintaining boundaries, all sources of ongoing stress.

If those communities are impacted by intergenerational trauma, as many are, then this trauma will inevitably be affecting many of the workers themselves. Critical incidents in a community, for example, affect workers both professionally and personally leaving them susceptible to multiple forms of trauma and more complex impacts over time. In addition, the trauma, grief and loss that staff see regularly in their roles often result in excessive workloads, pressure, lack of support, and stress, leading to burnout and high rates of staff turnover.

A related issue for First Nation and Métis frontline workers may be the lack of adequate support mechanisms to help workers maintain a balance between their personal and professional lives, which can generate a tremendous human cost, placing these workers at high risk for secondary trauma and burnout. In addition, many communities do not have the human infrastructure to support workers to consider implications to responding to trauma and crisis

through supervision and debriefing. This is an identified gap for frontline workers to be adequately equipped to manage the work-related impacts to trauma which ultimately leaves them isolated and more at risk for secondary trauma. The potential for exposure to lateral violence in the workplace, another legacy of colonization, is also not uncommon, and can represent a significant source of stress for First Nation and Métis workers who have limited options within the organization to have these issues adequately addressed. Implications to lateral violence can increase a worker's sense of isolation and feeling ill-equipped to address the workplace violence thereby exposing them to further trauma and harm.

All of the factors identified above are magnified for workers in remote First Nation communities. Workers are expected to act simultaneously in many roles in small communities, they practice in a very personal context with limited privacy, there is a scarcity of colleagues, and often a lack of adequate supervision, creating a sense of professional isolation. There is also a large workload of crisis situations, lack of resources, rotating staff, and lack of access to training, and challenges maintaining confidentiality and client privacy.

Emergency Response Coordination

First Nation communities encounter natural or manmade disasters or health and social conditions that result in emergency response situations. Emergency response planning and coordination is often handled by frontline workers or senior administration who may or may not be first responders. To date, addressing mental wellness as part of emergency management in First Nations has not been well articulated nor have formal measures been put in place to address impacts associated with responding to emergencies, including addressing secondary trauma or mitigating its risk. The lack of infrastructure and resources allocated to emergency response planning and coordination increases risk of trauma to those affected by the disaster and secondary trauma to the workforce responding to the disaster.

First Nation and Métis communities often identify crisis and trauma resulting from multiple sources including those from natural disasters to health crisis such as suicide epidemics to social crisis such as wide spread disclosures of sexual abuse to manmade crisis such as water contamination or geographical dispersion from manmade floods. In some instances, these types of crises can occur in close time proximity to each other that causes the community to be in a constant state of crises resulting in multiple impacts of trauma happening concurrently and not allowing for any reprieve for the community and frontline workers to recover from these events. These situations raise the probability of complex trauma being experienced by members of these communities. Issues that arise for frontline workers include burnout, compassion fatigue, high staff turnover and secondary trauma.

The challenges experienced by these workers including risks of secondary trauma are noted below:

Mental Wellness Professionals

First Nation and Métis mental health and addictions workers are particularly vulnerable to secondary trauma due to their personal and frequent exposure to the traumatic experiences of clients. In First Nation and Métis communities front line workers are often expected to be 'on call' to attend to the needs of the community as they arise and the workers often find themselves responding to crisis and trauma at all times. As most front-line workers are also community members, they find themselves impacted through multiple roles they may hold in the community; as first responders to the crisis or trauma, directly or indirectly impacted by the trauma as a family or community member and, possibly, as a decision maker or leader determining how to respond organizationally or politically to the family or community crisis. The potential for multiple impacts to a singular trauma leaves frontline workers vulnerable to excessive exposure to trauma that has the potential to lead to feelings of helplessness, numbness, avoidance and inability to respond empathically. These consequences can have an overall negative influence throughout the community when the leadership and/or management feel powerless to change the outcomes to trauma. Their decisions and behaviors are often critiqued and judged, placing these men and women at greater risk of secondary trauma as they feel a strong sense of personal responsibility to protect and support everyone. Feelings of guilt and shame may abound if they are unable to address the traumatic event particularly when their actions are called into question as reliable or helpful either within the community or from the larger lens portrayed by regional and/or national media.

Professionals

First Nation and Métis people are underrepresented in health professions such as nursing, social work, psychology and psychiatry. It is likely there are small numbers of First Nation and Métis professionals serving First Nation and Métis communities because they are underrepresented in their professions, offer inadequate pay, and have high demands in their role making recruitment and retention challenging. Therefore, we were unable to locate any findings regarding secondary trauma among First Nation and Métis professionals serving First Nation and Métis communities. It is anticipated, however, that many of the same challenges that exist for frontline community workers may also resonate for First Nation and Métis professionals who are working in the communities. Issues related to multiple roles, multiple impacts to trauma, lack of resources, lack of human and organizational infrastructures to support these professionals to mitigate risks they may experience in their roles in the community may exacerbate their own personal histories of trauma and put them at greater risk of experiencing secondary trauma and its impacts.

Since many First Nation communities employ and/or receive nursing services it is anticipated that a great number of these nurses may be non-Indigenous. Although we did not explore impacts directly related to these individuals it is worth noting that the complexity of issues that are often experienced by First Nation and Métis people often can be overwhelming to non-Indigenous nurses serving the communities. Many of these nurses find themselves ill-equipped to manage the layers of trauma with the scarcity of human and practical resources available to them which leads to high staff turnover. This group of professionals are also likely at higher risk for secondary trauma. However, what might be worth noting is the impact of secondary trauma

by non-Indigenous health professionals and/or the high turnover rates increasing the potential for harm to First Nation and Métis people. In these cases, they are more likely to encounter professionals who may not demonstrate appropriate empathy to their trauma experiences or do not have a good understanding of the complexity of the crisis. Encounters such as these may be perceived as culturally unsafe, discriminatory or racist health services increasing the negative impacts to the trauma experience and reducing the likelihood of seeking healthcare in the future.

In many cases the traumatic event has impacts that expand beyond the response of health professionals to other helpers or professionals in the community. This is particularly relevant for teachers who are often required to support students during times of trauma and crisis. Often teachers feel ill-prepared and ill-equipped to support students and their families to provide a helpful response and they have been observed to, sometimes, become immobilized causing them to have an unhealthy and unhelpful response to the incident. Similarly, translators (volunteer or paid) are also exposed to trauma when they support traumatized individuals by translating what has been witnessed, heard and shared about a traumatic event. Considerations for supporting this work force, who may be used regularly in First Nation or Métis communities, are often neglected or forgotten yet the impacts may be the same as first responders.

When dealing with emergency situations, there are instances when non-Indigenous emergency response personnel are deployed to support the communities, however when these professionals have little to no knowledge about the historical, social, political, economic or cultural realities of the community it raises the likelihood of First Nation and Métis people being retraumatized. First Nation and Métis workers and leaders, in turn, may feel more compelled to overlook boundaries in an attempt to support the community and ensure they access healthcare which could lead to First Nation and Métis workers being more susceptible to burnout and secondary trauma.

Police Officers

First Nation and Métis police officers working in First Nation communities are in a profession where they are exposed to situations that put them at risk for secondary trauma. In First Nation communities they are often responding to many challenging situations such as property crime, substance abuse, higher levels of danger, violence, and social problems including suicide, poverty/unemployment, inadequate housing, overcrowding, family violence and high rates of child welfare cases. These issues may be heightened in remote and isolated communities where police officers may have less access to supports, may work for extended periods of time without relief and may have personal relationships with those they interact with. Officers in non-isolated communities were more likely to report that gang activity and organized crime were very or somewhat serious problems. There may also be instances where police officers are called on to arrest one of their relatives or intervene with a family member who is suicidal, and then they are expected to help debrief others after the incident. Similar to frontline workers in the community police officers are at greater risk of holding multiple roles, be

exposed to trauma through these roles, have higher expectations placed on them from the community as well as their profession, and may have difficulty enforcing boundaries. Although this is a profession that is at higher risk for secondary trauma, for First Nation and Métis police officers it is anticipated that their risks for secondary trauma are more significant although there is limited literature identifying the unique challenges to this sub-population of the work force in First Nation and Métis communities.

Firefighters

The majority of First Nation communities do not have paid fire fighters located in the community and rely primarily on a volunteer fire department to respond to emergency situations. As volunteers these individuals live in the community and when they respond to an emergency are often responding to situations that are traumatic to their family, friends and neighbors. In most cases, limited training is provided to volunteer fire fighters beyond teaching them firefighting/fire safety techniques and in most situations, very little attention is paid to supporting these men and women in debriefing from trauma they may witness or experience while acting as a first responder in their community. Like their first responder counterparts, volunteer fire fighters often have high expectations placed on them with a scarcity of resources and may be expected to work outside of their scope or role such as attending to the clean up after a crisis whether it be a social crisis such as a suicide or a natural disaster. These additional expectations further expose them to witnessing and responding to traumatic events. It could be argued that these first responders will face similar difficulties to First Nation and Métis police officers working in First Nation communities such as holding multiple roles with higher demands and expectations thereby increasing the likelihood that these individuals will be exposed to complex trauma situations and be at greater risk for secondary trauma.

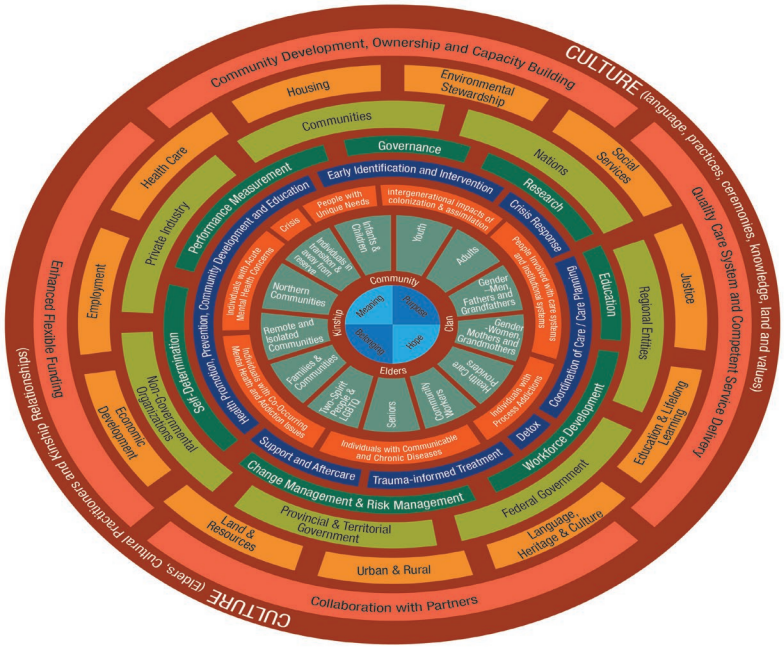
Elders and Cultural Practitioners

There is a resurgence among First Nation and Métis to reclaim their cultural knowledge and practices. This has led to better identification and access of elders and cultural practitioners located in the communities for people to access support. The use of elders and cultural practitioners to provide support during times of crisis or for traumatic events has become more and more of an expected practice as witnessed by the high demand for cultural supports during the Truth and Reconciliation national events and the inclusion of cultural practitioners as a recognized group for mental health counseling by First Nation and Métis Services Canada's First Nation and Inuit Health Branch. Cultural practitioners and elders in First Nation and Métis communities are not always salaried workers but are sought out and often volunteer their time, skills and knowledge to support people experiencing trauma. In some cases, these individuals are called upon by other communities and organizations such as child welfare, justice and others to provide support to individuals who have experienced trauma. Sometimes they are even identified as the support person for First Nation and Métis frontline workers, first responders and professionals to address secondary trauma. Yet as volunteers there is no processes to compensate them for their work nor is there any established process to support elders and cultural practitioners to ensure their wellness and mitigate their risk for compassion fatigue, burnout or secondary trauma

Recommendation / Next Steps

Addressing PTSD for First Nation and Métis people first requires a recognition that their lives have been shaped by colonial and historical trauma across generations that continues to impact individuals, families, communities and entire nations. It also requires acknowledgement that First Nation and Métis people continue to experience trauma at alarming rates that has consequences to their health and wellness. Preventing and mitigating secondary trauma among First Nation and Métis service providers must be embedded within their cultural, political, economic, social and historical reality. Therefore, one must include the concepts of CPTSD or intergenerational trauma in discussions of secondary trauma by recognizing frontline workers/first responders are at greatest risk of secondary trauma. We acknowledge that healing from trauma for trauma survivors must ensure they have *hope* in their future, a sense of *belonging* with a caring support network, define *meaning* to their experiences, and identify a sense of *purpose* in their lives. In doing so, we acknowledge *Hope, Belonging, Meaning and Purpose* as the four outcomes to the First Nations Mental Wellness Continuum Framework that can be used to guide this work.

The following are offered as recommendations and next steps as helpful approaches that are aligned with the key themes of the First Nations Mental Wellness Continuum Framework (the Framework).



Culture as Foundation

Culture as foundation is one of the key themes of the Framework. Two critical features of this are operating within the context of First Nation and Métis Worldviews and supporting traditional First Nation and Métis Healing Practices.

Operate within the Context of First Nation and Métis Worldviews

Culture as foundation is a key theme of Framework. As one researcher points out, perhaps the most obvious starting place for organizations in supporting staff lies in simply acknowledging that First Nation and Métis workers face specific challenges, and that they cannot be effectively supported within organizations that operate exclusively under a Western framework. For this reason, it is important to have supervisors and managers who are knowledgeable about the history and effects of colonization in Canada. It is also important to create workplaces where supervisors and front-line staff operate from the perspective of First Nation and Métis worldviews or, at least, make equal space for them alongside Western perspectives. Ultimately organizations that support policies around cultural safety and promote opportunities for staff to explore cultural humility as a concept to foster personal self-discovery and learning would be highly advantageous for those who access services (client/patient) and the staff. When organizations shift their core tenets to be considerate of outcomes for families and communities it better embodies First Nation and Métis worldview that recognizes wellness requires supporting everyone to address the colonial aspects of trauma.

It would also be helpful to support policy and systems transformation that recognizes First Nation and Métis knowledge and evidence in addressing PTSD and its impacts. First Nation and Métis communities must be acknowledged as supporting a workforce that is exposed to trauma and that organizational practices, policies and processes grounded in First Nation and Métis ways of knowing and doing must be foundational. Doing so would, in essence, be similar to supporting a trauma informed lens to help mitigate impacts to trauma by acknowledging First Nation and Métis knowledge as a healing centered model of care for First Nation and Métis people/communities. As highlighted in the Framework, First Nation and Métis worldview, values, and culture are the foundation of work to support mental wellness in a community context.

Matching the comprehensiveness of the Framework, it is critical that addressing trauma must be embedded within a First Nation or Métis worldview that requires a comprehensive approach to care. This approach must build on the recognition of interconnectedness of people, roles, relationships and health. As such this approach must have clear directives that multiple levels and layers of government, who have interconnected responsibilities to addressing PTSD and CPTSD, must be involved to provide culturally relevant and safe care for First Nation or Métis people across the lifespan. This approach must ensure equitable resourcing, both financial and human, across a continuum of care that ensures all layers of a system are responsive to the needs of First Nation or Métis from a two-eyed seeing approach. Further this approach must recognize First Nation and Métis' right to self-determination including the design and delivery of services with long-term, sustainable investment.

Support Traditional First Nation and Métis Healing Practices

Research is emerging that supports a return to First Nation and Métis traditional practices – of whatever kind have local relevance and meaning, both for First Nations and Métis people – as a remedy for intergenerational trauma. It seems reasonable to assume that these would be equally effective for secondary trauma among First Nation and Métis service providers. These

include traditional ceremonial practices enacted in cultural settings, access to traditional healers, and access to land-based activities, all of which have been shown to promote healing and wellness. First Nation voice has already identified 4 key outcomes – hope, belonging, meaning and purpose - that can be used to assess the extent of how wellness is being achieved when a First Nation worldview and lens is applied to the care model. A guiding concept here is the use of holistic collaborative approaches across the First Nation social determinants of health as outlined in the Framework.

Further work must be done to recognize the invaluable contributions of Elders and cultural practitioners in addressing trauma and mitigating secondary trauma in First Nation and Métis communities. Part of the recognition includes ensuring appropriate and adequate compensation that is commiserate with other helping professionals as well as ensuring this part of the workforce has access to supports to mitigate their own risk of exposure to secondary trauma.

Community Development, Ownership and Capacity Building

This is another key theme of the Framework**.** Communities should have the capacity to adapt, optimize and realign their mental wellness programs and services based on their own priorities. The following are possible next steps in addressing PTSD and secondary trauma for First Nation and Métis communities:

- Opportunities must be identified to support First Nation and Métis communities to build the capacity of their workforce, including the volunteer sector, so there is increased awareness and access to tools and information that could support mitigation of risk to trauma and secondary trauma. It is possible one such opportunity could be supporting First Nation and Métis communities to gather and share best practices derived in community that address PTSD/secondary trauma in the workforce. This type of opportunity could be invaluable to initiate dialogue on this important but silent topic within the community and for this workforce.
- First Nation and Métis communities require practical, human and financial support to engage in dialogue, shared learning and identification of new or existing tools and resources that could assist in the development of plans to address the needs of the workforce in mitigating risk of PTSD, CPTSD and secondary trauma.
- Since trauma is deeply entrenched within the historical and current life of First Nation and Métis people there are highly effective programs or initiatives underway, such as the Indian Residential School Health Support Program and Mental Wellness Teams, that have proven invaluable in healing from trauma. Ongoing advocacy and promotion for the sustained continuation of these types of programs or initiatives to be able to continue their work through a First Nation and Métis lens is vital.

Emergency management and coordination must recognize the rights of First Nation to self-determination as defined in the *United Nations Declaration on the Rights of Indigenous Peoples*. It is necessary for government, non-government and First Nations to collectively establish regional guidelines on culturally safe practices that ensure the wellness of those who are impacted by emergency management protocols (such as evacuees). These guidelines might

wish to embed an accountability measure that could be enacted when decisions on emergency management place First Nation and Métis communities at risk of losing their familial and community structures including those related to language, culture and identity. In the establishment of regional guidelines resources must be allocated for First Nation and Métis communities to adequately equip their emergency management systems to respond with the necessary resources in ways that safely attend to the needs and realities of those who may be displaced or disrupted by urgent and crisis situations. Again, it needs to be reiterated that non-Indigenous emergency response organizations should also be held accountable to provide culturally safe practices and must demonstrate organizational processes for cultural safety and cultural humility training by all staff.

Enhanced Flexible Funding

Funding disparities have long been an issue between First Nation and Métis and non-Indigenous service providers. In addition, wellness programs and services have long been uncoordinated and fragmented, with programs operating in government-controlled funding silos**.** Comprehensive planning and integrated federal, provincial, territorial and sub-regional models are needed for funding and service delivery. More funding, in particular for increased staffing, support services, and training, could help to address some of the factors that increase the risk of secondary trauma.

Emerging issues in First Nation and Métis communities requires comprehensive planning including the identification of adequately resourced systems that can address the acuity of trauma in addressing survivors of Indian Day School, the Millennium Scoop, the family/survivors of MMIWG and any future colonial impacts as they emerge.

Collaboration with Partners

It is important that organizations work collaboratively and cooperatively to ensure that workers suffering from or at risk for secondary trauma have access to a comprehensive continuum of the mental wellness services they need. As the Framework points out, the lack of clear roles and responsibilities and the fragmented programs and services across federal, provincial or territorial, regional, municipal, and community health systems make it difficult to address issues of worker wellness in a holistic manner. Improving collaboration with partners to support First Nation and Métis worker wellness will require:

- defining clear roles and responsibilities
- establishing leadership
- creating partnerships and networking
- developing system navigators and case managers
- providing advocacy
- supporting community readiness
- good governance structures

Currently there are models of collaborative partnerships that must be strengthened and identified as best practice models in the delivery of effective care for First Nation and Métis people. Examining and highlighting bilateral and trilateral working tables between federal, provincial and First Nation governments where there has been successful and effective collaboration are examples of best practice models that need further investments to ensure these approaches have sustainability and highlight evidence of addressing health inequities in systems of care.

Quality Care Systems and Competent Service Delivery

Clearly Defined Roles and Expectations

Organizations need to develop reasonable levels of expectations for worker roles and responsibilities, matched to their positions. Too often, for example, workers are "on-call" 24/7. Reasonable expectations would help to alleviate the stress associated with the multiple and over-lapping roles workers often have to play and help with maintaining work-life balance and boundaries. Consideration to create reasonable expectations would include:

- support for the development of adequate human infrastructure including volunteers, Elders and cultural practitioners as part of the infrastructure
- training at leadership, administration and staffing level on worker wellness

Training and Supports to Maintain Wellness

Organizations can provide training to staff on ways of dealing with work that could trigger trauma, as well as providing access to supports required to maintain wellness. Such supports could include:

- Continuous opportunities for debriefing of emotions.
- Support groups for caregivers.
- Involvement in activities of hope.
- Balancing a caseload with other professional responsibilities.
- Having Elders spend time in the workplace.
- Offering employees choices around the therapists they utilize.
- Providing access to therapeutic group sessions.
- Providing access to cultural practices, either personally or through the organization, to improve worker and organizational wellness

In addition, organizations can encourage workers in supporting their own wellness through establishing clear boundaries, practicing self-awareness and self-care, getting adequate exercise, sleep and nutrition, providing space to debrief with others and supporting spiritual practices. Access to skilled supervisors could help workers to define pathways to their own wellness.

Cultural Safety and Cultural Humility

The Truth and Reconciliation Calls to Action demand a macro and micro-reconciliation approach to address health disparities in Canada. The significant exposure and impacts to trauma for First Nations and Métis people demands transformative changes across systems. The development of cultural safety standards to be implemented by service organizations that provide services to/for First Nations and Métis people are recommended and demands a level of care that ensures the rights and dignity of First Nation and Métis people are respected and attended to. As part of cultural safety standards staff should be required to participate in cultural humility activities for self-discovery and to support systems transformation in how First Nation and Métis people access care.

Research

Investments in community defined and led research related to the cost of culturally unsafe practices is necessary. There is a need to examine the immediate to long-term responses to emergency/traumatic situations to understand the level of PTSD/CPTSD that may occur when responses are culturally unsafe and have not included community voice in determining a plan. This data can be used to develop policies that aim to better support communities to develop emergency response plans, using collaborative approaches, and define how to respond to emergency/traumatic situations ensuring wellness for all members of the First Nation or Métis community.

Legislation

Efforts to link the National Framework on PTSD with other existing and potential legislation, such as legislation on racism, would be invaluable to advance the recognition of racism and discrimination as a contributing and causal factor to the development and diagnosis of PTSD and CPTSD, particularly for First Nation and Métis people. The outcomes of racism largely go undiagnosed in First Nation and Metis mostly due to the lack of understanding held by the Canadian population about the colonial violence and trauma perpetuated against First Nation and Metis. For instance, access to healthcare services where cultural safety is an issue could provide a clearer idea around the complexities of mental wellness related to PTSD and racism. In addition, the by-products of racism related to PTSD in most cases results in personal dynamics that have larger implications, like lateral violence, which ultimately effects ones' connection to culture and identity at an individual and collective level.

Finally, there must be consideration for investing in ways to support this workforce at a broader community level and not investing solely in individuals in the workforce. Addressing trauma in First Nation and Métis communities requires a whole of community approach to healing that considers investing in a full basket of essential services that is accessible and addresses the First Nation and Métis social determinants of health.

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