What Justice Looks Like

Confronting Anti-Indigenous Racism and Building Safe and Comprehensive Mental Health & Addictions Systems for Indigenous Peoples

Produced in partnership between the First Peoples Wellness Circle and the Thunderbird Partnership Foundation, with support from the Firelight Group.

the firelight group

Acknowledgements

Our organizations would like to express our profound gratitude to the many brilliant and generous people who participated in our roundtables. The knowledge, experiences, and vision you shared formed the foundation of this report. For that sharing, we offer our deep commitment to continuing to work towards generating systems, spaces, and supports where First Nations, Inuit, and Métis people feel safe, valued, and respected.

Content Warning

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Executive Summary

Anti-Indigenous racism in healthcare in Canada has been both a source of, and a reflection of colonial violence for decades. Recently, the untimely and preventable deaths of people such as Brian Sinclair and Joyce Echaquan have made headlines and have generated a public conversation around anti-Indigenous racism in healthcare and how to combat it. The First Peoples Wellness Circle (FPWC) and the Thunderbird Partnership Foundation (Thunderbird) identified a gap in these conversations around the realities of anti-Indigenous racism within mental health and addictions systems in Canada. To fill this gap, FPWC and the Thunderbird undertook a process to engage with Indigenous peoples from across Canada to better understand their experiences with anti-Indigenous racism in mental health and addictions programming spaces, identifying innovative approaches to preventing and responding to anti-Indigenous racism, as well as articulating a positive future vision aimed at supporting the next generations.

Dialogue and input were gathered from a series of roundtable discussions that included 96 participants across 5 sessions, as well as a post-engagement survey to provide an opportunity for additional input.

Based on what we heard, a set of recommendations for action have been developed that speak to both the need to prevent and respond to anti-Indigenous racism within the systems where our people seek care, as well as the critical need to support the reclamation of the vision, strength, values, and ways of being that have sustained and strengthened our communities since time immemorial.

It is worth noting that, as governments and organizations consider our recommendations, implementation cannot be done in isolation from the peoples they seek to serve. First Nations, Inuit, and Métis peoples have the right, responsibility, and authority to make decisions related to the structures, policies, and practices within the systems delivering care. As such, interpretation and implementation of the recommendations that follow must be done in full and meaningful collaboration with First Nations, Inuit, and Métis communities themselves.

Overview of the Way Forward (Recommendations)

1. **Anti-Indigenous racism and cultural safety training** within mainstream settings must be based on a foundation of meaningful and reciprocal relationships with local Indigenous communities and organizations. Trainings should, at minimum:

    a. Speak to local priorities and realities;

    b. Offer a strengths-based perspective on Indigenous people and ways of knowing, being, and doing that challenges harmful stereotypes;

    c. Articulate how racism, white supremacy, misogyny, ableism, and homophobia operate and intersect to maintain unequal relationships of power, and how it is manifested structurally and interpersonally; and,

    d. Be mandatory, ongoing, and undergo regular evaluation.

2. **Adequate and sustained capacity to enact self-determination within mainstream systems.** First Nations, Inuit, and Métis people, communities, and organizations are often asked to participate in the difficult work of generating safe healthcare systems off the sides of their desks. Future efforts must include adequate and sustained capacity support.

3. **Generate systems of accountability and justice** where First Nations, Inuit, and Métis people can seek support and seek justice when faced with racist attitudes and actions. Important pillars of these systems are:

    a. Generating systems of accountability through Indigenous-led processes. This will allow for local priorities, concerns, and protocols to be centered;

    b. Involve regulators and licensing bodies; and,

    c. Regularly and transparently evaluate and report on system performance related to anti-Indigenous racism. Again, this should be Indigenous led.

4. **Building safe and supportive educational environments** which respond to epistemic racism by valuing and centering Indigenous knowledges, and developing pathways within institutions to support First Nations, Inuit, and Métis learners in building culturally rooted expertise. This will require education and training institutions to meaningfully work with local First Nations, Inuit, and Métis communities and organizations in a sustained fashion.

5. **Build safe and supporting working environments for Indigenous mental health and addictions staff** through various strategies such as cluster hires, partnerships with local Indigenous communities, ensuring pay equity, and developing leadership training and mentorship programs.

6. **Increase access to care for Indigenous people** by co-designing mental health and addictions programs and services with Indigenous communities to meet their unique and specific needs, based on long-term, adequate, and stable funding.

7. **Develop Indigenous mental health and addiction service standards** that clearly outline and provide systems of accountability for the level of performance that First Nations, Inuit, and Métis people and communities can expect to receive.

8. **Develop First Nations, Inuit, and Métis-specific assessments** that centre strengths and First Nations, Inuit, and Métis ways of knowing, being, and doing. This includes:

    a. Funding and opportunity for First Nations, Inuit, and Métis scholars, experts, organizations, and communities to co-develop these tools;

    b. Commitment from relevant professional associations at the national and provincial/territorial levels to push for implementation of these assessments; and,

    c. Health, government, and insurance organizations to mandate use of the culturally relevant, safe, and appropriate assessment tools that match the needs of each person seeking assessment.

9. **Support holistic and culturally relevant treatment practices** that speak to the specific needs of First Nations, Inuit, and Métis people, such as traditional and land-based practices, family, and community-centred care, responding to the Indigenous social determinants of health, and trauma-informed care.

This will require:

a. Enhanced funding for First Nations, Inuit, and Métis scholars, experts, organizations, and communities to articulate, implement, and evaluate Indigenous treatment modalities; and,

b. Opportunities to document and elevate these types of treatment practices as valid forms of knowledge and evidence.

10. **Support First Nations, Inuit, and Métis research and evaluation** grounded in local priorities, based on local metrics, and accountable to the communities these programs are meant to serve. This will support program and policy development, as well as understanding and monitoring of anti-Indigenous racism within these spaces.

11. **First Nations, Inuit, and Métis peoples supported in reclaiming places, ways of knowing, and systems** which are the sources of strength, and provide hope, meaning, belonging, and purpose. This includes supporting cultural resurgence, accounting for the Indigenous social determinants of health (SDOH), creating opportunities to practice deep relationality and generating collective strength, and generating First Nations, Inuit, and Métis-led, holistic, and comprehensive continuums of programs and services to support individual, family, and community well-being. Federal and provincial/territorial governments and their healthcare systems have an obligation to support these efforts.

12. **Support for ongoing dialogue with First Nations, Inuit, and Métis communities and organizations** to seek perspectives on the realities of and responses to anti-Indigenous racism within mental health and substance use spaces. This includes continuing and expanding the dialogue with several key stakeholders including Indigenous scholars, students, and young people. Attention must be paid to heeding the experiences and advice of those with multiple and intersecting identities including gender identity, gender expression, class, and disability status, among others.

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1. Project Background

First Nations, Inuit, and Métis peoples have faced differential treatment and access, overt and covert discrimination, cruelty, and indifference for centuries within healthcare settings. Many did not survive the very systems that were meant to, and obligated to, care for them. Though shocking, that statement should not be surprising. Healthcare systems are reflections of the values, priorities, and attitudes of the societies from which they arise. The continued denial of basic human dignity is deeply rooted in historical and ongoing colonialism.

Recently, several high-profile instances of anti-Indigenous racism in healthcare, brought to light in large part through social media, generated renewed energy to combat it, and identify opportunities to build systems developed by and for First Nations, Inuit, and Métis peoples themselves. In response to these calls for justice and change, the federal government supported a series of National Dialogues that sought to surface challenges and opportunities for transformation.

First Peoples Wellness Circle (FPWC) and the Thunderbird Partnership Foundation (Thunderbird) noted that the dialogues to date did not provide enough opportunity to consider the unique and important context of anti-Indigenous racism within mental health and substance use systems. As such, in late summer and early fall 2023, FPWC and Thunderbird partnered on a project, funded by Indigenous Services Canada (ISC). The project objectives were to:

- Better understand First Nations, Inuit, and Métis peoples' experiences of anti-Indigenous racism within the mental health and addictions services sector within both training and practice contexts;
- Identify best existing or potential interventions or approaches to prevent and/or respond to anti-Indigenous racism in mental health and addictions programs and services; and,
- Develop key factors and recommendations related to actionable strategies to be taken up by for governments, professional associations, training programs, and policy makers.

1.1 First Peoples Wellness Circle

The First Peoples Wellness Circle (FPWC) is an Indigenous-led national not-for-profit dedicated to enhancing the lives of First Nations, Inuit, and Métis peoples by addressing healing, wellness, and mental wellness barriers. The organization's purpose is to walk with and support First Peoples and communities to share collective intelligence for healing, peace-making, and living a good life. FPWC's approach is centred on promoting wellness pathways based on traditional knowledge and culture that supports healing and wellness and fosters a two-eyed seeing approach. FPWC envisions a nation where our First Peoples experience wholistic health and wellness by championing diverse cultural values, beliefs, and practices.

1.2 Thunderbird Partnership Foundation

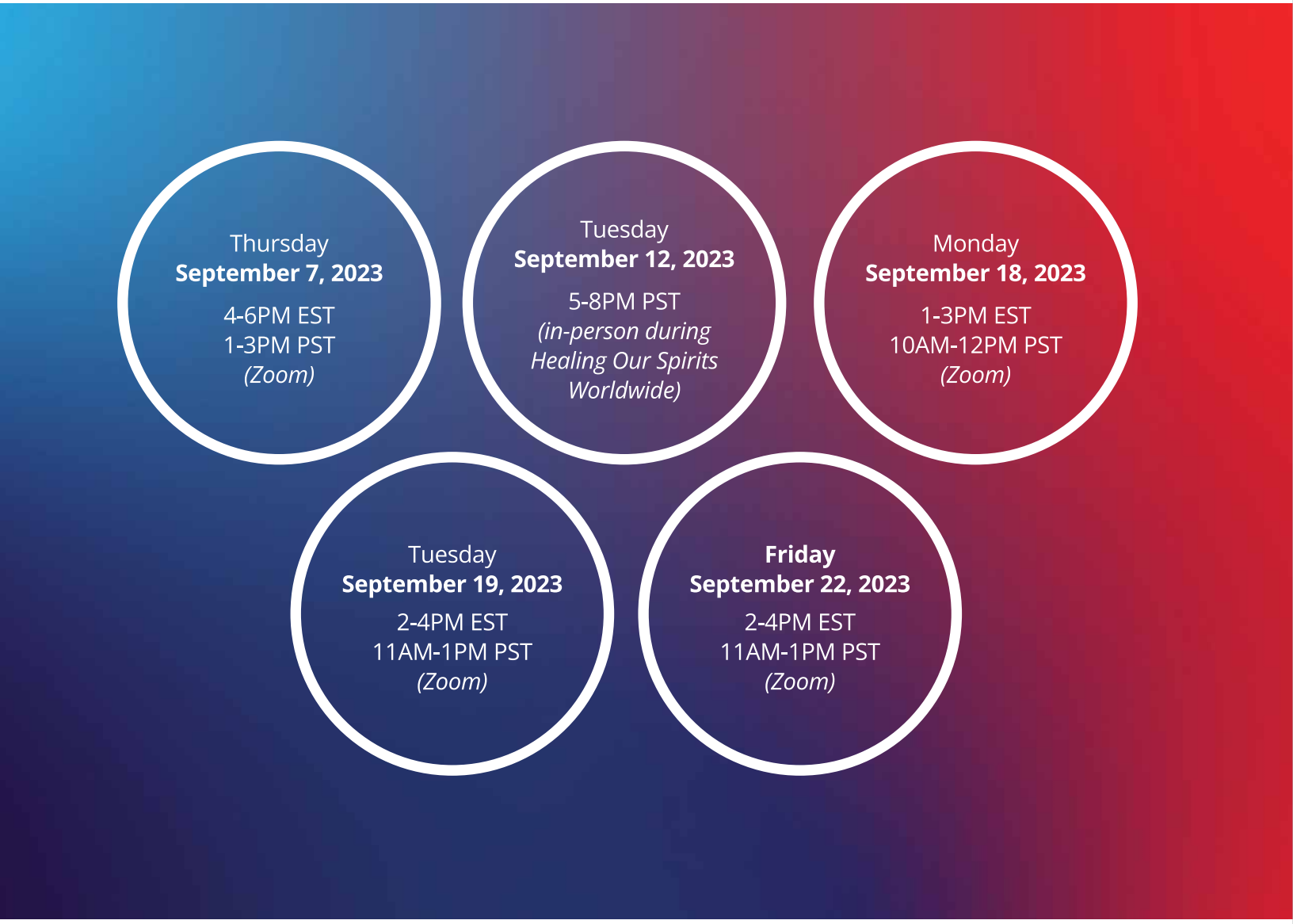
The Thunderbird Partnership Foundation (Thunderbird) is a national non-profit organization that is committed to working with First Nations to further the capacity of communities to address substance use and addiction. The Thunderbird supports an integrated and wholistic approach to healing and wellness serving Indigenous peoples and various levels of government through research, training and education, policy and partnerships, and communications. Thunderbird strives to support culture-based outcomes of *hope*, *belonging*, *meaning*, and *purpose* for First Nations individuals, families, and communities. To this end, the organization's top priority is developing a continuum of care that would be available to all Indigenous people in Canada.

2. Methods

2.1 Approach

2.1.1 Focus Groups

A total of five roundtable discussions were held both in-person and virtually, with each session lasting approximately two hours. These took place on:



Discussions were semi-structured, with questions and prompts offered by the facilitator(s), as conversational methods align with First Nations, Inuit, and Métis research practices and place emphasis on oral communication as a means of transmitting and gathering knowledge. This process made space for storytelling as a relational process where participants were able to share their experiences and perspectives in a safe environment.

All participants were offered an honorarium for their participation in the focus group to give thanks for contributing to this work.

2.1.2 Survey

In addition to focus group discussions, a short 5-question post-engagement survey was distributed online to those who registered to the roundtable discussions to provide some additional feedback and insights. The survey was open from September 7-24, 2023, and a total of 50 individuals responded to the survey.

2.2 Participants

A total of **96 participants** joined the discussions, with an average of 18-20 participants per session. Participants were employed by communities/Nations, health organizations, universities, and Indigenous political and advocacy organizations, among others. Further, social workers, addictions workers, health directors, cultural workers, youth workers, and mental health counsellors were among those in attendance.

Participants identified as:

First Nations	76
Métis	10
Non-Indigenous	8
Other	2

Participants were based in the following regions:

Newfoundland	1
Nova Scotia	6
New Brunswick	2
Quebec	3
Ontario	29
Manitoba	14
Saskatchewan	2
Alberta	7
British Columbia	32

2.3 Analysis

The focus group discussions were recorded and transcribed. All qualitative data was analysed using thematic-code analysis via manual coding, and employed a flexible approach to exploring themes and meaning from the qualitative research data. Manual coding is the process of identifying a passage in the text or other types of qualitative data, searching, and identifying concepts, and finding links and patterns between them.

2.4 Limitations

The most significant limitation in this project was the lack of participation from Inuit people and organizations. The limited timeframe to undertake the work played a large role in this fact. It also may be indicative of a theme that we heard from those who did participate; that is, the general lack of funding support and capacity within First Nations, Inuit, and Métis communities and organizations that results in the existing staff being overburdened.

Given the lack of Inuit perspectives in this work, it is doubly important to ensure that the implementation of any of the recommendations noted here is done in full and meaningful partnership with Inuit organizations and communities to ensure their needs and perspectives are centred in the work. Indeed, the foundation of relationships as a reflection of the right of self-determination must be at the centre of all efforts in addressing anti-Indigenous racism.

3. Defining Racism

The core of this work involves revealing the experiences of First Nations, Inuit, and Métis peoples with anti-Indigenous racism before identifying opportunities to challenge that racism. At its most basic, racism is, "a social injustice based on falsely constructed, but deeply embedded, assumptions about people and their relative social value; it is often used to justify disparities in the distribution of resources" (MacKinnon, 2004, cited in Loppie, Reading, and de Leeuw). **Anti-Indigenous racism** is defined as:

> *The ongoing race-based discrimination, negative stereotyping, and injustice experienced by Indigenous peoples within Canada. It includes ideologies and practices that contribute to the establishment, maintenance, and perpetuation of power imbalances, structural obstacles, and inequitable results in Canada as a result of colonial policies and practices* (Experiential Learning Hub, 2022).

Perhaps the easiest form of racism to identify is **interpersonal racism**, which is understood as racism that occurs between two people. In the context to this work, interpersonal racism can be observed between a healthcare practitioner and a First Nations, Inuit, or Métis person, which may look like physical or emotional violence or discrimination. Interpersonal racism can be overt, such as when a person makes derogatory remarks to another, or it can be more subtle, such as through small actions or non-actions. Subtle interpersonal racism can appear through actions such as a service provider offering assistance to white clients before attending to First Nations, Inuit, or Métis clients. Many different types of racism rely on stereotypes, which are "'social distortions' that do not accurately reflect the diversity within populations and can have a negative impact on relationships between individuals and groups defined as meaningfully different" (Walker, 2008, as cited in Reading, 2013). Stereotypes lead to assumptions about members of a group, and are often harmful, leading to people believing that all First Nations, Inuit, and Métis people are a certain way, or have certain traits.

Systemic racism is an often less visible, yet prominent manifestation of racism. The Ontario Human Rights Commission defines systemic racism as "patterns of behaviour, policies or practices that are part of the structures of an organization, and which create or perpetuate disadvantage for racialized persons" (OHRC, n.d.). Systemic racism is therefore discrimination against Indigenous peoples which is inscribed into Canadian institutions and systems, and is often invisible or not directly attributable to a single individual or group. For example, chronic underfunding is one of the key mechanisms through which systemic racism manifests in health institutions and systems. First Nations, Inuit, and Métis communities consistently receive inadequate funding to support the health and wellness of community members, leading to disparities in access to essential health services, receiving lower-quality services, and poorer health outcomes.

The term epistemology refers to knowledge systems, or how knowledge is justified, considered valid, and accepted as 'true'. **Epistemic racism**, therefore, is a type of racism that devalues certain forms of knowledge and certain holders of knowledge (Beagan et al., 2022). In Canada, knowledge is implicitly assumed to come from white Western scholars, researchers, and professionals, and the knowledge held by others (including First Nations, Inuit, and Métis peoples) is often not recognized as equally valid or legitimate (Beagan et al., 2022). Epistemic racism in the healthcare system privileges the knowledge of doctors, researchers, and healthcare professionals (who are often white, or non-Indigenous) over traditional or cultural knowledges held by First Nations, Inuit, and Métis peoples.

4. Rights & Responsibilities

As mental health and addictions services are an important form of healthcare, there are several important considerations regarding the rights of First Nations, Inuit, and Métis peoples to healthcare, and the responsibilities of various levels of government and organizations to provide services. It has become the job of activists and advocates to hold service providers, healthcare professionals, systems, and governments to account for these responsibilities. Some of these rights and responsibilities are outlined below.

4.1 Collective & Individual Rights (Inherent, Treaty, International)

Generally speaking, *collective rights* refer to the right of a group, such as the Canadian general public, or Indigenous peoples living in Canada, to access health care services in Canada. *Individual rights* refer to the ability of individuals to access and be provided equal care, regardless of their race, gender, or identity (Smith, 2002). Individual rights include rights to information, confidentiality, and consent to all procedures or treatment (Smith, 2002). All groups and individuals have an inherent right to equal treatment, and to access the healthcare services of their choosing. In Canada, a number of written and signed agreements enshrine this right in constitutional and case law.

In many regions of Canada, First Nations peoples are guaranteed a right to health through the numbered Treaties, as both the written and oral clauses of Treaties enshrine a right to health for First Nations (Craft & Lebihan, 2022). Where Treaties do not apply, overlapping federal and provincial/territorial legislation ensures all residents have access to healthcare, including the *Indian Act* and the *Canada Health Act*. While there is ongoing advocacy and reform efforts which are working to ensure that all residents, Indigenous and non-Indigenous, receive an equal level of care in practice, the legal right to equal care has been clearly established.

A number of international documents also outline the rights of Indigenous peoples to healthcare. The United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) states, in Article 24, that Indigenous peoples

have the right to traditional medicines, and that "Indigenous individuals also have the right to access, without any discrimination, to all social and health services" (UNGA, 2007). Section 2 of Article 24 also states that Indigenous peoples have an equal right to enjoy the highest possible standards of mental health, and states have a responsibility to ensure Indigenous individuals are able to achieve this. As UNDRIP has officially come into force in Canada as of 2021, the Government of Canada is obliged to ensure the full implementation of UNDRIP, including Article 24.

Similarly, the Truth and Reconciliation Commission of Canada (TRC) pointed to the legacy of subpar and destructive healthcare practices directed towards First Nations, Inuit, and Métis communities in Canada's colonial history. To address ongoing challenges in equity, Call to Action 18 states: "We call upon the federal, provincial, territorial, and Aboriginal [sic] governments to acknowledge the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools, and to recognize and implement the health-care rights of Aboriginal people as identified in international law, constitutional law, and under the Treaties" (TRC, 2015).

Following the 2020 death of Joyce Echaquan,[1] a mother from the Atikamekw Nation in Quebec, Joyce's Principle has been endorsed by the federal government and numerous professional associations across Canada:

Joyce's Principle aims to guarantee to all Indigenous people the right of equitable access, without any discrimination, to all social and health services, as well as the right to enjoy the best possible physical, mental, emotional and spiritual health. Joyce's Principle requires the recognition and respect of Indigenous peoples' traditional and living knowledge in all aspects of health (Joyce's Principle, 2020).

1 Additional information on Joyce Echaquan can be found in Section 6.0.

4.2 State & System Responsibilities

As groups and individuals have the right to receive adequate and equal healthcare, the federal government, provinces, territories, and healthcare professionals have the responsibility to provide that care. The *Canada Health Act* sets out five national principles, those of universality, comprehensiveness, accessibility, portability, and public administration (Government of Canada, 1985). Through these principles, it is clear that the Government of Canada, and the provinces and territories delivering services, have the responsibility to ensure that all residents are able to access equal health care services, and that public health insurance is available to all Canadians. In addition, the racist and assimilative aims of the *Indian Act*, which explicitly assigns responsibility for First Nations' health services to the federal government, have continued to influence the level of care provided to First Nations peoples today (Richmond & Cook, 2016).

Numerous professional associations have released statements acknowledging the existence of, and condemning, systemic racism within Canada's health and social services institutions. This includes the College of Family Physicians of Canada and the Canadian Medical Association, (CFPC, 2020; CMA, 2020). Particularly relevant here is the position statement from the Canadian Psychological Association called *Psychology's Response to the Truth and Reconciliation Commission of Canada's Report*, a position that was also formally endorsed by the Council of Professional Associations of Psychologists (CPA, 2018; CPAP). In addition, in 2019 the Canadian Association of Social Workers issued an official statement of apology and commitment to reconciliation (CASW, 2019). Many of these statements emphasize the responsibility of healthcare professionals to educate themselves, undertake honest self-reflection and dismantle internal prejudice, and advocate for First Nations, Inuit, and Métis patients and families.

5. Current State of First Nations, Inuit, & Métis Mental Health & Addictions

5.1 Mental Health & Substance Use Outcomes for First Nations/Inuit/Métis Peoples

First Nations, Inuit, and Métis substance abuse and addiction as compared to non-Indigenous residents. In 2017, 16% of Indigenous adults reported poor or fair mental health, which increased to 38% during the Covid-19 pandemic (Anderson, 2021). Indigenous youth in particular are more likely to suffer from poor mental health than other demographics, with nearly one in five Indigenous youth having been diagnosed with a mood disorder, and nearly a quarter being diagnosed with an anxiety disorder (Anderson, 2021). These rates were similar for First Nations and Métis youth, while Inuit youth were somewhat less likely to receive a formal diagnosis (which may reflect the availability of mental health care to Inuit) (Anderson, 2021). It is well known that suicide is an epidemic among Indigenous youth, with suicide rates among Indigenous youth being six times higher than those of non-Indigenous youth in Canada (CAMH, 2023). For Inuit youth, this rate rises to 24 times the national average.

Substance use and addictions are also a challenge, as 25% of Indigenous peoples in Canada struggle with addiction, as compared to 17% of the general population (Toth, 2022). In BC, First Nations people are disproportionately represented in toxic drug deaths (14.7% of drug deaths occurred in First Nations individuals, though they represent only 3.3% of BC's population), with the gap widening between First Nations residents and non-Indigenous British Columbians (FNHA, 2021). The history of mental health and substance use challenges among Indigenous populations are firmly rooted in colonialism, as policies and programs such as the dispossession of land, the residential school system, and the separation of Indigenous families and severing of language and culture led to widespread intergenerational trauma. The work of many First Nations, Inuit, and Métis scholars, leaders, and community programs have responded to these harms rooted in colonialism through cultural resurgence as intervention and healing. Today, culture as an intervention has been highly successful in improving the wellness of Indigenous youth and adults (Thunderbird, 2020; ITK, 2019). The work of many First Nations, Inuit, and Métis scholars, leaders, and community programs have responded to these harms rooted in colonialism through cultural resurgence as intervention and healing. Today, culture as an intervention has been highly successful in improving the wellness of Indigenous youth and adults (Thunderbird, 2020; ITK, 2019).

For example, the Native Wellness Assessment, developed by the Thunderbird, has been implemented in over 40 treatment programs and health services, with a corresponding increase in wellness reported from clients and patients (Thunderbird, 2020). Not only is the assessment tool culturally relevant, but assessments using the tool has demonstrated the positive impact of culture as intervention.

5.2 Defining the Current Mental Health & Addictions Systems for Indigenous Peoples

The mental health and addictions system(s) serving First Nations, Inuit, and Métis peoples operates as a piecemeal system divided between federal, provincial/territorial, and community mental wellness funding, programs, and services.

> **"We are a population that has been abused by systems for years and we are asked to go to those same systems to seek help for the damage levelled by those very systems."**
>
> *- Participant, September 18, 2023*

Federal mental health services and programs are delivered to status First Nations and Inuit beneficiaries, leaving Métis and non-status Indigenous peoples largely unable to access these services. Provincial/territorial mental health care services are provided to Indigenous peoples on the same basis as all other Canadians under the Canada Health Act, though perceptions remain that Indigenous peoples are solely a federal responsibility, making these services difficult to access for Indigenous people. Finally, funding to support community-based mental health programs and services is siloed in a way that makes it difficult to develop comprehensive and coordinated approaches to mental wellness services.

As such, this fragmentated mental health system is, at best, a loosely connected patchwork of programs and services with varying degrees of relevance for Indigenous peoples, or at worst, what one participant called "*not a system at all*" (September 18, 2023).

6. Anti-Indigenous Racism in Healthcare

> The evidence is all there for us, if we read, as solutions and recommendations have been on the table since the Royal Commission on Aboriginal People. Our experiences and intersections with these systems and the outcomes and impacts have been well documented. Our health disparities are a known outcome of the systemic racism experienced...We have the highest overdose and suicide rates; we have a population in this region with no hope... Racism is pervasive across systems and a training course is unlikely to correct institutionally indoctrinated beliefs. Until we decolonize systems, we will be at the mercy of systems designed to assimilate us.
>
> *- Survey Respondent*

Anti-Indigenous racism is institutionalized both within and outside of the Canadian health system. In fact, racism has been practised systematically by governments and the broader Canadian society from the very beginning of Canadian history. For example, colonialism required the disruption of Indigenous social, educational and knowledge systems, as well as access to sources of health and well-being such as land, waters, and food systems. This dislocation was enabled by federal legislation such as the *Indian Act*, and maintained through the residential school system, and the Sixties Scoop.

Colonial racism within health service delivery was perpetuated through legislation and policy. For example, provisions within the *Indian Act* allows the government to provide "medical treatment and health service" and "compulsory hospitalization and treatment for infectious diseases" (R.S.C. 1985, c. I-5). In the 20th century, this led to the establishment of 'Indian Hospitals' (also known as sanitoriums) to presumably treat Indigenous peoples with certain diseases and ailments, though in reality, these were utilized to achieve assimilation and isolation. These hospitals were underfunded, understaffed, often with poor sanitation and overcrowding (Kelm 1998).

Admission to these hospitals frequently happened through coercive means, and patients were not told where they would be going, or how long they might be gone – which could be anywhere from two to fifteen years. The hospitals were also sites of medical experimentations and sterilizations (Lux 2016).

It should then come as no surprise that this legacy of racism within health service delivery persists to this day. The cases of anti-Indigenous racism within healthcare that have made it to the public, usually through the news or social media, are horrifying: Brian Sinclair passing away in a Winnipeg emergency department after waiting 34 hours for treatment because the staff assumed he was intoxicated (Brian Sinclair Working Group 2017); Keegan Combes of Skwah First Nation (BC) passing away at age 29 after being delayed diagnosis and treatment from an accidental poisoning in 2015 (FNHA 2022); Joyce Echaquan, an Atikamekw woman and mother of seven, died after seeking medical care for stomach pains.

Ms. Echaquan live streamed the racist treatment she was receiving by hospital staff and passed away shortly after. These are examples that have made it to mainstream consciousness; we know there are innumerable examples that never get reported, in either the media or to authorities, or are reported and are ignored or denied.

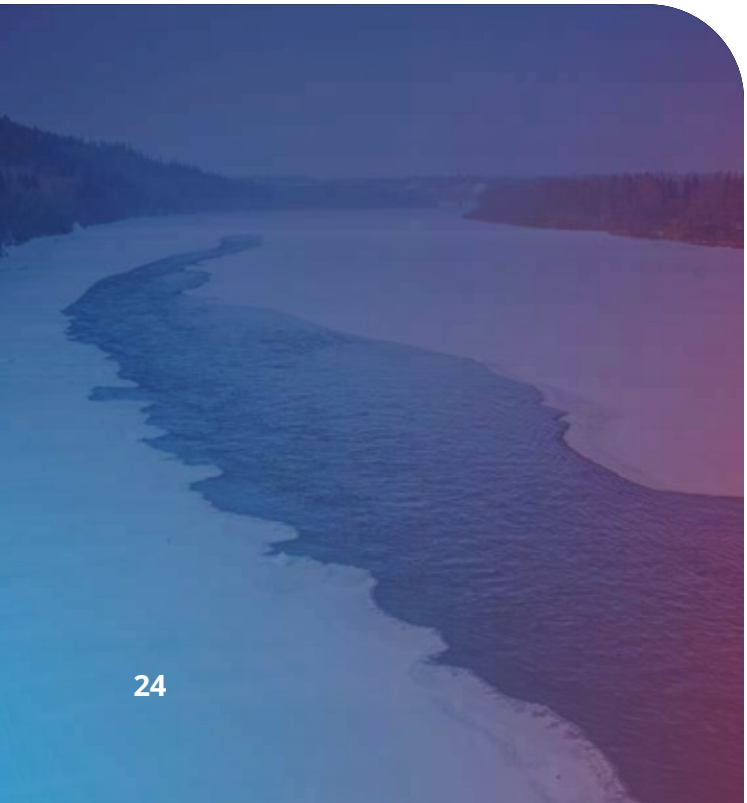
"I would say things are getting worse. Getting worse in that there are services in urban environments, which people automatically interpret as being available and accessible to Indigenous populations. But just because it's in an urban environment does not mean that it is actually in reality available and accessible to Indigenous people. And some of those barriers to availability have to do with systemic racism.

Some provinces have governments that don't believe in harm reduction. And so, they'll make services available, but they're on the other side of the city, and populations of people who use drugs and could benefit from those harm reduction services, live in poverty, and they have no housing, or they're couch surfing, they have no food security. So where is the transportation going to come from to get to the other side of the city to access those harm reduction services?

- Participant, September 22, 2023

Despite these high-profile cases and many public statements from politicians and health leaders condemning anti-Indigenous racism in health care generally, participants in our roundtable series, in general, provided a lukewarm assessment of the progress within mainstream systems in addressing anti-Indigenous racism. Reflective of this general sentiment, one participant shared:

> *They do a lot of performative things to make it seem like they are doing the work, but on the ground, there [are] continued racism, stereotypes, and assumptions that [are] built into the education and health systems that have not been properly addressed. There is lots of "box checking", but no real transformative change* (Participant, September 18, 2023).



Another participant shared a similar frustration around the lack of implementation, even once Indigenous people have done the work of developing resources and provided a path forward. They shared:

> *What I would say has improved is that there are more resources from leaders like the Thunderbird and FPWC… What's maybe not improving is that those resources aren't being implemented within the systems as much as they should be. And that the systems also remain predominantly problem focused, rather than solution focused. So just a continuation of like, Western approaches rather than like utilizing those traditional approaches more and utilizing the different resources that are being created by Indigenous folks.* (Participant, September 22, 2023).

6.1 Anti-Indigenous Racism in Mental Health & Addictions

This project sought, in part, to generate a better understanding of the ways in which anti-Indigenous racism shows up in mental health and addictions spaces specifically. What we heard from participants is that racism emerges in both structural, epistemic, and interpersonal ways.

6.1.1 Absence of Services is Racism

One dominant theme of the feedback includes the perspective that the persistent underfunding or lack of provision of adequate mental health and addictions services, along with the consistent jurisdictional wrangling over responsibility for Indigenous people, is itself a manifestation of racism. For example, one participant shared the example of seeking treatment for substance use for her daughter. She noted:

> **For two years I've been trying to put her, get her into rehab, trying to find all the supports for her. And then when I can get her into the emergency department, she's ready to go. But we're sitting around for hours. I don't know if because we're First Nations or if it's because she's an addict... But by the time I sit there with her for three, three hours she gets agitated. So, like I'm forced to take her out, so she doesn't upset the rest of the people sitting in the waiting room**
>
> *- Participant, September 19, 2023*

We also heard about how, when people can access treatment centres, they often relapse after leaving, because there is little to no aftercare.

6.1.2 Hiding Behind Jurisdictional Ambiguity

Participants shared that federal and provincial governments, as well as health systems, continue to utilize supposed jurisdictional confusion and ambiguity to skirt responsibility for the provision of adequate mental health and addictions services. One person shared:

> **...Governments themselves don't comply with the Canada Health Act, which says that every citizen – or what is provided to every person who lives in the province should also be available to First Nations. So, the Canada Health Act does not say, because First Nations people have distinct rights, that erases all of their rights under the Canada Health Act. There's nothing in the Act that says that. And so, provinces ignore their fiduciary responsibility to ensure that every person in the province, that they already receive money for, is then also provided available services that are relevant to their needs, and that they're accessible to their needs.**
>
> *- Participant, September 7, 2023*

The experience of care being denied based on a misunderstanding of legislative and constitutional responsibility was common amongst our roundtable participants. One shared:

> *There are places in this country where you're told "you're First Nations. We can't provide those services for you. We can't provide access to those harm reduction kits. We don't have enough money to give them out to First Nations. Go back to your reserve and get them" – well that's racist. That's racism at a systemic level* (Participant, September 22, 2023).

Another participant shared that First Nations people in their area who usually reside on reserve are being denied aftercare (post-substance use treatment) because they are not considered residents of the province (September 19, 2023).

6.1.3 Colonialism via Funding Policies

In addition to the racism reflected by the persistent lack of available and appropriate mental health and addictions programs and services, participants identified ways in which the terms and conditions of existing programs perpetuate the colonial logic of divide and conquer, which continues to hurt Indigenous peoples. For example, one roundtable participant shared that:

> **Due to federal funding for the Mental Health & Wellness and NNADAP programming, the system prevents us from providing services to those of our members who live off reserve. Continuing the practice of, "we will give you some resources but not what you really need or are entitled to". We've become the agents of oppression toward our own.**
> *- Participant, September 19, 2023*

We also heard that funding terms and conditions prevent communities from providing supports to community members – even those that are Indigenous – that are not registered band members. This indicates that these programs are not based on principles of justice, equity, or Indigenous rights, and instead continue to contribute to the ongoing colonizer/colonized dynamic in Canada.

6.1.4 Racism Generates Avoidance

Navigating complex mental health and addictions systems can be very difficult for people on their best day. Roundtable participants shared that navigating these systems for people experiencing mental health and substance use challenges is a huge barrier to care. We heard that these barriers are so profound, these programs and services may as well not even exist for Indigenous people in crisis. Layered on top of this is people's experiences with, or fear of, racism within mental health and addictions programs and services. One participant shared:

> *Indigenous people are worried about and avoid healthcare due to racism, but this impacts health outcomes. People blame themselves for not going* (Participant, September 12, 2023).

The result is that people in need are simply not accessing the limited programs and services that are available.

> **Nothing's going to change if we keep the status quo, or if we just move an inch. We're way past that inch. There's lots of tension and animosity and anger that has built up, and the only way we're going to do it is by making bold moves that demonstrate a commitment to trust and respect.**
> *- Participant, September 7, 2023*

6.1.5 Racism Leading to Poor Care

The roundtables revealed significant concerns that anti-Indigenous racism related to substance use negatively impacts the quality-of-care Indigenous patients receive. We heard one participant share that, after falling on ice and suffering a laceration and a concussion, hospital staff suggested she was under the influence of alcohol. Further, the staff refused her painkillers when closing her laceration (Participant, September 7, 2023). Her experience of medical staff refusing painkillers was shared with other participants of the roundtables. One person shared:

> **People that need it [painkillers] should be able to access it, not fear it. And I think that the pendulum swings too far with that because some of the prescribers... won't prescribe pain medication for people that are First Nations. [They say] "you can handle this pain. You have a high pain threshold. You don't need drugs!" or "Oh no. We don't want to give that to you." It doesn't seem to be based in a medical model.**
>
> *- Participant, September 18, 2023*

Simply, the pervasive narrative within healthcare systems of Indigenous peoples as addicts has led to situations where Indigenous peoples have been denied the appropriate use of pain medication. These instances further erode trust between providers and Indigenous patients.

7. The Way Forward (Recommendations)

Throughout the engagements on this project, a distinct tension emerged related to the way forward. Participants recognized the need for meaningful and immediate changes to the current mental health and addictions systems to address the racism that First Nations, Inuit, and Métis people are facing every day across Canada. At the same time, what emerged was a general sense that eliminating anti-Indigenous racism within mental health and addictions spaces requires a fundamental re-think of the current systems as a whole, and indeed a much larger societal shift that seeks to rebalance the unequal relationships of power between Indigenous and non-Indigenous peoples.

The vision for the future that we heard from roundtable participants, and what is reflected below, seeks to offer insights and recommendations on both of these tracks. Further, the insights and recommendations below are not to be understood as a menu of options for systems to determine which to implement because, as we heard, healthcare systems have tended towards the implementation of actions that are perceived as easier and less impactful. Rather, the insights and recommendations below should be viewed as the foundation, or the ground floor, for generating safe and adequate mental health and addictions systems of care for Indigenous peoples.

7.1 System Transformations

The roundtables identified several opportunities to make meaningful and sustained changes within current systems to prevent, reduce, and respond to anti-Indigenous racism. These insights are noted below.

7.1.1 Anti-Racism Education & Training

In general, roundtable participants expressed frustration that weak cultural competency and awareness trainings have been launched across the country as a way to quell criticisms about anti-Indigenous racism. We heard that the available trainings are not engaging, ineffective, and fundamentally incapable of addressing the power imbalances within systems and society that are at the root of inequality and racism. There was, however, an understanding that anti-racism education and training is necessary.

> **"...Education just about the negatives creates a worse narrative and a worse situation because then they all think that we're about our deficits, and that's it."**
>
> *- Participant, September 18, 2023*

Based on the roundtable discussions, meaningful education and training moves beyond the paradigms of 'awareness' and 'competency' and instead towards understanding and confronting white supremacy, colonization, including gendered impacts, and racism. Alongside a critical interrogation of the systems of power that continue to oppress Indigenous peoples, should be sharing of **strengths-based perspectives**. As one participant put it, we "*need to move from death, diseases, disability to strengths-based approaches based on language, land, culture*" (Participant, September 12, 2023). Within a training setting, this requires a deeply relational practice where health systems generate and maintain relationships with Indigenous organizations, communities, and Nations to co-develop and deliver tailored **local content**. Systems must also recognize that participating in and supporting in this way requires the provision of **capacity supports** to local organizations.

We also heard of the need for anti-racist education and training opportunities to include content around **intersectionality**, such as the unique and specific ways that Indigenous peoples with various identity factors experience racism and colonialism. For example, we know that colonialism has worked to separate Two Spirit and LGBTQ people from their traditional sources of identity and significance within Indigenous communities. As such, 2SLGBTQ folks experience discrimination based on both their sexuality and their Indigeneity. Roundtable participants also expressed the need for training opportunities to account for the unique barriers and discriminations faced by both urban Indigenous people and those living in rural and remote communities. Essentially, training must be able to surface these different experiences with discrimination to train healthcare workers on how to act differently.

Finally, we also heard for the need for ongoing accountability and commitments to life-long learning within healthcare settings. One participant shared, "*[h]ow do we monitor cultural competencies over time? Being culturally competent is a lifetime commitment that requires constant attention*" (Participant, September 12, 2023). This points to the need for **on-going and mandatory training** opportunities with outcomes tied to career advancement. This could be accomplished by including considerations for cultural learning and anti-racism within annual performance reviews. A roundtable participant exemplified this perspective in stating,

"*[t]here should be an expectation in systems that training is mandatory, and it should be followed up on in performance evaluation as an expectation of quality care*" (Participant, September 18, 2023).

Additionally, systems must undergo **ongoing evaluation and monitoring** of their performance related to anti-Indigenous racism by outside Indigenous-led agencies. Indicators of success should be co-developed by local Indigenous people, communities, and organizations. Results should be published with regular reports on anti-Indigenous racism incidents, investigations, and outcomes while respecting privacy and confidentiality.

> **"...There are nearly 1000 recommendations, Calls to Action, Calls to Justice through all of these reports. Our peoples have done all of the work up until up until this point, and it really is on settlers and settler systems to really be picking up that work and doing that work.**
>
> **And I totally agree, we need to still be walking alongside, so we still have to be walking together within that work, but I just think about... it's on the backs of Indigenous peoples to have to eradicate Indigenous specific racism within our healthcare systems, and it's not our work.**
>
> **It's not our work to undo colonization. That's settlers and settler health system's work."**
> *- Participant, September 18, 2023*

7.1.2 Self-Determination within Transformation

As mentioned above, First Nations, Inuit, and Métis communities and organizations must play a central, decision-making role in the transformation of systems to better support Indigenous wellness. However, roundtable participants shared that, to date, their participation was not accompanied by meaningful funding and capacity supports. Generally, the expectation is that this work can happen off the side of people's desks. Given the already-limited capacity of communities and organizations, this model is untenable and, frankly, a reflection of implicit racism.

In speaking of their experience where Indigenous organizations were asked by a mainstream provider to participate in a project, one participant noted that the lack of capacity supports effectively excludes Indigenous participation. They shared:

> *Part of the challenge around racism is that there were no resources for any of our Indigenous organizations to have representation there. … Who is there advocating for things to be better? No one advocates for resources for Indigenous people to sit at those tables. It happens in all areas. They should know better by now. If the cats away, the mice will play. Exclusion is racism. Them not considering that Indigenous people should be there despite decisions are being made for the Northern regions and for on-reserve. It is easy for them to go ahead if there is nobody there* (Participant, September 18, 2023).

Simply, the inclusion of Indigenous peoples and organizations in generating safe and comprehensive mental health and addictions systems is required, and that inclusion must come with adequate and sustained capacity supports to participate meaningfully.

7.1.3 Accountability and Justice

Our roundtable participants in general felt that there is little accountability and justice within mental health and addictions systems when Indigenous people experience and report cases of anti-Indigenous racism. For example, one participant shared:

> *Incident reporting services also re-traumatizes Indigenous people. Even if they initially report mistreatment from an institution, it usually requires follow-up with said institution and that alone deters people from following through with their complaints. Or the incidents are handled 'internally' and are just brushed under the rug* (Participant, September 18, 2023).

Indigenous-Led Processes

In contrast to current practice, participants identified the need to build systemic responses to complaints of racism and discrimination that are led by and for First Nations, Inuit, and Métis peoples. This could include the development of an Indigenous oversight body comprised of Indigenous healthcare professionals, community representatives, Elders, and Knowledge Keepers. This group should have decision-making authority and oversee the accountability process.

It must also include meaningful engagement and relationship building with local Indigenous communities and organizations to understand their needs, expectations, and priorities within a complaints process. Reporting mechanisms and supportive pathways must be clear, known, and confidentiality must be ensured. Investigations must be transparent, and Indigenous-led to ensure remedies are appropriate and meaningful for the person and community subjected to the racism and discrimination. Several participants also noted the potential of the development of an ombuds position to receive complaints and conduct investigations. Finally, space must be created for First Nations, Inuit, and Métis-led restorative and healing practices that seek to provide justice to the victims, meaningful consequences for the perpetrators, and learning opportunities for the system.

Involvement of Regulators

Roundtable discussions also revealed an interest in involving regulators and licensing bodies in ensuring professionals are trained in and adhering to practices of cultural safety and anti-Indigenous racism. For example, this could include requiring training as part of licensing requirements, as well as annual reviews as part of the existing self-assessments that psychologists and other mental health professionals are required to perform (Participant, September 7, 2023).

Accountability Process Evaluation & Reporting

As mentioned above, **system performance in anti-Indigenous racism should be regularly evaluated and reported on**. Specific to complaints processes, systems should solicit feedback from Indigenous communities to evaluate the accountability process and ensure it is meeting its goals and expectations, and then use this feedback to continuously improve and adapt the process.

7.1.4 Indigenizing Education & Training

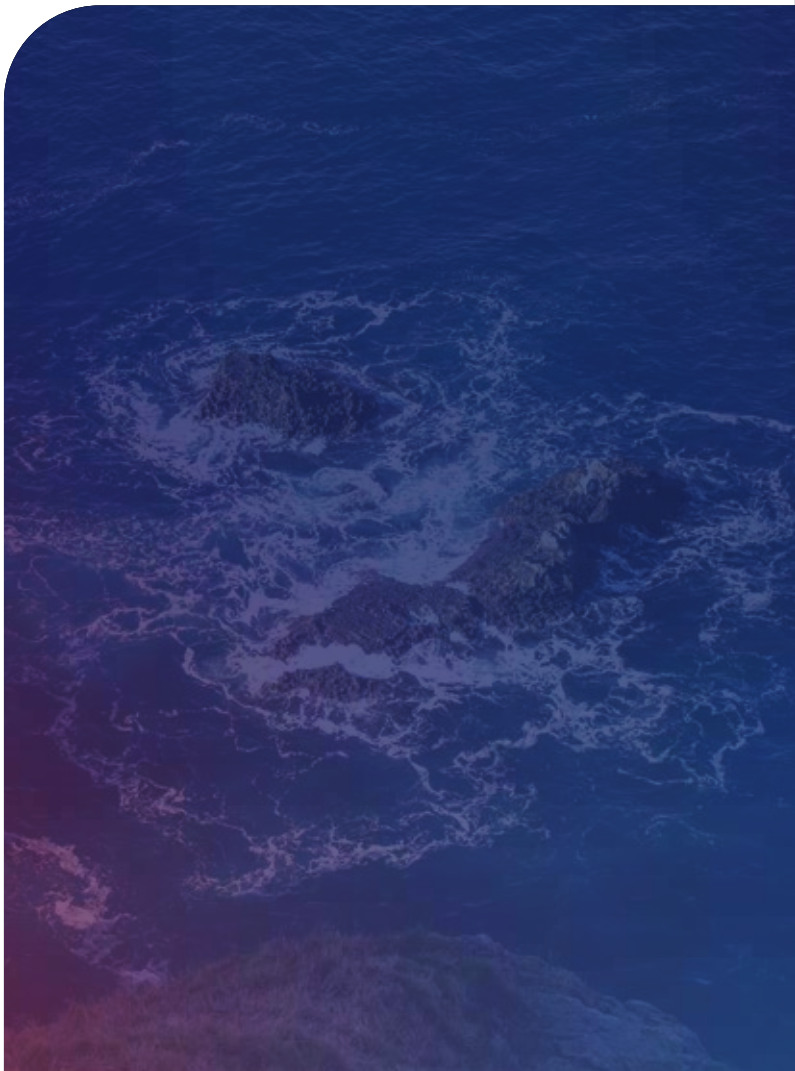
The need to develop and deliver meaningful education and training on anti-Indigenous racism within care systems has already been highlighted. However, we also heard for the need to fundamentally challenge the foundation of the curricula delivered through education and training systems. These systems work to reify and validate Western knowledge and worldviews as correct, and at best see First Nations, Inuit, and Métis ways of being as novel and quaint. Increasing the number of First Nations, Inuit, and Métis students in this kind of hostile environment is not a sustainable solution.

The current widespread unwillingness or inability to critically interrogate the assumed superiority of Western methods and meaningfully include First Nations, Inuit, and Métis knowledges within education and training settings for caring professionals is reflective of ongoing, if implicit, epistemic racism.

Increasing numbers of First Nations, Inuit, and Métis peoples within helping professions requires dismantling Western-centric curricula and generating instead curricula that is culturally relevant and safe, and values equally the insight, contributions, and wisdom of First Nations, Inuit, and Métis ways of knowing, being, and doing. In addition, learners must have access to First Nations, Inuit, and Métis scholars, mentors, and community leaders/Elders to support their training, so that they have access to cultural knowledge related to mental wellness and substance use. As with all the recommendations, **education and training institutions must meaningfully work with local First Nations, Inuit, and Métis communities and organizations to ensure curricula are also valuing and centering Indigenous knowledges, and developing pathways within institutions to support First Nations, Inuit, and Métis learners in building culturally rooted expertise.**

7.1.5 Recruitment & Retention of Indigenous Staff within Mainstream Systems

Throughout the engagements, we heard from Indigenous people working within mainstream healthcare settings who reported feeling tokenized, unsafe, and overworked. This fact makes recruitment and retention of First Nations, Inuit, and Métis staff very challenging. Roundtable participants identified several promising practices or considerations for mainstream systems seeking to expand their Indigenous workforce.



Several of these key insights include:

- **Cluster hires** to mitigate the risk of tokenization by the reliance of one or two Indigenous people within the system. By hiring in a cluster, Indigenous staff can turn to each other for support.
- **Establish partnerships** with local First Nations, Inuit, and Métis communities and organizations to support the development of and help facilitate recruitment of Indigenous candidates.
- **Pay equity** for Indigenous staff that accounts for experience and knowledge gained outside of mainstream post-secondary environments, such as cultural and ceremonial knowledge.
- **Evaluate workloads** of Indigenous staff to ensure compensation matches the level of effort and prevent burn-out by aligning workload with the number of staff positions.
- **Develop leadership training and mentorship programs**, in partnership with local Indigenous communities, to develop current and future generations of Indigenous leaders in the mental health and addictions space.

7.1.6 Increasing Access

As noted earlier, it is racism that allows the lack of services in mental health and addictions available to First Nations, Inuit, and Métis people to persist in Canada. Further, current service delivery models that do not account for Indigenous realities are, in effect, inaccessible to Indigenous peoples. One Indigenous care provider shared:

> *…The service delivery models often don't really consider that aspect of access. When your healthcare provider is hours away, boat rides away, float planes away, or 12-hour dirt roads away. When they also don't think of culturally safe and appropriate resources and spaces and individuals for First Nations, and they often don't think outside the box when providing services differently. And so really being creative to reach Indigenous populations instead of saying to the population, "I'm situated here in an urban center and you need to come to me," and then leaving it up to that person. So, we really need to think differently and how we could reach them. Instead of them reaching us* (Participant, September 19, 2023).

This points to the need for increased programs and services offered in a manner that reflects the needs, priorities, and realities of First Nations, Inuit, and Métis communities, no matter where they reside. As with many of the recommendations within this report, this starts through the developing and nurturing meaningful relationships with Indigenous communities and organizations in an effort to **co-design mental health and addictions programs and services**. This also requires **long-term, adequate, and stable funding** to support these programs.

> In terms of being solution focused instead of problem focused – I just love that. I've seen a lot of young people are just not interested in these reductive labels that confine them to one singular identity and erase or silence every other piece of who they are... If we're focusing [only] on mental health and [only] addiction, we're silencing every other aspect of that young person's identity, culture, and background and their history and their future. And so, ascribing some of these terms and some of these programs and spaces, I think, can be really limiting and unproductive. And that's when we find young people stepping away from these systems and trying to create their own systems of support and their own networks out of community that are out of reach of systemic violence and racism...
>
> *- Participant, September 22, 2023*

7.1.7 Service Standards

Numerous roundtable participants noted the potential offered by **the development of Indigenous mental health and addiction service standards that clearly outline the level of performance that First Nations, Inuit, and Métis people and communities can expect to receive**. These benchmarks will be useful to better hold systems to account in delivering safe and comprehensive mental health and addictions programs and services. Though standards may evolve over time and may differ between regions or Nations, some key elements that may be important to include in service standards for First Nations, Inuit, and Métis mental health and addictions

programs include cultural safety, holistic approaches and recognition of traditional healing practices, program development grounded in Indigenous self-determination, trauma-informed care, culturally relevant assessment and treatment plans, culturally relevant and safe data collection and evaluation, and equitable and accessible services, regardless of location, socioeconomic status, and legal status (via the *Indian Act*).

7.1.8 Assessing Strength & Centering Indigenous Knowledge & Practices

Part of challenging anti-Indigenous racism within mental health and addictions settings is centering Indigenous knowledge and practices within assessment, treatment, and service delivery broadly. The roundtables revealed several opportunities for this paradigm shift including centering strengths, developing Indigenous and community-specific tools, enabling holistic practice, and strengthening First Nations, Inuit, and Métis research.

Strengths-based, Indigenous-Specific Assessments

Currently, systems tend to focus on deficits. This risks setting up First Nations, Inuit, or Métis people in a sort of 'self-fulfilling prophecy'.

For example, we heard:

> *Indigenous people carry a lot of complex trauma that stems from residential school, and a lot of our issues are from disconnection from our culture, land, and sense of self. If we keep being assessed under Western standards, I think a lot of our people will internalize something is "wrong" with them and will perpetuate a cycle of helplessness. A lot of diagnoses are "symptoms" of the bigger issue - our complex trauma & disconnection. So, with meds and therapy, it's usually treating the "symptom" and not the whole picture - the root* (Participant, September 18, 2023).

Another participant conveyed what is at stake when assessments focus only on deficits. They shared:

> *We have a self-reported sexual abuse rate of 80%. So that says a lot about how impacted our people are, how much trauma they've gone through. So, I think one of the things that happens, you know, from standardized assessments is [what it] shows are really terrible. They're really bad. We have terrible health outcomes in a plethora of areas. I think that's what those mainstream assessments tell us* (Participant, September 18, 2023).

Government and systems enforce the use of these problematic assessment practices through policies and procedures. We heard from one psychotherapist, "*[w]e quickly diagnose and assess folks for them to be able to access services… a lot of services cannot be accessed unless there is a diagnosis, and the assessment has been done. And that's harmful because it might not be done in the way that it should be*" (Participant, September 22, 2023).

In contrast to these problematic assessment models, roundtable participants envisioned **strengths-based and culturally relevant assessment tools** that consider the individual within the context of their whole life, including the social determinants of health. One participant shared:

> *I think we need to reconceptualize that and look at what we are good at, what strengths we have, how we haven't been destroyed by the attempts to get rid of our culture and our existence. You know, it's reframing our strength of survival into that narrative and kind of helping people see that in themselves. And they use that to get well again and to find that balance* (Participant, September 18, 2023).

Assessments that can build understanding of the complex and dynamic lives of Indigenous peoples living within colonial Canada will move beyond individualistic pathologizing and consider each person's lived reality that includes rights and legal status, Indigenous social determinants of health, resilience and skills, cultural knowledge, and family and community connections, among many others. Accomplishing this requires:

- Funding and opportunity for First Nations, Inuit, and Métis scholars, experts, organizations, and communities to co-develop these tools;
- Commitment from relevant professional associations at the national and provincial/territorial levels to push for implementation of these assessments; and,
- Health, government, and insurance organizations to mandate use of the culturally relevant, safe, and appropriate assessment tools that match the needs of each person seeking assessment.

7.1.9 Enabling Holistic, Culturally Relevant Practice

In addition to assessments, we heard that current treatment modalities should be replaced and/or augmented with First Nations, Inuit, and Métis-specific treatment practices, aligning with the needs of the patient. For example, one participant shared:

> *Many of the mental health treatment modalities (cognitive behavioural therapy, dialectical behaviour therapy, interpersonal therapy, narrative therapy, etc.) may not be culturally appropriate or safe for Indigenous people. Cognitive behavioural therapy is a commonly used treatment modality to treat depression and anxiety and there is currently no culturally adapted model for Indigenous people as we would find for [other] racialized minority groups... Most of the treatment modalities have not been evaluated for their efficacy with Indigenous people* (Participant, September 7, 2023).

These may include traditional healing practices, land-based practices, cultural reconnection, story-telling and oral traditions, family and community-centred care, holistic approaches that address the social-determinants of health, and healing-centred care.

Just as with assessments, holistic, culturally-relevant treatment modalities requires dedicated and sustainable supports. This includes:

- Enhanced funding for First Nations, Inuit, and Métis scholars, experts, organizations, and communities to articulate, implement, and evaluate Indigenous treatment modalities; and,
- Opportunities to write about and elevate these types of treatment practices as valid forms of knowledge and evidence.

7.1.10 Indigenous Research

> **Data doesn't need to be gathered in an extractive way. It can be through conversations, through time spent, through consensual sharing circles. Looking at it as "what can we learn from the people in our communities" as opposed to just having folks tick boxes. Or worse, ticking boxes for them.**
>
> *- Participant, September 19, 2023*

Another site where epistemic racism is enacted is through Western-based research in mental health and substance use. This research reinforces unequal relationships of power between Indigenous peoples and non-Indigenous researchers/systems, risks appropriating Indigenous knowledge, reinforces stereotypes, and has little cultural relevance or community benefit. This perspective was widely shared by roundtable participants. One noted, "*the colonizers used our stories, our voices against us to define, to understand, to destroy the value and power of our knowledge*" (Participant, September 18, 2023).

Despite these reservations, participants recognized the value of high-quality, ethical data. One participant shared:

> *We need more information. […] There's a lot of anti-research sentiments in our communities, but we do need more data because… where I work there's no data. So, it's hard for me to argue with people that there's racism… because data doesn't exist… Even though I think that's what's happening. I don't have any way to prove that to the decision makers* (Participant, September 18, 2023).

Further, the fear of what is happening in the absence of meaningful data is common. One participant noted,

> *I know in Ontario that's very clear. They don't have data. They don't have a strategy yet. They don't have identity-based data sorted out. They are really kind of in their infancy in that space right now. So, I think it's scary that they might be using what little data they have to make any decision right now* (Participant, September 18, 2023).

As such, several roundtable participants advocated for **increased support for First Nations, Inuit, and Métis-led research** to support all areas of mental health, wellness, and substance use policy and programming, as well as understanding and monitoring anti-Indigenous racism within these spaces. Indigenous communities and organizations should be leading these efforts based on their own ethical principles and cultural values.

The roundtables also revealed the need for **First Nations, Inuit, and Métis-led program evaluations** grounded in Indigenous research practices, with accountability back to the people and communities these programs serve.

One participant shared:

> *There needs to be Indigenous develop evaluations of any programs, because that accountability should be back to us, not Treasury Board because Treasury Board has their own set of accountabilities and values. And those values have not always worked for us. For the most part they haven't because our communities are facing ongoing assaults from colonialism… And we're just we need to stop and try to figure out ways that we can do the things that…rebuild our Nations… what are things that are meaningful in our community? How can we collect that information in a good way that acknowledges and is responsive to our communities?* (Participant, September 18, 2023).

The First Nations Information Governance Centre (FNIGC) was identified as a best practice in advancing First Nations ethical research, and that similar models should be supported in provinces and territories across Canada, as well as similar Inuit and Métis models to meet their specific needs (Participant, September 18, 2023). However, these significant and important projects cannot be done without significant capacity support from relevant governments and health delivery organizations.

7.2 Resistance & Reclamation

Throughout this project, participants shared what they view as the sources of the challenges currently facing Indigenous peoples when it comes to mental health and substance use. At the core of these challenges is the forced disconnection of First Nations, Inuit, and Métis people from, "*our culture, land, and sense of self*" (Participant, September 18, 2023). In response to the spiritual crisis rooted in colonialism, one participant shared a vision of the future that was shared by many within our roundtables. They said:

> *My dream world is not [focused on] eradicating racism within the healthcare system or within the education system. My dream world is stepping outside of that and allowing or creating space and funding and opportunities for Indigenous children, youth, and Elders to come together and build that up themselves* (Participant, September 22, 2023).

A survey respondent added:

> *The answer is ultimately land back and reparations for what happened and continues to happen. That there's an interconnectedness with mental health, stolen land, genocide, MMIGW2S, missing and murdered Indigenous men, child protection and removing of children, residential school, Sixties scoop, etc. These issues cannot be seen as separate. The core will always come back to removing us from the land and everything else that followed. This is what is causing all the social issues Indigenous peoples face.*
> (Survey Response).

Essentially, **responding to the contemporary mental wellness and substance use challenges of First Nations, Inuit, and Métis people today requires reclaiming places, ways of knowing, and systems which are the sources of strength, and provide hope, meaning, belonging, and purpose** to Indigenous people, families, and Nations. This includes supporting cultural resurgence, accounting for the Indigenous social determinants of health (SDOH), creating opportunities to practice deep relationality and generating collective strength, and generating Indigenous-led, holistic, and comprehensive continuums of programs and services to support individual, family, and community well-being.

7.2.1 Accounting for the Indigenous Social Determinants of Health (SDOH)

The connection between individual and collective mental wellness outcomes and the Indigenous SDOH is profound. This includes interconnected cultural, historical, environmental, and socio-economic factors such as income and socio-economic status, access to housing and food, physical environments, access to education and information, social support networks, and individual and collective self-determination, among others. As such, generating positive mental wellness outcomes requires creating conditions within Indigenous communities, whether it be urban, rural, or remote, for people to live lives of hope, meaning, belonging, and purpose.

The centrality of attending to the Indigenous SDOH in mental health and addictions was highlighted numerous times within the roundtables, including several mentions of housing specifically. For example, in speaking about supporting people who use substances, one participant noted, "housing is imperative, we can't expect people to stabilize their health with no place to really call home" (Participant, September 22, 2023).

Ways in which governments (federal/provincial/territorial/municipal) must **support the SDOH of Indigenous people and communities** includes working in partnership with Indigenous communities in support of the recognition of Indigenous rights to self-determination, equity in resource allocation, employment and economic development, culturally-relevant holistic health and social services, language, culture, and education initiatives, safe and adequate housing and infrastructure, and food security, among other areas.

7.2.2 Practicing Relationality & Generating Collective Strength

A throughline that undergirded much of the roundtable discussions was the centrality of the principle of relationality in all responses to anti-Indigenous racism, and in cultural reclamation efforts. At its core, relationality is an understanding of the interconnected and interdependence of all things. This implies a deep responsibility to one another and thus reciprocity in building and maintaining collective wellness. This points to the value of identifying opportunities to come together to build collective strength. In particular, roundtable participants noted the potential of communities of practice.

One participant noted:

> **Physicians have a national association, midwives have a national association, dentists, pharmacists …The same cannot be said for psychologists; there is no national Indigenous psychologist's association. And there's only 25 registered Indigenous psychologists in all of Canada, that is actually really crazy to think about it… Those associations, what they're there to do is to support and mentor our young people going through these programs to be able to assist them and I think having these associations is one avenue that it may not necessarily be around equity, but I think it begins to bring people into our professions in a way that allows us to push for equity"**
>
> (Participant, September 7, 2023).

Collective voices are also vital to advocate for pay equity for Indigenous people working in the mental health and addictions sector. For example, one participant noted that, "*the lack of wages for the workforce is interpreted as a lack of quality and credibility, so the workforce has low self-esteem. We have a workforce, we know they have low self-esteem, but they're responsible for providing mental health and addictions services*" (Participant, September 7, 2023). This group could also drive the development of First Nations, Inuit, and Métis-specific standards of care, among other important tasks.

Given this feedback generated in the engagements, **support for a national association that gives collective voice for the First Nations, Inuit, and Métis mental wellness workforce is clear. To launch such an organization, significant and sustained funding support is required from federal partners.**

7.2.3 Supporting Cultural Resurgence

As mentioned previously, culture is the foundation and sources of strength for First Nations, Inuit, and Métis peoples. Throughout the roundtables there was also consensus on the idea that culture is medicine, and culture is healing when it comes to mental health and substance use. As such, the way forward includes **supporting cultural resurgence efforts both directly and indirectly related to mental health and addictions programming.** This may include language revitalization, land and waters-based practices, cultural practices, intergenerational learning (Elders and youth), invigorating traditional governance and accountability measures, and environmental stewardship, among others. Given the moral, legal, and Treaty responsibilities identified in Section 4, federal and provincial/territorial governments in Canada have clear obligations to support these efforts.

7.2.4 Supporting Distinctions-Based, First Nations, Inuit, & Métis-Led Continuums

Addressing mental wellness for First Nations, Inuit, and Métis peoples requires fundamentally transforming relationships of power between Indigenous peoples and Canada, including in the ways in which governments do business, so that First Nations, Inuit, and Métis people and families, regardless of culture, geography, age, gender, or ability, have access to a holistic continuum of Indigenous-led, culturally-safe, integrated programs and services. As roundtable participants expressed, this means **building a continuum of care system that is defined, developed and implemented by First Nations, Inuit, and Métis peoples themselves.**

First Nations

The First Nations Mental Wellness Continuum (FNMWC) Framework (2015) presents this vision for a coordinated, comprehensive approach to First Nations mental health and addictions programs and services, and practical steps towards achieving that vision, including:

- Culturally-grounded community development and capacity building that reduces risk factors and increases protective factors;
- Comprehensive, coordinated, high quality, culturally responsive mental wellness programs and services for First Nations; and
- Sustained commitment and collaboration of many First Nations, federal, provincial, and territorial partners supported by strong leadership and flexible funding.

Acknowledging that a distinctions-based approach is needed, the FNMWC provides a framework for how First Nations can work to enhance service coordination and support culturally safe delivery of services – and Inuit and Métis peoples must also define this continuum of care for themselves.

Inuit

Though Inuit participation in this project was limited (see Section 2.4: Limitations), Inuit groups have well established mental health and substance use priorities related to the development of a continuum of care comprised of Inuit-led programs and services. The 2016 National Inuit Suicide Prevention Strategy (NISPS), developed by Inuit Tapiriit Kanatami (ITK), is a comprehensive strategy seeking to prevent suicide across Inuit Nunangat through the development of coordinated prevention efforts at the community, regional, and national levels. The NISPS describes a continuum as "includ[ing] universal prevention; targeted prevention to build resilience in groups that may be at risk (e.g., youth, or those involved in the legal system); crisis intervention services for those facing acute stress and mental distress; and interventions for those with high or imminent risk for suicide" (ITK, 2016). In addition, NISPS embeds the development of this continuum within the context of community control and cultural grounding. For example, the strategy notes:

> *Inuit knowledge is a source of strength that can foster resilience and contribute to suicide prevention. We know that efforts intended to help our communities often fail when they are not guided by local knowledge and expertise. Inuit regions, communities and local organizations must lead the development and implementation of specific suicide prevention initiatives in order to ensure that they are successful* (ITK, 2016).

Métis

There was broad support amongst the Métis engagement participants for the notion of Métis-led continuums of care. Though there is not an established national model analogous to the FNMWC framework for Métis, participants flagged several areas where a continuum for Métis people may be unique. For example, we heard descriptions of Métis people falling through the cracks in terms of access because of a lack of understanding by provincially-funded programs around eligibility, and near exclusion from federal programs and supports (Survey response, September 19, 2023).

In addition, the National Inquiry on Missing and Murdered Indigenous Women and Girls established Métis-specific calls to justice which bolster what Métis participants in engagements shared related to a Métis-led continuum of care. For example, Call to Justice 17.23, "Call[s] upon all governments to provide Métis-specific programs and services that address emotional, mental, physical, and spiritual dimensions of well-being, including coordinated or co-located services to offer holistic wraparound care, as well as increased mental health and healing and cultural supports."

7.3 Keeping the Conversation Going

As mentioned in Section 2.4 describing the limitations of this project, federal and provincial/territorial partners should support further **dialogue with First Nations, Inuit, and Métis communities and organizations to seek perspectives on the realities of and responses to anti-Indigenous racism within mental health and substance use spaces.** This includes continued and expanded dialogue with several key groups including First Nations, Inuit and Métis scholars, students, and young people. Attention must be paid to heeding the experiences and advice of those with multiple and intersecting identities including gender identity, gender expression, class, and disability status, among others. These voices and perspectives are vital to the development and delivery of culturally-relevant mental health and addictions programs and services that respond to the needs of all people within our communities, and in the larger project of reconstituting traditional wisdom and practices.

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