

visions

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indigenous people: reconciliation and healing

why aboriginal people can't just "get over it"

what is indigenous cultural safety—
and why should I care about it?

visions

Published quarterly, *Visions* is a national award-winning journal that provides a forum for the voices of people experiencing a mental health or substance use problem, their family and friends, and service providers in BC. It creates a place where many perspectives on mental health and addictions issues can be heard. *Visions* is produced by the BC Partners for Mental Health and Addictions Information and funded by BC Mental Health and Substance Use Services, an agency of the Provincial Health Services Authority.

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Pg 3 illustration: "Journey of Hope" by Todd Stephens, Prince Rupert, BC c/o Native Northwest
Back cover: "Journey of Hope" by Todd Stephens, Prince Rupert, BC c/o Native Northwest

footnotes reminder

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we want your feedback!

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letters to the editor

Ever since I worked as a direct service clinician on a mental health team (many years ago now), I have greatly valued *Visions* magazine and continue to recommend it to service users and clinicians alike. The topics covered by *Visions* have always been closely aligned with the issues identified as most important by the people we serve and by our service providers. The content is not watered down or too academic but seems to find a respectful, professional and accessible middle ground that clearly highlights important, useful and often inspirational information. I have not seen another periodical that provides such well-presented, helpful and hopeful content. When I found out we could send *Visions* totally free of charge to people that wanted it, we took the opportunity to ask that several be sent to every Island Health mental health and substance use related facility for both professionals and clients to access. We would definitely recommend other health authorities/ organizations do the same. Thank you to everyone behind *Visions* and please keep up the fantastic work!

— Kelly Reid, Victoria, BC (Director of Operations, Mental Health & Substance Use, Island Health)

editor's message

This issue, voted for by readers, feels incredibly timely. The planning for it began just days after our new prime minister and two Indigenous cabinet ministers were sworn in. Not long after, the Truth and Reconciliation Commission released its historic report, suicides in the Attawapiskat community garnered national attention, and the Supreme Court of Canada made a landmark ruling about government's responsibility to non-status Aboriginal people. More and more, it seems, Indigenous issues are being talked about. We hope to play our part in the conversation in the pages ahead—in particular, helping unpack and make real some very complex issues.

I cannot thank our contributors and their colleagues enough for their generosity of time and expertise. The images are particularly symbolic for me. For the first time ever, not a single stock photograph was needed. Each image comes directly from a contributor: real people all sharing and shaping their stories *their* way. After reading this issue, I hope you feel humbled yet hopeful, as I have.

Visions poster insert

Note: There should be a colour poster tucked into this issue (if you didn't get it and want one, contact us). If you like *Visions Journal*, please display it prominently or share it with someone who can and help us spread the word about this magazine. We would appreciate it very much. Thank you!



Sarah Hamid-Balma

Sarah is Visions Editor and Director of Mental Health Promotion at the Canadian Mental Health Association's BC Division



from the artist of the painting on the cover

My English name is Jade Morgan, my Native name is Eeyence, which means Leaf. The painting features the Sacred Salmon. It nourishes your body, it creates food for people, and it keeps the ecosystem balanced. Its radiant colors keep our inner feelings exhilarated. It's beautiful to draw and carve in wood. It's good for commercial fishing. My dad was a high liner which means he was very good at catching fish, but when I was 12, he passed on because of fishing. I was sad and I think the salmon were sad too. In Steveston (Richmond, BC) there is a memorial site with salmon all around it. It has my dad's name on it and his boat, named after me: the *Jade Rachele*. I go out in the community to talk about my illness of schizophrenia and how it has impacted my life. I share the struggles, hopes, dreams and my healing journey. One day, I plan to continue my art at the Art Studio and to have my own one-bedroom apartment to live in.

glossary

This glossary seeks to define some of the key terms you may come across in this issue of *Visions*. All definitions were compiled from various sources by *Visions* staff and don't necessarily represent the views of those who contributed to this issue.

Colonialism	A way to control land, people, culture, and societies. Colonialism refers to the beliefs, philosophies, and politics that one group uses to claim their superiority or dominance over another group.
Colonization	Colonization is an act of colonialism and begins with taking over an area and sending people to live there. Colonization continues when one group or society imposes their values or ways of life on another group in order to suppress the group. Colonized groups are expected to assimilate or adopt the colonial ways of living.
Decolonization	The ongoing process of recognizing and removing colonial powers.
Indigenous	Refers to anyone who traditionally occupied a territory that is threatened by colonization. It may be considered more inclusive than terms like 'Aboriginal' because it looks at common experiences rather than legal status or designation.
Aboriginal	The descendants of the original inhabitants of North America. The term 'Aboriginal' includes First Nations, Inuit, and Métis groups.
Band	A governing body for a community required by the <i>Indian Act</i> . Bands are made up of a chief and councillors, who are elected.
First Nations	Someone who identifies as a member of a particular Nation or community within a Nation. Some Indigenous people have used it to replace the word 'band.' The term specifically excludes Métis and Inuit peoples. In some cases, it can be used to imply legal designation of Indian, but the term 'First Nations' has no legal definition.
Harm reduction	Policies, practices, and programs that reduce the harms (which includes health, social, financial, and other harms) associated with substance use rather than reducing substance use itself. The approach recognizes that eliminating all substance use is unrealistic, so there is an obligation to help people now, where they are at.
Indian	The legal term used by the government of Canada.
Status Indian	<p>A person who has registered as an Indian under the <i>Indian Act</i>. There are different kinds of status, and they show what specific rights an individual can have under the <i>Indian Act</i>. Someone who is 'non-status' is not legally recognized as an Indian and not eligible for services or benefits under the <i>Indian Act</i>. The status system and how a person gains or loses status is very complicated. You can find a more detailed discussion at indigenousfoundations.arts.ubc.ca and navigate to Government Policy > <i>Indian Act</i> > Indian Status</p> <p> Note: In April 2016, the Supreme Court of Canada ruled that non-status Indians and Métis people are Indians under the section 91(24) of the <i>Constitution Act</i>, 1867. The case does not give non-status Indians and Métis people the same rights as status Indians under the <i>Indian Act</i>, but it does clarify some government accountability.¹</p>
Treaty Indian	A person who is registered with a band or Nation that has signed a treaty with the Crown.
Métis	People of mixed Indigenous and European ancestry, who identify as Métis. You can learn more about the history of Métis communities in BC from the Métis Nation British Columbia at www.mnbc.ca .

glossary continued...

Residential School System	A system of schools implemented by the Government of Canada from the 1880s to 1996. Residential schools forced Indigenous children away from their families and communities in order to undermine Indigenous culture. Attendance at these government-funded, church-run schools was mandatory. Residential school survivors tell of the physical, sexual, emotional, and psychological abuses they experienced from school staff.
Reconciliation	The act of establishing new, equal and trusting relationships. Reconciliation may include learning about the past and present, acknowledging and remedying harms that have taken place in the past, and taking action to build a just and equitable future. The Truth and Reconciliation Commission expands on reconciliation in its report <i>What We Have Learned: Principles of Truth and Reconciliation</i> , available at www.trc.ca .
Red Road	Choosing to follow or uphold traditional culture, values, spirituality, or other important parts of one's Indigenous identity. It can mean different things for different people, but it generally implies moving away from dominant mainstream cultural identities, values, or expectations.
Reserve	Land that a band can use. The land is not owned by the band. It is owned by the Crown and the government has some control and authority over the land and how it's used.
Sixties Scoop	A policy from the 1960s to 1980s that saw Indigenous children taken away ('scooped up') from their families and placed in government care under the guise of child protection. Many lived in institutionalized care or foster care, and those who were adopted were often adopted by non-Indigenous families. It was difficult to obtain birth records, and many children grew up with no knowledge of their heritage or biological families. While services for Indigenous families have shifted, Indigenous children are still overrepresented in care.
Truth and Reconciliation Commission of Canada	A commission established by the federal government to witness and document the experiences of the residential school system, support those who are affected by the residential school system, educate the general public and make recommendations to government on the system's impacts and legacies. You can learn more about the Truth and Reconciliation Commission of Canada at www.trc.ca .
Two-Spirit	A pan-Indigenous term used by some in North America to describe different gender and sexual identities. Two-Spirit is often described as two identities (such as male and female) in one body. In addition, individual communities may have their own terms or understandings of gender and sexual identities.

Intergenerational Trauma and Indigenous Healing

Evan Adams, MD, MPH and Warren Clarmont

“Each generation of scientists stands upon the shoulders of those who have gone before,” a Nobel Prize-winning physicist once said, referring to how knowledge and skills are built and improved upon, generation by generation.¹ This is true of any profession, and it’s even truer in our personal lives.



Photo credit: First Nations Health Authority

Evan Adams

Dr. Evan Adams on the medicine of resilience

From our families of origin, we learn foundational life skills and ways of coping, inherit genes and knowledge, and much more. In this way, we figuratively stand on their shoulders as we keep building upwards. But what happens when the “shoulders” of one generation have been damaged by devastating experiences? How much does this damage matter to the success of future generations? And are there ways to mitigate the damage?

Some think that historical trauma, defined as “a cumulative emotional and psychological wounding over the lifespan and across generations, emanating from massive group trauma,”² dictates one’s destiny. At the other end of the spectrum, there are

those who dismiss historical trauma as “in the past” and consider personal responsibility paramount. The First Nations Health Authority takes a more balanced approach, acknowledging the damaging impacts of trauma on health while having great faith in the healing powers of resilience and cultural, spiritual and traditional knowledge and medicine. So we wholeheartedly believe that our vision for “healthy, self-determining and vibrant BC First Nations children, families and communities”³ can become a reality in spite of experiences of trauma.

For me, this belief is bolstered by the fact that I know many First Nations people who have managed to move past horrific trauma and live healthy lives. For example, when I was five, I saw my eight-year-old sister

Dr. Adams is the Chief Medical Officer of the First Nations Health Authority (FNHA). He leads a team of FNHA physicians—health and wellness partners to BC First Nations—who focus on First Nations health and wellness to shape a unique health care model in Canada. Dr. Adams previously served as Deputy Provincial Health Officer and was the first Aboriginal Health Physician Advisor for BC. He is a member of the Tla’amin (Sliammon) First Nation

Warren is from the Gitksan First Nation near Hazelton, BC. He has been the Senior Policy Analyst at the BC Association of Aboriginal Friendship Centres (BCAAFC) since 2004. He works with provincial and federal partners to develop strong social policy that positively impacts the health and well-being of Indigenous families living away from their home communities. Warren studied political science and history at the University of Victoria and lives in Victoria with his wife and two children

accidentally shot by a teenager who was playing with a gun. That incident, and my mother's subsequent long-term depression, greatly impacted my family. My mother had been through residential school, so she already had a lot to deal with emotionally. Now that I have children of my own, I understand her grief. My father was strong despite his pain; he had been raised on the land, traditionally, and had not attended residential school. He pushed us all to look forward, work hard and be strong. Today, my three sisters, my brother and I are all in the helping professions, and my parents have been married for more than 50 years. So we are blessed to have experienced the "medicine of resilience" in overcoming trauma.

There is a growing body of research on how resilience—the process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress—is actually a life skill that helps people persevere and become healthy and well. In fact, a recent Harvard health blog about resilience called it a "mind-body medicine that reduces the need for health care."⁴ And happily, research has also found that resilience can be taught, learned and cultivated—it is not something that only the lucky or the brave possess. Ways to cultivate resilience include:

- focusing on the positive, maintaining a hopeful outlook
- making meaningful connections with others
- keeping things in perspective (not viewing crises as insurmountable)
- meditating, praying and other spiritual / cultural practices
- exercising, including walking in nature
- being adaptable and accepting that change is a part of living

- moving toward goals and taking decisive actions

At the First Nations Health Authority, we are paying close attention to this exciting research on resilience—especially given that other research, on trauma, has found abundant evidence that our lifetime emotional experiences profoundly impact us and are primary factors in myriad physical and mental illnesses, including addictions, depression, cancer, heart disease, Type 2 diabetes, PTSD, and more.⁵

One expert on addictions and stress, Dr. Gabor Maté, believes that disease in an individual "always tells us about the multigenerational family of origin and the broader culture in which that person's life unfolds."⁶ In other words, our grandparents' and parents' experiences affect us. For Indigenous peoples in Canada, intergenerational trauma is rooted in imposed social and legal injustices in the form of racist, colonial and genocidal policies such as the Indian Reservation System and the Indian Residential School System. These injustices are documented extensively in the report of the Royal Commission on Aboriginal Peoples/RCAP (1996)⁷ and the report of the Truth and Reconciliation Commission

of Canada/TRC (2015),⁸ among others. These reports also document the consequences of these injustices, including geographic isolation, lack of opportunities, poverty, brokenness, and poor health outcomes.

Despite our traumatic collective past, First Nations people have shown incredible resilience and are making great strides to heal. The First Nations Health Authority is here because of those who have gone before us; we are standing on the shoulders of advisory bodies like the RCAP and the TRC, and we are a manifestation of many years of work on the part of First Nations toward self-governance, including establishing our own health care services and cultural supports. The motto of the First Nations Health Authority is, in fact, "Nothing about us without us." Together we work with, and on behalf of, BC First Nations, guided by our past experience, our present awareness and our future vision for First Nations health and self-determination. We know we are better together. And while we know that the path forward is long, winding and uphill, we also know that First Nations people are strong and well able to rebuild what has been damaged. Together, we can repair and restore the foundations of past generations

what is the first nations health authority?

The First Nations Health Authority (FNHA) is the first province-wide health authority of its kind in Canada. In 2013, the FNHA assumed the programs, services, and responsibilities formerly handled by Health Canada's First Nations Inuit Health Branch – Pacific Region. The FNHA works to reform the way health care is delivered to First Nations in British Columbia (BC) through direct services and collaboration with provincial partners. The FNHA is governed by and serves BC First Nations individuals and communities. For more information on the FNHA, visit www.fnha.ca

so that our beloved children, the next generation, have something to stand on as they continue to build upwards.

Warren Clarmont on the role of Friendship Centres in Indigenous healing

Beginning in the early 1960s, with changes to the federal *Indian Act* and with the release of reports like that of the Truth and Reconciliation Commission in 2015,⁸ the impact of residential schools and colonization on Indigenous people has become an issue of more immediate concern to non-Indigenous people. Amendments to the *Indian Act* enabled First Nations people to leave their reserve without written permission from the government-appointed Indian agent. This led to a mass migration of First Nations people from reservations to towns and cities across British Columbia as they sought education, employment, clean drinking water and other amenities, or fled violence and trauma at home, taking the opportunity to make a new life.

Many Indigenous people carried significant trauma with them, as a result of violence and abuse experienced at home, passed on by parents and family members who were residential school survivors; with a lack of settlement supports and an unfamiliarity with urban life, Indigenous people often ended up on the margins of society. This is nowhere more evident than in places like the Downtown Eastside of Vancouver, where a disproportionate number of Indigenous people have ended up after leaving their home communities. Many have dealt with, and continue to deal with, their trauma by using drugs and alcohol and by engaging in other



Photo credit: BC Association of Aboriginal Friendship Centres/Canadian Partnership Against Cancer

Warren Clarmont

self-destructive behaviours, which have had dire consequences, including incarceration, poor health, even death.

To address this reality, Indigenous people formed their own gathering places in towns and cities, often in the basements or houses of those who could afford them. It was in these gathering places that Indigenous people found familiarity and a sense of family, where they could gather and work together to settle and build a life in this new environment. Soon these gathering places evolved into non-profit service organizations that catered to Indigenous people moving into BC's urban centres. These non-profit organizations became known as Aboriginal Friendship Centres. Their mission was to improve the quality of life for Indigenous people through the provision of programs and supports, while maintaining their original identity as gathering places.

This collective soon formed an association in 1982 called the BC Association of Indian Friendship Centres, which later became the BC Association of Aboriginal Friendship Centres (BCAAFC). The purpose of this new association was to support collective negotiations with the federal and provincial governments and act as a unifying body for all member Friendship Centres.

Today, over 50% of status First Nations live off-reserve and in towns and cities. If we include non-status First Nations and Métis peoples in the total population, the off-reserve figure increases to 65-70%. The challenges for these individuals remain the same, however, and are in fact more pronounced than they are for individuals who live on-reserve due to racism and mainstream society's perception that Indigenous people

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Why Aboriginal Peoples Can't Just "Get Over It"

UNDERSTANDING AND ADDRESSING INTERGENERATIONAL TRAUMA

Jeffrey J. Schiffer, PhD

The political climate of Canada is changing. Shortly after the historic release of the Truth and Reconciliation Commission's (TRC) final report in 2015, Canadians elected a new prime minister committed to repairing the relationship between Aboriginal peoples and the Canadian state.

Jeffrey has Métis and German ancestry and holds a PhD in anthropology and education from Columbia University. He has worked in program development, community-based research and Aboriginal child welfare. Currently Program Director for the Office of Indigenization at the Justice Institute of British Columbia, Jeffrey is also an adjunct faculty member at UBC



Photo credit: Robyn Citizen

Jeffrey J. Schiffer

Within the past year, there has been a significant shift in the status quo—from deeply rooted attitudes that question why Aboriginal peoples can't simply "get over it" to an understanding of the intergenerational impacts of colonization and a commitment to truth and reconciliation as a project for all Canadians. In the words of the TRC, "reconciliation is about establishing and maintaining a mutually respectful relationship between Aboriginal and non-Aboriginal peoples in this country."¹

The colonization of North America attempted to assimilate Aboriginal peoples into the settlers' European ways of living. Settler policies and attitudes meant that Aboriginal

peoples were cut off from their traditional culture, languages, spirituality, economies, systems of governance and other important parts of their identity.² Understanding Canada's colonial history and debunking the racist myths that run through Canadian society is an important part of the truth and reconciliation process.³

Unfortunately, discrediting myths and negative stereotypes is not the only challenge we face. The legacy of colonization has affected the daily lives of millions of Canadians across many generations—and continues today.

Research shows that the consequences of trauma are not limited to the person immediately exposed to the traumatic

event.⁴ People close to the individual may experience vicarious trauma, which can have impacts similar to the impacts of personally experienced trauma. The concept of vicarious trauma emerged in the 1960s from studies of the prolonged effects of the Holocaust on survivors and their families. This area of research now includes survivors of natural disasters, war, residential schools and child abuse.⁵ Intergenerational trauma is any trauma, including historical oppression, that has an impact across more than one generation. This impact includes shared collective memories that affect the health and well-being of individuals and communities and that may be passed on from parent to child, and beyond.

The Indian Residential School System is one of the better-known examples of an intergenerational colonial system with impacts that still reverberate today. The schools were designed primarily to 're-educate' Aboriginal children to conform to the colonizer's world. Children were taken from their families and forced to live in unfamiliar, hostile environments, where beatings and other forms of ill treatment were the norm.⁶ At the height of this practice, more than 100 residential schools were in operation across the country, attended by some 100,000 Aboriginal children. Over 25% of these schools were located in British Columbia. The last residential school was closed only in 1996.²

As residential schools began closing their doors, provincial and territorial systems of child welfare emerged. The "60s Scoop" continued the residential school tradition of taking Aboriginal children from their families, but instead placed them in foster homes

or on adoption lists.⁷ The stark overrepresentation of Aboriginal children and families in the child welfare system continues today. In 2015, more than 50% of youth in care in British Columbia were Aboriginal.⁸ There are similar overrepresentations of Aboriginal peoples reflected in statistics concerning corrections, education, employment, health, and poverty and homelessness rates.⁹⁻¹¹

Chief Justice of the Supreme Court of Canada Beverley McLachlin labeled Canada's actions as "cultural genocide" against Aboriginal peoples.¹² The impacts of such policies echo across the generations. Aboriginal children in residential schools were forbidden to speak their language, practise their culture or engage in their spirituality.⁶ Many were subjected to heinous abuse and experimentation.¹³ After the release of the TRC final report, the TRC chair revealed that no fewer than 6,000 (and as many as 10,000) Aboriginal children had died in residential schools.¹⁴

When those children who had survived the residential schools returned to their communities, the impact of their experiences on attachment and family dynamics was profound. Many survivors report that not only did they return to their communities with a high degree of trauma but they had few resources to help them cope with their experiences. They had missed out on learning their own cultural ways of coping, and practising good health, wellness and parenting. Many survivors were later targeted by the child welfare system for conditions of poverty and neglect that were a direct result of their experiences in these institutions. Many of

the abuses and racist discourses that underpinned the Indian Residential School System continued within the child welfare system.¹⁵

In Canada in recent decades, several Indigenous models have emerged to address intergenerational trauma within Aboriginal families and communities. For example, Shirley Turcotte's Aboriginal Focusing-Oriented Therapy (AFOT) program demonstrates that intergenerational trauma is something both uniquely individual and inextricably collective, bleeding across generations. AFOT moves beyond cultural competence towards culturally restorative land-based practice. The program focuses on restoring the cultural practices and relationships that historically promoted wellness in Aboriginal cultures and societies, many of which are connected to land through ceremony, collection and use of medicines, and other activities.¹⁶

Trauma is overrepresented within Aboriginal families and communities in Canada. The exclusion of Aboriginal peoples from their lands and resources, the imposition of foreign land use and governance systems (including the reserve system and band form of governance),² the Indian Residential School System and the Aboriginal child welfare system have each left legacies of intergenerational trauma.¹⁷

Canada's colonial history, the racist attitudes and assumptions that are a part of Canadian society, and today's statistical realities are complicated. For those seeking immediate and practical solutions for our national project of

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Vision Quests and Questioning Visions

TAKING ON COLLECTIVE RESPONSIBILITY FOR ABORIGINAL TRUTH AND WELL-BEING

Nicolas D. Leech-Crier

“Virtually all aspects of Canadian society may need to be reconsidered.”¹

Tan’si! (Hello!)

I would first like to express my humble gratitude to the Indigenous Coast Salish people on whose ancestral territories I have been a welcomed guest for most of the past ten years.

Nicolas is a freelance writer and photographer. His Cree heritage and territory stretch across the plains of Canada. His First Nation is Saddle Lake in northern Alberta. He currently lives in Vancouver, BC



Photo credit: Dionne Pelan, UBC Learning Exchange

Nicolas D. Leech-Crier

I would also like to thank the City of Vancouver and *Visions* readers, staff and fellow contributors for allowing me to share my story with you. I believe that stories can heal the spirit and create amazing opportunities for learning.

In my traditional Cree culture (as in many other tribes), the Vision Quest is the pivotal ceremonial event in a young man’s life, when he is placed lovingly

by his Elders into the hands of Mother Nature and then left alone to fast and pray for insight and to seek out his spirit guide. It is an initiation—from a life of youthful dependence and nurturing into a life of the responsible warrior and family provider. Like many traditional ceremonies, the Vision Quest was forbidden to us for many years, viewed as unacceptable by the dominant colonial ideology of the

state. Yet despite this, we have fought against this dark storm in Canadian history to arrive here, in this dawning age of empowerment—of truth and reconciliation—gifted with the strength of our stories, our ceremonies, and the pride of our cultural significance in the “Great Notion” that is Canada.

In a way, Canada is currently experiencing its own Vision Quest, moving from a childhood of dependence on narrow, colonialist ideologies to take on a new role of responsibility for its First Nations peoples. I am excited to be a witness to these events, but my excitement is tempered by my memory of all those ancestors who are not here to be a witness with me. One of those people is my biological mother, whose story I carry with me as I write mine.

The last time this publication focused on Aboriginal people was Summer 2008. At that time, in an unprecedented move that would change the face of Aboriginal–Canadian relations, then Prime Minister Stephen Harper offered a formal public apology to the Native people of Canada for the more than 100 years of abuse and manipulation they had experienced in the residential school system as part of a culturally corrosive federal policy.² Harper organized a team of highly respected and capable investigators to compile evidence of the abuses that occurred during this shamefully unexamined era of Canadian history, with the intention that the residential school legacy be brought to light and dealt with honestly, once and for all.

So was born the first ever Truth and Reconciliation Commission (TRC) of Canada.

How we think of ourselves and the world we live in *is* mental health, for all people, Indigenous and non-Indigenous alike.

The final report of that commission was released as I wrote this article.³ Within the report’s approximately 3000 pages is testimony from more than 6000 survivors, their family members and other individuals. Millions of documents were collected during the commission’s six-year mandate of information gathering, and the report concludes with 94 recommendations to address the commission’s findings.

These recommendations, or “calls to action,” appear under 22 separate categories that cover the spectrum of challenges faced by present-day Aboriginal Canadians. From child welfare, education and justice to professional development and training of public servants, church apologies, reconciliation and newcomers to Canada, the TRC has drawn a comprehensive map for moving forward from the darkness of the past while honouring the present needs of Aboriginal Canadians.

Mental health takes on a central role in every category. After all, how we think of ourselves and the world we live in—how our minds/brains/hearts and spirits exist in unison to create our collective human experience—*is* mental health, for all people, Indigenous and non-Indigenous alike. Many of us are aware of the disheartening statistics regarding the disproportionate rates of substance abuse, suicide and incarceration

among Canadian Aboriginal populations.⁴ These statistics will take a long time for us to process, both as individual survivors and as Canadians. Accepting the truth of these statistics is only a first step, but it is most certainly a step that we will all want to take together, in confidence and solidarity. Finding a way to change those statistics is the next step—and that step, too, is one we must take together.

My biological mother struggled with mental health issues and addiction for much of her life. I never had the opportunity to meet and thank her for giving me this life; her own narrative of lifelong trauma sadly ended when she lost the battle against her own addictions. But from what I’ve been told by those who knew her, and from what I now see in myself and my sisters, my mother—whatever her struggles—was a respectable citizen and a practical optimist. In her day, Prime Minister Pierre Trudeau attempted to legislate our people out of existence with the tabling of the infamous 1969 White Paper, a proposal to abolish the *Indian Act* and assimilate the Aboriginal peoples of Canada, eliminating their distinct legal status. Although the White Paper was opposed by Aboriginal leaders across the country and eventually abandoned in 1970, it set the tone for state–Aboriginal relations for several decades.⁵ Now, less than

Naming and owning historical trauma connected to mental illness is powerful, not a weakness.

50 years later, to be able to see the humility and maturity with which Justin Trudeau presents himself and the Liberal Party's conscientious, action-based approach to real, timely and trustworthy change for the First Peoples of Turtle Island speaks volumes. I believe my mother would have been as proud to witness these events as I am. Elder Eugene Arcand eloquently summed up this momentous occasion as Canada's "rite of passage."⁶ Indeed.

Even if they do not experience a traditional Vision Quest, many First Nations people today undertake a "rite of passage" that is similar in many ways—we make a commitment to healing and nurturing our Aboriginal communities, helping to rebuild what we lost over the past few centuries. All too often, however, we must take on this responsibility as warriors, nurturers and providers without having had the benefit of a nurturing, traditional culture to prepare us for our journey. We must rely on the wisdom of our Elders, and the stories of our ancestors, to guide us as we rebuild and strengthen our communities.

I am one of those people who took on that commitment. In my early twenties, I discovered that I have a natural talent for writing, and it did not take long for me to find work as a writer and researcher at a national Aboriginal magazine in Calgary. But as I am a Native person

writing about Native issues, I feel strongly that any sort of "voice" I might be given should be used honourably, or not at all. And because I still struggle with my own scars, I sometimes find it challenging to keep my commitment to being a nurturer and healer—of myself and of my people.

Throughout my life, I have experienced symptoms of fetal alcohol spectrum disorder. The disorder was not well recognized when I was a child, and so I was never assessed or diagnosed. But prenatal exposure to alcohol can cause damage to the brain, resulting in life-long struggles with things that others take for granted—like cause-and-effect reasoning, executive decision-making and impulse control. I have had to learn about the disorder, as well as ways to overcome idiosyncrasies in my thought processes. This has made it challenging to write and do research, and to keep a job in which I can do both. So although I know that my voice is powerful and can be a source of strength and healing for Indigenous people, I am not always as successful a warrior or provider as I would like to be.

Even a warrior and provider needs nurturing and healing. A few weeks ago, I met my biological cousin Colleen Cardinal for the first time, after decades of separation via the adoption system. It was a powerful meeting, her now working with adoptees from

across Canada and me writing fancy articles about Native people. Colleen lives in Ottawa and actually attended the TRC unveiling ceremony in person; through the magic of modern technology, we were able to watch the webcast together via the Internet. She shared her thoughts with me:

Learning [more about] the behaviours I exhibited throughout my life really helped me understand why I acted the way I did and normalized the feelings of shame, guilt, anger and loneliness. For years I struggled with rage issues, startled easily, avoided confrontation, [experienced] hyper-vigilance, insomnia and physical ailments. As a *nêhiyaw iskwêw* [Cree woman], my responsibility is to continue healing, achieve wellness for my children and grandchildren—but most importantly, helping others by normalizing and contextualizing how colonial systemic violence has manifested itself in our lives over the decades of trauma we have experienced in our families and how we cope with it. Naming and owning historical trauma connected to mental illness is powerful, not [a] weakness.⁷

Colleen's words provided me with my own sense of healing and nurturing. Naming and owning. Power, not weakness. Commitment. Renewal. Respect. Relationship.

Sounds like progress to me. I *can* do this.

We *can* do this.

We *will* do this. ▽

Walking the Red Road

INDIGENOUS MENTAL HEALTH FROM AN ELDER'S PERSPECTIVE

Susan Tatoosh, as told to Stephanie Wilson

Mental health, to me, means balance. It means having emotional, spiritual, mental and physical well-being and a plan in place to maintain that balance. Spirituality has a lot to do with it—being able to practice what you consider as your strength.



Susan is an Elder and the Executive Director of the Vancouver Aboriginal Friendship Centre Society. She is also President of the Board of Directors of the Vancouver Native Health Society

Stephanie is Editorial Coordinator at the Canadian Mental Health Association's BC Division

Photo credit: Susan Tatoosh

Susan Tatoosh

That strength comes from core values and cultural teachings and beliefs. I think that you will find that the majority of people who maintain that balance in their lives have a healthier lifestyle.

When we talk about mental illness, it's the historical experience we've had as a people. That goes back to colonization, to the Indian Residential School System, to the government taking children away from families, through the "60s Scoop." A lot has to do with racism and discrimination. Those challenges contribute to mental disease. When you look at the majority of reserves across Canada,

and the urban Aboriginal population, poverty contributes to people's lack of choices: lack of education, lack of training, lack of good housing. Poverty means not being able to access what the general population takes for granted. I think poverty and the residential school experience have caused people to go down the path of alcohol and drug abuse: to forget, to hide the shame and the memory, not allow it to come out.

A number of people who are considered Elders now made a choice, probably 20 or 25 years ago, to walk the red road and to concentrate on their

healing. That generation encouraged the next to live a healthy lifestyle. We now have role models and more healthy choices—whether it's recreation, food and nutrition, or choosing career paths and educational paths in a way that allows us to participate.

The strength of the Elders and what they have to offer is important. And the acknowledgement of the strength and importance of culture, language, dance, song, storytelling—all of that is so very important to the identity of the individual. Once you start building that foundation, it contributes to your success and your mental well-being, having a sense of pride in who you are and what you can be with a little effort, and taking advantage of opportunities.

When non-Aboriginal people talk about the health of Aboriginal people, they lump together alcohol and drug addiction as the biggest mental health problem that Aboriginal people have. In fact, Aboriginal people are dealing with all the other areas of mental health, too. But those are put on the back burner, as if to say, "We don't have to deal with those." Aboriginal people have the same mental health issues as non-Aboriginal people. But medical practitioners don't consider those areas. They think: If you get Aboriginal people to quit drinking, get them to quit taking drugs, their mental illness will go away. Well, that isn't so and I'm sure I don't have to tell you that.

Elders made a choice to walk the red road and to concentrate on their healing. That generation encouraged the next to live a healthy lifestyle.

Finding strength in community and culture

We have 24 Friendship Centres in BC. The Friendship Centres are a transition point for people migrating from rural areas, from outside of the province, and from the reserve to an urban setting. In Vancouver, we have at least two dozen Aboriginal agencies that provide support services and education, employment, culture, health care, support for children and family—all the areas that we've recognized where the system has failed us. We have developed our own response and created our own supports. Some have been in place 50 years or more.

That makes the difference—between an environment where you don't feel welcome, where you're confronted with confusion and paperwork requirements, and an Aboriginal agency that meets your needs. You feel welcome, and you receive sensitivity about whether or not you can fill out forms or use the computer and do whatever needs to be done, or whether someone can sit with you one on one. There's a generation of our people who came out of the education system who could not read or write. They're the ones who seek out Aboriginal services as opposed to going somewhere else and being made to feel uncomfortable because they don't understand. All of this contributes to your well-being and your mental state. I come away feeling good about what happened at this

service agency, or I come away feeling not good enough to deserve a service.

The Friendship Centre is the hub of the community, this is our second home. When people are having troubles, they come here looking for help. We have a social worker with a psychiatric background who is only funded on a part-time basis, so we've been fighting for six years now to get that position funded full-time. We could certainly use a full-time position seven days a week.

We also get people coming here looking for their relatives. They know they are living in Vancouver, so they go to the Friendship Centre to find them. We have cultural activities here for West Coast First Nations, Prairie people and the Interior people who do the powwow circuits, and Métis. People know that their families are involved in cultural activities and they come here to look for them.

Culture is the saving grace, that's what keeps us sane. Even just sitting in a room with Elders, just listening to them, sitting there and listening takes you back home. It's that comfort of all those voices, the laughing. It's that homey atmosphere that also provides you that safety for that half hour that you're coming in out of the cold, coming in out of the noise and traffic. You find the Elders sitting in the room and you go in and you feel welcome. And then we have our daycare, where young people from age three to five are exposed to the culture. That takes them on their first step into the community.

For young people, we bring in the Elders and they learn words, they learn a song, they drum, they learn how to keep the beat, and they learn

to dance. One year we had regalia-making, where the little ones had a dull needle and sewed the buttons onto their regalia.

When people are coming back and finding themselves, working on their regalia is a very healing activity.

There's the sense of pride, and the sense of being part of the group that you're making your regalia for. And there's the serenity of mind in working with your hands, doing something that's cultural. For the time that you're in that group that's doing this, it's a very relaxing time. That's so important when you live in an urban area, to find an activity that is calming and relaxing and yet you have companions, you have companionship.

One of the things that we witness is the Elders finding their way back to their culture and finding themselves in a position where they're asked questions about their life and knowledge. This encourages them to be more participative. To go home to their communities more often, to talk to people and bring back that information, to be part of the group that is demonstrating culture—whether it's language, song and dance, or storytelling. Through that, you get the kids who have been in foster homes coming back. They want to learn how to powwow dance, they want to learn how to jig, they want to learn how to play the fiddle if they're Métis. It's something they didn't get when they were in foster care, and once they're on their own, it's what they want to do. A lot of times they come in and say, I don't know where I'm from, but this is my name. We can start at the grassroots level with them and say, "This is how you can trace your family back."

Culture, language, dance, song, storytelling—
all of that is so very important to the identity of
the individual and to their mental well-being.

There was a time when people were ashamed. I shouldn't say it's over—I think it's being addressed and people have challenged it, so that the shame is being replaced with pride. Proud of who I am, where I come from, who my family is. When you're faced with racism and discrimination, you're made to feel you don't belong. I think people have found ways to overcome that. Not always healthy ways, but for those who have found healthy ways, it's through culture. It's through that balance I spoke of initially, and it's recognizing that you need balance to deal with everything you're confronted with.

Sharing helps healing

We just don't have enough mental health workers, and that affects our community. I would love to have mental health workers available in the Friendship Centre. We get people coming in who need assistance right away. We've had to call outside help and say, yes, this person is this way, and then the mental health team comes and takes them to the hospital. It can be very traumatic. And my workers aren't trained in this area; they have no clinical background.

I don't know that the mental health agencies reach out enough. There's so much more information that could be shared—about mental illness and mental well-being. I attended a training course last fall. One of the speakers was a doctor who dealt

with mental health, and he shared so much information in such a short time. I don't think there was one out of ten or eleven in the class who didn't learn something that day. He was certified to work with people who had been through the residential school experience. He contacted me after and wanted to know if there was any way he could help at the Friendship Centre. That's the kind of interaction we need—with people who are willing to volunteer, to do that little bit extra that they don't necessarily get paid for.

Hope for the future

Knowing our young people are interested in education gives me hope. Our people are educated, they're getting good employment—permanent employment. There's interest in affordable housing. Young mothers are showing an interest in nutrition and activities for their children. Everything is moving towards a healthier community. Having our own agencies is probably the best support we can give our community. Creating a thriving community has been our vision for 20 years, 30 years. We've looked at participating in the economy, and now it's actually happening. And we're engaged in civic decision-making, getting out there and voting. Before, it was about letting them decide. Now we're part of the decision-making crowd. ▾

Surviving to Thriving

A PERSONAL JOURNEY IN MENTAL HEALTH

Jenz Malloway

My story of recovering from depression doesn't end with me crossing a 10k finish line in triumph, winning a literary award, or celebrating the success of my dream business—not *yet*, anyway.

*Jenz is a member of Yakweakwoose Village, located in Stó:lō territory. She has worked for Stó:lō Health Services since 2011, coordinating suicide prevention and training. She was one of the participants in the 2006 Fraser Health Authority video production Aboriginal Journeys in Mental Health: Walking the Path Together**



Photo credit: Sullivan Malloway

Jenz Malloway

When I was asked to share my mental health experiences, I agreed immediately; after all, I received the request at work, where I am very enthusiastic about my calling as a suicide interventionist and trainer and am an advocate of holistic wellness. What I didn't anticipate was my realization that although I am very skilled at surviving chronic depression, I am not at all thriving: I have continued to neglect many important aspects of my life, and this affects the extent to which I can actually call myself 'recovered.'

I struggle. My struggles started very early on, which is evident in the fact that I started playing sick or hiding

from the school bus in kindergarten in order to avoid the general busyness of school and the noise of other kids. By my late twenties, I had grown tired of feeling like a failure. Although I had been placed in gifted programs since Grade 4, I felt like a fraud because my assignments were often incomplete. Sometimes I could follow through on tasks—but at other times I couldn't seem to find the interest, energy or motivation. And I couldn't predict when I would disappoint myself or others. To this day, I am able to get by as 'eccentric,' but behind the scenes are heart-to-heart talks with teachers, counsellors, supervisors and teammates, who have encouraged me to have a broader, more balanced

view of my abilities and achievements. You may have noticed that I didn't specify friends in my list of supports. I am surrounded by caring colleagues and community members, but I still struggle to have intimate friendships or to feel that I am not just the fourth best friend of the people I rely on for fun, comfort and companionship.

In addition to being diagnosed with depression, as a young adult I was assessed as having mild traits of Asperger's disorder and strong characteristics of attention deficit disorder (ADD). I believe I have outgrown the behaviours that could be interpreted as autistic traits, but I am still strongly affected by ADD.

Here is where my story becomes one of success and gratitude. In my Aboriginal culture, it is understood that we all have a gift, which our experiences help us to discover. It's up to us to recognize—and to value—everything the Creator has given us. An Elder once told me, "*Of course we all have traits of ADD—we're hunters and gatherers!*" It's true: even though I'm not a hunter, I am always alert and sensitive to noise and movement to the point where I discreetly cover my ears in some meetings and avoid crowds when I can. In order to cope with overstimulation, I tend to screen things out completely rather than automatically filtering the input around me the way most people do. My senses are sharp, but I am easily distracted by my own thoughts and less relevant things—like the ghost of a tag ripped out of a t-shirt or a crooked seam in, well, anything. My brain can work against me, but I have been brought up to focus on my strengths. My experience and frustration with

In my Aboriginal culture, it is understood that we all have a gift. My gift (*sigh*, thank you, Creator) is that I think life is a beautiful miracle, even when I feel like I have lost hope.

the physical symptoms of depression and ADD mean that I can relate to the depressed and those who struggle.

Over time, I have found relief through many remedies, some prescribed and some natural. In addition to medication, I use a therapeutic light box on winter mornings to regulate my inner clock and help me maintain a regular sleep schedule, which my body doesn't tend to generate on its own. I've long suspected that a more traditional (outdoor) lifestyle would be beneficial to me, and I'm building more physical activity into my days in order to enjoy those benefits.

When I fall into depression, especially during our dark, rainy winters, I sometimes struggle to get out of bed. Sometimes I am lonely, and I always dread that innocent-sounding question, "How are you?" But I am not unique in facing these struggles. The fact that I have experienced them provides a helpful perspective in my role as a mental health support worker. Community members know that I am not surprised by the depressed mindset, nor am I shocked by anyone who expresses suicidal ideation. My gift (*sigh*, thank you, Creator) is that I think life is a beautiful miracle, even when I feel like I have lost hope. At my lowest point, I have never been suicidal because

I am surrounded by the things that are valued by my culture: the river ("Stó:lō" actually means "people of the river"), the mountains, the wildlife and their songs. I have been shown and I show others that we can nurture out spiritual selves with the tools provided right outside our doors. I use cedar boughs to physically brush off bad energy, whether it's my own or negative energy I've picked up from others. My office has woven cedar baskets above the doors so that when I leave I can send thoughts of work there and not take them home with me. Sometimes we are our own best resource—but if we have a cedar tree to tell our problems to, then we aren't really alone, are we?

Depression tries to tell me that I am alone at these times, but I know that depression lies.

I have a lifetime of bad habits and attitudes that I sometimes revert to if I am not careful. My thinking can be pessimistic, affecting my ability to support others; I become overwhelmed by the persistence of problems in my community—such as general racism and inadequate opportunities in education, employment and housing. I can find it very easy to pity myself and ruminate on stressors. When this happens, it is too easy and comfortable to isolate myself, overeat, and sleep

or read the day away. Getting back into my daily routine is the best medicine, and I've become quicker at acknowledging this over time. I find comfort in a meaningful job: I have been with my local health agency for over four years, and it's the longest I have been able to stay engaged and see long-term, rewarding results.

As with many things I enjoy, I can focus on work to a fault. My son, who also has ADD, is the same way when he has an interest. We have a tendency to overlook daily commitments set by school and work schedules, but we excel when we have a passion. At 13, he works each day to make the most of his brain, without medicating ADD. He is a great reminder of the importance of resisting impulses and practising discipline. When I was younger, I ruined many a novel by skipping to the last page. I still have to consciously resist doing this and avoid reading the plots of movies before I see them. It's about consequences—and realizing that self-indulgence doesn't equal gratification.

Raising my son is similar to a behavioural therapy strategy that I highly recommend, called activity scheduling.* During our first 10 years together as mother and son, I became aware that I *could* manage my depressive symptoms, thanks to the fact that the needs of a child are immediate and cannot easily be ignored. While I may be susceptible to depression, the demands of daily life as a parent—meals, child care, schooling, employment—all act to counter my own unhealthy impulses. My son is a remedy for me in a way that other family members cannot be. Depression is not normal to him, like it was in my

family when I was growing up. Instead, he reinforces and promotes life in our house each day by modeling to me what I have worked to instill in him. In this scenario, who is the chicken and who is the egg? It doesn't matter—as long as the system works!

Activity scheduling prompts people to break the cycle of depression by taking simple steps they may not normally be inclined to take, mainly by increasing their activity levels. When I decided to have a child, I didn't have a clear sense of how becoming a mother would change my daily life. I was able to focus intently on my son's needs, but I also became isolated, falling into a routine that did not help my mental state. I neglected my health in many respects, and my sedentary lifestyle had an impact on my social circle and connections. I made sure to rebuild a wider social life, but like many people, I have not yet achieved balance. For an individual who experiences depression, the small steps really count. This is why activity scheduling is so important to me and why I promote it to others.

Now that I have done what I have dreaded since I agreed to write this piece, I am grateful for the opportunity to reflect on my role as an active participant in my own mental health care. Focusing on myself has made me

face the fact that I need to remember more often to live fully rather than just vicariously through others. I can see that if I plotted my routines on a medicine wheel, the wheel would definitely look like a flat tire because of my busy schedule and lack of physical activity and outdoor time. It also wouldn't hurt my household if I nurtured my body and the bodies of my family members by learning how to cook a few more healthy meals. And my son has advised me that it's time we raise a puppy to take on camping and hiking trips. Examining my progress was more difficult than I expected—but having struggled and found help more than once, I know that self-awareness is my friend.

Depression, though? Depression is never a friend, even if it seems comfortably familiar. Anyone who reaches out to me after they've fallen into the trap of isolation as a result of depression will hear this question: "What has helped you get through this in the past?" I hope that when people need help identifying how they have survived, they know that being able to ask for help is a strength.

Some of us understand more than you might think. ▾

* See related resources below

related resources



To hear more of Jenz's story, order a copy of the Fraser Health video *Aboriginal Journeys in Mental Health: Walking the Path Together*. Contact the BC Partners and HeretoHelp at 1-800-661-2121 (toll-free in BC) or 604-669-7600.

To see a good example of activity scheduling that Jenz likes, see this one developed by the BBC in 2010 as part of their Headroom campaign. downloads.bbc.co.uk/headroom/cbt/activity_scheduling.pdf

Drawing from Métis Roots to Move Beyond Bipolar Disorder

Kim Bayer, MA

For many years, I worked as a community support worker during the day, helping others with mental health and addiction issues as well as child welfare situations, dis/abilities and a range of other stressors. In the evenings and weekends, I wrote poetry and songs and played in alternative rock bands.¹



Kim is Métis and lives in Vancouver. She has a bachelor's degree in psychology and a master's in cultural studies. She has worked in early childhood education and as a community support worker, social worker and program manager. Kim is an Aboriginal Liaison at UBC. She writes poetry and songs, and plays guitar

Photo credit: Susan Moore

Kim Bayer

After more than 15 years of this full schedule, I developed chronic anxiety. At the time, I dismissed the anxiety as nausea because I had no obvious worries in my life. Eventually, however, the nausea led to insomnia, and I decided to seek medical advice.

Diagnosis and treatment

My medical mystery took four years to solve: in 1995, I was diagnosed with bipolar disorder II. But my diagnosis was just the beginning. After I was diagnosed, I began seven years of lithium treatment. My recovery process was painfully slow, filled with starts and stops and a steep learning curve: not only did I have to learn about bipolar disorder but I also had to relearn all the other aspects of daily functioning, recovery and moving on. This, and learning how to navigate the medical

and mental health systems, eventually became an all-consuming task.

Despite the fact that my health improved with treatment, I experienced a few setbacks, which led me to take a year off work while I continued with my music. Eventually, however, I experienced a complete physical and mental breakdown triggered by toxic levels of lithium. Out of desperation, I turned to alternative treatments, which included bi-weekly sessions of acupuncture with electrical stimulation, along with a combination of natural and medication therapies. With this new regimen, by the end of the first year, I had reduced my daily lithium dose by half. By the end of the second year, I stopped lithium and anti-anxiety/depression medication therapies altogether. I continued

Nothing—not even bipolar disorder—can take away the things that inspire me. One of these sources of inspiration is being Métis.

with cognitive-behavioural therapy (CBT) sessions provided by the public mental health system, and private sessions for eye movement desensitization and reprocessing (EMDR), a non-traditional type of psychotherapy that focuses on the body's rapid eye movements to alter our responses to negative emotions.

For several years after my initial stabilization, at the beginning of each summer and winter, I continued to experience a few weeks of insomnia followed by mild depressive symptoms. As this pattern had been with me from my teenage years, long before my diagnosis, I feared that I would never truly be free of symptoms. I also felt the effects of the trauma that results from years of recurring episodes: I both anticipated and feared the onset of symptoms. Recovery between each recurrence was slow and painful—emotionally, mentally and physically exhausting (a bipolar episode feels like having the flu: it's debilitating to the mind, body and spirit).

I also felt that bipolar disorder took away the things that mattered most to me: during recovery, I had very little mental energy to focus on reading, let alone creative writing. My voice was tight and constricted, so I couldn't sing. Holding a guitar was also physically difficult; the weight of my instrument seemed symbolic of the medical condition that had brought

my life to a grinding halt. So much for insomnia and all-night creative sessions: once these sessions had seemed so exhilarating, but I realized that eventually they all ended the same way—with the crushing immobility that comes with depression.

Rebuilding from the Métis foundations

I knew that I had to rebuild all aspects of my life—work and play. One day at a time, as the saying goes. Within a few years, one course at a time, I completed a degree in psychology and then certificates in Aboriginal counselling and social services work. I then worked as a child welfare social worker. Ten years later, I completed a master's degree in cultural studies. All the while, the pieces slowly began to come together. I began running. First, I would run from one telephone pole to the next. Eventually I could run five kilometres, and then ten. I got a bike and rode everywhere. I learned that the world looks and feels different from alongside the road. This brought me new energy, a new perspective and the feeling that I could truly move on from the debilitating grip of bipolar disorder. Today, I continue on this way, whether it's one kilometre, one song, one poem or one academic course—it all fuels my overall goal of forward motion.

I also realize that nothing—not even bipolar disorder—can take away the things that inspire me. One of these sources of inspiration is being Métis.

I can always draw from this. We have a beautifully vibrant culture, filled with stories of resilience and the teachings of Elders and people of all ages. Despite the challenges we have faced throughout our history, our artists keep our culture alive, through beading, crafting, poetry, stories and music. On days when I am stuck spiritually, emotionally or creatively, I draw from this rich tradition. I call one of my Métis cousins to say “hello” or attend a Métis community event. Even visiting artists' websites can take me back to where I belong, and remind me of my culture, my creativity and my resilience.

Setting new goals

Along with this newfound perspective, since I was first diagnosed and began recovery, I have changed my life goals. I still write and play music for enjoyment and because it is part of what I'm meant to do in this world. But now my goals also include education and healing work with Métis and all Indigenous people. There is still much work to be done. The need for this work can be traced back a few hundred years, as Métis historical experience has been shaped by loss. With colonization came the loss of Métis land and all that our land means: a sense of place, identity, language and family connections. This loss disrupted traditional teachings and knowledge sharing, family structure and the practices of hunting, fishing and gathering food. These traditions were supplanted by violence, abuse, addiction and disconnection, and we Métis lost our spiritual, mental and physical wellness. To survive, some families chose to assimilate. For others, assimilation was not a choice: it was an imposed reality.²

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Some Days a Printer Cable Makes Me Cry

REFLECTIONS ON SUICIDE—FIRST NATIONS COMMUNITIES AND BEYOND

Chris Lalonde, PhD

I have two things to say about suicide. First, I've spent 20 years studying suicide as an academic researcher. I look at big data sets for patterns in suicide prevalence. My goal is to understand why young people are especially vulnerable to suicide.



Photo credit: Meleva Lalonde

Chris Lalonde

Chris is based in the Department of Psychology at the University of Victoria. He studies the relationships between identity formation, culture and health, with a particular focus on youth suicide, and has led a number of research projects looking into the culture and health of Indigenous youth and communities

Like all academics, I hope that my work will make a difference.

My work has focused on Indigenous communities and rates of youth suicide. But I always struggle to find the right words when it comes to a particular death. That's hard. And it will always be hard.

Second, and because of what I must tell you next, I now find it almost impossible but I *must*—somehow—find some way to talk about suicide again.

On December 25, 2014, my eldest son Peter took his own life. He was 28 years old.

On my grief

There are no words to describe the pain we feel as a family over our loss. But we are not alone in our pain. It's not

just immediate family members who suffer when someone takes his or her own life. Those left behind—friends, family, colleagues, acquaintances—suffer an almost intolerable anguish. That is the dark truth of suicide. It hurts all the time, every day.

I can't give you any reasons for why Peter decided to end his life. Whatever they were, he didn't share them with me, so I have no reasons to share. No one ever does. The dead take their reasons with them to the grave.

Even if he had left a note (he didn't), what would it really mean? What sense should we make of a suicide note? He is gone, and we are left behind to ask, *Why?* Finding an answer to that question is the most impossible part of suicide.

On a parent's grief

Like any parent who has lost a child, I rehearse every moment of Pete's life in search of something—*anything*—that I might have done wrong, or could have done better, or could have done differently, so that this terrible thing would not have happened.

And sometimes I do find something—or I might *think* I've found something that, done or not done or done differently, might magically have made a difference. And I worry and I ruminate over that thing until I exhaust myself—and I exhaust any possibility that that one thing was the one thing that caused him to take his life. But even with that, there is no relief: when I've finally convinced myself that there wasn't anything I could have done differently, I am left once again feeling hopeless and helpless.

And that in itself is a source of more anguish. I wonder, *Was that how he felt? Hopeless and helpless?* And the cycle begins again...

As time passes, I have learned to deal with those intrusive "what if?" thoughts. Or, at least, I think I have. I recognize them when they come. I know they will come again. I acknowledge the dark parts, and I try to counter them with better memories. For the most part, I win those battles: I have far more memories of Pete's life than of his death. It's a struggle, but my warm memories of Pete's life usually

help me push back the darkness. But I still struggle with the unexpected and unwelcome memories that appear without warning. I call them the "triggers from nowhere." Here's one example. A few months ago, I was cleaning up the garage and stumbled across a USB cable from Pete's printer. I spent an hour sobbing alone in my garage, holding a USB cable.

The triggers are many. I know they will diminish with time, with the help of my better memories of Pete and his life, and with support from friends and family. But for now they are many, and they might surface at any time. I acknowledge them, but I continue to invite in so many better memories of Pete to balance them out. There will be better, easier days, I tell myself—not today, not right now.

So that's half my story. I am like everyone else who has lost a loved one to suicide. We swim in an ocean of grief and we think we'll never be able to tread water long enough to survive this unless we can find something to hold onto that helps everything make sense. And we tread water, and we hope, and we tread water, and we hope ... but there are no simple answers for why someone takes his own life or what we, or you, or I or anyone else might have done to prevent it.

I hope there will come a day (just one) when I don't mourn his loss—that

there will be a day (just one) when I can simply remember Pete without pain. But it's not today.

On grief that strikes whole communities

The other half of this story is that I have spent more than 20 years as an academic studying youth suicide. I have written about my work in *Visions* in the past.¹ My long-time colleague Michael Chandler and I wrote about (and continue to study and write about) why it is that youth—and especially First Nations youth—are more prone to suicide than other people.

Our research has focused on the fact that it is a dangerous mistake to portray suicide as an "epidemic" in "the Indigenous" population. Yes, suicide rates are higher overall among First Nations youth, but there are First Nations in which no youth suicides have occurred over a 21-year period. In other First Nations, rates are 10 times higher than the provincial average. If suicide is an "epidemic," it's a strange one that strikes in some places and not in others.²

Just as it has become clear to my family and me that our search for a simple, single-event explanation for Peter's suicide is misguided, so too is the idea that simply being a First Nations youth automatically puts you at risk of suicide.

I also have a more profound and personal empathy with First Nations families that have lost children to suicide. They resent any suggestion that a population-level explanation for higher or lower suicide rates should be a source of consolation to them. It isn't. And it shouldn't be. And I get that.

It is a dangerous mistake to portray suicide as an "epidemic" in "the Indigenous" population.

Suicide rates are lower in First Nations communities that succeed in controlling their own political and cultural lives.

Knowing that youth suicide rates are lower in the reserve next door is cold comfort to a family that has lost a child.

Peter felt a loss of control over his own life. He worked hard to change that. But if someone had reported that the lucky folk in Nanaimo had a lower suicide rate than that of us poor Victorians, what would he (or I) have concluded? Pete would have been pissed off. We both would have been. And rightly so.

Solace in solutions, not statistics

I have used strong language here, but the fact is that the situation calls for much more than just strong language. If we are serious about solving the problem of suicide, we need to face the fact that we have little in the way of expertise—at either the individual or the community level.

But I would like to end this on a hopeful note. That's especially difficult given our own family experience and my topic of research. Truth be told, suicide prevention efforts are not always effective. But that doesn't mean we shouldn't try to develop approaches that work. Pete tried. We tried. First Nations communities have tried. Sometimes trying isn't enough.

But we can't stop trying. Our research shows that suicide rates are lower in First Nations communities that succeed in controlling their own political and cultural lives. (Readers can see this in

our earlier *Visions* article.¹) We need to know how and why this is so. *Why* have some First Nations communities managed to keep their youth healthy and whole? We need to focus on the things that are going right in First Nations communities and the factors that are building resilience in youth. This will have a positive impact in First Nations communities and non-Indigenous communities alike.

For me, the road ahead is clear. I still believe in the work I do, and I still believe it has value for our First Nations partners. Just as I rely on my happy memories of Pete to keep the darkness at bay, I need to—somehow—get back to my research. And while I know I won't be on that road today, I hope I will be one day soon. ▾

related resource

White, J. (2004). *Aboriginal youth: A manual of promising suicide prevention strategies*. suicideinfo.ca/Store/ProductDetail/tabid/520/ProductId/6/Default.aspx

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Today, Métis people embrace issues of self-determination. On a collective level, this means engaging in political advocacy for identity, rights and well-being, including social and economic development and health services. For example, in one Métis Nation health survey, depression and mental health issues were identified as a top concern.³

For this reason, the importance of sharing traditional Métis health knowledge, from Elders and communities, has significant and timeless value for both current and future generations.² On an individual level, this involves rebuilding our connections to our culture and identity. There is a way forward!

For more on my recovery, please visit my poetry and music website, www.fractionsofdestiny.com. Here you will find *Fractions of Destiny*, my collection of poems about urban living and finding balance, and *"I Am Machine" and Other Lies from the Edge*, my latest book of storied poems about my bipolar disorder journey. As we say in Métis, *Marsi!* (Thank you!) ▾

Shape Shifter or Schizophrenic?

A PERSONAL PERSPECTIVE ON IMPLEMENTING MENTAL HEALTH PROGRAMS IN FIRST NATIONS COMMUNITIES

Jacqueline McPherson

This is a very personal story, exploring the meaning of the work that I do and the impact of mental health issues—and the hope that surrounds mental health programming—in First Nations communities. I am the health director for the Osoyoos Indian band, and I work in all areas of health, with all age groups.

Jacki is Health Director for the Osoyoos Indian band and a member of the Okanagan Nation. She has developed provincial and national mental health policy and has implemented one of the most successful mental health programs in the Interior. Jacki is a founding member of the First Nations Health Directors Association of BC



Photo credit: First Nations Health Directors Association
Jacqueline McPherson

I have been working for eight years in this community, but I have been a health professional for 35 years. I have three grown children, and I am a member of the Okanagan Nation. Like many others who have grown up on the reserve, I have a large, extended family around that supports and cares for me.

My story begins about 10 years ago, when a family member was diagnosed with schizophrenia. At one point he thought he was becoming a spiritual being, one who lived two separate but distinct lives, one in the real world and one in the spiritual world—a shape shifter. At the time, I had little knowledge of schizophrenia;

watching my relative and his family go through this was frightening and often heartbreaking. I began a quest to learn as much as I could about mental illness: I wanted to explore the cultural perceptions of mental illness and to improve my peoples' understanding and access to the mental health care system.

Schizophrenia is largely misunderstood among First Nations (as are other mental illnesses). It is often perceived as behavioural problems; there is a tendency to blame the individual experiencing the symptoms. Often, symptoms of mental illness are addressed through ceremony and guidance to resolve the “behaviour”

rather than through medical intervention. Although these actions are critical to the well-being of the individual, such cultural perceptions of mental illness may impede medical treatment. I became interested in helping people find the right balance between cultural perception and medical treatment.

With the development of mental health educational programs, misperceptions about mental illness are slowly changing. In an attempt to further reduce the stigma associated with mental illness, some First Nations patients may choose to explore their cultural belief systems, including spiritual and ceremonial designations such as shape shifting, in order to explain their illness and educate their families and communities. Unfortunately, the medical system is not designed to support this paradigm, which involves sacred ritual and private designations. I have learned that there are limitations to the medical model; as a health professional, I sometimes must step back and respect the beliefs of my patients and their families. Treating mental illness is as much about identity as it is about medicine.

Other health professionals ask me how working with First Nations is different, especially on the reserves. I find it challenging to explain to colleagues the differences between First Nations and other groups in a way that they will understand—to be frank, sometimes even I struggle to understand the complexity of our communities and relationships. We are family-based, and each Nation is culturally unique, with its own values, traditions and identity. As First Nations, we have lived on our home land since time began. Our connections to each other and the land

Treating mental illness is as much about identity as it is about medicine. Each Nation is unique, with its own values and traditions.

are intertwined and inseparable. Our cultural practices combine physical and spiritual energy, and include respecting and acknowledging the presence of our ancestors, who continue to guide and support us, even in death. While the presence of our ancestors is comforting for the healthy, it can be confusing for those experiencing mental illness. Our belief structures can create complications for the patient and the treatment provider. Social challenges like poverty, addictions and violence add to this complexity.

From a historical perspective, our language, cultural values, way of life and our identity as Okanagan people have completely changed in only five generations. I still hear stories about the way my great-grandmother lived. Although her people struggled to access food and shelter, my grandmother remembers the ceremonial and social order that kept her family and the community healthy and moving forward.

In the recent past, with reserves, poverty and residential school, many of the traditions and cultural values have been lost, resulting in social chaos. Many of the social issues faced by our communities, especially our youth (including drugs, alcohol and violence), are the result of us coping with this chaos and loss of personal identity. The support system and

cultural practices that were once a source of strength for First Nations have been eroded. We are left with a foreign set of rules rather than a culturally relevant support system.

I am a survivor of this process. My parents were residential school survivors, and their parents were denied the right to raise their children in their language and culture. This background is relevant because when we deal with mental health issues in First Nations communities, the historical context must be considered at the same time. This makes the task daunting, but speaking from the perspective of an Okanagan woman, I believe the rewards are greater and far more personal.

When I started working with the Osoyoos Indian band, there was little awareness of mental health issues and even less of mental health programming. Jurisdictional issues made accessing resources outside the reserve frequently overwhelming and complex for families. The challenges were often systemic: communities did not know how to navigate the system, and the provincial health services felt that First Nations were a federal responsibility and didn't provide services to on-reserve patients. Dialogue was the first step—talking with Elders, families, health care practitioners, leadership and individuals who were dealing with mental health issues.

Our goal is to create strong, culturally relevant mental health programs within the community.

This created awareness to counter the stigma many families faced. It also created a sense of urgency.

With the support and direction of the Osoyoos Indian band leadership, I started a mental health program that was community-based and culturally relevant. Working closely with Interior Health, we began by building a referral model with Interior Health, the First Nations Health Authority (FNHA) and other organizations, which allowed us to assess those clients and their families in the community who needed urgent help due to serious mental health issues, connecting them with mental health specialists and programs.

Understanding treatment is only a small part of living with mental illness; once the client had appropriate health care, we worked to ensure that he or she had adequate housing and social supports. The next step was to foster independence, making sure the client could access training or employment. Then we focused on educating the families and community about different forms of mental illness, treatment options and supporting loved ones on a lifelong journey. The program focuses on the individual and his or her needs, but it is also inclusive of family, community and culture.

The future of Aboriginal health in BC is changing. We have the FNHA and, for the first time in the history of First Nations people, we have the

opportunity to advance the health of our communities. First Nations health has become the priority for our leaders, and has the support of government. The power of this process is that it reflects the collective knowledge and voice from all levels: leadership, community and individuals.

I have been fortunate to be involved with the First Nations Health Directors Association, an association of on-reserve health directors. This organization lobbies for resources and support for health directors and works closely on the planning and implementation of the regional health strategy. The FNHA understands the role that health directors play in every First Nations community and, more importantly, in the support of every individual and family coping with mental illness. Our goal is to create strong, culturally relevant mental health programs and support systems within the community that will prevent self-induced illness as a result of drugs and violence and that will help individuals and families dealing with mental illness. Our vision is a community that views mental illness as a disease treated through community-based, culturally relevant programs supported by family and community members.

My hope is that the fear and suffering experienced by my family is never so acutely experienced by another family. By collaborating with each other,

the FNHA and the provincial health authorities, we can ensure that the individuals and families experiencing mental health challenges receive the appropriate and culturally safe services that every person needs. ▾

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truth and reconciliation, the legacy of the past is daunting. However, we can see the possibilities for reconciliation in restorative practices that shift relationships. Intergenerational trauma brings to light the ways that resilience, adaptation and innovation are shared across generations. Restorative practices and approaches, whether they are used in the context of social work, education, health care or elsewhere, can be helpful for Aboriginal peoples if they:

- are grounded in the intergenerational Aboriginal knowledge systems, worldview and culture of the individual, family or community being served
- are framed within an awareness of and engagement with colonial history
- are strength-based and holistic rather than punitive and isolated, and
- result in measurable positive change for the individual, family or community being served¹⁸

Restorative practices and approaches provide a concrete means to address colonial history, while recognizing the complexity of intergenerational trauma and working toward the mutual understanding and respect that truth and reconciliation requires. ▾

What Is Indigenous Cultural Safety —and Why Should I Care About It?

Cheryl Ward, MSW, RSW, EdD Candidate, Chelsey Branch, MEd, MA, PhD Student
and Alycia Fridkin, MHSc, PhD

It's the first session in a therapeutic relationship. Susan, an Indigenous client, has just shared a story about her history, her experience at a residential school and what she has faced as part of a lifelong reality of colonial violence and racism.



Photo credit: San'yas Indigenous Cultural Safety Team

Members of the San'yas Indigenous Cultural Safety Team, in Indigenous Health at the Provincial Health Services Authority: (left to right) Laurie Harding, Cheryl Ward, Grace Atkinson, Chelsey Branch

The practitioner interrupts and says, "That was in the past. You really need to move on. I will allow you to talk about it this session, but going forward, I don't want to hear anything else about the past."

This fictional anecdote reflects a common narrative about Indigenous people—that colonization is *in the past* and Indigenous people need to *move on*. This narrative and others are prevalent in the health care system, and Indigenous people experience harm on a regular basis as a result of them. For example, the idea that Indigenous people are 'stuck' in the past can lead to the stereotype that Indigenous people

are unwilling or unable to 'get better.' This stereotype can foster prejudice, such as the feeling that treating Indigenous people is a 'waste of time,' which can result in discriminatory treatment, such as Indigenous people receiving a reduced quality of care. Being aware of how these narratives lead to stereotypes, and then to prejudice and discrimination—and harm—is an important step in fostering a safer and more effective health care system. This awareness is part of the journey towards increased cultural safety and increased equity in health and health care.

Cheryl is Kwakwaka'wakw and a member of the 'Namgis First Nation. An educator and curriculum writer who has worked on several Indigenous cultural safety projects, Cheryl developed the San'yas Indigenous Cultural Safety training program at the Provincial Health Services Authority (PHSA), where she is currently the Interim Director of Indigenous Health and Provincial Lead for the San'yas program. Cheryl studies Indigenous-specific racism at Simon Fraser University

Chelsey is the Manager of the San'yas Indigenous Cultural Safety program at the PHSA. She is a White settler of Irish and English ancestry and her research interests are focused on non-Indigenous people's responses to Indigenous-specific racism in educational settings. Chelsey lives on the unceded territory of the Coast Salish peoples in Vancouver

Alycia is a Senior Policy Analyst in Indigenous Health at PHSA. She is a White colonial settler with Eastern European ancestry, living and working on unceded Coast Salish territory in Vancouver. Her academic research focuses on the meaningful involvement of Indigenous people in health policy decision-making

This article opens up a dialogue on the long-standing issue of Indigenous people experiencing harm while trying to access services—in health care, justice, child and family services and education. We argue that a cultural safety approach presents a promising way forward.

Why cultural safety?

What, exactly, is cultural safety? Why is cultural safety important in addressing the social inequities experienced by Indigenous people?

Most people are aware of the statistics that indicate significant health and social disparities between Indigenous and non-Indigenous people. For example, there are higher suicide rates in the Indigenous population, and Indigenous people tend to have poorer health than other Canadians.¹ Indigenous youth don't graduate from school at the same rate as non-Indigenous youth, and Indigenous children are five times more likely to be in foster care than other children.² These realities are troubling—as they should be. But what is also important is the *context* in which these inequities occur, namely, the way social, historical, political and economic factors have shaped and continue to shape Indigenous peoples' health. This context helps us answer questions such as "Why do Indigenous people have drastically different health and social outcomes?" and "Is there something wrong with the system?" Asking and answering these questions can help to disrupt narratives that blame Indigenous people for the failure to address their own health issues. How we understand these issues, and how we answer these questions, is critical to any action we take.

The concept of *cultural safety* can be used as a framework for examining and understanding these questions. Originating in New Zealand in the field of nursing education, cultural safety has become an influential perspective in developing better health care for Indigenous people. It differs from concepts such as cultural awareness and cultural sensitivity, cultural competency and cultural humility. The table below explains some of these differences.

Cultural safety considers the social and historical contexts of health and health care inequities and is not focused on understanding "Indigenous culture." Many people come to the San'yas Indigenous Cultural Safety training program expecting to learn about the formal cultural ceremonies and practices of Indigenous people because they have been led to believe that this is the key to working with people who are culturally different

cultural safety differs from the following concepts:	
Cultural Awareness	An attitude that includes awareness about differences between cultures. ³
Cultural Sensitivity	An attitude that recognizes the differences between cultures and that these differences are important to acknowledge in health care. ³
Cultural Competency	An approach that focuses on practitioners' attaining skills, knowledge, and attitudes to work in more effective and respectful ways with Indigenous patients and people of different cultures. ^{4, 5}
Cultural Humility	An approach to health care based on humble acknowledgement of oneself as a learner when it comes to understanding a person's experience. A life-long process of learning and being self-reflective. ⁶
Cultural Safety	An approach that considers how social and historical contexts, as well as structural and interpersonal power imbalances, shape health and health care experiences. Practitioners are self-reflective/self-aware with regards to their position of power and the impact of this role in relation to patients. "Safety" is defined by those who receive the service, not those who provide it. ^{4, 5}



The colonial elephant in the room⁹

from themselves. San'yas learners are often surprised to learn that a cultural safety approach to providing care is about paying attention to the roots of health and health care inequities, such as colonization.

**A way forward:
Cultural safety training**

Actively practising cultural safety requires shifting the gaze away from Indigenous peoples' cultural differences and practices towards one's own beliefs, practices and histories—and how these impact Indigenous people. Cultural safety training helps practitioners see the impact of their own social, political and historical contexts on their practice. This is the heart of the matter: cultural safety involves developing an ongoing personal practice of critical self-reflection, paying attention to how social and historical contexts shape health and health care systems, and being honest about one's own power and privilege, especially as these relate to Indigenous people.

The San'yas Indigenous Cultural Safety training program is an educational initiative launched by the Indigenous Health Program of the Provincial Health Services Authority (PHSA) in the province of BC. Formerly known as Indigenous Cultural Competency (ICC) training, the program has changed its name to reflect the notion of cultural safety, as well as the Indigenous concept of *san'yas*, which means "knowledgeable" in the Kwak'wala language. The San'yas program helps to address gaps in health between Indigenous and non-Indigenous people. It focuses on Indigenous people, as opposed to offering a more generalized diversity training, and provides organizations and practitioners (those in health care and those outside health care) with the knowledge, awareness and skills necessary to promote safe experiences for Indigenous people in the health care system, something that is certainly not standard today.^{7,8}

To understand the lived experiences of many Indigenous people, we need to know the "colonial context," the historical and ongoing process of White European domination over Indigenous peoples and lands. This includes colonial policies such as the *Indian Act* and the legacy of the residential school system, and the impact of these on Indigenous peoples' health and social lives. Because colonialism is always present but rarely talked about, this context has been called the "colonial elephant in the room."

In the San'yas Indigenous Cultural Safety program, thousands of participants have shared openly what they haven't been taught about history as it relates to Indigenous people. Although some changes to the BC public school curriculum are underway following the recent Truth and Reconciliation Commission,¹⁰ the topic of colonization and its legacies is still largely omitted from mainstream public education. For example, most Canadians learn at a young age that Canada was "discovered." Grade-school textbooks with images of European explorers finding "new lands," and of hard-working pioneer families struggling to make a life in a challenging environment all reflect a colonial settler narrative and identity that many Canadians still hold dear. You might well ask: Where are Indigenous people in all of this? Despite some efforts to teach about Indigenous peoples' cultures in school, the omission of Indigenous perspectives of Canadian history effectively erases the colonial context from mainstream consciousness.

But even more deeply disturbing is what many Canadians have been

Indigenous people have been grossly misrepresented and are often portrayed as “inferior,” “uncivilized,” and “not fully human.”

taught about Indigenous people, not only in public school but also in mainstream literature and media. Indigenous people have been grossly misrepresented and are often portrayed as “inferior,” “uncivilized,” as “savages” and even as “not fully human.”¹¹ Although counter-narratives and self-representations by Indigenous people are beginning to emerge in various media, Indigenous people are still stereotyped everywhere in society, including the health care system.

The colonial elephant is a metaphor for the silence that exists around what we have been taught—and not taught—about the colonial context, and how the colonial context continues to impact Indigenous people in a range of social contexts. Not acknowledging the colonial elephant and its ongoing influence can make it difficult for practitioners to make informed and appropriate decisions concerning Indigenous people’s health and health care. It also perpetuates denial of the ways that colonial ideology continues to shape our society today.

Thinking about cultural safety in practical terms

Remember the experiences of “Susan” at the beginning of this article, and consider the following questions from a cultural safety perspective:

- What social or historical factors might have inhibited Susan’s access to this care?

- What might have been some of the trust issues that came up for her in the therapeutic context, and how might they have differed from those issues faced by non-Indigenous people?
- What might it have been like for Susan, as an Indigenous person, to be told to “move on”?
- What are some implications of being told that she was only “allowed” to talk about the past during that first session?
- How likely is it that Susan will return for another session with this therapist, or even return for therapy at all?

Everyone in health care needs to ask questions like these in order to actively work towards cultural safety. We have a responsibility to do so, as professionals who follow a professional code of ethics and as moral individuals.

Putting cultural safety into action

1. **Do something!** Having good intentions is not enough. Take action to make change. Speak out against racism, ask questions of those with more understanding, find allies and create a support system for yourself that can help you advocate for culturally safe approaches.
2. **Take responsibility for your own learning.** Read, reflect and ask questions. Do not expect this learning to come from Indigenous people.
3. **Take time for self-reflection.** Be aware of your own assumptions and biases. Question everything you have ‘learned’ about Indigenous people and take steps to actively disrupt the stereotypes.
4. **Commit to lifelong learning.** Be prepared to be uncomfortable. Understanding colonialism and the legacy of racism is an ongoing and difficult task.

Where can I get cultural safety training?

For more information about the San’yas Indigenous Cultural Safety training program, visit our website: www.sanyas.ca. ▼

debunking myths



The most common stereotypes discussed by San’yas participants are that Indigenous people are “all drunk,” “drug-seeking” and more likely to drink or use substances than other groups of people. The myth that Indigenous people have a genetic predisposition for alcohol intolerance or “addiction” is not supported by scientific literature.¹² In fact, there is evidence that Indigenous people are more likely to abstain from alcohol or less frequently consume alcohol than non-Indigenous people.^{13, 14} Despite these facts, such racist assumptions are frequently made in health care settings, and this has a direct impact on Indigenous people’s health and access to care.⁷

“Our Story, Our Journey, Our Strength”

THE NEW BC SCHIZOPHRENIA SOCIETY STRENGTHENING FAMILIES TOGETHER—FIRST NATIONS PILOT PROJECT

Cindy L. Charleyboy, BA

I am thankful for this opportunity to share details about an exciting program that the BC Schizophrenia Society (BCSS) is offering to First Nations communities. Previously, my work with the BCSS provided an opportunity to create a First Nations language resource designed to help families coping with mental illness in the Interior region.



Photo credit: Monica Lamb-Yorski, Williams Lake Tribune

Participants celebrating at Tletinqx'tin after program completion

Cindy is the (BCSS) Program/Services Manager and lives in Williams Lake, BC. She grew up in a European and Inuit family and has worked in language revitalization in the Tsilhqot'in and Northern Shuswap communities. Along with Elders, the Nations' knowledge keepers, Cindy has co-developed language camps and teaching tools for adults and children

The intent was to help local First Nations make sense of the medical language used in the mental health field. The one-year project was undertaken in partnership with three local Nations in the Interior: the Tsilhqot'in, the Carrier and the Northern Secwepemc. The project provided us with an initial understanding of the gulf that exists between the medical-language community and the First Nations language community.

In the past year, I have been privileged to begin new work with the BC Schizophrenia Society. The BCSS has developed a pilot program called Strengthening Families Together –

First Nations edition (SFT-FN). This program builds on our previous work to provide better support and clearer information for Aboriginal families facing the challenge of supporting a loved one living with mental illness. It incorporates education in medical language, medical and community support services and traditional First Nations storytelling and healing practices that are particularly relevant for the health and well-being of Aboriginal families.

The 10-session program provides participants with information on symptoms and treatment of various mental illnesses, working with the health and justice systems,

advocating for ill family members, addictions and concurrent disorders, and so on. Our aim is to continue to make the program more relevant and responsive for First Nations communities across the province. In consultation with Elders and community partners, the BCSS has adopted “Our Story, Our Journey, Our Strength” as the program’s theme. We feel it effectively represents the process a family undergoes when loving and supporting a person living with a mental illness: our need to be heard, to learn more and to move forward with hope.

Our story

Our personal stories are the fabric of who we are, where we come from, and how we walk in this world. Everyone has a story to tell, and families living with mental illness are no exception. When shared, our stories provide us with the opportunity to understand, learn and grow together. The SFT–FN Program provides families with a culturally safe and caring place in which to share their stories, learn from others and renew their hope.

Our journey

Many people lose their way in the choppy waters of mental illness. The journey to recovery and wellness is often long and lonely. The program provides an opportunity for families

to walk together in their search for support, guidance and understanding, helping families gather information about mental illnesses, share their personal experiences and challenges, and learn from these experiences and each other. When we travel together, our journey becomes easier. Together, we grow stronger.

Our strength

The new program is family-centred, founded on the belief that experienced family members are best suited to guide and support other families in their healing. Our trained facilitators all have at least one family member living with mental illness, so they have lived experience, wisdom and knowledge to share. They, too, are walking the path to wellness. Their lived experience is our strength.

The first phase of program development is now complete. With the support of an advisory team, primarily from the Stó:lō Nation, we have worked with community representatives to review our curriculum and program delivery. We have also produced two DVDs specifically for an Aboriginal audience. The first DVD, narrated by Lawrence Roberts,¹ promotes awareness of the SFT–FN program to the general public. The second DVD is a curriculum resource: it presents the story of Adria, a young First Nations woman from the

Tsartlip Band on Vancouver Island, and is narrated by Adria Roberts herself. Adria takes us on her personal journey, before and after being diagnosed with schizophrenia.

The language of healing

In our experience during the first of the 10 sessions, when First Nations families are introduced to the SFT–FN program, there is a tangible feeling of thankfulness and relief. Family members of people living with mental illness, community members, band staff and council members are actively showing their support for families who frequently live in isolation—not only geographically, but also medically, financially and emotionally because these resources are not easily available to them. During the first meeting, a respectful dialogue is begun, with the collective intention to end stigma and discrimination and move forward to provide family education and support. BCSS staff members are invited to participate in this often humbling experience, in which cultural sensitivity and storytelling are the foundation for family healing. We believe we can embrace the power of all cultures, all languages and all communities to lead families towards a healthy, new way of being. Collectively, we can help to heal our confusion, frustration, isolation and loneliness as we work together to understand the complex issues around mental illnesses.

The remaining nine sessions offer opportunities for families to be introduced to local resources and support systems. Establishing family connections with people who work within the support system is important to start the dialogue and

Our personal stories are the fabric of who we are, where we come from, and how we walk in this world. When shared, our stories provide us with the opportunity to understand, learn and grow together.

the process of trust building. Over and over again during the pilot project, we heard from participants that First Nations communities look forward to having this program interpreted in local languages, and having video resources and role plays that respect local cultures.

The bridge between languages is now open; however, we must listen carefully and conduct respectful, open conversations about how to transform medical knowledge into First Nations knowledge without losing the intent of the medical message.

Sechanlayagh! (Thank you!) For more information about the SFT-FN project, please contact our project coordinator, Cindy Savage, at csavage@bcss.org. ▾

the first pilot program

In March 2016, the Tletinqox'tin community in the Cariboo Chilcotin region of BC (Anaham), completed the first pilot program in the community. Participants, Elders, family members and band council were on hand to celebrate the success of the pilot program, and to acknowledge the families in the community that had risked taking the journey to talk about mental illness. Many participants shared their feelings about the experience. Aggie Harry said she was inspired to push for and take the program because there are many people in her community struggling with mental illness. "I think it will be a lot better because there are now more people who know about mental illness," she said. "Even myself, I have people in my family that are like that. Now I know where to go and who to contact for help."

"My own experience is that individuals who have mental illness are eager to seek help once they have a diagnosis," Chief Joe Alphonse said. "The biggest struggle is often for families. The course was good because it challenged community members."

"I learned things about mental illness I have never learned about before," Rosaline Harry said. "I work with a lot of youth so it will help me deal with how they act."

Yunesi'tin Elder Dorothy Myers was one of the facilitators for the course. She said that it is hard to see a loved one go through mental illness, and she encourages people to watch for signs of depression and to take the time to look after themselves: "It's good to go somewhere you like to go. Sometimes I go to the river or I sit in the church and pray."

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receive "entitlements." Friendship Centres also act as a bridge between Indigenous and non-Indigenous peoples in BC, creating awareness of the issues facing Indigenous people and creating partnerships with mainstream organizations and community entities with similar mandates.

Healing intergenerational trauma remains a core tenet of the work of Friendship Centres, in addition to their role as "hubs of reconciliation" between Indigenous and non-Indigenous people. From the

perspective of Friendship Centres, supporting the health and well-being of Indigenous children and families is the solution to breaking the cycle of intergenerational trauma. Increased resilience and decreased dependence is the desired state for all Indigenous people; working together with non-Indigenous people through reconciliation is the means to achieve this.

The BC Association of Aboriginal Friendship Centres, in partnership with the First Nations Health Authority and other organizations

in the province, is committed to this work of healing—and optimistic that together, we will succeed. Supporting Indigenous people, wherever they live in BC, is not only the right thing to do—it benefits all British Columbians and Canadians as well. ▾

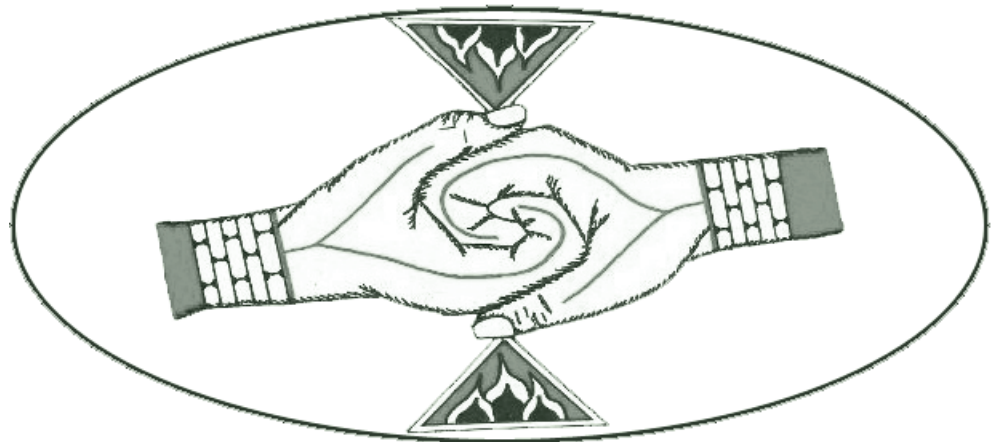
Indigenizing Harm Reduction

MOVING BEYOND THE FOUR-PILLAR MODEL

Native Youth Sexual Health Network

The model on the facing page (bottom) and the examples below are the culmination of more than 10 years of community knowledge, research, and Indigenous HIV-movement wisdom. This knowledge is the result of collective learning, listening and resisting done by many youth leaders and mentors of the Native Youth Sexual Health Network (NYSHN).

The Native Youth Sexual Health Network (NYSHN) is an organization by and for Indigenous youth. NYSHN works across issues of sexual and reproductive health, rights and justice throughout the US and Canada



Contributed by: Native Youth Sexual Health Network

“Community building / the cycle of life” by artist Erin Marie Konsmo

It includes the lived experiences of young people, Elders, other community members and Indigenous peoples living with HIV. The knowledge thus does not belong to a single individual, and it is a living praxis that shifts with community needs and voices.

With staggering rates of HIV, Hepatitis C, and injection-drug use amongst Indigenous peoples, it is clear that current mainstream models of harm reduction and public health may not be meeting Indigenous peoples where we’re at, or meeting our needs.

What could harm reduction look like outside of urban centres in rural, northern and remote communities?

The four-pillar model and its limitations

Indigenous peoples have much experience reducing harm in many ways—particularly harm caused by the violence of ongoing colonialism. Mainstream harm reduction models and practices, while they move in the right direction, do not always adequately meet the needs of those in northern, rural or remote communities. Indigenous peoples have many Nation-specific understandings and traditions



that mainstream services often ignore or interrupt.

The four-pillar model (top) is familiar to many harm reduction workers, academics and health policy analysts. But the interpretation and implementation of this model can sometimes work to uphold colonial ideals of health, power and oppression.

By shifting our focus away from particular interpretations of these pillars—like policing, prisons, court-mandated care and assuming that “risk” is individual instead of systemic—we offer here a critical analysis of what reducing the harm of colonialism can look like. We do not suggest a “one size fits all,” prescriptive approach. Instead we offer an opportunity to reinterpret these ideas in community-specific ways that recognize the diversity of Indigenous peoples.

The four-fire model

By focusing on community well-being and the restoration of various Indigenous knowledge systems,

life ways, ceremonies, culture and governance structures, Indigenous peoples of many Nations and cultures can reduce the harm we experience in our lives.

The guidelines and examples below will help to increase insight into Indigenous understandings of harm reduction, but they are not meant to be comprehensive or exhaustive. Indeed, we hope community workers and advocates will use them to develop their own implementation practices. We ask that you respect where this knowledge comes from and identify the roots of your learning when you share this knowledge with others.

We understand harm reduction in this context as broader than simply substance use and meeting people where they’re at with their use. While we respect and appreciate the work of safe injection sites, the provision of safer drug-use equipment, and so on, this is a systemic look at how harm reduction can be expanded and redefined by Indigenous peoples and communities.



Avoid a pan-Aboriginal approach to service provision. Don't assume all Indigenous peoples are the same or have similar traditions.

Using the four-fire model

Cultural Safety

“Acknowledge the power differences that exist between service provider and client/patient. Allow and create spaces for Indigenous peoples to feel safe to be our whole selves when receiving care.”

For Indigenous community-based service providers and community members:

Indigenous youth may not always feel safe and at home with their culture for many reasons. Allow them to name who or what kinds of support they are interested in having, or learning more about, whether they are traditional or Western/mainstream.

Work directly with Elders, knowledge keepers and traditional supports in your community. Build relationships and trust so you can make referrals with confidence, but be open to individuals' hesitations and concerns. Avoid shaming young people (or anyone else) for choosing a mainstream method or wanting to try multiple options.

Respectfully work with and gently challenge abstinence-based programs that cite “traditional values” as a reason for not allowing people who are using substances to access ceremony or traditional medicines. Being 100% sober all of the time may be an extremely difficult task; if it is a minimum requirement for support, many community members

may not qualify. Create options that meet people where they're at, while respecting traditional and community protocols—like welcoming people into a space without them needing to actively participate, or ensuring there are people present who know how to work with individuals under the influence in respectful, humanizing ways to de-escalate any concerns or harmful interactions.

For non-Indigenous service providers and harm reduction advocates:

Good intentions are often not enough. Be aware that you are part of the legacy of trauma and violence experienced by Indigenous peoples as a result of the actions of (even well-meaning) service providers, health care professionals and others. This means you must develop trust and build relationships while showing that you are making an effort to end that legacy. Actively inform the Indigenous and non-Indigenous people you are working with of your efforts, and be open to being held accountable for your actions or inactions, even if they were well intended.

For example, avoid complaining about or becoming frustrated by low turnout in medical programs or clinic settings. Have regard for the systemic factors influencing community behaviour. Not going to a clinic or hospital may actually be a form of harm reduction,

since Indigenous peoples are often denied care and discriminated against, and even face death as a consequence of colonial attitudes of health care practitioners. Your actions can help to change this. Leverage the power and privilege you have for the benefit of Indigenous peoples. Advocate for meaningful involvement of Indigenous communities and individuals. If Indigenous people are only frontline workers or temporary staff, but not management, challenge this and endeavour to change it.

Reclamation

“Colonialism uprooted and distorted many structures and ways of life within our communities. Reclaiming cultural practices can strengthen us.”

For Indigenous community-based service providers and community members:

Talk with each other and actively listen to each other's stories. Make a sincere effort to not judge, and be aware of your judgments when they come up. Involve all kinds of leaders, especially young people, in discussions about how best to support one another. It can be hard to understand what really is “traditional” or “Indigenous,” especially when things like religion, gender stereotyping and the taking away of our children all distorted how we pass on our values and practise our culture.

The resurgence of Indigenous understandings and identities of gender and sexuality is essential to our communities. Two-Spirit and gender-non-conforming people have always been at the frontline of resistance.

For non-Indigenous service providers and harm reduction advocates:

Be comfortable with the uncomfortable.

That is, learn how to talk about colonialism and recognize how you may be complicit in a system that supports colonial structures and practices. Be willing to support and advocate cultural activities—like ceremony—that don't fit into standard, Western disease-control models of effective prevention and treatment.

Self-Determination

“Allow individuals, communities and Nations to decide specifically for ourselves what works best for us.”

For Indigenous community-based service providers and community members:

Work with community members individually to find out what their needs are and what works for them, knowing these will probably differ from person to person. What you think is the main concern may not be the main concern for someone accessing services or looking for support. Maintain confidentiality and privacy as much as possible, even in small communities. Ensuring that basic needs—like food, clothing and safe housing—are met is a first step to building trust. After these needs are met, other issues can be addressed. People often develop their own coping mechanisms and strategies that should not be overlooked. For example, what is labelled as “problem substance use” may be helping with anxiety or trauma.

For non-Indigenous service providers and harm reduction advocates:

Avoid a pan-Aboriginal approach to service provision. Don't assume all Indigenous peoples are the same or have similar traditions. For example, there are 198 distinct First Nations

in BC alone. You don't need to be a cultural expert, but you need to be aware of cultural appropriation. Know whose territory, specifically, you are in, and the various communities you serve and share space with.

If you have more anthropological knowledge of Indigenous cultural traditions or practices than an Indigenous community member has, or has access to them, look at why this might be so. Consider the barriers that communities face in accessing their culture.

Sovereignty

“Principles like non-interference teach us to support and meet people where they're at.”

For everyone: Court-mandated treatment is not the answer to everything, especially if those treatments or supports are not meeting someone where they're at, like requiring sobriety or non-use all of the time. Harm reduction is not always about reducing the amount of substances used. Harm reduction can be about identifying and knowing what behaviours or consequences are harmful, and knowing which of these can be reduced and for whom. For example, drinking alcohol may seem

like a problem, but it can be far more dangerous to be thrown out of the house as a consequence of being under the influence, especially if this occurs in the winter.

For Indigenous community-based service providers and community members:

If we focus solely on substance use, we miss the larger story—the systemic reasons that we, as Indigenous Nations, are facing such alarming statistics when it comes to sexually transmitted and blood-borne infections, as well as harm and death associated with substance use. We also must focus more on understanding the factors that contribute to this reality to avoid internalizing harmful beliefs about our communities and Nations as inherently bad or unhealthy. Trust that individuals know what is best for them in the moment. Shaming our people for struggling will get us no closer to restoring what was taken from us.

For non-Indigenous service providers and harm reduction advocates:

Be a respectful guest and visitor. Honouring original agreements between Indigenous Nations, Indigenous peoples and settlers is just as important to this work as clinical practice. ▼

use of the word “indigenous”

We use the words “Indigenous” and “Indigenous peoples” to highlight and credit the work of international Indigenous human rights defenders who made the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) a reality that many nation states (including Canada) have now endorsed. The UNDRIP is based on international human rights laws and standards and reinterprets these baseline standards for human rights within an Indigenous context. We understand that health, rights and justice must be central to conversations about harm reduction.



*“I am the result of the love of thousands
Honouring my ancestors, I choose life
the journey of hope”*

Native Northwest Arts is looking at ways to enhance awareness and dialogue about suicide. They are inspired by this art by Nisga'a artist Todd Stephens titled "Journey of Hope." With the artist's permission, they are hoping to incorporate the art into a poster or t-shirt, with any proceeds donated to suicide prevention. If you have interest or ideas, contact Native Northwest at nativenorthwest.com or via their Facebook page.



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Mental health and substance use
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